

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.

“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 as-

sess 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.

Keystone/AP/P. Rahman

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.

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*

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Ke Xu, a health economist at WHO.

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.



Paul Garwood

Shaban Rafik (in blue), a 20-year-old Lady Health Worker, consulting women in the town of Chikar in Pakistan which was badly affected by the October 2005 earthquake.

Great distances from homes to health centres, widespread illiteracy that limits educational and employment aspirations of women, and tribal customs that forbid women to work or be visited by male health workers compound difficulties faced by many Afghan and Pakistani women and children seeking health care.

Due to these barriers, few women use services that are provided by health facilities staffed by male health workers. A 2002 survey found that only 40% of Afghan basic health facilities employed female health-care providers.

That is why Nagis, an Afghan woman aged in her 30s and who uses just one name, gave birth at home recently to a daughter who died several days later. She said that during her pregnancy she couldn't go to the clinic in her village of Rabat, north of the Afghan capital of Kabul, because there were no female doctors or midwives there.

"It is generally considered taboo here for men to treat women," Nagis said.

Pakistan has been tackling the barriers to women receiving basic health care by training an army of Lady Health Workers to raise health awareness among communities that are cut off from hospitals and health centres by

social barriers and distance, Dr Zareef Khan, Deputy National Coordinator for the programme, said in an interview with the *Bulletin*.

The campaign started with 8000 workers in 1994 and now has 92 000 across the country. By the end of 2006, 100 000 workers will be in the field and a further 10 000 should be introduced by 2008.

Khan, an architect of the health worker scheme, said Pakistan's high maternal and infant mortality forced the government to improve the delivery of health services to the population.

Prospective workers do three months in-class training to learn how to provide basic health services, such as family planning, immunization, hygiene, and maternal and child health. Then they do a further 12 months' work experience in the community, before being sent to a village in the area where they come from.

"Pakistan's health system is unable to cater for all the population in rural

areas. In some areas, the closest basic health unit is seven kilometres from someone's house," Khan said.

But the Lady Health Workers programme provides at least one worker in every village with a population of at least 1000 (or 150 households).

A. H. Jokhio, H. R. Winter and K. K. Cheng found in their study

published in the *New England Journal of Medicine* in 2005 that perinatal and maternal deaths decreased significantly when female health workers helped train birth attendants and connected them to formal health services.

"I am very happy in the work that I am doing because I am raising awareness and working for humanity,"

said Sajda Yacoub, who has been a Lady Health Worker in Pakistan for 12 years.

Efforts to introduce similar programmes in Afghanistan are taking shape, but WHO predicts that it could be eight years before enough Lady Health Worker-equivalents are in place.

“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.”

Khalda Perveen, a Lady Health Worker in Pakistan.

WHO's representative in Afghanistan, Dr Riyad M. F. Musa Ahmad, said maternal health-care services are unequally distributed throughout the country and most women, especially from rural areas, have little or no access to health care when they are pregnant and give birth.

In some remote Afghan areas, female doctors and community health workers have been introduced to provide obstetric and gynaecological care, Ahmad said.

Afghanistan's Ministry of Public Health, with the support of partners including WHO and UNICEF, is training community midwives and female community health workers to serve in the country's rural areas, where 77% of the population lives.

“My presence here has encouraged more women to come [to this health clinic] ... They feel more comfortable dealing with female doctors.”

Dr Wahida Jalal Marzada, the first female doctor at a health clinic in the district of northern Salang, Afghanistan.

Based on population data and government targets, Afghanistan needs up to 10 000 midwives to deliver babies and manage life-threatening complications, according to Ahmad. In 2002, Afghanistan had only 467 midwives.

The new initiative's aim is to train 1200 midwives annually so the 10 000 target can be reached in no more than eight years.

Afghanistan also needs between 22 000 and 84 000 female community health workers, similar to Pakistan's Lady Health Workers, but to date

just 5000 male and female workers have been trained.

“My presence here has encouraged more women to come [to this health clinic],” says Dr Wahida Jalal Marzada,



Sajda Yacoub, who has been a Lady Health Worker in Pakistan for 12 years.

Paul Garwood

who last year became the first female doctor at the northern Salang district's health clinic. “They feel more comfortable dealing with female doctors.” ■

Paul Garwood, *Islamabad*

Maternal health care wins district vote in Uganda

One district in Uganda has dramatically reduced the number of women's deaths due to pregnancy and childbirth. Now the government is considering how to extend the same level of maternal care to women to the country's remaining 75 districts.

When Dr Godfrey Egwau, a consultant obstetrician at Soroti Regional Referral Hospital's maternity unit, stood for parliament in February, voters knew that if he won he would move to the capital, Kampala, about 280 km away.

Women in Soroti district weighed this and overwhelmingly voted for his opponent. Egwau, who dreamed of going into politics, lost the election.

Many associate Egwau with the high standard of maternal care provided here. He is proud of the district's record, but says the good work is not his achievement alone.

“When I stood for parliament in the last elections, they refused to vote for me, saying ‘this is our good doctor, he cannot go!’ It's true, we have succeeded, but we need to move away from individualization,” Egwau said.

Many women across Uganda give birth without knowing whether they are HIV positive.

But pregnant women, like Connie*, who come to the Soroti hospital receive routine HIV counselling and testing. Of some 500 admissions a month, 30–40 test positive and are provided with treatment to prevent transmission of HIV from mother to child.

When the 22-year-old mother's result was positive, she was given medicine to prevent her from infecting her daughter, counselling, and she was put on antiretroviral (ARV) treatment.

“Our rule is simple: for each mother there must be a baby to go back with and for each baby, there must be a mother to go back home with.”

Dr Godfrey Egwau, a consultant obstetrician at Soroti Regional Referral Hospital.

Since February 2005, life-saving ARV medicines have been provided free to patients in Uganda who are HIV positive.

Soroti district became the test ground for a pilot of the WHO programme, Making Pregnancy Safer (MPS) from 2001 to 2004, the central principle of which is to make skilled care available for every birth. Since

then, the district has continued to provide this high level of maternal care. Thousands of women like Connie have benefited.

Uganda is one of many countries taking the MPS approach, including Bangladesh, Bolivia, Kenya, India, Indonesia, the Lao People's Democratic Republic, the Republic of Moldova, the Philippines, Timor-Leste, the United Republic of

Tanzania and Zambia.

“The success of the Making Pregnancy Safer initiative in Uganda

* not her real name



Carolyn Nakazibwe

Dr Godfrey Egwau talking to a mother who gave birth to her 8th baby at Soroti Regional Referral Hospital.

is evidence enough that with proper technical, financial and social support of whatever kind, and by working directly with local governments and health managers, we can make a difference,” said Dr Quazi Monirul Islam, Director of WHO’s Making Pregnancy Safer Department.

According to a report entitled: *Making Pregnancy Safer in Soroti*, presented by Egwau in September this year, Soroti district reduced maternal mortality from 750 deaths in 2000 to 190 deaths for every 100 000 live births in 2006.

“Our rule is simple: for each mother there must be a baby to go back with and for each baby, there must be a mother to go back home with,” Egwau said. “It is an exciting thing to work in this district, because you see results.”

“We think MPS (Making Pregnancy Safer) is something that can be duplicated [in other parts of Uganda].”

Dr Jacinto Amandua, Commissioner for Health Services at the Ugandan Ministry of Health.

Under the WHO programme, according to Egwau, 43% of women living in Soroti now give birth with help from a trained health worker, as opposed to 26% before the MPS project started. The national average stands at 38%. The district has also recorded a 100% antenatal attendance (at least one antenatal visit), Egwau said.

Serere Health Centre IV, about 27 km from Soroti town, provides pregnant mothers with most services, including minor surgery. Women are only referred to the main hospital in Soroti if they need a Caesarian section or if there are major complications.

Serere has one ambulance driver, Yusuf Kayondo, 28, who earns Shs 95 000 (US\$ 52) a month and is on call 24 hours a day.

Even when the district suffered a year of insurgency in 2002 by rebels of

the Lord’s Resistance Army, Kayondo stayed on and drove out in his four-wheel drive to every pregnant mother in outlying villages who contacted him by radio or village phone.

Sometimes he fetches women 20 km away on bad-to-non-existent roads. “They give me rough directions, ‘pass the village church and the big mango tree. It is the house nearest to the lake’,” Kayondo said.

Of hundreds of pregnant women he has transported since he started five years ago, two died during the journey due to excessive bleeding.

“My business is saving lives. As long as my [ambulance] is okay, I am okay; that is all that matters,” said Kayondo, whose ambulance was provided as part of the MPS project.

Despite the lack of resources and shortage of skilled health workers, the principles of Making Pregnancy Safer have been embraced in outlying parts of Soroti district.

Akobo Community Health Centre is run by a nurse who doubles as midwife. It serves three villages each

with 25 community volunteers who scout for cases that need urgent medical attention and educate people about reproductive health, malaria and other health issues.

The centre has no running water or electricity, and has had no medicines since May, but it does have a bicycle ambulance that transports pregnant mothers to Serere Health Centre.

According to one community leader, Akoboi used to lose 30 women a year in child birth while the last year has gone by without a single death of a pregnant mother.

Beyond Soroti, maternal mortality is a major concern in Uganda's 75 other districts. In 2000, average maternal mortality stood at 880 deaths for every 100 000 births.

In Kampala, Dr Jacinto Amandua, Commissioner for Health Services at the Ministry of Health, said the government could adopt the MPS model across the country within the existing health budget.

Amandua said the government has been recruiting more health workers and purchased 163 ambulances over the last two years. Access to health centres within 5 km radius has also improved from 49% to 72%, according to the health ministry's Demographic Health Survey.

"We think MPS is something that can be duplicated [in other parts of Uganda]. It is something for which investment in health is necessary," said Amandua. ■

Carolyne Nakazibwe, *Soroti*



Bicycle ambulance transporting a pregnant mother from Akoboi Community Health Centre to Serere Health Centre.

Carolyne Nakazibwe