How do you bring health care to the poor?

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If you want to provide poor people in developing countries with decent health care, you need to overcome several barriers at the same time. That is the conclusion of researcher Bart Jacobs, based on years of research in Cambodia – and on his experience in several other low- and mid-income countries. The local community and existing social networks play an important role, but the authorities also have a role to play. His analysis has in the mean time been partly incorporated in Cambodian national policy, and it resulted in a PhD at the Antwerp Institute for Tropical Medicine and the Vrije Universiteit Brussel.

Immediately after defending his thesis, Jacobs returned to Laos, to suit the action to the word. There he advises on the development of health insurance and health equity funds, that reimburse reimbursing health providers for the services rendered to the poor. Systems we in the West take for granted. But in a poor country, not much can be taken for granted. Even if there are vaccines, surgical techniques, drugs, mosquito nets and other things that bring much benefit for little money, that doesn't mean they reach the poor.

Because the health care supply doesn't reach them, or because their demand doesn't get to the suppliers – and often both.

In the previous half century, the life expectancy of an earthling rose from 46 to 65 years, but that doesn't imply the poor had an equal part in it. More than 90% of childhood mortality takes place in only 42 – poor – countries. If twenty reasonably simple interventions were available for everyone, childhood mortality would go down with two thirds.

In a low-income country, Cambodia, Jacobs investigated how demand and supply could be reinforced, for instance by financing health care interventions through local communities, or by organising equity health funds or similar mechanisms. 'Pagoda-initiatives' are such a 'similar mechanism': Buddhist monks from a local temple – a pagoda – beg with the richer people in the community and then pay physicians to treat the poor for free.

But who is poor, and who decides so? When somebody presents at the hospital, it is too late to decide if they can be considered as poor, because many poor never present at the hospital in the first place. If they know beforehand that they are entitled to free care, they will look for care more easily. Defining who's entitled can be done best within the local community, that knows who are its poor members. Thanks to this identification system more poor people contact physicians and hospitals.

Jacobs also examined the supply side: does it make sense for the authorities to abolish user fees for certain groups, or to monitor the performance of health care providers?

After the introduction of user fees – whereby patients (partly) pay for the care they receive – however strange it may seem, more patients showed up at the hospital. Because they had the feeling they were better taken care of, by better paid and therefore better motivated doctors. Unfortunately the extra patients were (relatively) rich; the poor did not show up more. Even in the case of free care, they need to lend money, because travel costs an loss of income are not covered. The health equity funds now also incorporate those costs.

In the mean time, partly due to Jacobs' results, Cambodia started with a nationwide identification of the poor, and stimulated the head monks of pagoda's everywhere to also create a pagoda health equity fund in their region. The pagoda system now reaches some 300 000 poor.

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