Value-Based Health Care Delivery

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This presentation draws on Michael E. Porter and Elizabeth Olmsted Teisberg: Redefining Health Care: Creating Value-Based Competition on Results, Harvard Business School Press, May 2006, and "How Physicians Can Change the Future of Health Care," *Journal of the American Medical Association*, 2007; 297:1103:1111. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means — electronic, mechanical, photocopying, recording, or otherwise — without the permission of Michael E. Porter and Elizabeth Olmsted Teisberg. Further information about these ideas, as well as case studies, can be found on the website of the Institute for Strategy & Competitiveness at http://www.isc.hbs.edu.

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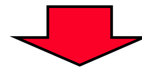
Redefining Health Care Delivery

- Universal coverage and access to care are **essential**, **but not enough**
- The core issue in health care is the **value of health care delivered**

Value: Patient health outcomes per dollar spent



- How to design a health care delivery system that **dramatically improves patient value**
  - Ownership of entities is secondary (e.g. non-profit vs. for profit vs. government)
- How to construct a **dynamic system** that keeps rapidly improving

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Creating a Value-Based Health Care System

- Significant improvement in value will require **fundamental restructuring of health care delivery**, not incremental improvements

> Today, 21st century medical technology is often delivered with 19th century organization structures, management practices, measurement, and pricing

- Process improvements, care pathways, lean production, safety initiatives, disease management and other overlays to the current structure are beneficial but **not sufficient**
- "Consumers" **cannot fix the dysfunctional structure** of the current system

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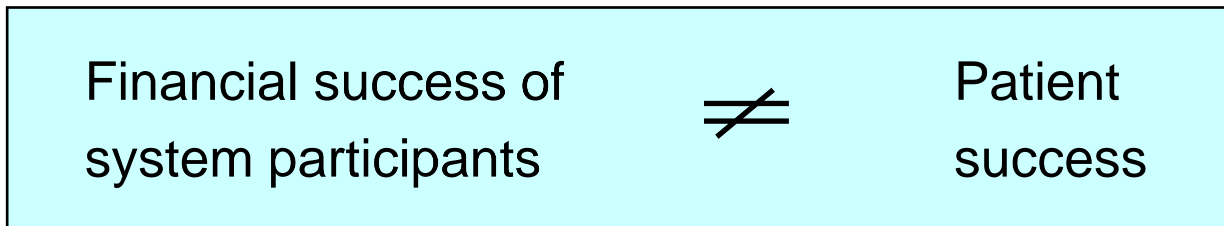
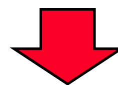
Harnessing Competition on Value

- **Competition for patients/subscribers** is a powerful force to encourage restructuring of care and continuous improvement in value

- Today's competition in health care **is not aligned with value**





- Creating positive-sum **competition on value** is a central challenge in health care reform in every country

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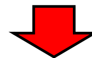
Principles of Value-Based Health Care Delivery

The fundamental issue in health care is **value for patients**, not access, volume, convenience, or cost containment

$$\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}$$

- Outcomes are the **full set of patient health outcomes** over the care cycle
- Costs are the **total costs of care for the patient's condition**, not just the cost of a single provider or a single service



How to design a health care system that **dramatically improves patient value**

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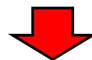
Principles of Value-Based Health Care Delivery

Quality improvement is the key driver of cost containment and higher value, where quality is **health outcomes**

- Prevention
- Early detection
- Right diagnosis
- Right treatment to the right patient
- Early and timely treatment
- Treatment earlier in the causal chain of disease
- Rapid cycle time of diagnosis and treatment
- Less invasive treatment methods
- Fewer complications
- Fewer mistakes and repeats in treatment
- Faster recovery
- More complete recovery
- Less disability
- Fewer relapses or acute episodes
- Slower disease progression
- Less need for long term care
- Less care induced illness



- **Better health** is the goal, not more treatment
- Better health is **inherently less expensive** than poor health

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Value-Based Health Care Delivery

The Strategic Agenda

1. **Organize into Integrated Practice Units (IPUs)**
   - **Including primary and preventive care for distinct patient populations**
2. **Measure Outcomes and Cost for Every Patient**
3. **Utilize Bundled Reimbursement Models for Care Cycles**
4. **Integrate Provider Systems**
5. **Grow by Expanding Excellent IPUs Across Geography**
6. **Create an Enabling Information Technology Platform**

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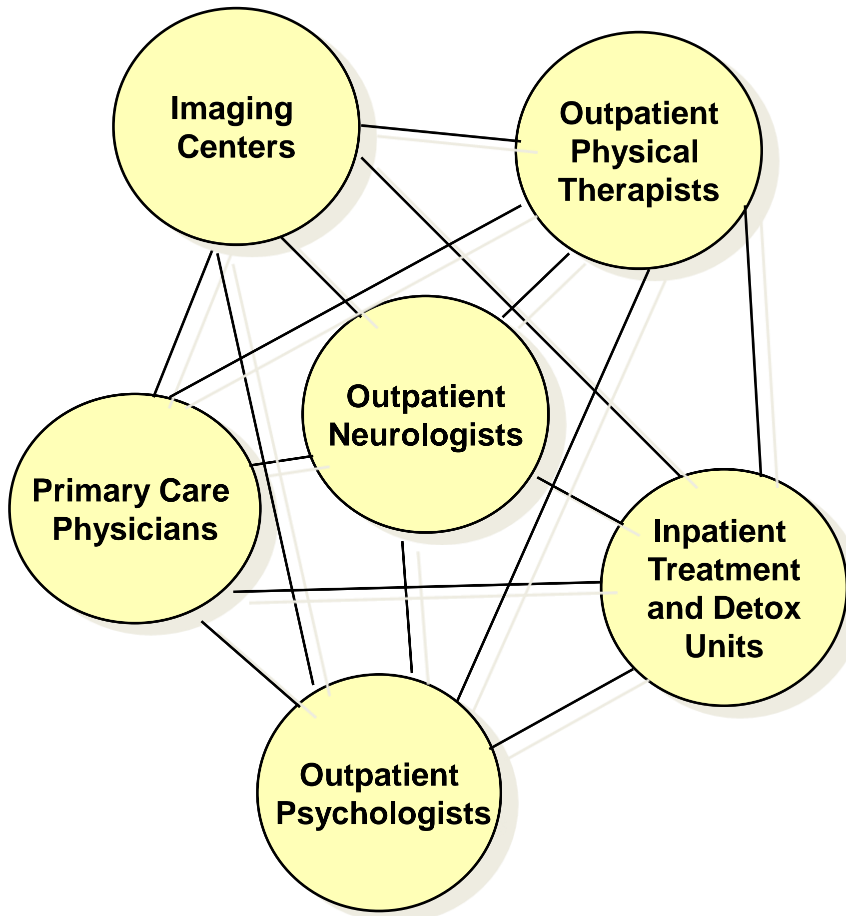
1. Organize into Integrated Practice Units

Migraine Care in Germany

Existing Model:
Organize by Specialty and Discrete Services



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

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1. Organize into Integrated Practice Units

Migraine Care in Germany

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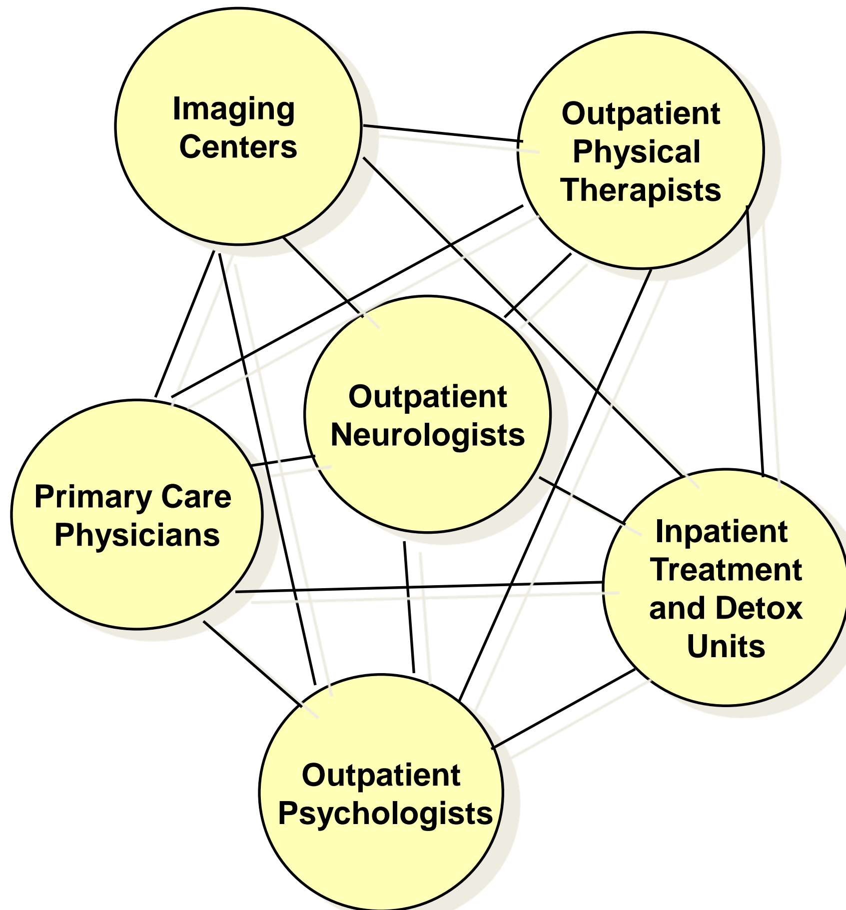
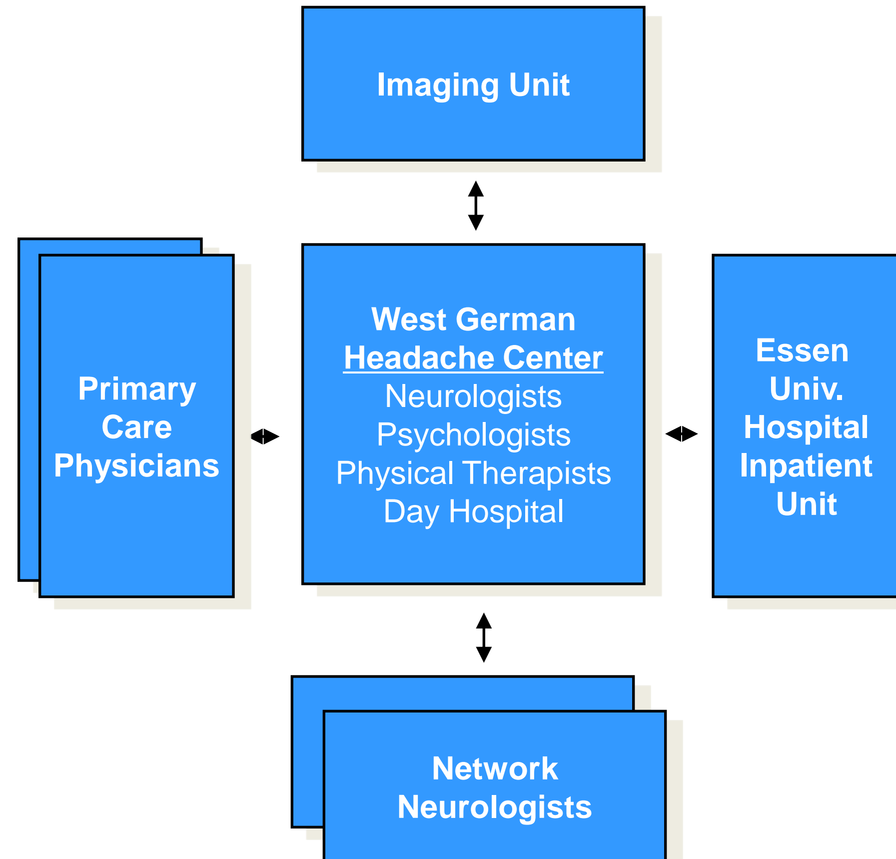
Organize by Specialty and Discrete Services



New Model:
Organize into Integrated Practice Units (IPUs)



Source: Porter, Michael E., Clemens Guth, and Elisa Dannemiller, *The West German Headache Center: Integrated Migraine Care*, Harvard Business School Case 9-707-559, September 13, 2007

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Integrating Across the Cycle of Care

Breast Cancer

	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/MANAGING
INFORMING AND ENGAGING	▪ Advice on self screening ▪ Consultations on risk factors	▪ Counseling patient and family on the diagnostic process and the diagnosis	▪ Explaining patient treatment options/shared decision making ▪ Patient and family psychological counseling	▪ Counseling on the treatment process ▪ Education on managing side effects and avoiding complications of treatment ▪ Achieving compliance	▪ Counseling on rehabilitation options, process ▪ Achieving compliance ▪ Psychological counseling	▪ Counseling on long term risk management ▪ Achieving Compliance
MEASURING	▪ Self exams ▪ Mammograms	▪ Mammograms ▪ Ultrasound ▪ MRI ▪ Labs (CBC, Blood chems, etc.) ▪ Biopsy ▪ BRACA 1, 2… ▪ CT ▪ Bone Scans	▪ Labs	▪ Procedure-specific measurements	▪ Range of movement ▪ Side effects measurement	▪ MRI, CT ▪ Recurring mammograms (every six months for the first 3 years)
ACCESSING	▪ Office visits ▪ Mammography lab visits	▪ Office visits ▪ Lab visits ▪ High risk clinic visits	▪ Office visits ▪ Hospital visits ▪ Lab visits	▪ Hospital stays ▪ Visits to outpatient radiation or chemotherapy units ▪ Pharmacy	▪ Office visits ▪ Rehabilitation facility visits ▪ Pharmacy	▪ Office visits ▪ Lab visits ▪ Mammographic labs and imaging center visits
	MONITORING/ PREVENTING	**DIAGNOSING**	**PREPARING**	**INTERVENING**	**RECOVERING/ REHABING**	**MONITORING/MANAGING**
	▪ Medical history ▪ Control of risk factors (obesity, high fat diet) ▪ Genetic screening ▪ Clinical exams ▪ Monitoring for lumps	▪ Medical history ▪ Determining the specific nature of the disease (mammograms, pathology, biopsy results) ▪ Genetic evaluation ▪ Labs	▪ Choosing a treatment plan ▪ Surgery prep (anesthetic risk assessment, EKG) ▪ Plastic or onco-plastic surgery evaluation ▪ Neo-adjuvant chemotherapy	▪ Surgery (breast preservation or mastectomy, oncoplastic alternative) ▪ Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)	▪ In-hospital and outpatient wound healing ▪ Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue) ▪ Physical therapy	▪ Periodic mammography ▪ Other imaging ▪ Follow-up clinical exams ▪ Treatment for any continued or later onset side effects or complications

Legend: Breast Cancer Specialist (shaded); Other Provider Entities (white)

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Integrating Across the Cycle of Care

Breast Cancer

	MONITORING/ PREVENTING	DIAGNOSING	PREPARING	INTERVENING	RECOVERING/ REHABING	MONITORING/MANAGING
INFORMING AND ENGAGING	Advice on self screening Consultations on risk factors	Counseling patient and family on the diagnostic process and the diagnosis	Explaining patient treatment options/shared decision making Patient and family psychological counseling	Counseling on the treatment process Education on managing side effects and avoiding complications of treatment Achieving compliance	Counseling on rehabilitation options, process Achieving compliance Psychological counseling	Counseling on long term risk management Achieving Compliance
MEASURING	Self exams Mammograms	Mammograms Ultrasound MRI Labs (CBC, Blood chems, etc.) Biopsy BRACA 1, 2… CT Bone Scans	Labs	Procedure-specific measurements	Range of movement Side effects measurement	MRI, CT Recurring mammograms (ever months for the first 3 years)
ACCESSING	Office visits Mammography lab visits	Office visits Lab visits High risk clinic visits	Office visits Hospital visits Lab visits	Hospital stays Visits to outpatient radiation or chemotherapy units Pharmacy	Office visits Rehabilitation facility visits Pharmacy	Office visits Lab visits Mammographic labs and imaging cent visits
	Medical history Control of risk factors (obesity, high fat diet) Genetic screening Clinical exams Monitoring for lumps	Medical history Determining the specific nature of the disease (mammograms, pathology, biopsy results) Genetic evaluation Labs	Choosing a treatment plan Surgery prep (anesthetic risk assessment, EKG) Plastic or onco-plastic surgery evaluation Neo-adjuvant chemotherapy	Surgery (breast preservation or mastectomy, oncoplastic alternative) Adjuvant therapies (hormonal medication, radiation, and/or chemotherapy)	In-hospital and outpatient wound healing Treatment of side effects (e.g. skin damage, cardiac complications, nausea, lymphodema and chronic fatigue) Physical therapy	Periodic mammography Other imaging Follow-up clinical exams Treatment for any continued or la onset side effects or complicati

☐ Breast Cancer Specialist
☐ Other Provider Entities

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The Role of Volume and Experience in Patient Value

The Virtuous Circle of Value

Improving Reputation

Greater Patient Volume in a Medical Condition

Rapidly Accumulating Experience

Better Information/ Clinical Data

More Fully Dedicated Teams

More Tailored Facilities

Rising Process Efficiency

Rising Capacity for Sub-Specialization

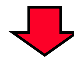
Wider Capabilities in the Care Cycle, Including Patient Engagement

Greater Leverage in Purchasing

Costs of IT, Measure-ment, and Process Improvement Spread over More Patients

Faster Innovation

Better Results, Adjusted for Risk



- Volume and experience have an **even greater** impact on value in an IPU structure than in the current system

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Fragmentation of Hospital Services

Sweden

DRG	Number of admitting providers	Average percent of total national admissions	Average admissions/ provider/ year	Average admissions/ provider/ week
Knee Procedure	68	1.5%	55	1
Diabetes age > 35	80	1.3%	96	2
Kidney failure	80	1.3%	97	2
Multiple sclerosis and cerebellar ataxia	78	1.3%	28	1
Inflammatory bowel disease	73	1.4%	66	1
Implantation of cardiac pacemaker	51	2.0%	124	2
Splenectomy age > 17	37	2.6%	3	<1
Cleft lip & palate repair	7	14.2%	83	2
Heart transplant	6	16.6%	12	<1

Source: Compiled from The National Board of Health and Welfare Statistical Databases – DRG Statistics, Accessed April 2, 2009.

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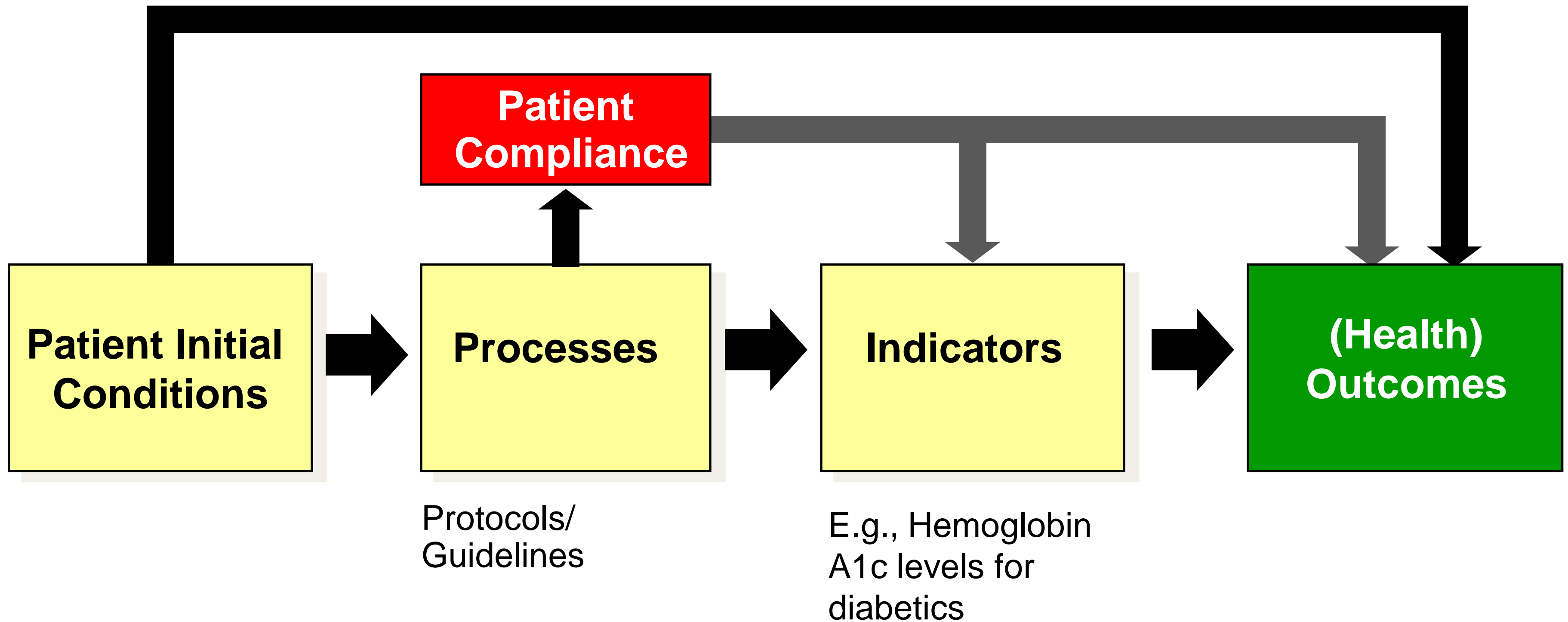
2. Measure Outcomes and Cost For Every Patient



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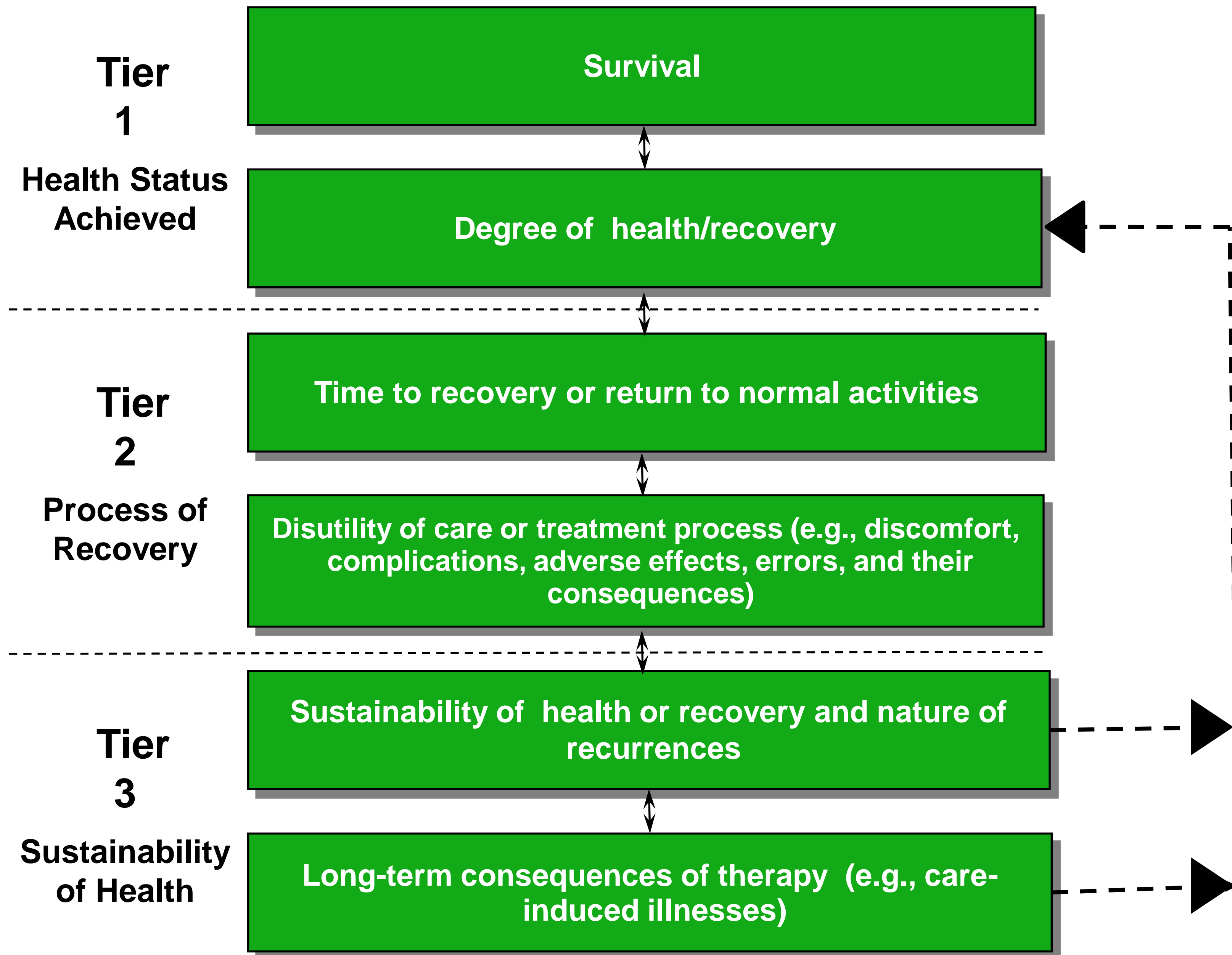
The Outcome Measures Hierarchy



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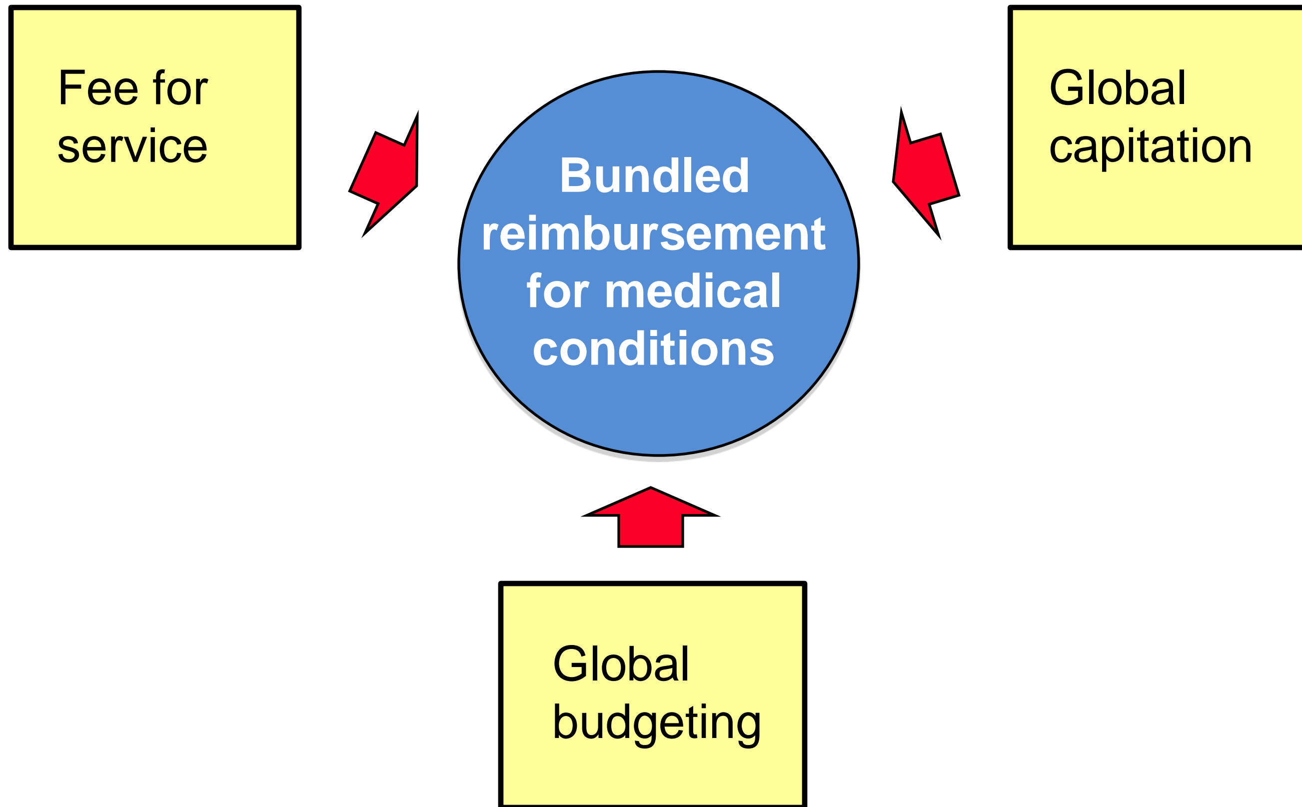
3. Utilize Bundled Reimbursement Models for Care Cycles



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What is Bundled Payment?

- **Total package price** for the care cycle for a medical condition
  - Includes responsibility for **avoidable complications**
  - Medical condition capitation
- The bundled price should be **severity adjusted**

What is Not Bundled Payment

- Prices for **short** episodes (e.g. inpatient only, procedure only)
- **Separate** payments for physicians and facilities
- **Pay-for-performance** bonuses
- "**Medical Home**" payment for add-on services

- DRGs can be a **starting point** for bundled models

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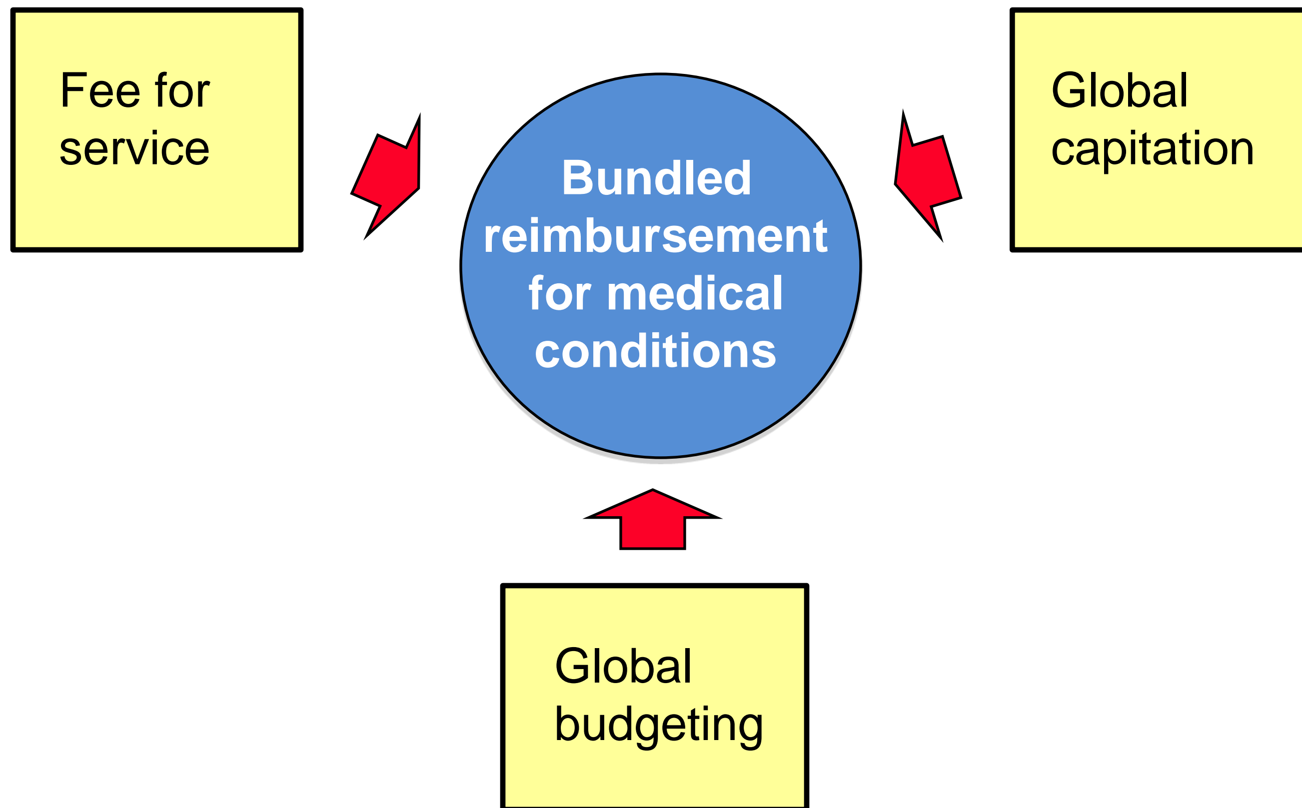
3. Utilize Bundled Reimbursement Models for Care Cycles



- Bundled reimbursement motivates **value improvement, care cycle optimization**, and **spending to save**
  - Let **experts** decide the value of individual services and products within the bundle, rather than outside parties
- **Outcome measurement and reporting** at the medical condition level is needed for any reimbursement system to ultimately succeed

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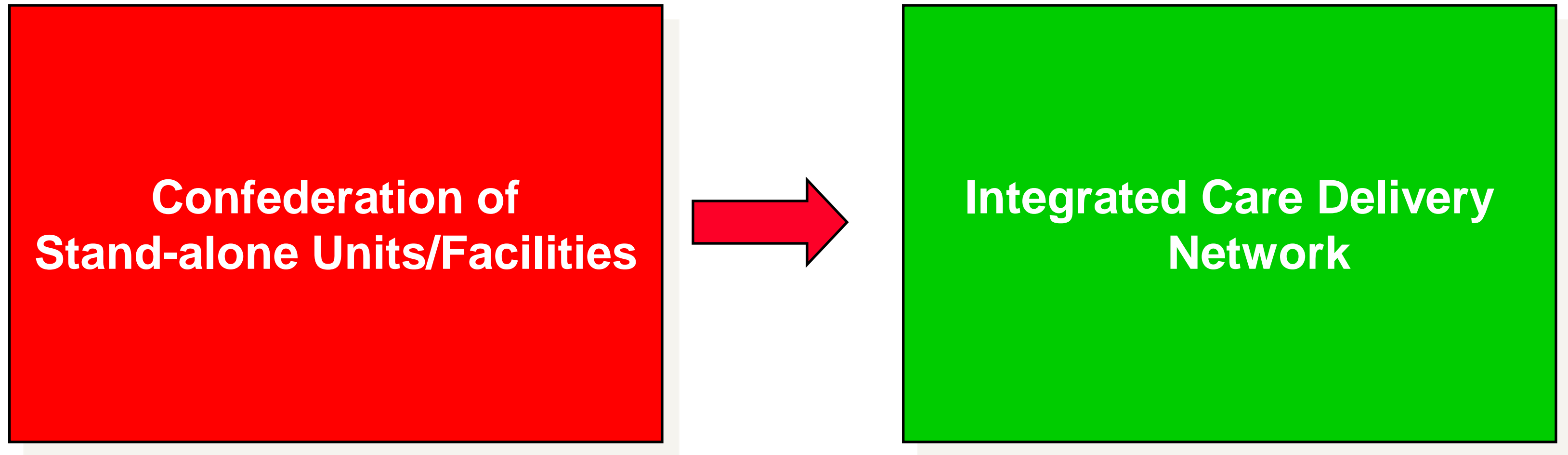
4. Integrate Provider Systems



- Fragmented and duplicative services
- Passive referrals

- The provider network is **more than** the sum of its parts

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Levels of System Integration

1. **Rationalize service lines/ IPUs** across facilities to improve volume, avoid duplication, play to strength, and concentrate excellence
2. Offer specific services at the **appropriate facility**
   - E.g. acuity level, cost level, need for convenience
   - Refer patients to the appropriate unit
3. Clinically integrate care **across facilities,** within an IPU structure
   - IPUs extend across facilities
     - Consistent protocols, consultations with experts
   - Integrating across the full care cycle
   - Linking **preventative/primary care** units to specialty IPUs
   - Connecting **ancillary service** units to IPUs
     - E.g. home care, rehabilitation, behavioral health, social work, addiction treatment

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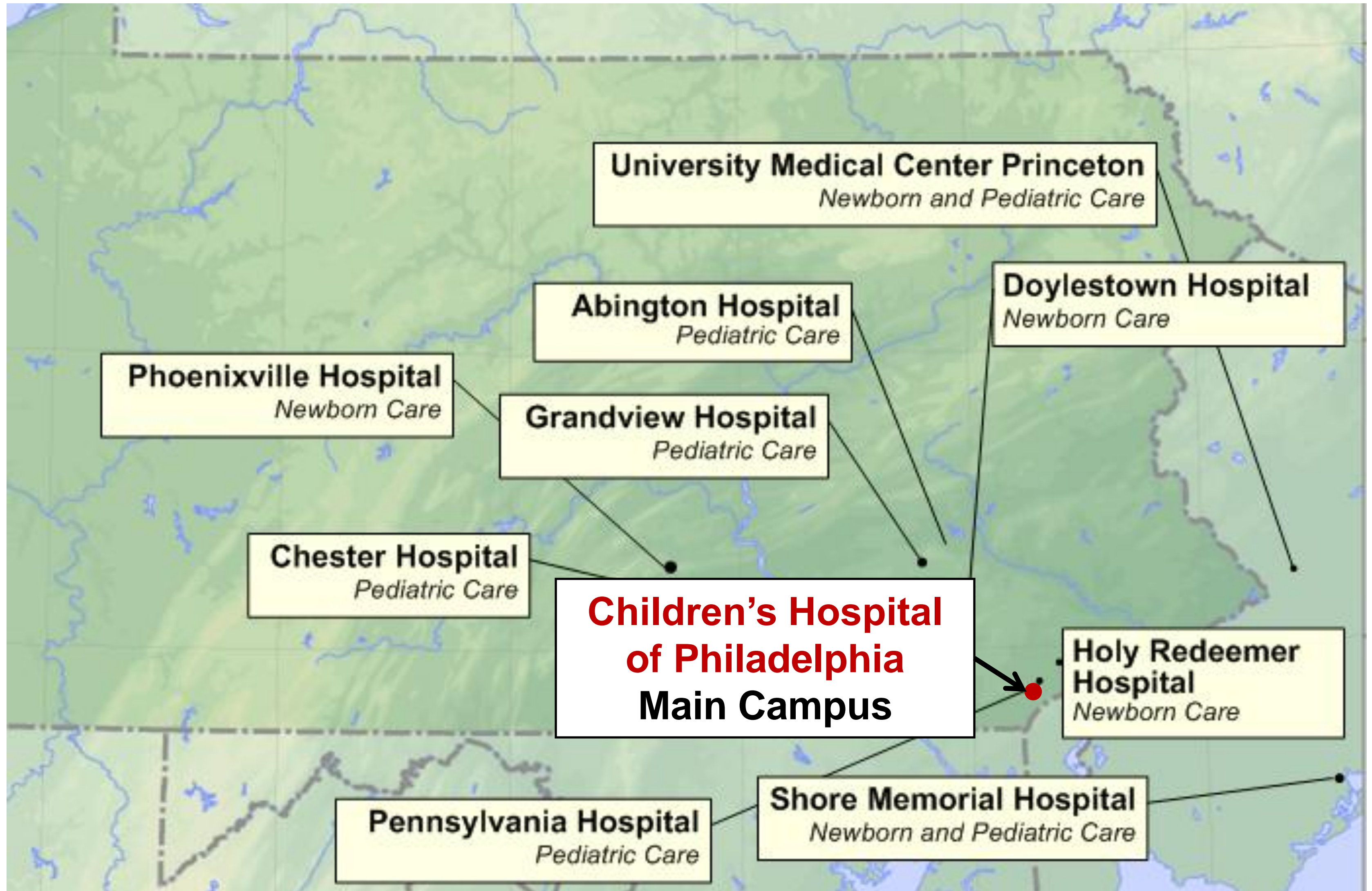
5. Grow Excellent Services Across Geography

Children's Hospital of Philadelphia (CHOP) Hospital Affiliates



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Models of Geographic Expansion

Diagnostic Centers

Second Opinions and Telemedicine

Affiliation Agreements with Independent Provider Organizations

Locate Convenience Sensitive Services in the Community

Expand Complex IPU Components (e.g. surgery) to Additional Locations

Focused Hospitals in Additional Locations

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6. Create an Enabling Information Technology Platform

Utilize information technology to enable **restructuring of care delivery** and **measuring results**, rather than treating it as a solution itself

- Common **data definitions**
- Combine **all types of data** (e.g. notes, images) for each patient over time
- Data encompasses the **full care cycle**, including referring entities
- "**Structured**" data vs. free text
- **Templates** for medical conditions to enhance the user interface
- Allowing access and communication among **all involved parties**, including patients
- Architecture that allows **easy extraction of outcome and process measures**
- Interoperability standards enabling communication among **different provider systems**

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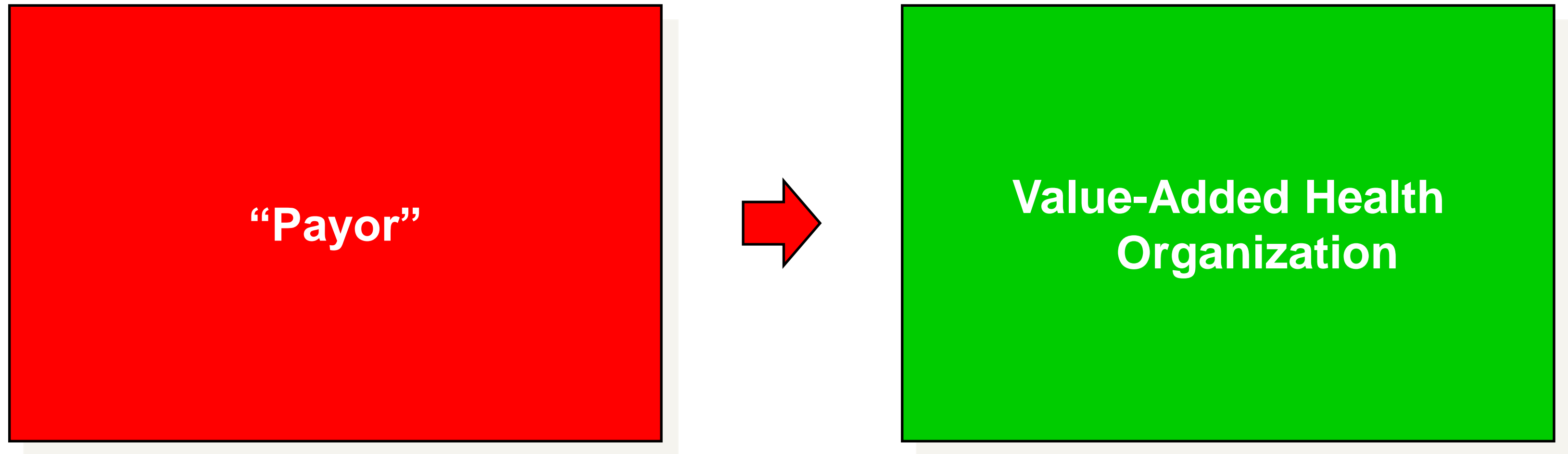
Value-Based Healthcare Delivery:
Implications for Health Plans



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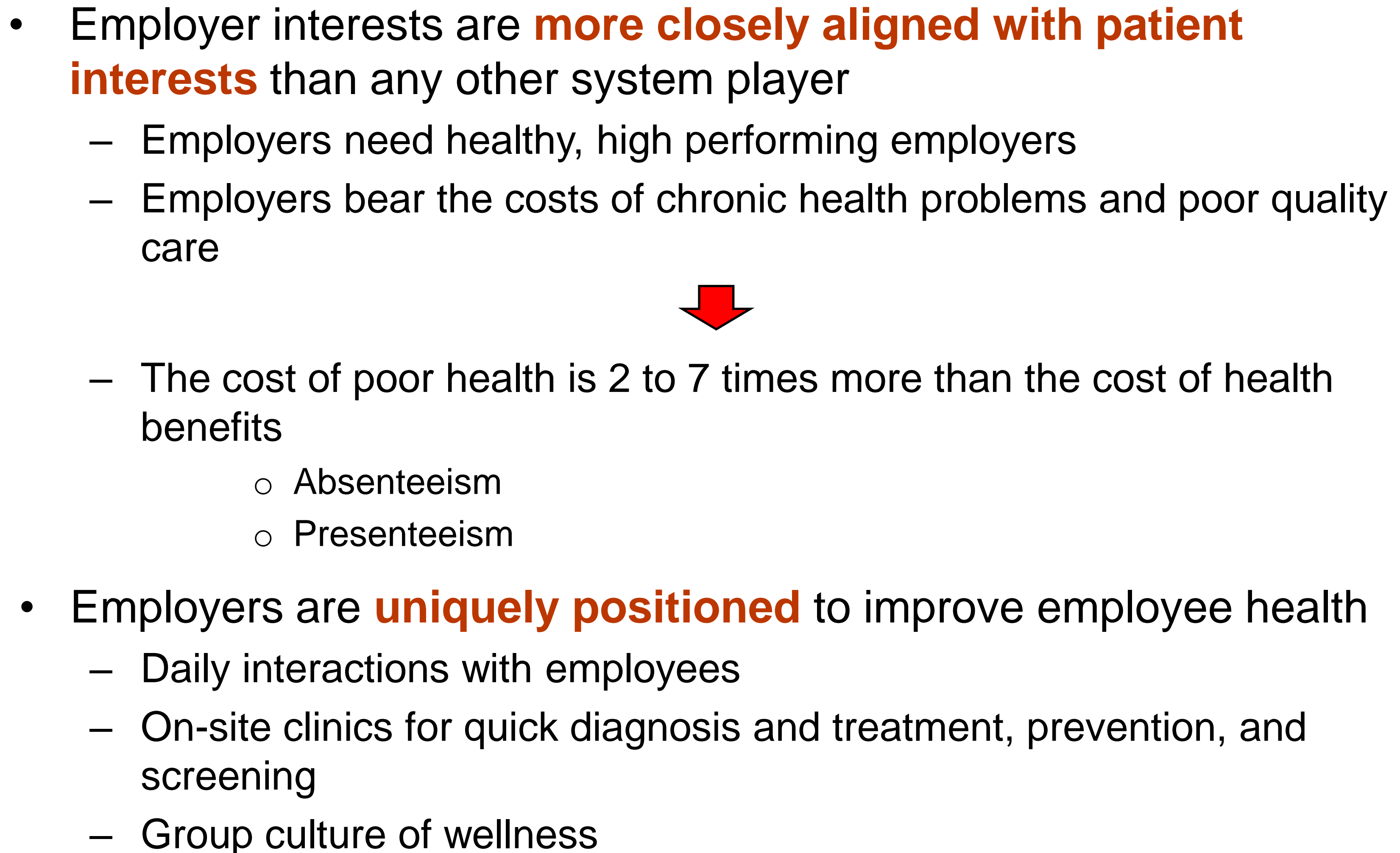
Value-Based Health Care: The Role of Employers



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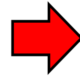
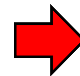
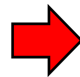
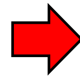
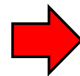
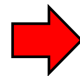
Transforming the Roles of Employers

Old Role		New Role
Set the goal of **reducing health premium costs**		Set the goal of **employee health**
Focus on **direct cost** of health benefits		Focus on the **overall cost of poor health** (e.g., productivity, lost days)
Use bargaining power to negotiate **discounts** from health plans and providers		Work with health plans and providers to improve overall **value** delivered
Shift costs to employees via premium payments, co-payments		Improve access to **high-value care** (e.g. wellness, prevention, screening, and disease management)
Evaluate plans and providers based on **process compliance** (P4P)		Evaluate plans and providers based on **health outcomes**
Limit or eliminate the employer role in health insurance		Take a leadership role in **expanding the insurance system** to encompass individually purchased plans on favorable terms

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A Strategy for U.S. Health Care Reform

Shift Insurance Market :

- Build on the current **employer based system**
- Shift **insurance market competition** by ending discrimination based on pre-existing conditions and re-pricing upon illness
- Create large statewide and multistate **insurance pools to** aggregate volume and buying power and provide a viable insurance option for **individuals and small groups**, coupled with a **reinsurance system** for high cost individuals
- Phase in **income-based subsidies** on a sliding scale for lower income individuals, at a pace that reflects progress of value improvements
- Once viable insurance options are established, **mandate the purchase of health insurance** for higher income and ultimately all Americans
- Give employers a choice of providing insurance or a payroll tax based on the proportion of employees **requiring public assistance**

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A Strategy for U.S. Health Care Reform

Restructure Delivery:

- Establish a universal and mandatory **outcomes measurement and reporting system**
  - **Experience reporting** as an interim step
- Shift reimbursement systems to **bundled payment for cycles of care** instead of payments for discrete services
  - Including primary/preventive care bundles for patient segments
- **Remove obstacles to restructuring** of health care delivery around medical conditions
  - E. g. Stark Laws, Corporate Practice of Medicine, Anti-kickback, Malpractice
- **Open up value-based competition** for patients within and across state boundaries
  - E.g. Harmonize state licensing, insurance rules
  - **Minimum volume standards** as an interim step
- Mandate **EMR adoption** that enables integrated care and supports outcome measurement
  - National **standards** for data definitions, communication, and aggregation
  - **Software as a service** model for smaller providers
- Set rules that encourage **responsibility of individuals** for their health and health care through incentives for healthy behavior

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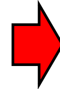
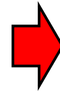
Health Care Delivery in Resource-Poor Settings Suffers from Similar Problems

Current Model		New Model
• The product is **treatment**		• The product is **health**
• Measure **volume** of services (number of tests, treatments)		• Measure **value** of services (health outcomes per unit of cost)
• Discrete **interventions**		• **Care cycles**
• **Individual** diseases		• Sets of prevalent **co-occurring conditions**
• **Fragmented, localized,** pilots, programs, and entities		• **Integrated** care delivery systems

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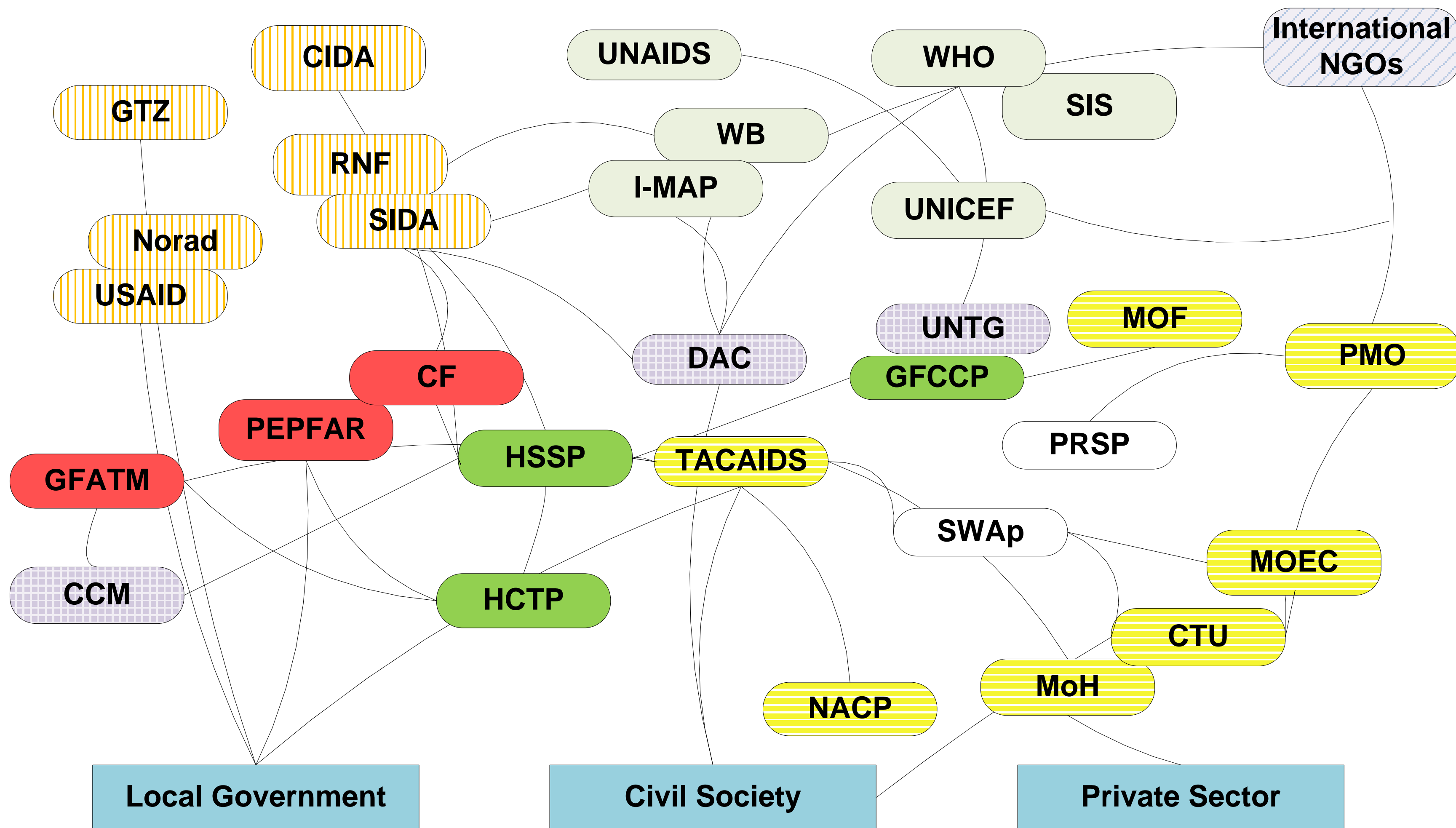
Relationships Between Various Stakeholders in Tanzania



United Nations
Bilateral Aid
Drug-delivery programs
Tanzanian government
Coordinating committees
Plans and programs
IMF/World Bank
Nongovernment organizations

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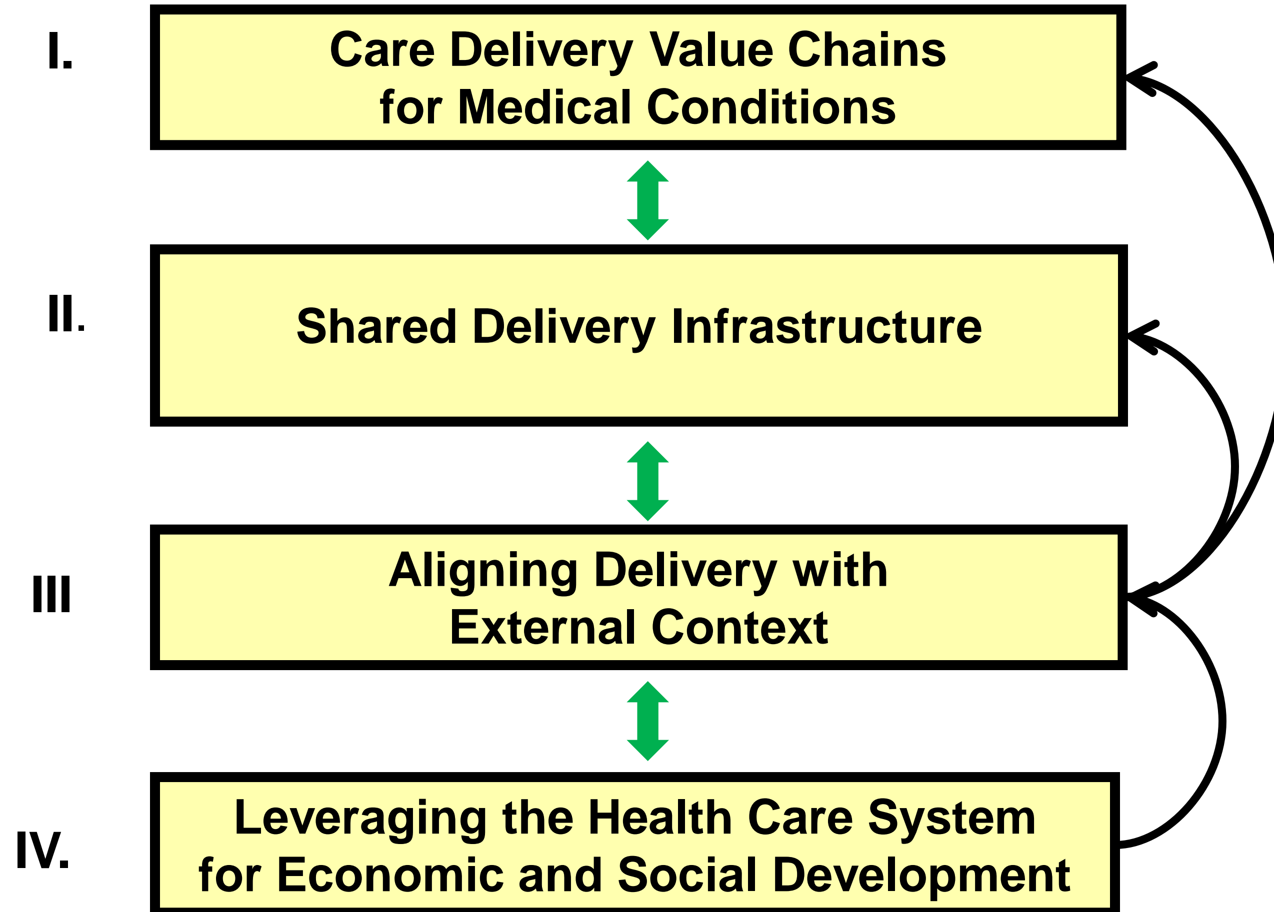
A Framework for Global Health Delivery



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The Care Delivery Value Chain

HIV/AIDS

	SCREENING/PREVENTING	DIAGNOSING/STAGING	DELAYING PROGRESSION	INTITIATING ANTIRETROVIRAL THERAPY	ONGOING DISEASE MANAGEMENT	MANAGEMENT OF CLINICAL DETERIORATION
INFORMING/ ENGAGING	▪ Prevention counseling on modes of transmission and condom use	▪ Explanation of diagnosis and the implications ▪ Explaining the course of HIV and the prognosis	▪ Explanation of the approach to forestalling progression	▪ Explanation of Medication Instructions and Side-Effects	▪ Counseling about adherence; understanding factors for non-adherence	▪ Explanation of the co-morbi[d] diagnoses and the implications ▪ End-of Life Counseling
MEASURING	▪ HIV testing ▪ Screen for sexually transmitted infections ▪ Collect baseline demographics	▪ HIV testing for others at risk ▪ Clinical examination CD4+ count and other labs ▪ Testing for common co-morbidities such as tuberculosis and sexually transmitted diseases ▪ Pregnancy testing	▪ CD4+ Count Monitoring (Continuous Staging) ▪ Regular Primary Care Assessment ▪ HIV Testing for Others at Risk ▪ Laboratory Evaluation for Medication Initiation	▪ HIV Staging and Medication Response ▪ Highly Frequency Primary Care Assessment ▪ Assessing/Managing Complications of Therapy ▪ HIV testing for others at risk (bi-annually) ▪ Laboratory Evaluation	▪ HIV Staging and Medication Response ▪ Regular Primary Care Assessment ▪ Laboratory Evaluation	▪ HIV Staging and Medication Response ▪ Regular Primary Care Assessment ▪ Laboratory Evaluation
ACCESSING	▪ Testing centers ▪ High risk settings ▪ Primary Care Clinics	▪ Primary Care Clinics ▪ On-sight laboratories at Primary Care Clinics ▪ Testing Centers	▪ Primary Care Clinics ▪ Laboratories (on-site at primary clinic) ▪ Pharmacy ▪ Food Centers ▪ Community Health Workers/ Home Visits ▪ Support Groups	▪ Primary Care Clinics ▪ Laboratories (on-site at primary clinic) ▪ Pharmacy ▪ Community Health Workers/ Home Visits ▪ Support Groups	▪ Primary Care Clinics ▪ Laboratories (on-site at primary clinic) ▪ Pharmacy ▪ Community Health Workers/ Home Visits ▪ Support Groups	▪ HIV Staging and Medication Response ▪ Regular Primary Care Assessment ▪ Laboratory Evaluation ▪ Primary Care Clinics ▪ Pharmacy ▪ Laboratories (on-site at primary clinic) ▪ Community Health Workers/Home Visits ▪ Hospitals & Hospice Facilities ▪ Support Groups ▪ Food Centers
	▪ Connecting patients with primary care system ▪ Identifying high risk individuals ▪ Testing at-risk individuals ▪ Promoting appropriate risk reduction strategies ▪ Modifying behavioral risk factors ▪ Creating a medical record	▪ Formal diagnosis and staging ▪ Determine method of transmission and others at potential risk ▪ Identify others at risk ▪ Screen for TB, syphilis, and other sexually transmitted diseases ▪ Pregnancy testing and contraceptive counseling ▪ Create management plan, including scheduling of follow-up visits ▪ Formulate a treatment plan	▪ Initiate therapies that can delay onset, including vitamins and food ▪ Treat co-morbidities that affect progression of disease, especially tuberculosis ▪ Improve patient awareness of disease progression, prognosis, and transmission ▪ Connect patient to care team, including community health work	▪ Initiate comprehensive anti-retroviral therapy and assess medication readiness ▪ Prepare patient for disease progression and side-effects of associated treatment ▪ Manage secondary infections and associated illnesses	▪ Managing effects of associated illnesses ▪ Managing side effects of treatment ▪ Determine supporting nutritional modifications ▪ Preparing patient for end-of-life management ▪ Primary care and health maintenance	▪ Identifying clinical and laboratory deterioration ▪ Initiating second-line, third-line drug therapies ▪ Managing acute illness and opportunistic infection either through aggressive outpatient management or hospitalization ▪ Provide additional community/ social support if needed ▪ Access to Hospice Care

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Care Delivery Value Chain

Illustrative Implications for HIV/AIDS Care

- **Targeted prevention** for at-risk individuals creates more value than across the board efforts
- **Early diagnosis** helps in forestalling disease progression
- **Intensive evaluation and treatment at the time of the diagnosis** can forestall disease progression
- **Improving compliance with first stage drug therapy** lowers drug resistance and the need to move to more costly second line therapies

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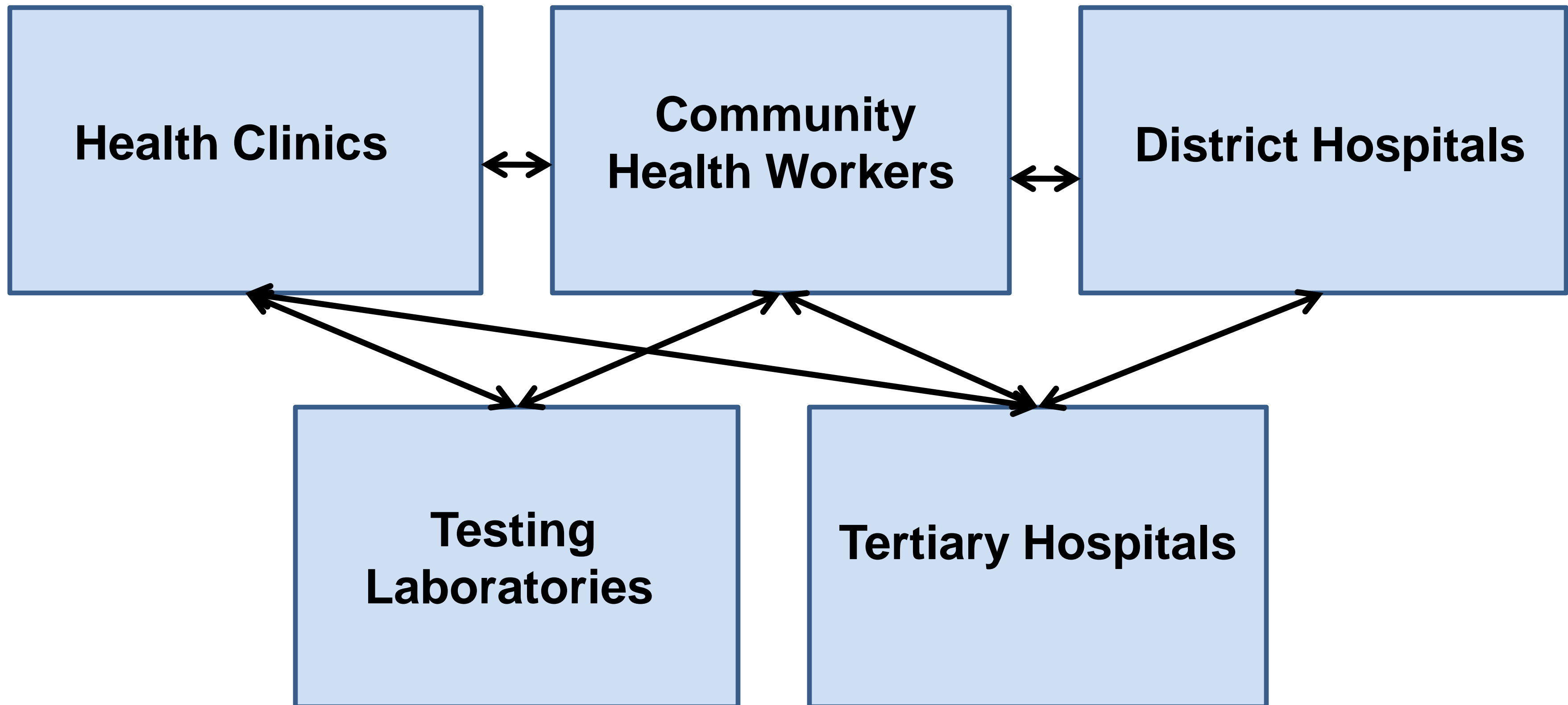
Shared Delivery Infrastructure



Cross Cutting Issues

- Supply Chain Management
- Information and IT
- Human Resource Development
- Insurance and Financing

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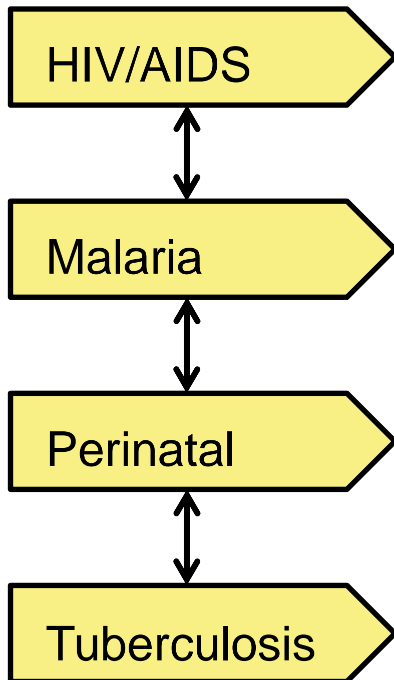
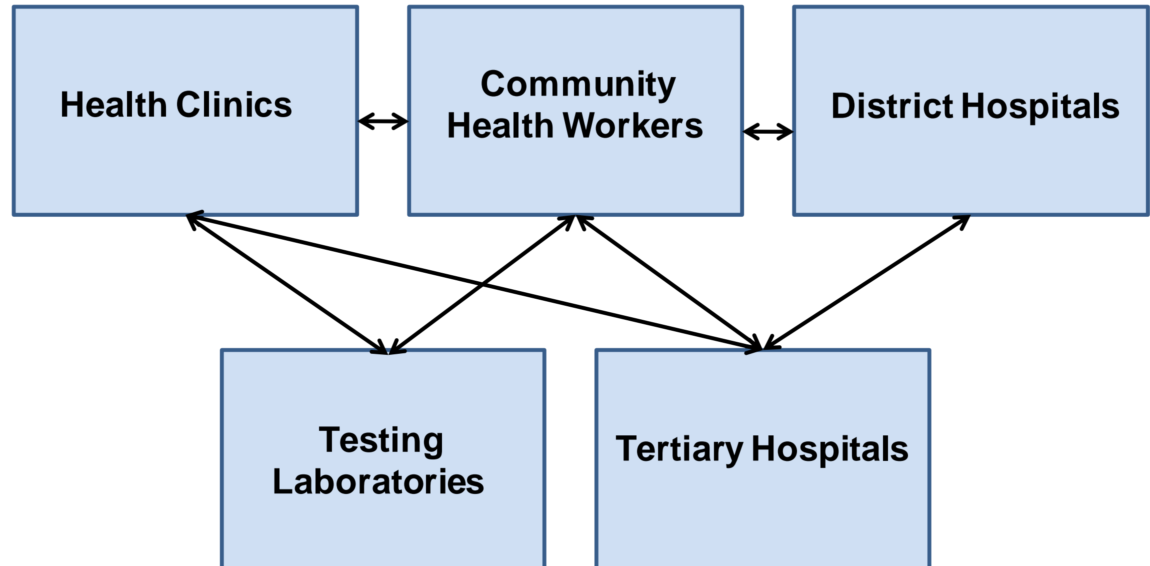
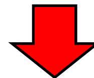
Integrating “Vertical” and “Horizontal”

Care Delivery Value Chains



Shared Delivery Infrastructure





- Integrating care across related diseases
- What care at what facilities
- Integrating care across the system

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Shared Delivery Infrastructure
Illustrative Implications for HIV/AIDS Care

- Screening is most effective when **integrated into a primary health care system**
- Providing **maternal and child health** care services is integral to the HIV/AIDS care cycle by substantially **reducing the incidence of new cases of HIV**
- Community health workers can not only improve compliance with ARV therapy but can **simultaneously address other conditions**

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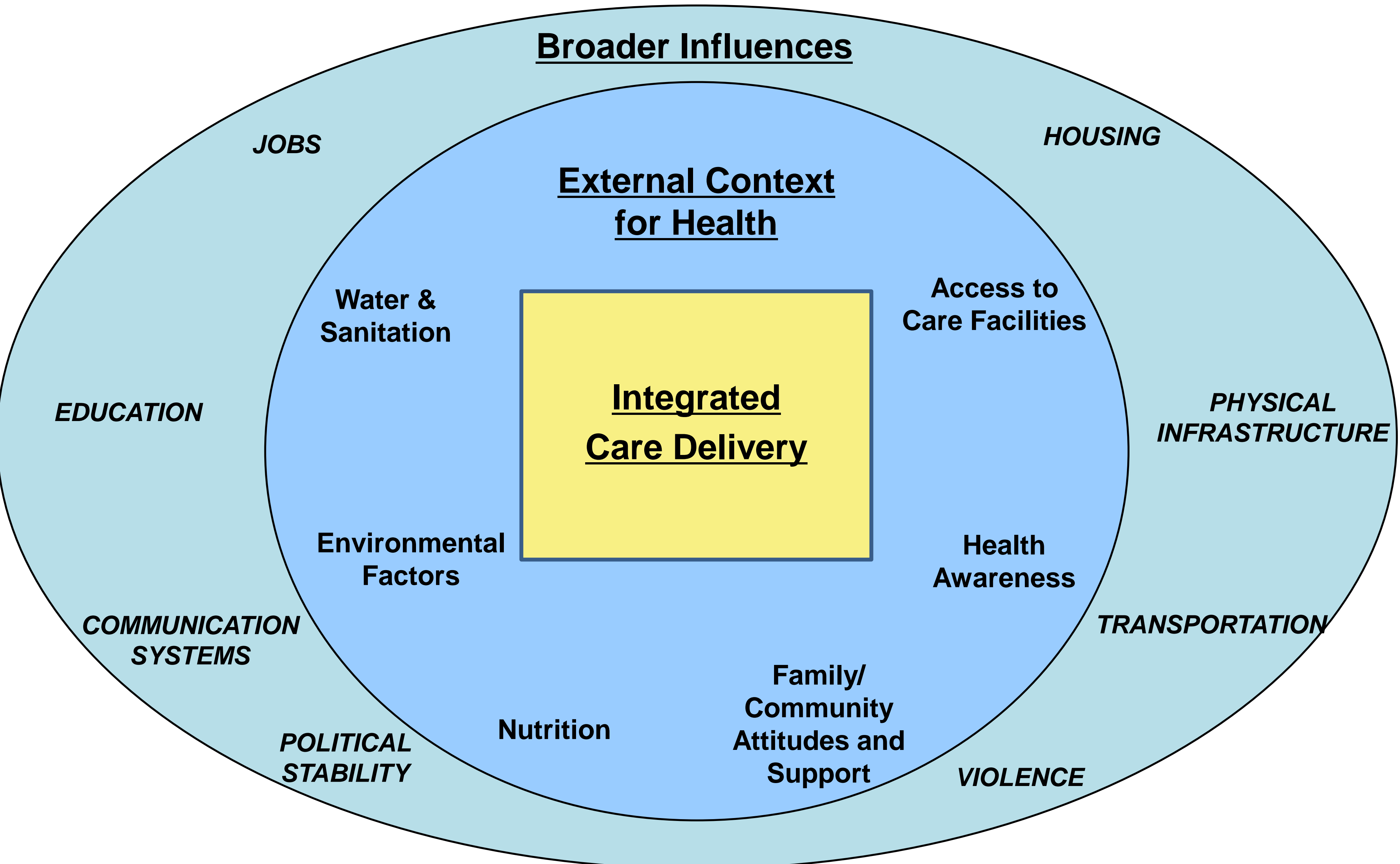
Integrating Delivery and Context



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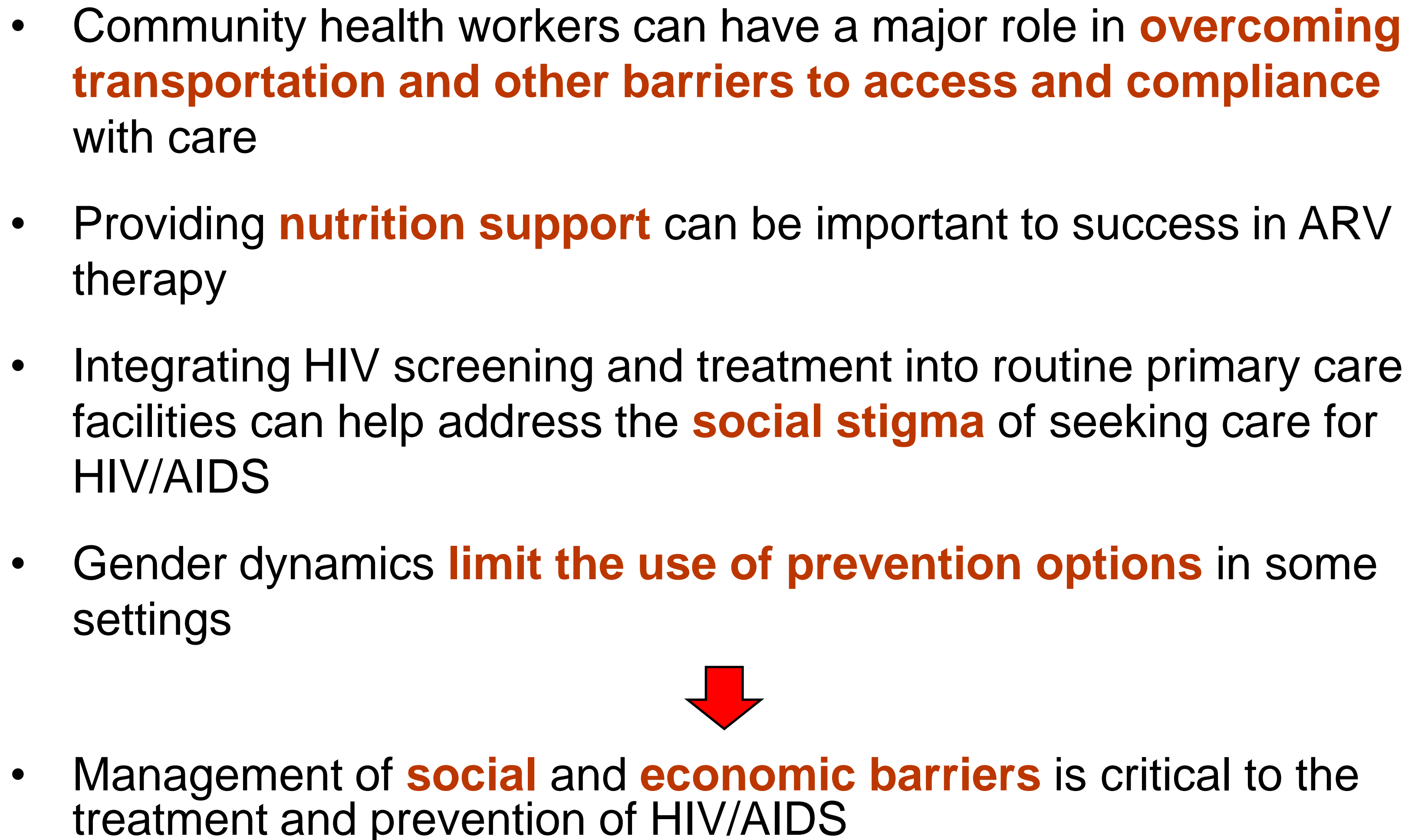
Integrating Care Delivery and Social/Economic Context

Illustrative Implications for HIV/AIDS Care

- Community health workers can have a major role in **overcoming transportation and other barriers to access and compliance** with care
- Providing **nutrition support** can be important to success in ARV therapy
- Integrating HIV screening and treatment into routine primary care facilities can help address the **social stigma** of seeking care for HIV/AIDS
- Gender dynamics **limit the use of prevention options** in some settings



- Management of **social** and **economic barriers** is critical to the treatment and prevention of HIV/AIDS

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The Relationship Between Health Systems and Economic Development

Better Health **Enables** Economic Development

- Enables people to work
- Raises productivity

Health System Development **Fosters** Economic Development

- Direct employment (health sector jobs)
- Local procurement
- Catalyst for infrastructure (e.g. cell towers, internet, and electrification)

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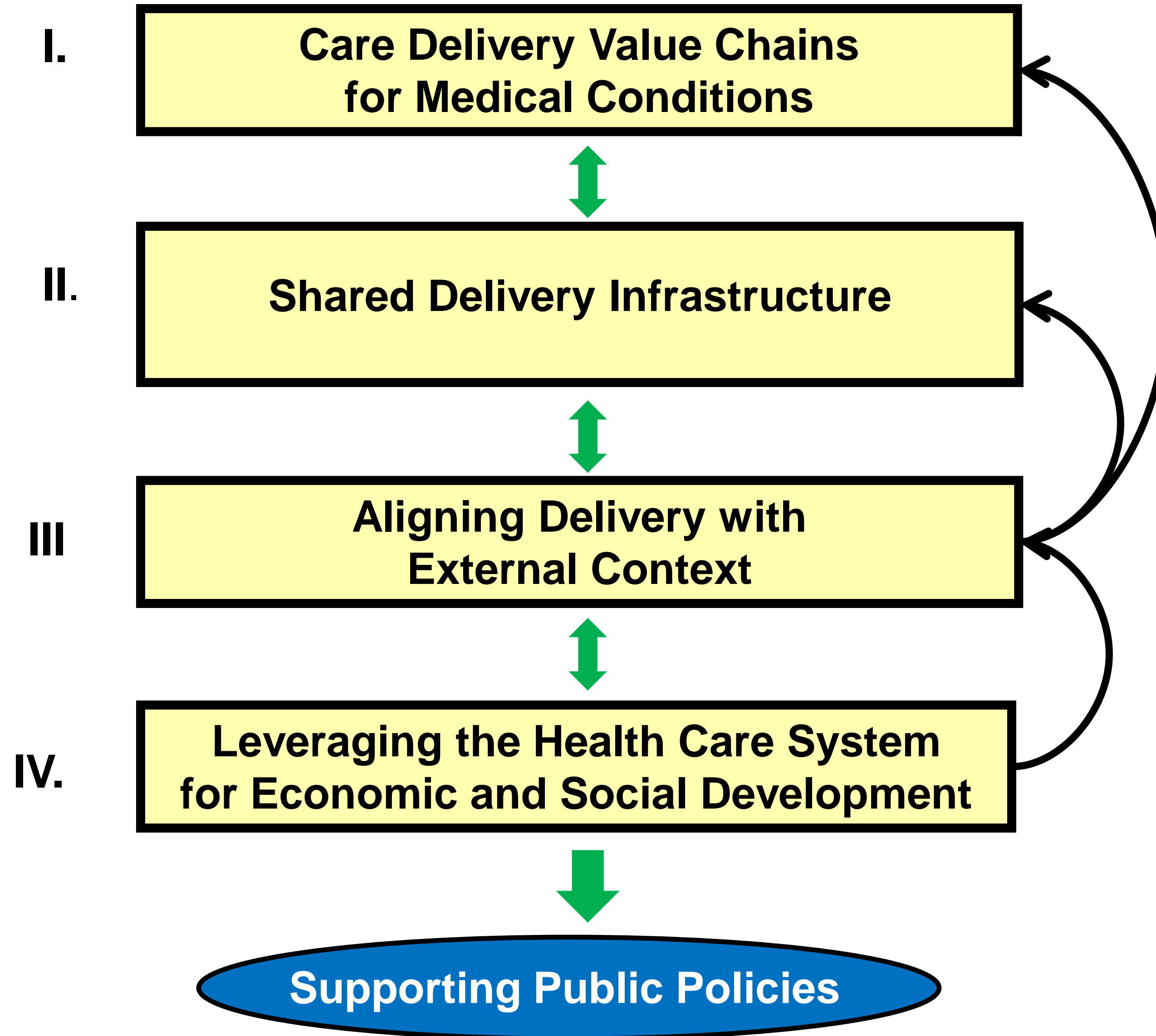
A Framework for Global Health Delivery



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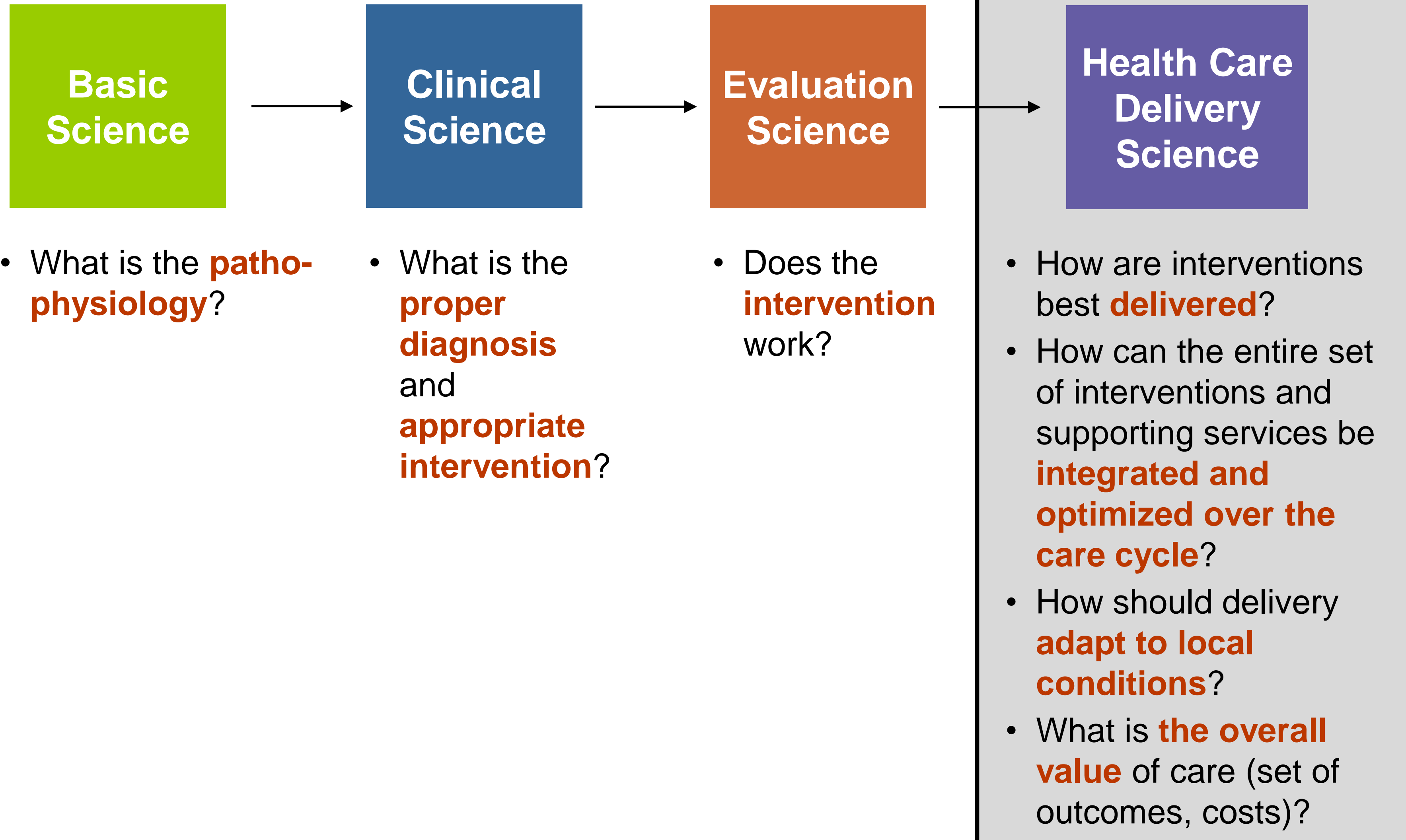
A New Field of Health Care Delivery



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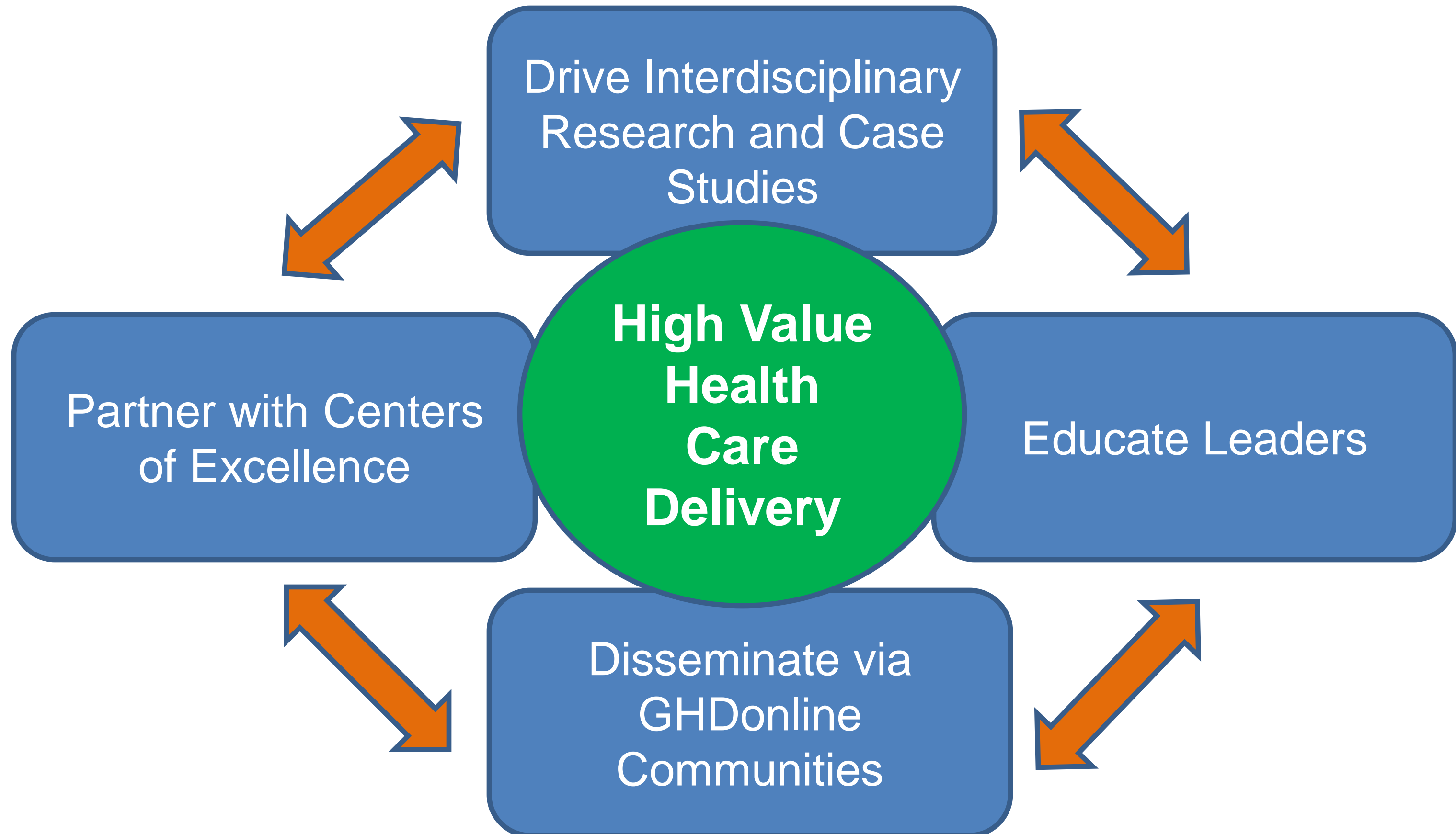
Global Health Delivery Project



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Value-Based Health Care Delivery Curriculum

Global Health Delivery

Teaching Materials

- Case studies
- Teaching notes
- Videos of case discussions
- Videos of guest protagonists
- Videos of topic lectures
- GHD Online

Selected Articles and Course Notes

- Applying the Care Delivery Value Chain: HIV/AIDS Care in Resource Poor Settings
- Delivering Global Health
- Redefining Global Health Care Delivery

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Value-Based Health Care Delivery

Global Health Case Studies

Completed Case Studies

- Botswana's Program in Preventing Mother-to-Child HIV Transmission
- BRAC's Tuberculosis Program: Pioneering DOT Treatment for TB in Rural Bangladesh
- Building Local Capacity for Health Commodity Manufacturing: A to Z Textile Mills Ltd
- CIDRZ Operations & Care Delivery Model in Zambia
- The AIDS Support Organization (TASO)
- The 100% Condom Program
- HIV Voluntary Counseling and Testing in Hinche, Haiti (and case coda)
- Iran's Triangular Clinic (and case coda)
- Multi-Drug Resistant Tuberculosis Treatment in Peru
- Partners In Health: HIV Care in Rwanda
- Polio Elimination in India
- The Academic Model for the Prevention and Treatment of HIV/AIDS (AMPATH)
- The Anti-Malarial Supply Chain: Botanical Extracts Ltd.
- The Peruvian National Tuberculosis Control Program
- Tobacco Control in South Africa (and case coda)
- Treating Malnutrition in Haiti
- Tuberculosis in Dhaka: BRAC's Urban TB Program

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Global Health Case Studies

Near Completion

- Zambia's National Malaria Control Program
- Community-Based Health Insurance in Rwanda
- Measles Policy
- ABE Pharmaceuticals

In Process

- Avahan: HIV Prevention
- Avahan: HIV Prevention Scale Up
- Human Resources and Task Shifting in Swaziland
- Information Technology in Low Resource Settings: Open MRS
- Partners Against Resistant Tuberculosis: A Network for Equity and Resource Strengthening (PARTNERS) in Peru
- Surgical Capacity in Uganda
- Thailand and Quality Improvement

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Recent and Upcoming Course Offerings

- Summer 2009 - HSPH/HMS: Global Health Effectiveness Program
- July 2009 - HSPH: Introduction to GHD
- Fall 2009 - HMS: GHD Seminar
- Fall 2009 – Sloan MIT Global Entrepreneurship Lab
- Fall 2009 – Harvard Undergraduate Global Health Course
- January 2010 - HSPH: Introduction to GHD
- Spring 2010 – Malaria Executive Education
- Winter 2010 Harvard Business School, Global Health Design and Delivery
- July 2010 – Train the Trainers for Global Health Delivery Educators
- Summer 2010 - HSPH/HMS: Global Health Effectiveness Program

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