

REACHING THE POOR WITH HEALTH SERVICES

2008

Cambodia

Exempting the Poor from Hospital User Fees

The Issue

Cambodia's Health Equity Funds seek to address the classic limitation of efforts to exempt the poor from user fees: the loss of income that such exemptions have typically represented for service providers, and the providers' resulting reluctance to grant them.

This problem dates from the late 1980s, when developing country health ministries increasingly began to introduce user fees in their facilities, on the advice of leading international agencies and as a way of helping deal with their dire financial situations. On paper, the ministry plans usually included a provision for exempting the poor, and sometimes these were effective. But often, they were not. Implementation often consisted of little more than circulars to facilities that front-line providers tended to ignore or interpret very narrowly, especially when a significant portion of user fee revenue was retained at facilities and represented a badly-needed source of health worker income. In such settings, few exemptions were granted, leaving poor people to bear the brunt of user fees along with everybody else.

The most obvious solution to this problem—that is, to reimburse service providers for the income they lost in attending to poor clients—suffered from equally obvious difficulties. One was cost. As noted, Governments had been attracted to user fees in large part because of their potential for revenue generation, but to the extent that fee income remained at the facility level, the resources of central health ministries remained the same. To make reimbursement payments to facilities for the income they had foregone in granting exemptions represented an additional expense that few ministries felt they could afford. Also important were logistical challenges: even had ministries been willing to bear the

cost, most would have faced formidable challenges in developing systems to verify the accuracy and honesty of facility reimbursement claims, and to transfer funds promptly to the facilities concerned.

Cambodia was one of many countries confronted with this problem. Its health system had been virtually destroyed during the Khmer Rouge regime of the 1970s and the civil war that followed. Reconstruction had proven difficult, with the ministry unable to provide adequate and reliably steady financial support to its outlying facilities. Thus, user fees had been introduced in 1997, with almost all of the revenues retained by facility staff in order to supplement salaries and help cover running costs. The government had issued a decree exempting the poor, but few exemptions had been issued. The resulting cost to the poor had become a major concern.

The Approach

In response, some of the many external non-government organizations active in Cambodia began experimenting with alternative approaches to health financing in the areas where they were working. Among the approaches emerging from this experimentation was that of a “health equity fund” (HEF)—a fund operating independently of the health system, whose staff identified people in particular need of financial assistance for health services, especially hospital care, and paid health service providers for the service provided to the needy.

By late 2006, there were twenty-six HEFs in operation. Each of the twenty-six projects is autonomous. All share the basic defining characteristic noted above—that is, all feature



an independent organization identifying poor people and reimbursing service providers on their behalf. However, there is also considerable variation among them.

Administration. Although a few HEFs are administered directly by international agencies, most are managed by Cambodian non-governmental organizations (NGOs). Many different types of NGOs are involved. For example, some are pre-existing national organizations; others are local, created specially to operate the HEF. In at least one case (Kirivong), Buddhist monks from local pagodas play a prominent role in the administering agency.

Definition of Eligible Population. All HEFs define the people eligible for support in terms of specified household characteristics. However, the procedures used in determining which characteristics apply are usually considerably less formal than the proxy means testing procedures (like those described in the Colombia and Mexico Progresas Reaching the Poor briefs) which use statistical analyses of household survey data to determine which characteristics are most closely associated with poverty. More often, the Cambodia HEF procedures draw on the views of knowledgeable local observers concerning the characteristics that most clearly denote poverty. The characteristics most commonly identified include the occupation and marital status of the household head, number of dependents, land ownership, housing construction materials, and possession of productive assets.

After a list of characteristics is drawn up, people lacking a certain portion of them are deemed eligible for HEF subsidies. In some cases, more than one poverty level is established, with those deemed “very poor” being eligible for greater benefits than those categorized as “poor.”

Identification of Eligible Population. Once the criteria for HEF support have been defined, those people meeting those criteria have to be identified. This is done in two different ways: passively and actively.

Passive identification features a determination of the poverty status of people once they arrive at the health facility. This is typically done by HEF staff members stationed in the participating health facilities. If a patient reporting to the facility reception lacks the money to pay the facility’s admission fee, the receptionist refers her or him to an HEF staff member, who asks a series of questions about the household. Should the responses indicate that the patient is poor accord-

ing to the definition used, the HEF representative arranges for the provision of program benefits for that person. HEF staff members also often visit the facility wards to determine if there are other patients who qualify for benefits—say, patients who were able to pay the admission fee only by borrowing heavily or by selling important productive assets. Where possible, HEF staff visit recipients of support in their homes after discharge, in order both to double-check their financial status and to provide social support.

Active identification, also known as pre-identification, involves surveying a district’s population, in order to determine in advance who is poor enough to qualify for HEF assistance. Those who qualify are issued some sort of identity document that they produce upon arrival at a participating health facility. In some cases, the survey is conducted by outside investigators using a formal questionnaire. In others, the procedure is considerably simpler, drawing on the local knowledge of respected community leaders.

The two approaches are not mutually exclusive, and some HEFs use some combination of the two. This is because each approach is recognized as having both advantages and limitations. Advocates of the passive approach cite its simplicity and thus low cost, its acceptability to people in the areas covered, and the possibility of implementing it without the extended period often needed to establish a pre-identification system and the considerable effort to keep it up-to-date. At the same time, they acknowledge that the passive strategy risks missing the many poor people not aware of the financial support available and reluctant to come for service. Practitioners of active or pre-identification argue that the greater complexity and cost of this approach are more than justified by the greater accuracy and coverage among the poor that it permits. See Table 1 for information about the identification procedures and criteria used to identify beneficiaries for four hospital-based HEFs in Cambodia.

Proportion of Population Found Eligible. Application of the procedures just described has led to varying percentages of the population found to be eligible for HEF support, reflecting in part differences in economic conditions among the districts covered, and no doubt also in part the result of differences in the definition procedure used. In general, the percentage of the population found eligible ranged from approximately 12% to 25% of the total. These percentages are usually well below the 35–75% of the population in the areas concerned living below the \$1/day poverty line.

Table 1. Procedures and Criteria Used in the Four HEFs to Identify the Poorest.

	Svay Rieng	Pearang	Kirivong	Sotnikum
Identification process				
Identification method	Household assessment	Household assessment	Household assessment	Household assessment
Selection place	Household	Household	Village	Hospital NGO office
Selection time	Ex-ante	Ex-ante	Ex-ante	At the illness episode
Selection process	Pre-identification (proxy means testing) Verification (Data entry (database))	Pre-identification (proxy means testing) Verification (Data entry (database))	Pre-identification Approval by Chief Monk Edition of entitled list	Passive identification (proxy means testing) at episode of illness, at hospital, by local NGO staff
Selection tool	Formal scored questionnaire	Formal scored questionnaire	Informal list of criteria for community-based targeting	Informal. Non-formalized interview.
Entitlement document	Equity certificate Database	Equity certificate Database	Voucher (non-permanent) Entitled list	None (except records in the books of the NGO)
Alternative process	Passive identification at episode of illness, at hospital, by hospital staff	Passive identification at episode of illness, at hospital, by NGO staff	Certification letter signed by the pagoda chief monk	None
Criteria				
Household characteristics	Occupation of household head Marital status No. children <18 years No. elderly dependents	Occupation of household head Marital status No. dependents	No. dependents (alt. criteria)	Marital status No. disabled members No. dependents No. children at work
Health status		Length of severe illness during the previous year		Chronic disease in household
Productive assets and belongings	Type of housing Transport means Size of land No. cows, buffalos and pigs	Roof and wall and m ² /person Size of productive land Electronic items Transport means Farm assets and livestock Power supply Quantity of rice harvested	Type of housing Size of farmland Transport items (alt. criteria) Farm animals (alt. criteria) Electronic items (alt. criteria)	Size of land/rice fields Productive assets
Income/expenditures		Cash income/expenditures Health expenditures during the previous year	Household income	Lack of food security
Others				Appearance and social capital
Scoring	Score/criteria and threshold	Score/criteria and threshold	None	None

Source: Noirhomme et al., Health Policy and Planning, 2007

Services Covered. The services supported by the HEFs are delivered through government facilities. Most HEFs deal primarily or exclusively with fees charged for services in district hospitals, which are considerably higher than those charged for primary care at lower-level facilities and thus further beyond the means of poor patients. Some of the HEFs have begun to extend the scope of their activities to include costs to patients of primary care provided at lower-level facilities.

Benefits provided. As indicated earlier, the most common benefit offered by HEFs is payment of user fees on behalf of those found eligible for support. Often, the payment is for the full amount of the fees concerned, but other patterns exist. In some cases, for example, the proportion of the fees covered varies according to just how poor the patient is. Some of the HEFs go beyond this by also providing transportation, food allowances, and other benefits when needed.

Cost. On average, the annual cost of operating the HEFs appears to be on the order of \$US 0.50 per person found eligible for support. However, this figure varies widely depending upon the benefits provided, the approach employed to identify beneficiaries, and other considerations. A recent WHO study suggests a range from \$US 0.10–0.15 to nearly \$US 2.00 per eligible person.

Source of Funds. The funds required to cover these costs come primarily from external agencies. They and international NGOs receiving their support have also played a leading role in introducing HEFs and the broader reforms of which they have been a part. A notable exception to this funding pattern is the Kirivong HEF, referred to above, where the Buddhist pagodas helping administer the project also raised a part of the required resources by soliciting donation from better-off families in the project area.

The Initial Record and Future Prospects

During their initial two or three years, most of the HEFs with available data have recorded significant increases in the number of people receiving hospital services with HEF support.

By the end of 2004, the latest period for which data are available, HEF support recipients varied between less than 10% to over 50% of all patients in the hospitals concerned.

Data on hospitalizations for HEF beneficiaries and non-beneficiaries in four hospital-based HEFs (Sotnikum, Svay Rieng, Pearang, and Kirivong) between the third quarter of 2000 and the last quarter of 2004 can be seen in Figure 1. Increases in patients at three of the HEFs took place after these were launched (Sotnikum and Svay Rieng) or after household equity certificates were distributed (Pearang). According to data collected for the latter three hospitals, it seems that the HEF-supported patients are new clients who previously could not access the services for financial reasons. While it can be assumed that the creation of the HEF affected the patient numbers for these three hospitals, the proportion of patients using the hospital at Kirivong was too small to draw any conclusions about HEF impact on hospital access in that area.

Although the HEFs have yet to be as rigorously evaluated as some other health equity projects, they appear to be achieving their objective of reaching Cambodia's lowest economic groups. In one rural HEF (Sotnikum), over 90% the patients it supported were either poor or very poor, compared with 60% in Cambodia as a whole and 75% in the district where it operated. In another (Kirivong), HEF beneficiaries were significantly poorer than other district residents with respect to all of the dimensions measured: occupation, literacy, income, land ownership, and others. A further suggestion, or at least hint, that this is the case comes from data indicating that the number of paying hospital users has remained steady as the number of HEF beneficiary users has risen, implying that better-off people have continued to use their own funds rather than draw upon HEF resources.

The twenty-six HEFs established by late 2006 cover about a third of Cambodia's 76 health operational districts. The HEF concept has received strong governmental support, and has become part of the government's poverty reduction strategy. As a result of this and continuing donor interest, the number of districts covered by an HEF is expected to rise significantly over the coming years.

Figure 1. Hospitalizations for HEF beneficiaries and non-beneficiaries in the four HEFs.



Source: Noirhomme et al., Health Policy and Planning, 2007

This brief is intended to summarize good practices in reaching the poor with health, nutrition, and population services. It is based primarily on a 2006 series of three articles published in the journal *Health Policy and Planning*: Mathieu Noirhomme *et al.*, “Improving Access to Hospital Care for the Poor: Comparative Analysis of Four Health Equity Funds in Cambodia” (vol. 22, 2007, pp. 246–62); Bart Jacobs and Neil Price, “Improving Access for the Poorest to Public Sector Health Services:

Insights from Kirivong Operational Health District in Cambodia” (vol 21, 2006, pp.27–39); and Wim Hardeman *et al.*, “Access to Health Care For All? User Fees Plus a Health Equity Fund in Sotnikum, Cambodia”, (vol. 19, 2004, pp. 22–32). Without wishing to implicate them any way for the brief’s contents, the editors thank Frederic Bonet, Bart Jacobs, Bruno Meessen, Mathieu Noirhomme, Ir Por, and Wim Van Damme for information provided through personal communications.

