

BORDER CROSSING **Tessa Richards**

Brave new world

Social innovations hold the potential to deliver cost effective and equitable health care to poor and marginalised people

How can healthcare systems get more health for their money? In these straitened times this question is concentrating minds in rich and poor countries alike. Much of the debate is focusing on how to cut inefficiency and increase the quality of services. But there is also a call for new thinking.

The World Health Organization recently launched an initiative to encourage the development of innovative, low cost technologies to tackle entrenched global health problems. The Bill & Melinda Gates Foundation has invested in public-private partnerships to do the same. A further idea that is exciting attention is the potential of social innovations to improve health.

The concept of social innovation to improve health is not the easiest to pin down. In pursuit of a definition I approached Charles Gardner, who heads the innovation arm of the independent, Geneva based Global Forum for Health Research. He was happy to explain.

“When people talk about innovation in health systems,” he said, “it conjures up an image of new technical tools for prevention, diagnosis, and treatment. These are clearly important. But the delivery of services is at least as important. Social innovations are new ways of managing people, information, and services orientated to bring particular benefit to the poor and marginalised. Most are driven by social entrepreneurs who see a preventable problem and have the vision and business acumen to find a sustainable new solution to it.” I asked for examples.

His first was the Aravind Eye Hospital in Madurai, southern India, which won the Bill & Melinda Gates award for global health last year. The hospital was started in 1976 by Govindappa Venkataswamy. His goal was to tackle the region’s huge burden of preventable blindness, largely due to premature cataract formation.

He started to invite people to attend for one stop eye examinations and provided treatment, which in many cases involved cataract surgery, as required. People who could pay were charged a small fee. The revenue thus raised funded care for those too poor to pay for it.

Over the years the enterprise has grown. Venkataswamy’s small hospital has been replaced by five others linked to 25 satellite clinics. An estimated 27 million people have been assessed and treated and the local burden of illness from blindness reduced appreciably. Aravind has also established a research and teaching institute and developed a thriving business; its low cost ophthalmological products are now exported widely.

While it has been listed among the world’s top 50 most innovative companies, it is also recognised as a business model that reaches the poor. Its annual reports describe extensive outreach projects, including support for eye hospitals in South America and national eye care plans in Africa.

The second example Gardner proffered is from Brazil. More than 18 years ago Vera Cordeiro, a paediatrician, noted the high rate of readmission to hospital among poor children from Rio de Janeiro’s favelas (urban slums). Recognising that this was due to the adverse social environment they came from she developed (and found financial backing and volunteer help for) a two year programme of long term child and family support.

Other examples of social innovation—including conditional cash transfers to promote healthy behaviour, community engagement projects, and new uses for mobile phones—will be aired at next week’s meeting of the Global Forum in Havana. The forum will discuss the potential of technological advances and social innovations to spur faltering progress towards the United Nations’ millennium development goals.



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Those who doubt the power of social entrepreneurs to improve health and protect the environment should take a glance at the websites of three relatively new organisations that have been set up to further the social innovation movement: Ashoka, Skoll, and Schwab. Ashoka links and awards fellowships, and several of the personal stories of its fellows are humbling. For many, particularly those from low income countries, the impetus for their action has stemmed from gruelling personal experience.

Of course, there is a myriad of sung and unsung examples of social innovations in rich countries too. Last month the NHS Birmingham North and East primary care trust appointed its first “social entrepreneur in residence”. Her brief is to improve health and tackle health inequalities through developing new, self sustaining local enterprises. Current projects include a gym to provide physiotherapy, exercise classes, and health information to (predominantly) Asian women, and football coaching for people with mental health problems.

Evaluation of the effect of these initiatives is under way, as is a new telephone service to support self treatment for patients with chronic disease. Andrew Donald, the trust’s deputy chief executive, is passionate about the power of such local projects to encourage communities to look after themselves.

“We have to reach for different ways to push the message that prevention is better than cure,” he said. “NHS services are too focused on treatment. Our money will go further if we put more resources into commissioning projects aimed at disease prevention and health promotion.” This, he and many others believe, is the key to getting more health for the money.

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