SPECIAL ARTICLE

MICROFINANCE: AN ALTERNATIVE MEANS OF HEALTHCARE FINANCING FOR THE POOR

According to recent World Health Organization estimates, every year 25 million households (more than 100 million people) are forced into poverty by illness and the struggle to pay for healthcare.[1] This coupled with the lack of basic health infrastructure in rural and remote areas aggravate the health conditions of the poor, leaving them in a perpetual state of poverty. Access to health services and health protection is a key component of the fight against poverty as good health is a major driver of economic development and a necessity for the poorest nations' climb out of poverty.

An efficient healthcare system is critical in breaking the vicious cycle of poverty and poor health. Moreover, it is critical in meeting the Millennium Development Goal (MDG) of "marked improvements in the health of the poor by the year 2015." For many developing countries, the goal of providing affordable healthcare to all has been an arduous task. In an attempt to improve access to affordable healthcare, a number of sub-Saharan African countries adopted several models of healthcare financing, most of which have been wholly unsuccessful at reaching the poor. These healthcare financing models range from a "free health care for all" model to a fee collection at the point of service popularly referred to as cash-and-carry model. Funding for the "free health care for all" was unsustainable because governments were unable to generate sufficient tax revenues. Consequently, very limited public expenditure was dedicated to public health, particularly in the rural areas.[2] Likewise, the "cash-and-carry" healthcare model made healthcare accessible only to those who could afford it, excluding the poor from health care utilization.

Recent interventions by NGOs in the form of community based health insurance schemes or Mutual Health Organizations (MHOs)[1] have been fairly successful in improving access to healthcare. In 2003, realizing the potential that MHOs have to increase healthcare utilization and protect people against catastrophic health expenses, the government of Ghana became the first country in Africa to set up MHOs in every district in Ghana through the National Health Insurance Act. As of January 2007, approximately seven million people (35% of the total population) have enrolled in MHO. Enrolment in MHOs is low, especially among the poor. Many, particularly those in the informal sector, still have difficulties joining MHOs due to the irregularity of their incomes. Individuals who become members of MHOs eventually abandon their memberships because of their inability to make payments on their dues and insurance premiums.[3]

Recognizing the challenges of healthcare financing in developing countries and that the failure to reach the poor may undermine a successful implementation of MHOs in Ghana, this paper seeks to make a case for why the microfinance model is best suited to fill the gap in improving access to healthcare. First, the paper will discuss why microfinance institutions are best suited to provide alternate forms of healthcare financing. Second, we will highlight the advantages that it offers its clients and the healthcare system as a whole. The paper concludes with a discussion of how the integration of healthcare financing into microfinance can improve affordability of MHO premiums for the poor ensuring continuous access to healthcare, which, in the author's view, is a good solution to what has proven to be a perpetually difficult problem for African nations.

Providing healthcare to the poor is a Herculean task; one that consumes a large portion of a government's scarce resources, and one that businesses perceive to be commercially unviable. The challenge governments face in financing healthcare lies in their ability to create accessible and affordable healthcare systems that have scale (reach), permanence (multi-generational), and are supported by sustainable financing mechanisms. Thus, the issue of poverty and human development cannot be tackled without a critical look at innovative strategies that create an efficient, affordable, and accessible health care system. The microfinance model, by virtue of its demonstrated ability to reach the poor, is an innovative tool that can be used to improve the delivery of healthcare to the poor, particularly those in remote rural areas.

[1] Mutual health organizations (MHOs) are health insurance organizations based on communities or associations that are managed by members and created to provide financial protection from health risks.

Over the past 30 years, microfinance has proven to be one of the few poverty alleviation strategies that has helped impoverished individuals improve their household economic situation through job creation, development of micro enterprises, improved access to education, and healthcare. Born out of the simple notion that the poor can save and are bankable, microfinance is the dissemination of small loans to help the impoverished who will otherwise not have access to loans, to engage in a variety of economic activities. Microfinance has been successful in reaching the poor and helping them gradually escape from poverty because of its strong competency in using scarce resources to efficiently reach the underserved.

Because of its success at poverty alleviation, the microfinance model is increasingly being replicated to provide much needed auxiliary services for the poor. Currently, several Microfinance Institutions (MFIs) integrate non-financial services, such as training sessions on nutrition and health, particularly HIV/AIDS, reproductive health, and malaria preventive measures into their credit schemes. These services, in addition to access to credit, have had a positive impact on the health and nutrition practices of the poor. However, the affordability of health services continues to be a problem. A few microfinance organizations have began to, in addition to health education, adopt innovative strategies based on the microfinance model to facilitate linkages to health service products and providers by financially empowering the poor to finance their healthcare needs.

An MFI-organized and managed alternate healthcare financing scheme provides access to preventive and curative health services as well as financing in the form of health savings plans and emergency health loans. These financing schemes are different from some of the community-based health insurance and MHO schemes. As aptly put by Ke Xu, a health economist at the WHO, "such schemes are not about health insurance per se…they are there to protect people from the financial risk incurred by having to pay high costs for health care service".[4] The microfinance model provides the poor and the financially vulnerable options and the wherewithal to cope with financial shocks associated with sudden illnesses by providing health savings plans, emergency health loans to access to health products within the community.[5] The provision of such financial products by MFIs is likely to make the MHO premiums more affordable to the poor.

Integrating healthcare financing into a well-established microfinance organization is a unique way to bring healthcare financing to many communities and to mitigate the financial risks associated with poor health. MFIs are the perfect intermediaries in this effort as they can leverage the outreach and the rapport that they have established with their clients and the community to reach a greater number of people, thereby making these financing mechanisms available to a larger population. An MFI-managed alternate health financing scheme is no magic bullet, but for the poor, it can contribute toward the removal of barriers to healthcare services; and for governments ensure the long-term sustainability of MHOs. This collective pooling of health risks minimizes the income drainage the poor experience from the high cost of healthcare and creates accessibility to the 'quality health care' services. More importantly, the poor have improved access to healthcare with minimal reliance on a third party footing the bill.

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