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Tulane University School of Public Health and Tropical Medicine

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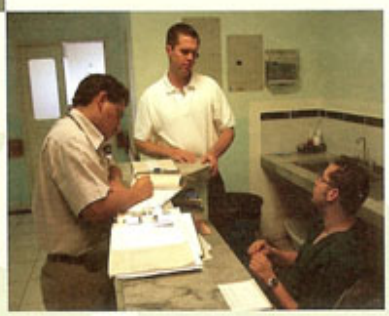
VOLUME 8, NUMBER 2
FALL/WINTER 2008



Gaus consults with colleagues on issues facing the upstart hospital in Quito.

High in the mountains of rural Ecuador, Tulane alumnus David Gaus' has spent the better part of a decade implementing a model of secondary health care that is focused on quality care and sustainability. The hospital he and his colleagues at the Andean Health and Development (AHD) organization built in Pedro Vincente Maldonado is the first financially self-sustaining rural secondary-care hospital in Ecuador. Their success has been noticed -- they have since been asked by the ministry of health to replicate their model of health care in other hospitals.

In the process, Gaus has become not just a family physician but a politician of sorts, gaining the trust of the community, seeking necessary resources, and developing associated programs, such as employer-based health plans – all in pursuit of a long-held dream.

Filling the Gaps

STORY BY MADELINE VANN

Developing a sustainable health care model in rural Ecuador

FROM ACCOUNTANT TO HOSPITAL ADMINISTRATOR

After Gaus completed his undergraduate degree in accounting at Notre Dame in 1984, he went to Ecuador to work with the nonprofit Working Boys Center in Quito, an institution that helps poor families there improve their economic potential. He was so moved by his experience at the mission that he made a personal commitment to return to school for a medical degree so that he could provide care to the people he had come to know.

"That experience the first time in Ecuador gave me a passion and a drive and a level of energy that I never had in me," says Gaus. That's what kept him going those eleven years at Tulane and in residency at St. Luke's Hospital in Milwaukee, Wisc., until he moved back to Ecuador in 1997. "Passion is a powerful thing. When you find that, it is not to be understated how powerful that can be," says Gaus.

In a peculiar twist of fate, advice columnist Ann Landers helped find the funding for his pre-med classes at Notre Dame and his combined MD/MPH&TM at Tulane, which he received in 1992. Landers was a friend of former Notre Dame president Fr. Theodore Hesburgh, who supported Gaus' ambitious determination to return to Ecuador with a medical degree in hand. Hesburgh continues to play a leading role in the AHD advisory board.

Tulane professor emeritus and AHD board member Barnett Cline recalls meeting Gaus when he first came to Tulane.

"He wasn't scheduled to take courses in tropical medicine 'til spring semester but he came over to meet me, introduced himself and told me right off the bat that what he was going to do with his life was get his medical degree, tropical medicine training, and go back to Ecuador and work there the rest of his life. I was skeptical at the time," admits Cline, whose research focused on tropical diseases in Africa, South America, and the Far East.

But by 1997, Gaus was back in Ecuador, degrees in hand, working with Erik Janowski, a 1992 MPH graduate, and Tom Chiller, a 1994 MD/MPH&TM graduate, in the newly formed AHD.

"We started off thinking we were going to do a primary health project but we discovered during the course of those first three years as we opened up a temporary facility that there were a lot of complicated patients coming in that we couldn't take care of," says Gaus, recalling the clinic that was a mere 20 square feet in size. "There was nowhere to refer those patients other than the city. We decided we needed to build a small rural hospital that would stand between primary and tertiary care."

"AHD has successfully identified and filled an important gap in local health care," he says. While many people focus on primary health care in developing countries, it's important to remember that "the health system has many layers."

AHD faced a steep learning curve, challenged to understand local politics and cultural nuances even as they built the hospital the community needed.

"The community convinced us that what they needed was a hospital. We ultimately had to see the problem for ourselves. But in hindsight, it truly was a bottom-up process. They knew all along what they needed. They lived these problems every day," Gaus says.

DEFINING THE SELF-SUSTAINING RURAL SECONDARY-CARE HOSPITAL

"There are certain fundamental principles that we have talked about since the beginning of AHD," explains Cline. "To provide true quality medical care; to provide access for everyone, not limited to those who have the means; to use skilled management practices, transparency, and accountability in all aspects, especially the financial side; and to involve the community in a very active way, in

partnership with key groups in the community. Sustainability has always been an issue. After nine or ten years of hard work, AHD has finally reached that goal of full cost recovery by means of many creative approaches to funding."

In Ecuador there is a network of 4,000 primary health care providers but most hospitals are located in urban areas. According to Gaus, Ecuador dedicates only 2.1% of its national budget to health care, among the lowest proportionate allocation in the Western Hemisphere. Meanwhile, nearly half of people living in rural Ecuador do so in extreme poverty, earning less than US$150 a month.

Gaus and his colleagues at AHD looked at the existing models of health care in Ecuador and saw gaps in care.

"We noticed that there were three kinds of hospitals. Ministry of Health hospitals struggle with lack of resources and undertrained personnel and lack of equipment. That model wasn't working. The other option was the missionary model which might provide good quality care but is clearly from the industrialized world and when those resources dry up, the project ends, people go home and the population is left at even greater risk. They don't address the sustainability option. The other hospital is private, which has all the bells and whistles and adequately trained people, but they only serve paying patients, which are about one third of the population at most," recounts Gaus. "So our question was, how do you provide quality health care services, 24 hours a day, seven days a week, to a population that has very little resources, in a financially sustainable way?"

Ten years after his return to Ecuador his team was doing just that, providing "high-quality health care that never closed, took good care of everybody who came into the place, and in a completely financially sustainable way based on what is available in Ecuador."

But, he laughs, "I could write a book about how not to do it because I have made every mistake humanly possible."

In order to become financially sustainable AHD had to develop a web of payment options. Gaus and his colleagues assume everyone is going to be able to pay and requires some kind of proof that they cannot do so. Costs are then covered through a changing mix of financing from the national social security program, contributions from local governments, prepaid health care packages, and self-pay.

"What has been accomplished here is a model for organizing and operating a rural hospital, a quality rural hospital, in a developing country, and the potential to adapt that model to the public sector. What we are really trying to do here is create a model of rural secondary health care that is replicable and sustainable and transferable to other parts of the world," observes Cline.

OF POLITICS AND PUBLIC HEALTH

Gaus highlights three lessons of the many he has learned for other public health and medicine students and professionals seeking to change health care delivery:

1. YOU CAN'T DO EVERYTHING! Public health professionals know how many elements, such as good roads and clean water, are important to overall health, but no one can effectively address every possible aspect of health. Focus on what you are good at and what the community needs.

2. FIND SOMEONE YOU TRUST to interpret the local political and cultural nuances. The only thing worse than not having someone to do this is choosing a person who is either bad at it or has his or her own agenda.

3. LISTEN TO THE COMMUNITY, because they often already know what they need and what will work.

Ultimately, he attributes his success to perseverance.

"The more important question is, when we got down there with no money, against all odds and without any clear idea of what we were doing, how did we get it done? There's a stick-to-it-ive-ness, a perseverance that you need to have," he says.

FUTURE STEPS

The success in Pedro Vincente Maldonado has led to a request from the ministry of health to set up a pilot in a state hospital in La Mana to see if the model is portable.

AHD also recognized a lack of family medicine physicians and administrators in Ecuador and has arranged a residency program in Pedro Vincente Maldonado that will provide training for Ecuadoran medical trainees who might be good candidates for rural practices.

Ideally some of those local physicians will take on the administrative role Gaus has held building local capacity, while freeing him up to focus on fundraising and teaching, says Cline. Building long-term leadership capacity in Ecuador is a key goal of AHD.

ADDITIONAL READING:
Gaus D, Herrera D, Heisler M, Cline BL, Richmond J. *Making secondary care a primary concern: the rural hospital in Ecuador. Rev Panam Salud Publica. 2008;23(3):212–7.*