News

Countries test new ways to finance health care

A host of innovative schemes to cushion the poor against the financial risks of getting sick, such as low-interest loans, medical-savings accounts and insurance financed by a community-funded risk pool, are being tested in several countries.

Every year an estimated 25 million households — more than 100 million people — are plunged into poverty when they or their relatives become ill and they must struggle to pay for health-care services out of their own pockets.

These out-of-pocket payments have been identified as one of the main reasons why people receiving microfinance credits default on loan repayments, says Myka Reinsch, Director of Microfinance and Health Protection for Freedom from Hunger, a US-based nongovernmental organization (NGO) that provides such credits.

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"Time and again we hear from microfinance institutions that the reason their clients can't repay loans or start businesses that flourish is health problems that either they or their family members are facing," Reinsch says, adding that healthy clients save more money, establish successful businesses, take out larger subsequent loans and continue to be clients.

To address the problem, Freedom from Hunger is now working on Microfinance and Health Protection (MAHP), a programme that aims to address the financial problems associated with health-care access.

It is one of a number of development organizations studying health-care financing alternatives that received grants last year from the Bill and Melinda Gates Foundation.

Freedom from Hunger received US$ 6 million and the Aga Khan Foundation received a similar amount for a five-year-long life insurance programme, with plans to add health insurance later.

These are two of several initiatives across the globe that have sprung up in recent years to address one of the greatest but most basic challenges for health care: financing.

Ke Xu, a health economist at WHO, says such schemes are not about health financing or health insurance per se, but that they are there to protect people from the financial risk incurred by having to pay high costs for health-care services.

For many of the recent schemes, Xu says: "The goal is to turn an out-of-pocket payment to a pre-payment system, which is not linked to your health condition and not linked with whether you use health services or not."

These and other programmes that are piloting health-financing alternatives are preliminary. For instance Reinsch says it's too early to assess Freedom from Hunger's programme, launched as a pilot in Benin, Bolivia, Burkina Faso, India and the Philippines in January 2006. However a look at the types of problems it is addressing can give insight into new, financial-related approaches to health care.

Freedom from Hunger is working with a different microfinancing group in each of the five countries participating in this programme.

In Bolivia, Crecer (Crédito con Educación Rural), a not-for-profit civil education and microfinancing organization, provides its clients and their families medical-emergency loans.

In keeping with Crecer's group-liability requirement, the loan must be co-signed by a fellow microfinancing client, who provides some form of good-faith collateral such as property or livestock.

Crecer anticipates offering the service to members (borrowers become members of the group) who have completed two loan cycles so there is a loan-repayment history. The loan term will be for 12 months or less, with weekly or bimonthly payments.

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Mohammad Yunus, this year's winner of the Nobel Peace Prize, is pictured talking to people from a village in Bangladesh about the benefits of the microcredit system. Yunus, the founder of Grameen Bank in Bangladesh, won the prize for his pioneering work providing microcredit in the form of small loans to help poor people set up a business.

For Freedom from Hunger's MAHP project in West Bengal, India, the microfinance institution BANDHAN is developing an informal health education system to teach people how to take control of their own health and how to access health services in their communities. This effort is combined with an emergency health loan.

Freedom from Hunger's programme in Burkina Faso, called Réseau des Caisses Populaires du Burkina (RCPB), is testing a health-savings product in which participants put money into a medical savings account and receive cards listing their balance.

Participants can take these cards to a local clinic or pharmacy and receive health services or prescriptions, and the money from the appointment is automatically deducted from their account. This way, Reinsch says, patients don't have to worry about showing up with cash.

In neighbouring Benin, Freedom from Hunger is working with the non-profit Association Pour la Promotion et l'Appui au Développement de Micro-Entreprises (PADME), which is looking at a programme combining credit with education based on Freedom from Hunger's model.

Participants, mostly women, are given a micro-loan to start a business, but periodic meetings — at which they make their loan payments — double as education sessions covering health, nutrition, family planning and sound business practices, according to Freedom from Hunger's web site.

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Such programmes can learn from previous attempts to address health-care financing issues.

For instance, Michael Kent Ranson studied a programme in Gujarat, India, run by the Self-Employed Women's Association's Medical Insurance Fund.

He looked at what effect reimbursing all or part of the costs of hospitalization had on poor families and found that health insurance reimbursement more than halved the percentage of what he termed "catastrophic hospitalizations", that is, those that cost more than 10% of annual household income, and of hospitalizations that resulted in impoverishment.

This system helped to protect the poor, but problems remained. For one, health-care expenses even after coverage were still often catastrophic; for another, programmes that exclude the wealthy collect limited premiums and may not be sustainable. Ranson also noted that the amount of money spent on hospitalization may have been skewed by items that don't carry receipts, such as bribes and gifts for health-care personnel.

In Cambodia, the health ministry, in conjunction with UNICEF and Médecins Sans Frontières (MSF), tried to address the problem of so-called informal payments, which add hidden costs to medical care that aren't reimbursable by insurance.

It did this by formalizing those payments and making them part of the official process, which meant they were covered. In addition, such informal payments were prohibited, but in return, health-care workers got a bit more money.

With the blessing of Cambodia's health ministry, MSF and UNICEF set up the Health Equity Fund, administered by an NGO specialized in the area, to step in and pay for health care for those who couldn't.

It turned out that, according to an analysis of such a fund in Sotnikum, Cambodia, published in *Health Policy and Planning* in 2004, the Health Equity Fund's main strength lay in preventing expenditures by encouraging people to seek care before catastrophic illness. ■

Theresa Braine, *Mexico City*

Pakistan, Afghanistan look to women to improve health care

Women health workers have been vital in improving the health of women and children in Pakistan. Inspired by its neighbour's experience, Afghanistan is embarking on a similar programme to encourage women to work in the health sector.

Khalda Perveen ventures where trained doctors rarely dare to go. She is among more than 90 000 Lady Health Workers who are working to increase health awareness and improve child and maternal health across Pakistan, particularly in poor rural areas where three-quarters of the country's population live.

"In remote areas where there are no doctors, Lady Health Workers perform an important role: we go to areas where other health professionals won't go," Perveen, 29, said. "But still some people don't accept us and think that as women … we shouldn't be working."

Run by the Pakistani government's National Programme for Family Planning and Primary Health Care, the Lady Health Workers scheme was launched in 1994 to reach out to remote, tribal communities where strict adherence to social and religious customs has long hampered women's ability to work as health workers and seek health care.

Similar traditions exist across the border in war-torn Afghanistan, where maternal and under-five child mortality are high. More women — an estimated 1600 per 100 000 — die in childbirth than in any other country, bar Sierra Leone, according to WHO. Child mortality is also among the world's highest. According to WHO's most recent estimates, 257 children in Afghanistan die out of every 1000 born.

Afghanistan has much work to do after two decades of conflict and neglect — particularly during the 1992–96 civil war and subsequent Taliban reign — left the country's health system in tatters.

Now the country is embarking on a programme similar to that of the Lady Health Workers that is credited with significantly improving health care across Pakistan.