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Catastrophic health expenditure

Sir—Ke Xu and colleagues (July 12, p 111)[1] present impressive evidence of the degree of catastrophic health expenditure in many countries, especially those in transition. Our work and field research with Médecins Sans Frontières in Cambodia confirms that there are indeed reasons to be concerned, since debt incurred to cover health expenditure is fast becoming the main cause of poverty.[2]

However, we worry that the methods used by Xu and co-workers could have underestimated the severity of the situation for two reasons. First, people often fund health expenditure by making debts or obtaining credit from the provider. These mechanisms might be incompletely accounted for, since people often do not, or incompletely, declare such types of expenditure, unless explicitly asked to do so, which is unusual in general expenditure surveys. Second, catastrophic health expenditure in Cambodia is mainly incurred when using unregulated private practice, for the most part for unnecessary treatment.[3,4] Such practices have been growing since 1999 (the date of the survey used in the study for Cambodia).

Xu and colleagues are cautious in identifying catastrophic health expenditure as a cause of poverty. Indeed, in many countries the use of savings, or existing social assistance and solidarity networks, might protect people facing high out-of-pocket expenditure from poverty. However, as has been described for other regions,[5] we note that in Cambodia many people not only cut back on consumption, but also sell productive assets and take children out of school to cover health expenditure. Such actions could jeopardise future income generation. The most common strategy, however, is to borrow the money needed. The loans, on which interest rates as high as 10% per month are common, then place a constant drain on resources. With the emergence of a land market—which did not exist before economic liberalisation—such debts often result in rural subsistence farmers selling their land, thus undermining their livelihoods.[3,4]

The main solutions proposed by Xu and colleagues involve the reduction of out-of-pocket expenditure through the development of social insurance, or funding of health services by way of general taxes. There is no doubt that these are the preferred long-term solutions. However, we doubt both the ability and the willingness of the government of a country such as Cambodia to develop such strategies.

Developing social insurance systems or a sound general tax base in a country where these do not yet exist will take decades, and both will depend on a highly regulated health-care provision system to ensure that money is spent efficiently. Increased donor funding, both for the development and functioning of public health-care provision, and social assistance through safety net procedures—to ensure that the poor actually have access to such services—are needed in the short term.

If governments and donor agencies are serious about reducing poverty then catastrophic expenditure and how it creates poverty should receive due attention. Realistic solutions, both long term, such as proposed by Xu and colleagues, and short term, such as donor-funded health equity funds in Cambodia, need to be developed and funded.

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1 Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL. Household catastrophic health expenditure: a multicountry analysis. *Lancet* 2003; **362:** 111–17.
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3 Van Leemput L, Van Damme W. Dengue epidemic in Thmar Pouck, April–December 2001: disease and its cost in rural Cambodia. Phnom Penh: MSF Cambodia, 2002.
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5 Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? *Lancet* 2001; **358:** 833–36.

Sir—Ke Xu and colleagues' article[1] raises important questions about health expenditure and the financial security of households, an issue that has, as noted by the authors, "long been ignored on the health policy agenda". Xu and co-workers' study adds to the evidence on the effect of health systems on households, and the time has come to put this and other research to use for effective policy making. We have learnt a lot about the equity and efficiency of health-care financing mechanisms, and a few key lessons are essential.

First, the uncertainty of health need, the catastrophic costs of medical care, and the risk-averse nature of individuals, places risk pooling at the centre of health-care financing. Collective arrangements for funding health care, such as health insurance, can protect individuals from financial loss when adverse health events arise. Individual risk is reduced by pooling a large number of people—the larger the risk pool the more precisely insurers can predict the probability of financial loss due to illness; therefore, the more accurately they can plan for, and spread, risk.

Health systems in many low-income and middle-income countries do not take advantage of the equity and efficiency that accrue from risk pooling through insurance. Common constraints include low individual incomes, high prevalence of informal incomes that escape taxation, and low administrative and tax-collection capacities.[2] These constraints typically result in low amounts of health-care spending and risk-pooling, health-related capital stock—such as beds and drugs—and human resources—such as nurses and doctors.

Second, low-income countries, due to lower degrees of, and less targeted, public expenditure, are generally characterised by greater inequality in the distribution of financial and health-related resources than more developed countries.[3] Direct payment (paying out-of-pocket) is the least equitable and efficient form of health-care payment. However, it is the primary means of financing health expenditure in many low-income and middle-income countries. Private insurance has been

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