NGOs contributions to present and future health systems for the poor

Nance Upham

- Apprehending health care within a broader socio-economic context.
- Global advocacy capacities to influence policy making and implementation.
- Proven capacities to implement efficient comprehensive primary health care.
- Capacities to innovate and prepare health systems for the future.
Introduction

Health System for the poor need not be and should not be “poor health system for the poor” but, rather, can and must be inscribed into the national and international effort of “better health for all”

NGOs are on the record to favour “best of” in Primary Health Care

NGOs’ assets:
know how to deliver good health care to poor populations international powerful advocacy for health as a human right
Overview

What are the specific contributions of NGOs to efficiency in health care delivery for poor populations?
We have looked at four aspects:

1. Apprehending health care within a broader socio-economic context.
2. Global advocacy capacities to set health policy making and implementation
3. Proven capacities to implement efficient comprehensive primary health care
4. Capacities to innovate and prepare health systems for the future.

When we speak of “NGOs” we mean specifically “PINGOs”, Public Interest NGOs.
While BINGOs (Business Interest NGOs) may play a role in health delivery, this is outside the purview of this presentation.
The broader determinants of health

Health care ‘works’ not as a specific commodity but as part of a broader socio-economic assistance and education project for poor communities

BRAC provides health care and agricultural support as well as
• Tuberculosis care
• Microcredit
• Health insurance….

GK provides Primary Health Care and secondary and tertiary care
• health education,
• training for women,
• schooling
• banking and microcredit and community health insurance…
It is a characteristic of NGOs to provide health services within part of a broader package of socio-economic assistance to poor people: from education to farming, from credit to promotion of women.

- NGOs delivery Vs State delivery – or collaborative system?

Major NGOs most intensely involved in health care tend to favour collaboration with strong State public health system:

- Save the Children
- IUATLD
- International Association for Health Promotion
Credit mechanisms represent important levers out of poverty

The principles of credit are understood by main NGOs in the field of microcredit for health and poverty alleviation.

“Faute d’argent, c’est douleur non pareille”

2005 UN year of Microcredit- Thousands of NGOs held Summit on microcredit.

Community financing for health care proper works well among the employed and over and above basic economic sustainability of household.

Good financing for health care for all as a public good is essential – importance of cost sharing across income level

User fees as barriers – community participation as incentives
From PRSP to international advocacy

Global advocacy capacities to influence policy making and implementation

NGOs as the new partners in global health policy making:

- PRSPs - Country Coordinating Mechanisms of the GFATM – 3by5
- Filling PRSPs on four Ws of health care to poor populations

NGOs as international advocacy network:

- Save the Children and the Millenium Development Goals

NGOs can be instruments or main actors

- In Tuberculosis control, WHO study sees NGO complementarity with public health systems
Proven capacities to implement efficient comprehensive primary health care

NGOs have demonstrated that PHC Systems are:

- efficient
- equitable,
- promote community participation
- foster women’s emancipation
- AND utilize resources efficiently
The case of the People’s Health Center in Bangladesh

Building a PHC:

- Starts with health care that is organised by and from the communities
- Responds to prevalent existing pathologies in the populations concerned
- Organizes a concentric system of human resources

First level primary health care is the foundation, the base for secondary and tertiary care.

Has maximal efficiency.
Mobility past and future

**Capacities to innovate and prepare health systems for the future.**

Mobile medicine dates back from the origin of epidemics control.

Resource poor countries have used mobility with primary health care to achieve maximal efficiency in combating epidemics - Vietnam Roll Back Malaria in the 1990s

NGOs have favoured flexibility and mobility of staff: going TO the patient

PHC with flexible, swift response, when people need secondary or tertiary care.

State backed “selected PHC” models have been based on fixed post with poorly trained staff often enough with no supplies, discrediting PHC in the process.
Use of latest technology - Internet / satellite links = health and education to the poorest of the poor

The Ratanakiri Mailman in Cambodia’s indigenous tribal isolated regions.
Mobile eye clinics – mobile surgery – mobile epidemics control. – Mary Stopes Int.

Health care for the future:
Primary Health Care system with internet connection – mobile teams of support, would combine efficiency, rapidity of response, epidemiological surveillance with Global health watch and response capabilities.