World Bank Seminar

Waivers, exemptions, and implementation issues under user fees for health care

Equity Funds and Other Waiver Systems in Cambodia

A Case Study[1]

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[1]. This didactic case was prepared by Ricardo Bitran for the World Bank's Safety Nets Social Protection Division. For questions or comments, contact the author at: Bitrán y Asociados, Avda. Nueva Tajamar 481 TN Of. 1108 (Las Condes), Santiago de Chile, Tel., (562) 339-7690, Fax: (562) 339-7699, e-mail: ricardo.bitran@bitran.cl.

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Contents

1 User fees for health care in Cambodia 1
2 Waiver and exemption systems 2
3 Equity funds 3
4 Other pro-poor schemes 3
5 The task 3
Appendix A: Economic and health indicators for Cambodia and selected countries 4
Appendix B: Poverty and use of health services 5
Appendix C: Allocation of government health spending 6
Appendix D: Determinants of health service use? 7
Appendix E: The equity fund scheme 8

1 User fees for health care in Cambodia

Cambodia's health sector relies heavily on user fees to finance ambulatory and hospital health services, and fees are high and common both in public and in private facilities. This reliance on user fee revenue reflects in part limited public funding for health care. In 1999 government annual health spending per capita was a mere $2.85. Knowles (2001) remarks that

> Overall health sector funding in Cambodia absorbed 12-13 percent of GDP in 1996-97, by far the highest share among Asian developing countries. Another striking feature of the financing of Cambodia's health sector is the large role played by out-of-pocket household expenditures, which accounted for 82-84 percent of total sector financing during the same period. In contrast, the government plays a relatively minor role in sector financing, accounting for only about 4-5 percent of the total. Official donor assistance (ODA) and direct funding by NGOs also contribute significantly to sector financing, accounting for about 8-12 and 2-3 percent respectively of total sector financing during this period.[2]

The average monthly salary of a government health worker in Cambodia fluctuates between $10.00 and $15.00, an amount that is below the poverty line. User fee revenue allows health workers to increase their income to about $150-$180 per month and also allows individual and institutional providers, both public and private, to pay for drugs, medical supplies, equipment, and other expenses. Since 1996 user fees are the Government of Cambodia's (GOC) official policy in accordance with the National Health Financing Charter (NHFC).

User fees help to finance staff and non-staff costs in government health facilities, and therefore make provision possible. Yet the existence of a system of equal fees for all, and the lack of a system of waivers or exemptions constitutes one of the greatest constrain to access to health care by the poor. A report by the World Bank concluded the following (see Annex :

> Reducing out-of-pocket costs of health services for the poor will be critical. […] Fee exemptions at public facilities are also heavily skewed in favor of wealthier Cambodians. Less than 1 per cent of the poorest are exempted from user fees at commune clinics and district health centers and none are exempted from inpatient fees at public hospitals. Existing fees for use of health services must be enforced and cost recovery expanded, in parallel with a transparent and effective system of fee exemptions and a free supply of drugs targeted exclusively to Cambodia's poorest. This will help reverse current inequities in access to health services and increase affordability for the poor. This needs to be implemented alongside greater cost recovery in secondary and tertiary health facilities such as provincial and central hospitals.[3]

According the the World Bank's Cambodia Poverty Assessment (1999), the average visit to an ambulatory facility, whether public or private cost the patient $30.00, an amount equivalent to one-third of annual per capita non-food consumption; the patient who was hospitalized paid user fees that varied between $89 in a private hospital and $145 in a public hospital –about twice annual non-food household spending per capita. Utilization rates by the poor were considerable lower than those by the non-poor, and this difference appears to be largely attributable to the high user fees. In the foreseeable future, however, Cambodia's health system is likely to maintain its heavy reliance on user fees, as public funding for health care, while projected to increase per capita, will remain modest.

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[2]. Knowles, J. 2001. Health Sector Financing (Chapter III) in World Bank. 2002. "Promoting Pro-Poor Health Financing Policies in Cambodia (Draft).

[3]. World Bank. 1999. "Cambodia Poverty Assessment." Report No. 19858-KH.

2 Waiver and exemption systems

A major obstacle to acceptable levels of exemptions, i.e., ones consistent with Cambodia's high poverty, is the conflict that exists between health staff income and their awarding of exemption to patients. Wilkinson *et al.* (2001), in a recent study of cost recovery for health services in Cambodia, noted:

> **There is a systemic conflict between a viable exemption scheme and a viable salary incentive scheme.** There is an inherent tension in a facility seeking to operate a viable exemption scheme and a viable salary incentive scheme. The two systems are essentially in competition, especially in facilities which are operating at, or near to full capacity. In this situation, every exemption provided is effectively paid for by the staff themselves from their salary uplift. If, as in Takeo, the hospital is operating at full capacity, and is striving towards improving efficiency, then granting exemptions would be virtually intolerable. Ironically, exemptions are more likely to be granted in facilities which are performing less well, and where serving a patient for free does not necessarily mean excluding a fee-paying patient. The competition, outlined above, between patients for more exemptions and staff for greater salary incentives is actually part of a broader systemic tension, inherent in the design of the health financing scheme, between equity and efficiency. There is a real danger that increasing equity, by lowering costs and providing more exemptions to the poor, will undermine efficiency, both at facility level and O.D. level. Conversely, as facilities strive towards greater efficiency, there is a real danger that the poor will become even more marginalised. If the tensions outlined above are to be relieved, it is clear that the mechanism for financing exemptions must be completely separated from the mechanism for financing salary supplements and operating costs.

Espinosa and Bitran (2001) observed that exemption policies vary widely among provinces and districts in Cambodia. For example at Rovieng health center 24 percent of the population under its responsibility was exempted from paying fees in 1999 (1999 Budget Table supplied at Roveing HC). By contrast, at Pereang operational district the rule is that no exemption is granted, except in very special cases. The policy, there, is to keep fees low enough to make everybody pay while at the same time avoiding problems of financial accessibility for the poor. In Takeo Hospital, the rate of exemptions was estimated as 2 percent while Pursat Hospital the value of exemptions accounted for 13 to 15 percent (Pursat Report on user fee payments, January 2000).

Those authors remarked that the observed exemption rate in Cambodia was low considering that 36 percent of the Cambodian population lives below the poverty line (Cambodia Poverty and Social Sector, Ministry of Planning, 1999). Exemption levels are lower than those observed in Ethiopia and Mali, although they may be similar to the percent exempt in most African countries (Nolan and Turbat, 1995). In addition, continuity of care is not guaranteed since exemption policies are set up autonomously by each health facility.

Wilkinson *et al.* (2001), reached the following conclusions:

?? There is a major failure of exemption schemes in hospitals to protect the poor. However, exemptions are provided more readily at health centers. In contrast to hospitals, exemption schemes at health centers are generally well publicized and exemptions are provided quite readily. Exemption rates at health centers ranged from 8 percent to 50 percent, with a median value of 25 percent.

?? With a few notable exceptions, there is an abject failure of exemption schemes in national and provincial hospitals to provide a reliable safety net to enable the poorest and most vulnerable sections of the community to access essential health care. With the exception of Pursat, in all of the provincial and national hospitals evaluated, staff expressed concern that increased exemptions would result in lower salary uplifts and lower income for operating costs.

?? Paying for health care, particularly secondary or tertiary care is still a major cause of destitution among the poorest sections of the community.

They made the following recommendations:

- ?? Separate the mechanism for financing exemptions from the mechanism for financing salary supplements and operating costs.
- ?? Explore and pilot alternative mechanisms for financing exemptions (e.g. reimbursing facilities for exemptions granted, or using equity funds, insurance schemes, voucher schemes, community finance schemes)
- ?? Contract NGOs and/or Community Based Organizations (CBOs) to develop and pilot more effective and efficient ways of identifying the poor and enabling exemptions.
- ?? Establish and promote flexible or deferred payment schemes, to take into account the seasonality of illness, and seasonal variation in ability to pay.

3 Equity funds

The strong conflict that health providers face between exempting patients and increasing their income has led some donors -DFID in Phnom Penh's Urban Health Project, MSF and UNICEF in Sotnikum, and the Swiss Red Cross in Takeo- to collaborate with the GOC in the establishment of the so-called equity funds (EFs). These are health financing initiatives that are aimed at protecting the poor from cost recovery by injecting external funds into health facilities (health centers or hospitals) and by managing those funds to exempt the poor from fees while compensating the provider for the associated user-fee revenue forgone (see description of the EF model in Appendix E).

Independent analyses of EF operations by Knowles (2001), Hardeman (2002) and Bitran (2002) indicate that EFs achieve good targeting outcomes and are a cost-effective way of protecting the poor from user fees. EFs alleviate poverty, prevent poverty, and improve health status among the poor. Further, evidence from Phnom Penh's Urban Health Project shows that, by managing referrals from the ambulatory to the hospital level, EFs can also improve efficiency in consumption.

At the OD level, EF operations would cost annually $463,334; at the PHD level they would cost $1.47 million; at the country level $33.82 million. The latter figure is about equal to current government health spending, implying that full public funding of EF operations would require a doubling of public health spending.

4 Other pro-poor schemes

EFs are not the only mechanism available to Cambodians to protect the poor from user fees for health care. Further, while EF seem to work well at the rural level, where EF staff familiarity with the local population allows fewer targeting errors from beneficiary identification, EFs may not be feasible or advisable at the urban level (Phnom Penh's Urban Health Project seems an exception but may not be replicable on a more massive basis owing to the high input of expatriate staff). Another model is the one adopted at Calmette's Hospital, where public funds are regularly channeled to this large private facility operating in Phnom Penh through a simple payment system, to finance exemptions awarded to poor patients. In addition, there is limited testing of a health insurance scheme in Cambodia, an initiative that should be studied with World Bank support.

5 The task

1. What would you, as a World Bank expert, recommend the Government of Cambodia regarding cost recovery and pro-poor financing schemes, such as those described here?

2. What should the World Bank do in Cambodia on these issues?

Appendix A: Economic and health indicators for Cambodia and selected countries

Table 1 Economic and health indicators for Cambodia and other countries

	Cambodia	Haiti	Bangladesh	Laos	Vietnam	China	Philippines
Economic and health expenditure indicators							
Population (millions)[a]	12	8	128	5	78	1.250	77
Per capita GNP 1999 ($)[a]	260	460	370	280	370	780	1.020
Per capita GNP 1999 measured at PPP [a]	1.286	1.407	1.475	1.726	1.755	3.291	3.815
Military expenditures in 1997 (% of GNP) [a]	4,1	NA	1,4	3,4	2,8	2,2	1,5
Per capita health expenditure at official exchange rate in 1997 ($)[b]	21	18	13	13	17	20	40
Per capita health expenditure in international dollars in 1997[b]	73	55	70	53	65	74	100
Public per capita health expenditure in international dollars in 1997[b]	7	18	32	33	13	18	48
Health and demographic indicators							
Male life expectancy at birth in 1999 (years)	52.2	50.6	57.5	54.0	64.7	68.1	64.1
Female life expectancy at birth in 1999 (years)	55.4	55.1	58.1	56.6	68.8	71.3	69.3
Disability-adjusted life expectancy at birth in 1999 (years)	45.7	43.8	49.9	46.1	58.2	62.3	58.9
Infant mortality rate in 1998 (per 1,000 life births)	102	71	73	96	34	31	32
Male under 5 mortality in 1999 (per 1,000 life births)	138	120	113	143	39	35	48
Female under 5 mortality in 1999 (per 1,000 life births)	129	111	116	126	31	40	41
Fertility rate in 1999	4.5	4.3	3.0	5.6	2.5	1.8	3.5

Source: WHO 2000, except infant mortality that comes from The World Bank 2000/2001.

NA: Not available.

Appendix B: Poverty and use of health services

A main finding arising from the available analysis of health services utilization by socioeconomic status (World Bank, 1999) is that the poor use health services significantly less than the non poor, and that the main obstacle to use by the poor seems to be the private costs of health care (mainly user fees). Other important obstacles to consumption of health care by the poor are physical access to qualified health care providers, quality of care, and educational levels. The relatively lower health status of the poor may be explained in part by their comparatively lower accessibility to health services. An examination of the information shown in

Table 2 exemplifies the lower use of health services made by the poor. For instance, children living in better-off households exhibit vaccination coverage rates that are three times those of children of poor households. Similarly, children with acute respiratory infections (ARI) or suffering from diarrhea are significantly more likely to be taken to a health care provider if they are non-poor than if they belong to low income households. Similar contrasts arise with regard to maternal and obstetric health services, as shown in the table. And the members of lower income households are significantly less likely to seek care from public and private providers than those with higher socioeconomic status, and more likely to self treat of to go without any treatment.

Table 2 Provision of child and maternal health services, and selection of provider, by socioeconomic status, 1998

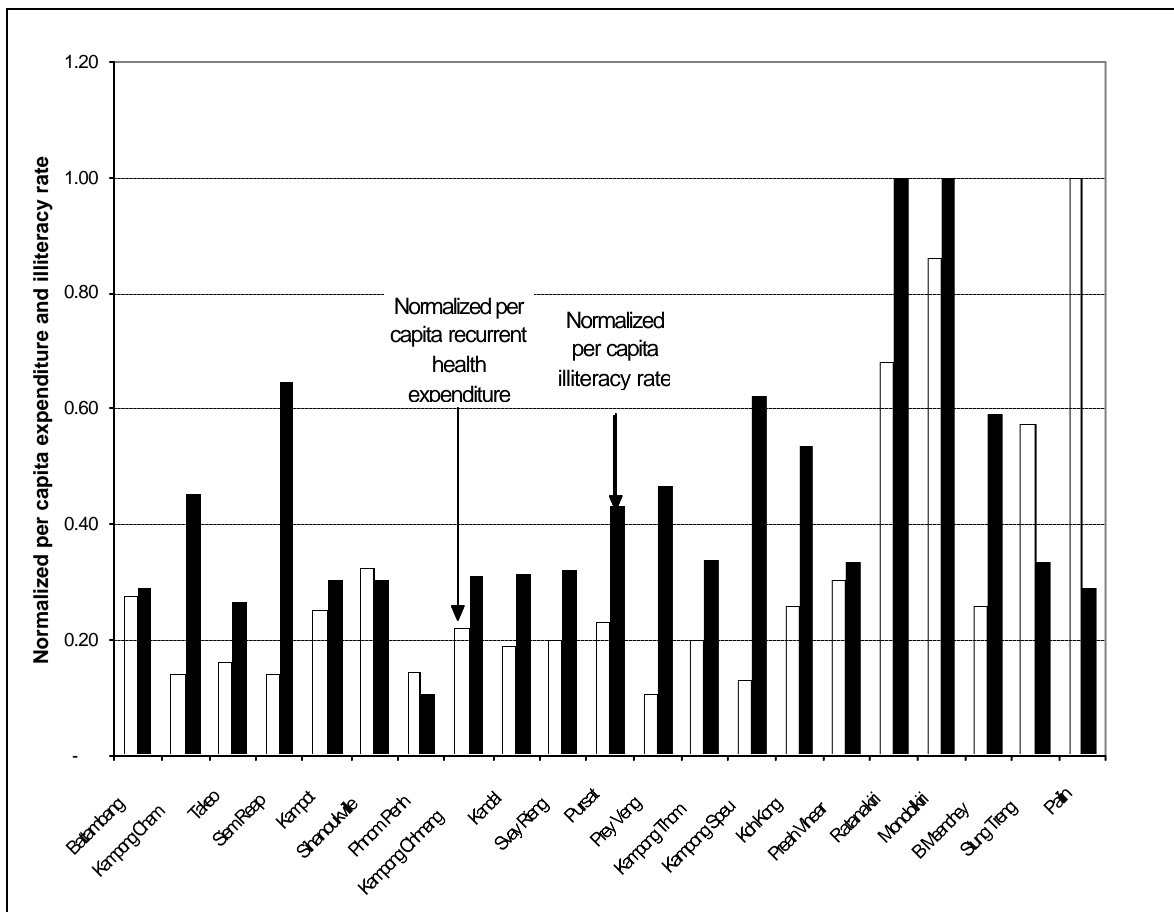
	Socioeconomic status				
	Poor	Below average	Above average	Better off	Cambodia
Infant and child health care					
Children 12-23 months old having all vaccinations (percent)	25.9	31.6	39.6	74.5	38.9
Children with ARI taken to a health provider (percent)	19.6	29.3	35.1	52.0	30.9
Children with diarrhea taken to a health provider (percent)	25.6	26.1	32.1	50.3	30.1
Maternal health care					
Percent receiving antenatal care from a trained provider	19.5	25.2	38.2	71.8	34.3
Percent delivering in a medical facility	2.4	3.4	6.4	40.6	9.7
Percent of births attended by a trained provider	16.9	25.6	36.7	75.0	34.0
Percent of mothers receiving 2 or more tetanus toxoid injections	13.6	17.0	20.5	40.4	20.8
Provider choice (percent)					
Public providers	14.6	17.5	21.7	28.4	20.0
Private providers	29.3	35.8	43.7	46.8	38.7
Self treatment	27.0	26.3	21.5	15.0	23.2
No treatment	21.8	16.2	9.4	8.0	14.0
Total	100.0	100.0	100.0	100.0	100.0

Source: Knowles 2001.

Appendix C: Allocation of government health spending

Cambodia has been attempting to reallocate the government's budget for health care on the basis of regional poverty. Success, so far, has been limited, as shown in Figure 1. The figure shows the per capita government health budget allocated to each province in 1999, normalized between 0 and 1, and the equally normalized illiteracy rate in the same year, as a proxy for poverty. To be equitable, the allocation of public health budgets should be somewhat correlated with illiteracy, or follow the same pattern as illiteracy. Both measures are indeed positively correlated, with a Pearson correlation coefficient of 0.39. This means that the government has allocated its recurrent health budget more or less according to illiteracy, generally sending more money per capita where illiteracy (and thus poverty) is high, and less where illiteracy is low. Yet the correlation is weak and there are grave exceptions. In many provinces where illiteracy is relatively high –Kampong Speu and Siam Reap are examples– the per capita recurrent public budget is relatively low. Increasing the per capita allocation of public resources in the poorest provinces of Cambodia would enable the health facilities substantially to lower their user fees for the poor. Such a reallocation would be equitable on a national scale and it would greatly improve access to health services by the poor.

Figure 1 Allocation of government recurrent budget per capita and illiteracy rates by province, Cambodia, 1999



Source: World Bank (2002).

Appendix D: Determinants of health service use

Why do poorer Cambodians use health services less? The World Bank (Prescott *et al.* 1999) carried out a multivariate analysis of health services utilization. Results show that both demand- and supply-side variables have important effects on health services utilization. Key reasons could include high private costs, low quality of care, low household income, and low levels of parental education. A summary of results is presented below.

?? **Wealthier and better educated individuals are more likely to use health services and to use private health services rather than public providers and drug vendors.**

?? **Health facilities and providers are more often locally available to wealthier individuals.**

?? **Household consumption expenditure per capita is strongly positively associated with the probability of treating an illness episode among both adults and children, with the income elasticity of treatment estimated at 0.15 for adults and 0.18 for children.** There is also a shift in utilization of health services from public providers and drug vendors to private providers as household living standards improve. Among children under age 15, a 1 percent increase in consumption expenditure per capita reduces the probability of using a public medical provider by 0.11 and reduces the probability of using a drug vendor by 0.04, but increases the probability of using a private health provider by 0.17. This is in line with evidence from other countries that suggests that as people's incomes increase, they shift from self-treatment and, treatment in the public sector to private sources of health care. This implies that demand for private health care can be expected to increase substantially with economic growth in Cambodia.

?? **Schooling is significantly and positively associated with the probability of adults obtaining treatment.** For children, only the schooling of adult males (typically the father) in the household has a significant positive effect on the probability of obtaining treatment. Surprisingly, the schooling of adult females appears to avail-have no effect. Better educated adults are more likely to use private providers, and children in households with better educated adult males are less likely to be treated by drug vendors. Female children are less likely than male children to obtain treatment from private providers.

?? **Among supply-side variables, the presence of a doctor or nurse in a village significantly increases the probability that individuals will use health facilities.** This effect is stronger for children than for adults. Children are 19 percent more like- to get their illnesses treated if they live in a village that has a doctor than if they per-live in a village without one, while the corresponding number for adults is 7 per- cent. The availability of a clinic in a village significantly increases the probability of adults and children in that village obtaining medical treatment from public providers and reduces the probability of their obtaining care from private sup-providers and drug vendors. Correspondingly, the availability of a private clinic in a village increases the probability of individuals in that village obtaining treatment from private clinics and reduces their utilization of public health facilities.

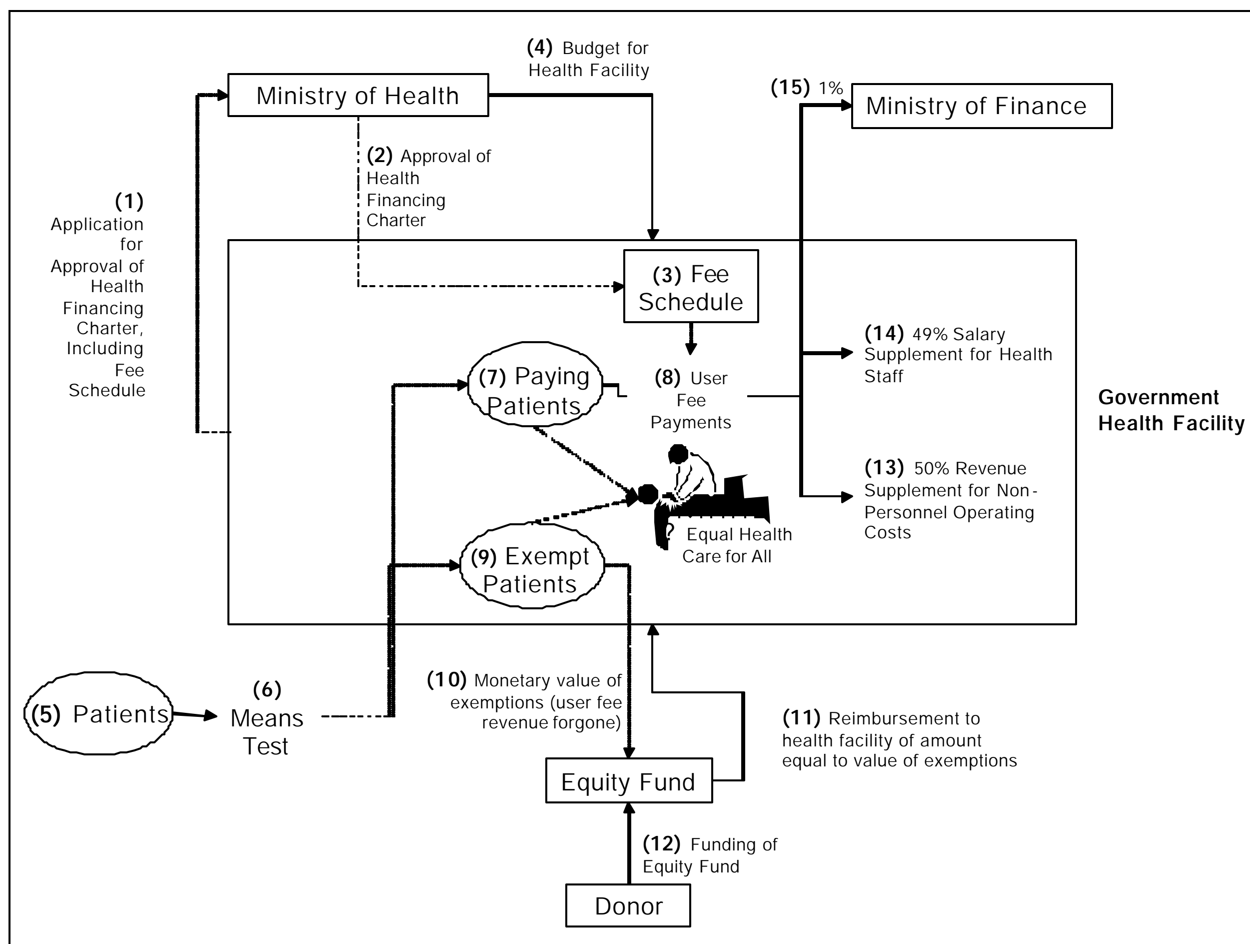
?? **Affordability is also an important factor. The price of a medical consultation has a significant negative effect on both adults' and children's probability of obtaining medical treatment.** The price elasticity of demand for health care is estimated to be -0.07 for adults and -0.05 for children. However, estimated drug price effects are insignificant, possibly reflecting the substantial measurement error that exists in the price proxies used.

Appendix E: The equity fund scheme

Equity funds (EFs) were conceived in Cambodia to finance the cost of health services provided at no charge or at reduced prices to the poor. The basic mode of operation of an EF is illustrated in Figure 2. The process of setting up an EF begins with the submission by the health facility to the MOH of an application for approval of its health financing charter, including its fee schedule (**Action 1**). Once the charter is approved by the MOH (**Action 2**), the facility officially adopts its fee schedule (**Action 3**), including some criteria to exempt the poor. The MOH, in turn, quantifies the budget for the health facility, in principle taking into account the provider's expected ability to generate complementary revenue from users (**Action 4**). Patients arriving in the facility (**Action 5**) and wishing to be exempted from fees are subject to a means test to determine their eligibility (**Action 6**). Patients applying but found not eligible for exemptions, along with patients not applying for exemptions (**Action 7**), are subject to and must pay the provider's customary fees (**Action 8**). Exempt patients, instead, are offered care for free or at a reduced price (**Action 9**). Periodically the health facility reports to the EF on the level of exemptions provided as well as on the monetary value equivalent of the subsidized services (**Action 10**). For example, the provider may keep a record of all services delivered for free and then, based on the user fee revenue forgone, at established prices, it bills the EF. The latter in turn reimburses the provider, after controlling and approving the statement submitted by the provider (**Action 11**). The EF requires a periodic refill of its fund (**Action 12**), which gets depleted with the reimbursements to the provider. EF financing has been, until now, the role of donors (e.g., the Swiss Red Cross in Takeo Hospital, the U.K. and Save the Children in Sotnikum, and the U.K. in the Phnom Penh Urban Health Project), but there is nothing in the design that would preclude the government from financing EFs.

Not all EFs operate in exactly the same way; there are variations which may have important behavioral implications and consequences on the performance of the health system. They include the management of the exemption process; where lies the responsibility to establish eligibility (health staff at the facility or specialized staff within or outside the facility); when the exempt status is granted (at the household or when patients seek care), the method used to pay the provider (fee-for-service, payment per case) the insertion of EF in referral system (at the health center including or excluding exemptions for referrals, or directly at the hospital); and the type and extent of financial protection (only provider fees are covered, or other costs, such as transportation and food, are also covered).

Figure 2 Operation of Cambodia's equity funds



Source: World Bank (2002).