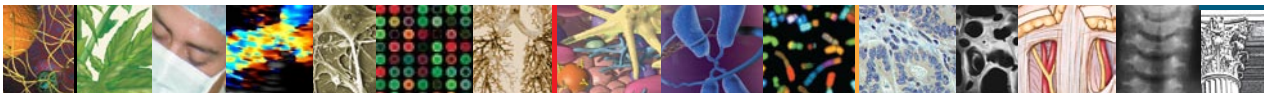

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Perspective

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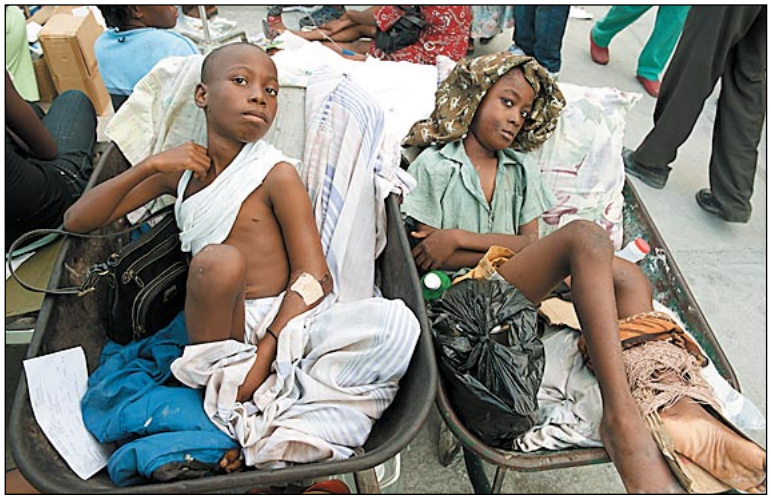
Recovering from Disaster — Partners in Health and the Haitian Earthquake

Tracy Kidder

The earthquake of January 12 killed many of Haiti's doctors and nurses and destroyed a large part of the country's medical infrastructure. But Zanmi Lasante (ZL), the Haitian branch of Partners in Health (PIH), was left intact. ZL had been the largest health care provider in rural Haiti. After the quake, it became (temporarily, at least) the largest and one of the most important in the entire country.

PIH was founded in 1987 by Dr. Paul Farmer and a small group of colleagues. Together, they built a clinic in a rural, desperately impoverished squatter settlement of farmers who had lost their land to a hydroelectric dam. PIH now works in 12 countries on four continents, but in many ways Haiti remains its heart and soul. ZL has become a comprehensive public health system supported by international donors but staffed almost entirely by Haitians: about 4000 people in all, including some 120 doctors, 600 nurses, and 2000 trained and salaried community health workers. It has brought AIDS and tuberculosis under control in the province called the Central Plateau, vaccinated nearly everyone in its large catchment area, cleaned up water supplies, built houses for the poorest patients, renovated and supported schools, and launched programs to feed thousands of Haitians daily with locally produced food. All in all, ZL directly serves 1.2 million people, at no cost to the local population, and has built or renovated 12 hospitals and clinics, six with surgical facilities, all with well-stocked pharmacies, and made the Haitian Ministry of Health its partner in their ownership and operation.

Members of ZL's staff were some of the first health care workers to respond to the disaster. Some ZL doctors have homes in the capital and happened to be there at the time of the quake. One of them, Dr. Patrick Almazor, set up a clinic in his backyard and spent the night caring as he best he could for about 50 injured people. Dr. Louise Ivers of Harvard Medical School was also in Port-au-Prince, attending (ironically enough) a United Nations meeting about emergency preparedness. Once she had escaped from the crumbling building where the meeting took place, she and a number of volunteers set up an



Wheelbarrows Serve as Stretchers and Cardboard for Splints at Chascot Clinic in Port-au-Prince.

impromptu clinic in a driveway, using license plates for splints.

The leaders of ZL know their way around Haiti, and they aren't obliged to wait for instructions from PIH headquarters in Boston. As soon as they heard of the devastation, several of the senior doctors at ZL's hospitals loaded up trucks with supplies and headed for the city, looking for groups of people in need. All around Port-au-Prince, people in ruined neighborhoods were organizing provisional, unsheltered settlements. Within a couple of days, members of ZL's staff had created four mobile clinics and were systematically searching out those encampments, bringing food and water, treating people with minor wounds, and transporting the severely injured to the various surgical facilities that were being set up around the city. That effort has since expanded and continues.

For a long time, the majority of Haitians have been denied the most basic of human rights: the right to clean water, decent shelter, and adequate nutrition. At their hospitals and clinics, ZL's staff deals every day with the results — with chronic disasters of disease, such as kwashiorkor and malaria, eclampsia and diarrheal diseases. On an average day, their largest hospital receives about 400 patients, and their community health workers carry medicines to more than 4700 homes. In the first 3 weeks after the earthquake, the 12 facilities had to continue this work while also caring for thousands of wounded people, some with compound fractures, some even with compartment syndrome, some already with gangrene, who made their way from the capital in the crowded taxis and trucks that are the nearest thing to public transportation in Haiti.

Some veterans of medical catastrophes believe that the earthquake caused orthopedic injuries in a greater proportion of the population than any other disaster has done. ZL had 14 operating rooms at its own sites but no orthopedic surgeons on hand. PIH has many partners, though, and in the weeks after the earthquake, offers of personnel and supplies came from 153 organizations — from medical equipment corporations and sporting goods companies, American medical schools and teaching hospitals, and Haitian-American associations. PIH's Boston headquarters created a virtual small airline to manage the transport, which within 3 weeks after the earthquake included 70 flights carrying 150,000 pounds of supplies and medical equipment and 205 volunteers, most of whom were already organized into surgical teams. When the flights arrived in Haiti, ZL's operations director Loune Viaud managed their unloading and amid the chaos of the wounded city arranged for distribution of cargo and personnel to the large variety of sites where they were needed. For a time PIH was managing or helping to manage and supply 24 operating rooms that performed surgeries day and night. PIH also helped to coordinate the transport of patients to the U.S. Navy's hospital ship *Comfort*, which arrived 8 days after the quake. And Farmer, in his role as the United Nations' deputy special envoy to Haiti, helped to coordinate the relief effort at the national level — an all but impossible job, since thousands of organizations were clamoring to play a part.

Viewed as a whole, the international medical response to Haiti's catastrophe has been praiseworthy, grand in scale, and successful in alleviating some of the suffering and in saving many lives. But it has been far from good enough. PIH clinicians tell me that the current estimates of 200,000 dead seem likely to be accurate, and they add that many thousands

Photo courtesy of Dr. David Walton of Partners in Health.

would not have died if they had received medical care in time. One reason for delay was the clustering of Haitian government offices and international organizations in the capital city, near the earthquake's epicenter. That is, Haiti lost a lot of the resources that could have been used to marshal a more effective response. But many of those resources weren't very good to begin with. Haiti's vulnerability to disasters stems fundamentally from poverty. This poverty is both material and institutional and is manifested not only in buildings made with unreinforced concrete but also in a Ministry of Health that in the aftermath of the earthquake lacked buildings, vehicles, Internet access, computers, and even pens and paper.

A slide show is available at NEJM.org

The long history of poverty in Haiti reflects badly on Western governments in general and that of the United States in particular. It reflects badly on private aid organizations as well. At least 10,000 nongovernmental organizations (NGOs) were operating in Haiti at the time of the earthquake. That number alone represents a sad indictment, given that a great many of those groups had been working in Haiti for years, during which Haiti remained one of the world's poorest countries. With some notable exceptions, the NGOs haven't worked together, and they haven't worked with Haitian authorities. Collectively, private aid organizations have constituted a parallel government that has not coordinated its efforts or been accountable in any way to the Haitian citizenry. Of course, Haiti's own elected governments have been weak and have suffered from corruption — the usual excuse for not working with Haiti's leaders. But it is obvious that any organization that is really interested in helping Haiti must include Haitian authorities in all projects and employ and train Haitians.

Photo courtesy of Dr. David Walton of Partners in Health.

Patients in Port-au-Prince Receive Medical Care in a Tent Erected to Replace a Damaged Hospital Ward.

ZL calls this approach "accompaniment." It has served as the guiding principle of the organization for decades. One recent story suggests that it could play the same guiding role in Haiti's reconstruction. The University Hospital in Port-au-Prince, the city's largest hospital, was a far from exemplary place before the earthquake, mainly because it had been grossly underfunded for decades. After the earthquake, about three quarters of its buildings were either demolished or unsafe. Yet it was revived into a functioning surgical center by an impromptu group of Haitians and foreigners, which included the hospital's Haitian director and head nurse, a Haitian staff that returned to work gradually, and 10 foreign medical organizations. A Franco-American couple, Dr. Mark Hyman and Dr. Pier Boutin, deserve credit for getting surgeries under way. Teams from the International Medical Corps, the Canadian and Norwegian Red Cross, Médecins du Monde, Mount Sinai Hospital of New York, Dartmouth–Hitchcock Healthcare System, Partners Healthcare, and others all worked in concert. A pair of PIH doctors and a PIH volunteer, Jim Ansara, performed a great deal of the logistic work.

One crucial role was played by Dr. Evan Lyon of Harvard Medical School, who had spent the better part of a decade as a physician for ZL but had recently been caring for an underserved population in rural Alabama. When Lyon arrived back in Haiti 4 days after the earthquake, Farmer asked him to coordinate all the different NGOs gathered at the University Hospital — "to make sure," as Lyon put it, "that nobody made their own decisions, but that all of us were led by the Haitians."

Clinicians who worked there reported that the effort ran with a minimum of fuss, without turf wars among the various groups, and that the hospital's Haitian leaders took the lead. I recently asked the hospital's director, Dr. Alix Lassegue, whether in his experience NGOs tend to bypass Haitian authorities. They did indeed, he said. "But with Dr. Lyon's help, I was able to prevent some NGOs from doing just what they wanted. The good thing was that he could speak Creole. He had the experience of working in Haiti." Dr. Lassegue continued: "It was an unusual experience, the help from Zanmi Lasante. I had them join my managerial team and discuss how to handle a difficult situation. It is the first time I had this kind of relationship with an NGO." Haiti needs many more new beginnings of this kind.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Mr. Kidder is a writer and a member of PIH's development committee.

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Medicare's Opportunity to Encourage Innovation in Health Care Delivery

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The Democrats' loss of their 60-vote Senate majority after Massachusetts' January 19 special election creates major challenges for passage of comprehensive national health care reform. Critics of the Democrats' proposals have raised concern about the cost, the expanded government role in health insurance markets, and the lack of new mechanisms for controlling the growth of health care spending. Whatever the fate of current reform proposals, Congress cannot avoid important decisions about Medicare. Without new legislation, Medicare payments to physicians are scheduled to be cut by 21% on March 1, 2010, and the Hospital Insurance Trust Fund will become insolvent by 2017. Regardless of whether it addresses these challenges in separate legislation or as part of a broad reform package, Congress also needs to support efforts that encourage efficiency improvements in the medical delivery system.

One approach to accelerating delivery-system change would be comprehensive reform of Medicare's provider-payment system. Such reform was proposed early in last year's debate but was eliminated as legislators began to understand that comprehensive payment reform could be highly disruptive for hospitals and physicians who are unprepared to rapidly modify their clinical operations. Instead, legislation passed by both the House and the Senate directed the Centers for Medicare and Medicaid Services (CMS) to implement a series of voluntary pilot programs, including a national payment-bundling demonstration and a program allowing accountable care organizations that successfully control growth in per-beneficiary spending while meeting quality goals to share in Medicare's savings.

Congressional reform proposals also include a new Center for Medicare and Medicaid Innovation (CMI) intended to facilitate beneficial delivery-system changes. The CMI would be charged with testing innovative payment and service-delivery models designed to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care — objectives that should have bipartisan support. Several aspects of the proposed CMI offer hope that this effort could be fundamentally different from previous Medicare-sponsored experiments.[1]

First, the CMI would run pilot programs rather than demonstration projects. The proposal would give the secretary of health and human services authority to expand pilots that she determines would reduce spending or improve the quality of care. This provision is critical, because the need for congressional approval has delayed or derailed past initiatives. For example, in Medicare's heart-bypass demonstration project, in which a global fee was paid for services provided by hospitals and cardiac surgeons, participating providers improved the quality of care and reduced costs, but Congress never expanded it beyond the seven initial hospitals. Another demonstra-