

# The Harvard Crimson

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## More than Just a Hobby

### What Harvard can do to advance global health

By [Paul E. Farmer](#)

How can a research university address problems of health-care delivery, especially for the poor or otherwise vulnerable? The possibilities are, as we say in a clinical lab when counting blood cells, “TNTC”—too numerous to count. But for those who wish to build robust academic programs in global health, there are three chief categories of action: research, training, and service. This triad is familiar to anyone who works in a teaching hospital. However, problems as significant as health-care delivery cannot be solved by medical schools, teaching hospitals, or schools of public health alone. All parts of the University—from undergraduates to emeriti, the college to the professional schools, and the alumni to administration—have something to offer. Harvard’s global health agenda is ambitious, and its time has come.

That agenda has been transformed in recent years, as I know from personal experience. In the fall of 1984, newly arrived to Harvard Medical School after a year volunteering in a rudimentary clinic in central Haiti, I knew I wanted to work in what was then called “international health.” Even then, it was obvious that Haiti needed not only improved infrastructure and personnel but also new ways of delivering services. With the help of friends, the NGO Partners In Health was founded to help build delivery systems in Haiti and elsewhere. But what sort of training should someone with my interests pursue here at Harvard? It wasn’t a propitious time: there was not, at one of the world’s best medical schools, a formal training track for someone with such interests, nor were there many students in my class with similar aspirations.

Much has changed since then. Many of our small cohort of students did pursue careers in “global health equity,” the next and better iteration of international health. We had a lot of help along the way, but not because there were a plethora of career ladders in global health. I studied medical anthropology and trained in infectious disease, but these were not global health training programs. In fact, there were no such programs, in large part because global health is not a discipline or a field but rather a collection of problems.

These problems—which range from the grotesque absence of basic services for the world’s bottom billion to the poor quality of delivery of care in some more affluent nations—are increasingly recognized for what they are: a rebuke to our unequal world and a source of unnecessary suffering and social instability. This is obvious to poor families facing catastrophic illness, the leading cause of

destitution in many nations; it is recognized by the citizens and leaders of countries still struggling to break the cycle of poverty and disease.

I am glad to see that U.S. research universities, too, now all seem to boast programs in global health. But claiming to have programs in global health is not the same thing as creating programs that can make a difference to populations facing poverty and ill health; nor is that the same as having career pathways and sound training programs, not just for our own students and faculty, but for students and colleagues in the places we work. Harvard needs to accompany its students and faculty and alumni by tackling the big three problems—building sound platforms for research, training, and service delivery—with all of the resources at our disposal.

This should be easier at Harvard than at any other American university for at least three reasons. First, because so many faculty are already working on the health problems that plague the most vulnerable in countries rich, poor, and in between. Second, because so many of our students and trainees wish to work in this arena, which wasn't true not long ago. And third, because the University's leadership, from President to Provost (both outgoing and incoming are doctors interested in global health) to Deans, all believe in moving global health forward as a serious academic enterprise.

How do we advance the research agenda when it must reach from bench science to the social sciences and humanities and every field in between? Sue Goldie, who leads the Harvard Global Health Institute, has worked with others to compile a directory of what's going on here already, and it's a long and impressive list. Both volume and quality will continue to increase with even a modicum of support, and will increase more rapidly with greater investments and support for junior faculty seeking to make global health the focus on their work rather than a hobby.

Tackling the training challenges in an equitable way is a thornier problem. According to the Consortium of Universities for Global Health, 70 American universities have formal academic programs in global health, almost all of them developed within the last several years; of the 131 U.S. medical schools, over a hundred have programs in global health. But, again, the "hobby" approach differs from true accompaniment. We've started, with the help of undergraduates and Partners In Health sites in Africa, a global health study abroad program (GEO-Scholars), and similar programs are flourishing at the Medical School. Well-mentored opportunities are rarest in the poorest countries—the places to which most students are drawn.

Funding post-graduate medical education is a much more resource-intensive affair. Almost a decade ago, we started the country's first residency in internal medicine and global health equity, with the expectation that private philanthropy and support from the Brigham and Women's Hospital would be followed by support from public sources: global health initiatives like the President's Emergency Plan for AIDS Relief have proven their worth and should be complemented with rigorous training and research. But the training of U.S. doctors does not include public financing of their training when outside the United States, or for that matter in poor regions outside the teaching hospital but within the borders of the country. We still don't have federal support for residency programs in global health. Training specialists in medicine—fellows in cardiology, say, or the surgical specialties—also takes a lot of resources, and these typically come from the federal government in the form of large training grants. But federal training grants in global health, though cheered by many leaders and perhaps right around the corner, are stalled by the financial crisis.

And every training program at Harvard should be “mirrored” by similar commitments to help our host countries address their own training needs, since in each of these countries there are talented students and trainees who would also like to devote themselves to improving the health of their fellow citizens. Consider Botswana (which has no school of public health), Rwanda (not a single oncologist but plenty of cancer), Haiti (which lost its nursing and medical schools to a devastating earthquake) and Lesotho (which doesn’t have a single medical school but does have enormous need for physicians and plenty of talented young people). “Aid” to people in such countries—and I’ve just mentioned a few in which Harvard students and faculty work—cannot consist only of exporting our research and our training. This model of assistance has been long discredited.

A better term for what Harvard might do to help build a proper field of global health is “accompaniment.” To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end. As at a commencement like the one we celebrate this week, we’re not always sure where the beginning and end might be. In this accompaniment, America’s universities can line up with many worthy partners. For example, the Clinton Health Access Initiative is advancing an ambitious program to allow faculty members from a half dozen American universities to support medical training in Rwanda; similar efforts are needed in dozens of countries.

Research and training in global health are for naught if they fail to improve the delivery of health services or if we fail to train, and learn from, our peers and partners. The word “global” shouldn’t deceive us: Boston is on the globe, too, and some people in the United States suffer from deficiencies in infrastructure and personnel not all that different from what I saw in rural Haiti in 1983. One thing we’ve learned in the United States is that it’s very expensive to give poor-quality health care to poor people in a rich country.

Taking global health from a hobby to a serious pursuit is well within our reach if we commit adequate resources to a series of tasks that include research, training, and improved delivery of quality care. Harvard can’t do this alone, but working with the right partners—including those laboring in places far from Cambridge—we can forge ethically sound endeavors in which we generate new knowledge while saving lives and improving the quality of many more.

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