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Health financing for poor people: resource mobilization and risk sharing

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This authoritative and well presented book provides a very welcome analysis of the challenges related to shortages of financing for health — and the problems caused by a lack of financial protection and exclusion from social pooling mechanisms — that face poor agrarian and marginalized urban populations around the world. The book evolved from background work carried out for the WHO Commission on Macroeconomics and Health, with the mandate to "examine alternative approaches to domestic resources mobilization, risk protection against the cost of illness, and efficient use of resources by providers." It is divided into three parts, each of which consists of several chapters: part 1 discusses global and regional trends; part 2, country case studies; and part 3, expenditure gaps and development traps.

One of the book's strengths is its systematic assessment of experiences with community financing for health care — and its critical evaluation of the pros and cons of community financing. It provides a useful typology of the multiplicity of community-based financing schemes that have been described in recent years, separating them into: 1) cost-sharing schemes, based on patient out-of-pocket payments managed with community involvement; 2) community prepayment plans, which pool resources to be used by members in case of illness; and 3) provider-based health insurance, where a hospital or other health-care provider forms the basis for a risk-sharing pool. All of these schemes share a "predominant role of collective action in raising, pooling, allocating or purchasing, and supervising the management of health-financing arrangements."

The schemes that the book uses to illustrate these descriptions are very heterogeneous. They include hospital-based prepayment plans in Kenya and Uganda; district-level financing plans with government involvement; a financing pool plan run by the Grameen Bank in Bangladesh; and the Cooperative Medical System, which, before its collapse in the 1980s, covered 90% of China's rural population. Although diverse, these schemes share common goals — to mobilize financial resources for health, to protect individuals and households against costs of illness, and to give communities a say in the management of their health care.

How have community financing schemes fared in meeting these goals? The evidence is mixed. Despite a flourishing of interest in the schemes, apart from China there are no credible estimates of the numbers of people or the percentage of national populations that are covered by community financing. The ability of the plans to raise revenues for health care is generally recorded as the percentage of the recurrent, local costs of providing health care. Studies that have measured revenues and costs are not standardized; they show a wide range of estimates — generally far short of 100% cost recovery, even after excluding capital costs and centralized administration. For hospital-based plans, cost-recovery rates are much lower; for example, 2.1– 7.2% for three such plans in Kenya, Uganda, and the United Republic of Tanzania.

Although there is very little evidence for the effectiveness of health-care plans in protecting against the costs of catastrophic illnesses, some plans do well in terms of social inclusion. The Grameen Bank health scheme in Bangladesh, for example, covers 58% of the poor population in its areas of operation, compared with 1.8% of the non-poor. However, the book voices the concern that many community plans may leave out the poorest groups, who are unable to pay even modest premiums or user charges. Without an external subsidy, the poorest may well be excluded from participation.

Community-based health-care plans have other weaknesses. For example, they are generally unable by themselves to raise sufficient revenues to pay the costs of curative health care for their members. This is particularly true for catastrophic illnesses — including HIV/AIDS — and chronic diseases that are increasingly prevalent in countries experiencing the epidemiologic transition. Health-care plan managers often lack the skills necessary to run health financing collection and health delivery systems. And, as long as they are based on voluntary membership, such plans are subject to the principle of adverse selection — individuals who are sick and know that they will probably need services are more likely to join than those who are healthy and present minimal risk.

Community financing plans should therefore be seen as a complement to, and not a substitute for, government involvement in health financing. Ideally, such plans provide a step in the transition toward larger, more stable, and better-financed risk protection pools. The Republic of Korea and China (Province of Taiwan) provide excellent examples of settings that have incorporated previously existing agrarian-based rural risk-sharing schemes into near-universal national health insurance programmes.

The book calls on governments to take the necessary steps to enable community-level plans to be more effective and to help make the transition to larger participant pools. Governments can subsidize the financial contributions of poor households, facilitate links with public and private provider networks, and provide reinsurance against the expenditure fluctuations that plague small insurance pools. If governments — and the donors that support them — can effectively take these steps, many of the world's poor who are currently excluded from financial protection against the costs of health care will benefit. ■

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