



# From Health Equity Funds to Integrated Social Health Protection Schemes

Evidence from Kampot and Kampong Thom  
Operational Health Districts from 2010-2012



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## Abbreviations

AD	Administrative district	KHR	Khmer riel
AFH	Action for Health	MOH	Ministry of Health
BFH	Buddhism for Health	MPA	Minimal package of activities
BMZ	German Federal Ministry for Economic Cooperation and Development	NGO	Non governmental organisation
CPA3	Complementary package of activities (level 3)	OD	Operational [health] district
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH	PHD	Provincial Health Department
GRET	Groupe de Recherches et d'Echanges Technologiques	P4P	Pay for performance
HC	Health centre	SHPP	Cambodian-German Social Health Protection Programme
HEF	Health equity fund	SKY	Sokhapseap Krousar Yeung
HIV	Human Immunodeficiency Virus	URC	University Research Corporation
HSSP2	Second Health Sector Support Project	USD	United States dollars
ISHPS	Integrated social health protection scheme		
KfW	Kreditanstalt für Wiederaufbau		

## Disclaimer:

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# Executive Summary

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The Cambodian-German Social Health Protection Programme (SHPP), supported by the German Federal Ministry for Economic Cooperation and Development (BMZ), has since 2008 supported the extension of health equity funds (HEFs) – the most widespread social health protection schemes for the poor – to vulnerable groups and families at risk of high health expenditures. This approach intends to transform existing HEFs into integrated social health protection schemes (ISHPSs) by giving vulnerable households access to almost the same medical benefits as HEF members at public health facilities, once they buy into the scheme with affordable contributions. This approach differed from formal micro insurance in the sense that it aimed at enrolling families with increased risk, and that contributions were intended to only be symbolic to empower clients of the scheme. Thus, the scheme was a self-targeting mechanism to channel public subsidies to families with perceived increased risk and which were demanding public services. The scheme was still seen as an insurance mechanism by its members but the pooling of risk and funding was not an objective of its design. Voluntary enrolment and targeting approaches are only intended as a transitional strategy for targeting subsidies, until sufficient resources are available to move to universal health coverage.

Two ISHPSs were established in Kampong Thom operational health districts (ODs) in 2008 and 2011 respectively, as an initiative of the German Government through the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). The two schemes also received support from the Australian Government and the Second Health Sector Support Programme (HSSP2) – a sectoral programme financed by the Royal Government of Cambodia and a group of development partners. The initial partner in the implementation of the scheme was the Groupe de Recherches et d'Echanges Technologiques (GRET) – a French nongovernmental organisation (NGO) which started a micro health insurance project known as SKY in 1999.

While HEFs are the most prevalent social assistance mechanism targeting the poorest population segment, differences in income between the poor and the majority of the population are small, and households that do not meet the strict national poverty criteria are excluded from HEF benefits even if they have specific or high risk factors.

Moreover, HEFs face a major challenge as the costs per beneficiary rise. Extending the role of HEFs beyond their current focus on the poorest families can address those concerns, at least in part.

HEFs mitigate the negative effects of high health spending for poor households, but they do not provide a way to further protect households when their economic situation improves and they are no longer eligible for social assistance, but are still vulnerable to high health expenditures. Allowing such households to voluntarily enrol in social health protection schemes built on HEFs, through prepayment of affordable contributions, is an effective way to expand protection to them. This buy-in into existing HEFs also improves HEFs' cost efficiency and strengthens their purchasing power, which consequently increases their ability to influence the quality of public health services. An extension of HEFs therefore allows: (1) the realisation of economies of scale and scope, offsetting the continuously increasing costs per beneficiary that potentially undermine the sustainability of existing HEFs; (2) the expansion of social health protection coverage in an effective way; (3) the targeting of public subsidies to the poor and self-identified households that know that they are at increased risk; (4) increased accountability of providers, as contributing members are more prone to demand appropriate service provision; and, (5) improving overall equity in utilisation of public services, as the majority of actual service costs are financed through supply-side financing mechanisms but access is determined by people's ability to pay user fees.

Complementing this overall approach, the schemes in Kampong Thom include a number of key components:

- A 'pagoda component', which facilitated the involvement of faith-based organisations in the scheme, specifically in increasing community participation, strengthening communication and interaction between the health providers, the scheme operator and the community, mobilising local religious institutions to collect funds for transport and food allowances for the poorest members, and strengthening community accountability.
- Transport vouchers for poor members to access health centre services.

- Access facilitators, who were placed at health centres and hospitals in order to assist with and ensure access to services by scheme members, manage transport vouchers, promote the scheme to attract voluntary members, and monitor the presence of health staff and quality of services provided.
- A safe motherhood grant – a conditional cash transfer to improve the health of pregnant women, mothers and newborns by increasing the use of pregnancy check-ups and attended deliveries.

The provider payment mechanisms put in place used capitation and later ‘adjusted capitation’ in Kampot, and performance-based case payments in Kampong Thom for primary-level care. Capitation was also used at hospitals, but differences between actual user fees and total monthly capitated transfers were reimbursed once a year. The schemes also included a range of monitoring, evaluation and quality assurance mechanisms.

As of the first quarter of 2012, the ISHPSs covered all health centres in Kampot and Kampong Thom ODs (12 and 21, respectively), and the two provincial referral hospitals. Approximately 16% of the overall population in Kampot OD was covered under the scheme there. Eighty per cent of scheme members were identified poor households. In Kampong Thom OD, the ISHPS covered 30% of the population, with 86% poor members.

In Kampot OD, there was an increase in contact rates at health centres by ISHPS members. The average annual contact rate per person for voluntary members at public health centres increased from 2.07 in 2008 to 3.06 in 2011, and from 0.4 in 2008 to 1.47 in 2011 for poor members. In Kampong Thom OD, where the ISHPS only started in 2011, the utilisation of health centre services by scheme members in 2011 was 2.19 contacts per person for voluntary members, and 1.06 for poor members. Unfortunately, these numbers only provide information on the utilisation trend, as comparison between groups is not possible because of the case-mix between groups and how the denominators are built. In the case of poor members, all pre-identified households represent the denominator, but for voluntary members it is composed of self-targeted families that demand public services because of their higher perceived need for health care. Comparison of utilisation rates with the general population suggest that the scheme was successful in targeting these families with increased risks, and at increasing utilisation among the poor. Despite declines in utilisation trends in the first quarter of 2012 in

both ODs, the utilisation rates of both voluntary members and poor members in the two schemes were well above the national average.

The introduction of transport vouchers for health centre services, in 2010 in Kampot and from the start of the scheme in Kampong Thom, correlated with a substantial increase in utilisation of health services by poor scheme members. The average cost of transport benefits per poor scheme member per year was USD 0.60 in Kampot and USD 1.10 in Kampong Thom. Despite the variation between the two ODs (due partly to geographical differences, among other factors), both costs are relatively low when considered at the population level: USD 0.079 and USD 0.29 per capita, respectively. The transport voucher approach was an effective way to improve the health status of poor households, primarily by reducing the delay in utilisation of primary health services. However, to be cost-effective this benefit should be contained, by limiting its use to distant villages and to two transferable vouchers per household member per year.

Faith-based organisations played an important role in mobilising resources from communities. In Kampot, KHR 28,985,000 (approximately USD 7,000) was raised between 2010 and the first quarter of 2012 towards transport and food support for poor scheme members to access health centre and hospital services. In Kampong Thom, KHR 8,803,000 (approximately USD 2,147) was raised during the same period. Beyond the financial dimension, community resource mobilisation was an important method of ensuring the active engagement of local religious authorities in the scheme. This involvement proved beneficial to the schemes’ effective implementation, especially in terms of local institutions facilitating access to health services for the poor and ensuring that abuses were dealt with at the local level directly by community representatives. Reminding the scheme members that transport benefits were financed by resources collected and managed by religious authorities was also an effective way to assert moral compliance and limit abuse. Faith-based organisations played an important role in the organisation of scheme promotions and outreach activities, and contributed to creating trust in the scheme.

The safe motherhood grant supported an increase in health service utilisation for deliveries. It increased awareness and compliance of pregnancy and newborn check-ups (thus having an educational aspect beyond its primary objective), and also served as a way to encourage retention of voluntary members in the scheme.

# Introduction

## 1. The Cambodian-German Social Health Protection Programme

The Cambodian-German Social Health Protection Programme (SHPP), supported by the German Federal Ministry for Economic Cooperation and Development (BMZ), aims to improve the access of the poor and vulnerable to effective and affordable quality health care and increase health service use by the population.

Within the overall SHPP programme, the Social Health Protection Project implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) specifically seeks to improve the quality, accessibility and utilisation of public and private health providers in selected provinces of Cambodia. The project primarily supports three of the five strategic areas of the Cambodian Health Strategic Plan 2008-2015: health financing, health service delivery, and health systems governance. Both gender and the needs of vulnerable groups (older persons and people with disabilities) are crosscutting issues across all areas.

Under these objectives, the Social Health Protection Project has supported the extension of health equity funds (HEFs) – the most widespread social health protection schemes for the poor – to vulnerable groups and families at risk of high health expenditures. This approach was initially oriented at linking HEFs and micro health insurance, but developed into a more comprehensive and rational concept which focuses limited public subsidies towards poor and vulnerable people, and improves the effectiveness and efficiency of supply-side financed public health services. The Social Health Protection Project now intends to transform existing HEFs into integrated social health protection schemes (ISHPSs). The initial interventions were in Kampot and Kampong Thom operational health districts (ODs), in 2008 and 2011, respectively, as initiatives of the Ministry of Health (MOH). The two schemes also received support, in part of the period of operation, from the Australian Government and the Second Health Sector Support Programme (HSSP2).

This report reviews the initial ISHPS experience and presents evidence from their operation in two ODs in Kampot and Kampong Thom province. The information presented is based on annual reports, external evaluations and data from the scheme operators. The report initially sets out the approach and advantages of moving from a HEF to ISHPS system. It then moves on to discuss the ISHPSs in Kampot and Kampong Thom ODs. First, the design of the schemes and their main components are laid out. Second, evidence is provided on the schemes’ operations, in terms of population coverage, revenue collection (covering contributory and non-contributory funding mechanisms, and community funds); and purchasing (covering utilisation of health services and additional benefits). The final section presents conclusions, challenges and recommendations.

## 2. Health Equity Funds: Challenges and potential

Out-of-pocket expenditures on health are a major challenge for Cambodia’s population. They lead to indebtedness and impoverishment across all population groups, and pose considerable barriers to accessing health care, especially for poor and vulnerable groups such as older people, people with disabilities, the near-poor and people with precarious work. To address these challenges, Cambodia’s Strategic Framework for Health Financing foresees the development of social health protection schemes targeting different sections of the population. HEFs are the most widespread of such schemes, targeting the poorest segment of the population.

However, differences in income between the poor and the majority of the population are small, especially in rural areas. Households that do not meet the strict national poverty criteria are excluded from HEF benefits even if specific risk factors (such as chronic disease) would justify their inclusion. Ill health is also a major risk in rural areas, and designing targeting mechanisms for every specific group would be a tedious and ineffective way to channel limited public subsidies. Free health care, on the other hand, is often perceived as an impractical solution

for various reasons and as suggested by international experience. Moreover, HEFs face a major challenge as the average costs per beneficiary rise. This occurs due to smaller pools of potential beneficiaries, resulting from decreasing poverty rates and higher benefit reimbursement rates. Extending the scope of HEFs beyond their current focus on the poorest people in society can address those concerns, at least in part.

### 3. Moving towards universal health coverage: Transitional mechanisms

Unaffordable costs of health care keep families in poverty and reduce productivity in times of illness. Social assistance schemes that pre-identify poor households (such as HEFs) can mitigate the negative effects of high health care spending for the poor. But current social health protection schemes in Cambodia do not provide a way to further protect households when their economic situation improves and they are no longer eligible for social assistance according to local poverty criteria. Even if no longer extremely poor, these near-poor households are still vulnerable to the negative effects of high health care costs and economic shocks, and thus still need social protection. Once without HEF coverage, these households not only risk falling back into poverty, but their potential economic productivity is also hampered. The majority of the Cambodian population is currently in this situation.

Furthermore, unpredictable and recurrent out-of-pocket health care spending puts all but the wealthiest households at risk of catastrophic expenditures and impoverishment. This is especially the case in rural areas, where limited access to cash makes households more prone to rely on high-interest credit or asset sales to deal with economic shocks. This situation is exacerbated by consumption practices and structural weaknesses in the public health care sector.

In an emerging social health protection system, it is difficult to initially cover all segments of the population. It therefore makes sense to develop transitional social health protection schemes, each focusing on a certain population group (such as the formal or informal sector populations), which will in the long term merge or be replaced by comprehensive, inclusive universal systems.

However, establishing several such schemes at the same time implies initial inefficiencies due to fragmentation of resources (financial pools) and burden (risk pools),

and imposes managerial and administrative challenges. Building on existing schemes is thus a better way to reduce this fragmentation and enables an easier transition to universal health coverage, even if this means abandoning these transitional arrangements at some point. This is also the approach suggested in the Cambodian Strategic Framework for Health Financing, which foresees three dedicated social health protection funds. In the long term, these funds should be harmonised, connected by equalisation mechanisms and replaced by comprehensive national mandatory or automatic coverage schemes.

One way to begin this transition for HEFs would be to facilitate voluntary enrolment for high-risk households into a modified form of HEFs, through prepayment of affordable contributions. This buy-in into existing HEFs would also improve the funds' cost efficiency and strengthen their purchasing power, and consequently increase their ability to influence the quality of public health services. Under such arrangements, a HEF becomes an ISHPS, with single fund and risk pools and a single operator. This can help the ISHPS to target public resources to households at risk of high health care spending and willing to use public health services. Contributions from voluntary members complement funding from public subsidies (but cannot be expected to recover the full costs of services) and most importantly empower them as clients, able to demand quality health services.

ISHPSs make use of existing HEF structures, standards and administrations to improve:

- Efficiency
  - » Increased scheme membership reduces the average fixed cost per beneficiary, which is necessary in the context of declining poverty rates and increasing case-based payments.
  - » A single management structure reduces transaction and staff costs, allowing scheme operators to benefit from economies of scale and scope.
  - » Voluntary contributions complement public subsidies.
  - » Utilisation of underused public facilities increases.
  - » The cost burden for dealing with illness complications at public health facilities is reduced by enabling timely access to health services for people at high risk or with greater health care needs.

- Equity
  - » ISHPSs protect the poor as well as other vulnerable households that are at high risk of catastrophic health care spending
  - » All people in the catchment areas have access to a social health protection scheme
  - » All scheme members receive financial support to access health services on the same basis, which can contribute to reducing stigmatisation and discrimination against the poor by health service providers.
  - » Households at higher risk or with higher needs have access to financial protection and public health services.
  - » Access and utilisation of (already subsidised) public services is no longer biased towards people that can pay user fees.
- Quality of care
  - » A larger membership pool strengthens the scheme's purchasing power by improving its negotiating capacity for quality health services.
  - » Contributions by voluntary members increase ownership and self-awareness, making it possible for them to demand quality services and accountability for all scheme members.
  - » Responsiveness and accountability of public services is expected from members and the scheme operator, which acts as their agent.

Figure 1: Kampot provincial map with Operational District borders and location of health centres.

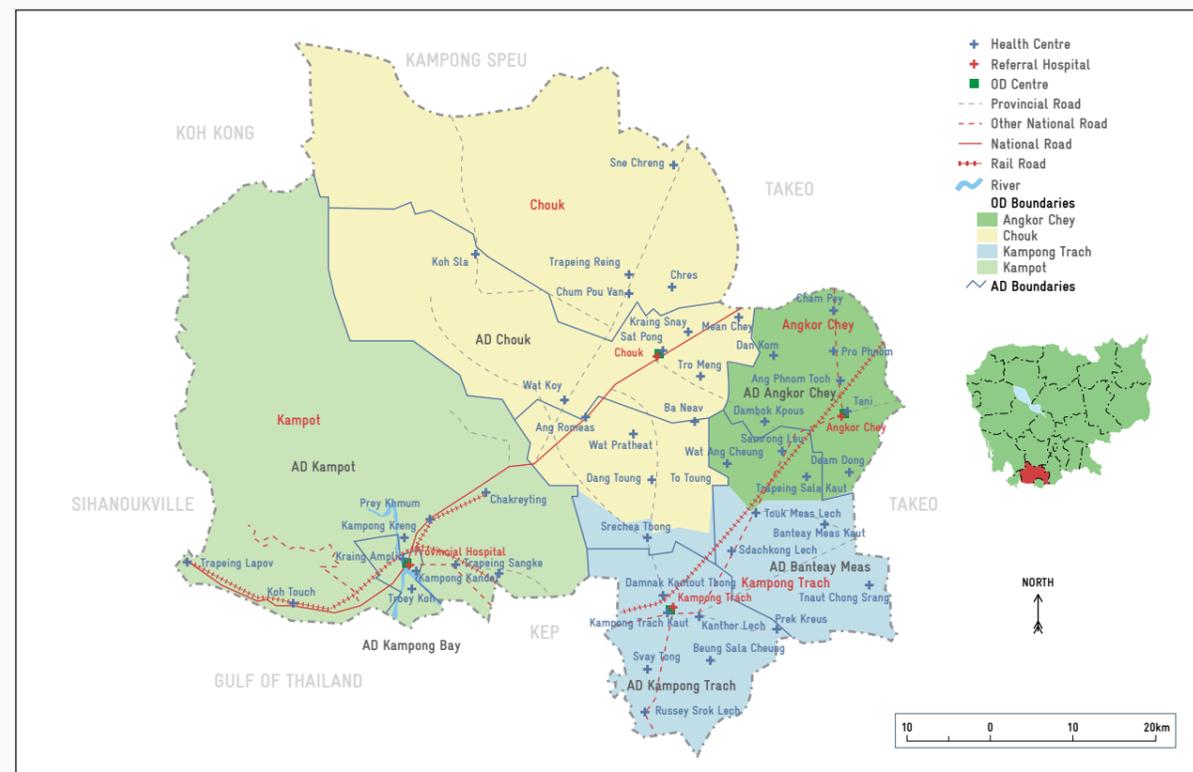
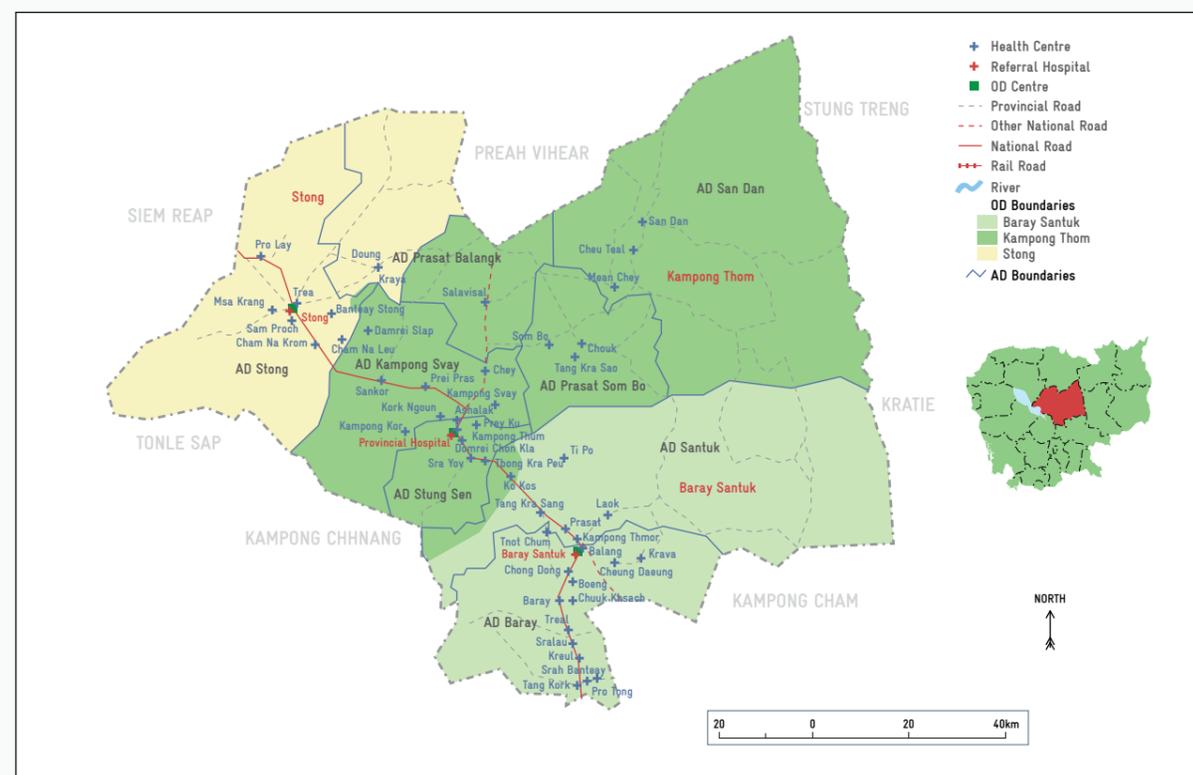


Figure 2: Kampong Thom provincial map with Operational District borders and location of health centres.



# Integrated Social Health Protection Schemes

SHPP supported the development and implementation of social health protection schemes in Kampot and Kampong Thom ODs from 2007 and 2008, respectively. In view of the rationale for extending HEFs set out above, and under the leadership of MOH, SHPP initiated a transition of HEFs into ISHPSs in these two ODs. The first ISHPS was launched in 2008 in Kampot OD, with the participation of local stakeholders such as the Provincial Health Department and faith-based organisations.

Under the ISHPS in Kampot OD, MOH/HSSP2 funds were used to purchase direct medical benefits for poor households, which had been initially identified by commune councils and later by the national Identification of Poor Households Programme (IDPoor) led by the Ministry of Planning. Poor households were registered in the scheme and given access to health services (direct medical benefits) and additional support in the form of food and transport allowances (direct non-medical benefits). GIZ supported the ISHPS operations under the scheme's operator, Groupe de Recherches et d'Echanges Technologiques - Sokhaphheap Krousar Yeung (GRET-SKY) - as well as quality improvement activities at health centres.

Following preparations in Kampong Thom OD in 2010, an ISHPS was launched there in 2011, with Action for Health (AFH) as its operator. Until then, AFH had been operating a standard HEF which provided only access to hospital services for the poor. As in Kampot, local- and national-level partners were involved. The scheme design in Kampong Thom also drew on lessons learned in Kampot; for example, the roles of faith-based organisations in the scheme, and experiences with provider behaviours toward payment mechanisms. Some experiences with insurance principles had already made the scheme possible, as GRET-SKY implemented a micro health insurance scheme in a limited geographic area until the end of 2009. The separated scheme was temporarily maintained through 2010 during the negotiations and preparations for the launch of the ISHPS.

## 1. ISHPS design

### 1.1. Overall approach

ISHPSs include full subsidisation of benefits for the poor, as with HEFs. But in addition, they give voluntarily enrolled households access to almost the same medical benefits<sup>1</sup>, once they buy into the scheme. Specifically, an ISHPS:

- Provides an identical card or booklet to all members (both voluntary enrolments and identified poor) as a single identification mechanism for health care access.
- Conducts awareness-raising and promotional activities, to encourage increased utilisation of public services by those most in need, particularly during the promotional periods for voluntary enrolment.
- Facilitates community participation, by seeking feedback from beneficiaries after facility visits and engaging local authorities (such as commune councils and village chiefs) and faith-based groups (such as pagodas, mosques and churches) in the scheme's promotions, voluntary enrolment and service feedback mechanisms.
- Provides all members with the same essential medical benefits package with MPA (minimal package of activities) services provided at health centres and CPA 3 (complementary package of activities, level 3) services provided at the provincial referral hospitals, while the poor continue to receive additional transportation and food assistance as with HEFs.

ISHPSs are a social assistance and protection mechanism. They combine active targeting of the poor and self-targeting of vulnerable households. Automatic enrolment of the poor without contributions enables them to access services. Voluntary enrolment aims to protect vulnerable households from becoming impoverished as a result of health care expenditures. Contributions of voluntary members are affordable prepayments that are not expected

<sup>1</sup> Under HEF standards, poor households also have access to tertiary-level facilities in the capital city, Phnom Penh.

to recover the full costs of the benefits or cross-subsidise other socioeconomic groups. Thus, applying conventional insurance concepts to assess the cost-effectiveness and sustainability of this social health protection mechanism would be misleading, especially since the aim here is to protect groups at higher risk and promote timely and predictable access to public health services, which are already subsidised. This should be kept in mind when reviewing the data in this report. Self-targeting enables subsidies to be channelled towards vulnerable households that have no other alternative than public services – services that are a second choice for households with sufficient disposable income and are thus underused. Overall, the strategy is less costly than subsidies for the entire population or large target groups such as the near-poor.

Scheme access facilitators were placed in health centres and the provincial hospitals in order to ensure access to services by scheme members. Their duties included:

- Assisting with access to services by scheme members, in particular the poor and illiterate;
- Reimbursing transport vouchers;
- Promoting voluntary enrolment among the population, especially users of public health facilities and families with sick members;
- Monitoring the presence of health staff and the quality of services provided;
- Monitoring the use of safe motherhood grants.

## 1.2. Specific interventions

### Pagoda component

A ‘pagoda component’ (funded by the Australian Government through GIZ from 2010 to 2012) facilitated the involvement of faith-based organisations in the scheme, specifically by:

- Increasing community participation;
- Strengthening communication and interactions between the health sector and the community;
- Mobilising local religious structures to collect funds for transport and food allowances for the poor households in the scheme.

The involvement of pagodas in social health protection schemes in Cambodia was first initiated by the NGO

Buddhism for Health (BFH) in Kirivong OD, Takeo province. Due to the low fees for health centre consultations, the costs for an NGO to implement a HEF at the health centre level would outweigh the direct benefits for the poor, thus making it unattractive to potential funders. In response to this challenge, BFH directly involved pagodas in the operation of schemes in order to substantially reduce salary costs, office rent and other expenditures. But beyond being a response to the overhead costs of NGOs operating a HEF for health centre services, the ‘pagoda component’ was also a way to gain the trust of the community by developing long-term relationships with local religious authorities and engage them directly in the management of social health protection schemes. Not only would the overhead costs of the HEF be reduced to an acceptable level for donors, but pagodas would work directly with the poor, organising donations to cover non-medical costs (such as transport to health centres) and reimbursing beneficiaries. The social accountability of scheme members was also reinforced, as benefits were financed from resources collected from the community by the religious authorities.

Drawing on this concept, a ‘pagoda team’ was established in Kampot OD in early 2008, with the purpose of coordinating and facilitating the participation of faith-based organisations and other key community stakeholders in the scheme. Consisting of a field coordinator and three pagoda/mosque facilitators, the team worked directly with three ‘principal committees’; two of which coordinate the activities of the 43 participating pagodas, and one for the 32 participating mosques.

The committees were responsible for mobilising resources for non-medical benefits for the scheme’s poor members, such as transport and food allowances, as well as raising awareness about the scheme in the community. In particular, outreach activities in the community addressed the issues of understanding of benefits and perceived need for health care, making scheme members (especially the poor) fully aware of their entitlements, and encouraging members to seek treatment, even for illnesses they did not perceive as severe.

Initially the committees were also responsible for the management of funds and direct payment to scheme members, but it was later decided that they should focus on fund collection, pooling, and oversight of fund disbursement, in order to ease the administrative burden on the committees. The direct responsibility for management and disbursement of funds was thus transferred to the scheme operator (GRET-SKY).

The principal committees themselves were organised according to the administrative district (AD) boundaries (there are two ADs within Kampot OD). They originally met quarterly, and later biannually. Representatives from all the pagodas in each AD attended their respective meetings, and both pagoda principal committees participated in a joint annual meeting. Analogue structures were also created for ethnic Cham Muslims, who represented over 20% of the population in the province.

Each individual pagoda and mosque also had its own committee. In total, 43 pagoda and 31 mosque committees were established. These were chaired by the head of the pagoda/mosque, with another cleric as treasurer, between three to five lay members (usually elderly members of the community) and a commune council representative (either the head of the commune council or a council member). Once established, specific meetings were often unnecessary as in practice the members came together every seventh day for religious practises. In Kampot, ‘clusters’ of pagodas and mosques also existed in many areas prior to the establishment of the pagoda component, and rotating meetings were held to share best practices within these clusters on a quarterly or biannual basis. The heads of the principal committees also participated in a scheme steering committee at the OD level, to address issues of implementation.

In Kampong Thom OD, similar structures were put in place in 2010. Two principal committees were formed with a total of 39 pagodas organised along AD boundaries, and a separate committee was formed for eight churches. Similarly to Kampot, the faith-based organisations focused on fund collection, pooling and oversight, along with raising awareness of the scheme in the community.

### Transport vouchers

While HEFs cover the cost of transportation to and from hospitals for inpatient care, the cost of transportation to health centres has been identified for a long time as a major barrier for the poor in accessing primary care. In Cambodia, the cost of transportation to health centres is normally higher than the cost of treatment at public health centres, especially for poor families who often reside in more remote villages. This financial barrier is further exacerbated by the opportunity cost of long journeys to health centres. To address this, transport vouchers for poor members to access health centre services were introduced in ISHPSs in both ODs. Vouchers could be exchanged

by poor scheme members for cash with access facilitators located in the health centres every morning (see below).

The provision of transport vouchers in Kampot started in 2010, with one voucher per household member per semester. Vouchers were transferable among household members, but their validity was limited to six months to avoid overuse. The value of the vouchers was based on the distance from that specific village to the health centre. Vouchers were integrated into the scheme booklet provided to households (which they used to access the services), and every poor member household was visited and informed about this additional benefit.

In Kampong Thom OD, the introduction of transport vouchers took place in the second half of 2010. Vouchers were distributed to all poor members in the scheme living two kilometres or more from their nearest HEF-affiliated health centre.

In Kampot, transport vouchers – as well as transport and food allowances for hospital-level services – were initially reimbursed with funding from the Australian Government, and managed by the faith-based organisations’ principal committees. The funds collected by the committees were reserved for later use. The scheme operator, GRET-SKY, prepaid the allowances to scheme members and provided detailed invoices for verification and reimbursement to the principal committees. This procedure was modified in late 2010, following the recommendations of an interim scheme evaluation, and the role of the committees focused on oversight, with funds they collected going towards the transport and food allowances to ensure reasonable management burdens and ownership. This change in strategy was also extended to the ISHPS in Kampong Thom OD.

### Safe motherhood grants

Complementing the ISHPSs was a safe motherhood grant – a conditional cash transfer focusing on mothers and newborns care. Specifically, the grants aimed to:

- Improve the health of women of reproductive age, by increasing the accessibility and proportion of medically attended deliveries;
- Promote a continuum of care for women, from pre-pregnancy to the neonatal period, by encouraging women to be regularly monitored for complications and risks;

- Retain voluntary members in the scheme by introducing women, during their pregnancy and post-delivery care, to public health services, and so to strengthen demand for public reproductive health services through trust building.

Financed by the German Government, the safe motherhood grants offered a direct cash incentive of approximately USD 30 to all pregnant women in the scheme (both voluntary members and poor members) who registered for the grants within the first six months of pregnancy. The grant was in fact divided into two cash transfers: one was awarded upon completion of conditions in the antenatal and birth phase, and the other after completing conditions in the postnatal phase. Women who adhered to the conditions of the first phase but not the second were still entitled to receive the first cash transfer. Upon registration, a safe motherhood booklet was issued to the pregnant woman and used by nurses and doctors in public health facilities to log and keep track of services provided.

The safe motherhood grant operated from 2008 to mid-2011 in Kampot OD, and from 2007 to mid-2011 in Kampong Thom OD. It was thereafter phased out, as a similar voucher for reproductive health services was launched in both ODs by the Cambodian Government. Funded by the KfW Development Bank and implemented by MOH through AFH, these vouchers aimed to improve access to reproductive health services, including safe motherhood, family planning and safe abortion services by providing them free of charge, as well as allowances for transport and food, and a 'baby care package' (unconditional cash transfer). Unlike the safe motherhood grant, the voucher is only intended for the poor members in the ISHPSs, and is not linked to conditions such as the fulfilment of certain protocols.

### 1.3. Stewarding (stakeholder collaboration and community networking)

#### Formal agreements

In both Kampot and Kampong Thom ODs, contracts and memoranda of understanding were signed at the health facility, district, provincial and national levels with the relevant health centre chiefs, Provincial Health Department directors, OD chiefs and the Ministry of Health. Both the Provincial Health Department and OD authorities were active participants in the relevant steering structures of the schemes in both ODs (described next).

#### Box 1: Safe motherhood grants

The grants were paid in two instalments

**1st instalment upon completion of antenatal care and safe delivery:**

- Attendance at a minimum of three antenatal care check-ups;
- Testing for HIV, and use of Prevention of Mother to Child Transmission services if HIV-positive;
- Medically attended delivery at a health facility.

**2nd instalment upon completion of postnatal care:**

- Attendance of a minimum of two postnatal care check-ups;
- Immunisation of the newborn within the first four months after birth.

In addition, in Kampong Thom, OD authorities hold a quarterly review meeting with AFH to adjust the capitation rate (see provider payment mechanism section, below) and discuss the performance of health providers and the ISHPS overall. In Kampot, meetings with OD authorities were on a more ad hoc basis, but still took place frequently.

#### Steering committees

In Kampot OD, the scheme operator supported the creation of a provincial-level steering committee. The committee met on a quarterly basis, bringing together all the key stakeholders in the scheme across the province. It played an important role in addressing challenges and problems with the scheme, by providing a formal platform for the scheme operator to voice the concerns of itself and its constituent scheme members.

In Kampong Thom, there was initially no steering committee at the provincial or OD level. However, the scheme operator participated in a health financing steering committee for the provincial referral hospital, chaired by the deputy Provincial Health Department director and attended by the OD director, Provincial Health Department director and all health centre chiefs. The Provincial Health Department also established a provincial steering committee to bring together all key health financing and social health protection stakeholders on a regular basis.

#### Religious authorities

At the community level, religious authorities were actively involved in the scheme through the pagoda component and associated activities. The pagoda component teams in each

OD provided capacity development to all principal committees to strengthen their ability to carry out their functions around resource mobilisation and awareness-raising activities. Quarterly meetings for each committee offered an opportunity to monitor progress and raise any problems or issues.

The committees also conducted community outreach activities in their catchment areas with the technical support of the pagoda component teams. Each village was visited at least four times a year. Local authorities (commune council chiefs or deputies, and village chiefs), representatives of the OD, health centre staff and scheme operator staff also participated in these activities. During outreach activities, information on the schemes was disseminated and villagers were encouraged to use contracted public health facilities. Community outreach activities were also used to gather feedback from members and to address any issues or concerns that they raised.

The ongoing commitment of the faith-based organisations at the community level was a major strength of the schemes, both in terms of mobilising resources for the poor and raising awareness of the social protection scheme. Engagement by provincial-level religious authorities was less direct, although in Kampot representatives of the principal committees took part in the provincial social health protection steering committee chaired by the Provincial Health Department, and in both schemes provincial-level religious representatives and officials from the Religious Affairs Department were kept informed of the schemes' ongoing activities.

#### Commune councils and village chiefs

Commune councils and village chiefs did not have a formal role in the structure of the schemes, but were invited to all relevant meetings as well as outreach activities. In addition, the chief of the commune council association was invited to the steering committee meetings in each province. In the future, GIZ will support the commune councils to strengthen their role in the management and oversight of local health services, through SHPP's new governance component. Notably, the councils also contributed financially to the transport voucher mechanism, which provided further legitimisation.

### 1.4. Provider payment mechanisms

Providing the appropriate economic incentives is a core element for improving health facility service provisions. A key instrument for this is the provider payment mechanism,

which regulates the transfer of funds from the purchaser, here the scheme operator, to the health service providers. However, the leverage of the funds, such as for quality, is limited in the Cambodian public health sector context where salaries, drugs and other running costs are covered from the supply-side through annual budgets. However, when linked to appropriate quality control mechanisms, payments of even small amounts can signal expectations of the scheme and users to providers. Pay-for-performance (P4P) builds on such links and was therefore tested in ISHPSs. The mechanism was seen as a management tool rather than only a reimbursement system.

In each scheme, there was a single provider payment mechanism for services for both voluntary members and poor members of the scheme. The use of a single mechanism contributed to equity in treatment for voluntary members and poor members. Differentiated prices were considered in the initial design to promote service provision to the poor. However, this was not retained as international evidence on supply-induced-demand is weak, and differentiation would also have brought the risks of discrimination towards voluntary members who were thought to be at high risk/demand.

Nonetheless, the provider payment mechanism itself differs between the two ODs and has evolved over time. The scheme in Kampot initially calculated a simple monthly capitation at the health centre and hospital levels. This system was initially well received by providers, as they were paid in advance and the first estimations were based on historic user fees. However, as utilisation rapidly increased, providers continued to make inappropriate comparisons with foregone user fees, and delays in payments became regular, the scheme moved to 'adjusted capitation', whereby health facilities were paid using a capitation adjusted according to contact rates of the previous quarter. The table below summarises the rates used.

Table 1: Adjusted capitation rates in Kampot OD.

Annualised utilisation by scheme members	Capitation rate
Below 2 contacts	KHR 300 per member per month
Between 2 and 3.5 contacts	KHR 500 per member per month
Above 3.5 contacts	KHR 400 per member per month

The capitation rate for the hospital was fixed, but adjustments could be made, and renegotiation occurred on an annual base. However, this payment did not transfer any

risk to the hospital, as differences between actual user-fee values for services and capitation payments were equalised each year. This made the system acceptable to the hospital but resulted in a de facto advance payment system with limited incentives to control costs.

In Kampong Thom, ‘boosted capitation’ was used under the administration of the scheme operator GRET-SKY until the end of 2009, which at the time only implemented micro health insurance. This mechanism ensured a minimum volume of members and payments to the facilities. This made the system acceptable to providers, but also gave them little incentive to increase population coverage. In early 2010, with the change of operator and following preparations for ISHPS, reimbursement of official user fees (fee-for-service) was temporarily introduced. This resulted in a strong increase in reported utilisation, and the costs for the scheme increased rapidly. In 2011 a new mechanism was designed and introduced to reduce inappropriate use or inducement of services, and link remunerations of health centres to performance and quality. The new case- and performance-based system was also intended to reconnect supervision, client satisfaction, annual planning and quality improvement plans to facility remuneration.

The key principles for the reimbursement of health services at health centres were:

- Flat-rate payments per case for general services (excluding deliveries and inpatient treatment) adjusted on a quality factor (annual health centre assessment score);
- Ceilings on the maximum total reimbursements for general services, based on reasonable utilisation rates for the poor and voluntary members;
- Quarterly bonuses for service quality improvements corresponding to a maximum of 25% of total reimbursements over the period.

Quarterly bonuses were calculated as a factor of client satisfaction, which was measured by surveys, quarterly output achievements and total reimbursements over the period. Indicators, weights and targets for the calculation of bonuses were reviewed from year to year, to align with the national priorities and provide incentives for continuous quality improvement. Client satisfaction surveys were conducted quarterly by village health support group volunteers with the support of the operator, the OD team and GIZ.

At the hospital level, the key principle for reimbursement of health services after the discontinuation of fee-for-service payments in 2010 was flat-rate payments per case for outpatient and inpatient services, as well as deliveries. This method of payment was used to reduce average length-of-stay, which tends to be unnecessary long at private and public hospitals in Cambodia.

## 1.5. Monitoring and evaluation and quality assurance mechanisms

This section briefly reviews the roles of the various stakeholders involved in the monitoring and evaluation processes of the schemes.

### Provincial Health Department and Operational District managers

Provincial Health Department and OD staff monitored the quality of care in contracted health facilities through regular meetings with scheme operators and health care providers. In these meetings, quality issues were raised and necessary supervision visits were planned with all parties concerned. As mentioned, in Kampong OD the Provincial Health Department also led quarterly meetings of the steering committee, which served as a platform to discuss concerns, while in Kampong Thom OD the Provincial Health Department director attended the provincial referral hospital’s health financing steering committee.

### Health care providers

All public health facilities were subject to regular quality assessments by MOH. Both health centres and hospitals had quality improvement committees, which developed and oversaw quality improvement plans based on the results of the assessments.

In Kampong OD, the main incentive for health facilities to improve quality was the additional income they could receive through the scheme for higher utilisation rates, reflected in future capitation payments. In Kampong Thom OD, incentives to improve quality came from payment adjustment to health providers according to the results of the quality assessments, and from the possibility of a quarterly bonus based on the findings of the client satisfaction survey, along with key performance indicators on core services (antenatal care, vaccination, delivery and hospital referral rates).

### Quality Assurance Office of the Ministry of Health

The Quality Assurance Office assisted in the health facility assessments in collaboration with local health authorities and GIZ. Originally it had a significant role in carrying out assessments, but with support from GIZ the capacity of the ODs to undertake the assessments was developed to the extent that the Quality Assurance Office later functioned primarily as an oversight and certification body for the assessments.

### Department of Planning and Health Information of the Ministry of Health

The Department of Planning and Health Information of MOH facilitated review meetings with provincial health authorities and health care providers, and collected and analysed data and reports from the scheme operator. They also conducted ad hoc field visits, in line with their national mandate to monitor all existing social health protection schemes.

### Health Equity Fund implementers

University Research Co. (URC), an American NGO financed by USAID, is the HEF implementer responsible for overseeing all HEF activities nationally. As such, it regularly received data from the schemes on HEF utilisation by poor members, and also had its own monitoring officers in Kampong Thom OD.

### Scheme operators

Scheme operators had a range of methods for monitoring and evaluating the schemes’ performance. Both operators provided monthly data on coverage, utilisation and payments to health providers to implementing partners (URC and GIZ) and the Department of Planning and Health Information.

The operators also supported village-level representatives and volunteers to conduct client satisfaction surveys among health centre users. As described above, the results were used (alongside other performance indicators) to calculate quarterly bonus payments for health centres in Kampong Thom OD. The results of the client satisfaction surveys implemented through the village health support group volunteers were also discussed by the quarterly health centre management committees, which were in charge of addressing the results and developing quality improvement plans.

### Complaints and client feedback

Scheme members had several ways of raising complaints and providing feedback to scheme operators, through:

- The pagoda component outreach activities;
- The access facilitators placed at health facilities;
- Exit surveys for inpatients at the provincial referral hospitals;
- Client satisfaction surveys for health centre users;
- A 24/7 hotline for queries and complaints.

Issues raised about the quality of services were dealt with immediately, or if necessary discussed in the steering committees.

## 2. Results

In the first quarter of 2012, the schemes included all health centres in Kampong Thom and Kampong Thom ODs (12 and 21 centres, respectively), and the two provincial referral hospitals.

### 2.1. Population coverage

In Kampong Thom, as of the first quarter of 2012, scheme membership amounted to 16 percent of the overall OD population. Of these members, 85% were pre-identified poor. All pre-identified poor households in the OD were covered by the scheme.

After a steady increase in voluntary membership from March 2010 to March 2011, to a peak of 8,280 members, voluntary membership decreased to a low of 4,417 members in June 2012. An investigation by GIZ into the causes of the high dropout rate found a variety of issues related to problems with scheme management, poor perception of public health services, and a lack of understanding about the benefits of the scheme among members. Other reasons included changes in the payment periods from monthly to biannual or annual contributions, dissatisfaction with

'splitting' large families among multiple scheme booklets<sup>2</sup>, the suspension of registration for the safe motherhood grant, and the discontinuation of 'free' rabies vaccinations.

However, the major challenge was delays in funding of subsidies to the operator, which resulted in subsequent delays in reimbursement for services to health facilities and strong discouragement of utilization by providers. These delays were related to contractual complications which, in November 2011, resulted in the termination of the contract with GRET-SKY (by June 2012). This coincided with issues in the performance of the operator and uncertainties for voluntary members regarding the continuation of their coverage. The resulting damage in trust will be difficult to remedy, as the selection of a new operator by MOH/HSSP2 was delayed for almost a year due to a slow competitive procurement process.

In Kampong Thom OD, as of March 2012, the scheme covered a substantial 30.5% of the population. Of these, 86.4% were pre-identified poor. In the OD, 95.3 percent of all pre-identified poor households were covered by the scheme.

## 2.2. Revenue collection

Contributions by voluntary members in Kampot and Kampong Thom ODs were, as of the third quarter of 2011, USD 4.5 and USD 4.3 per person per year, respectively<sup>3</sup>. The contributions were deemed affordable for the target population and had been verified through willingness-to-pay surveys conducted by GRET-SKY in 2007 and 2008.

## Contribution management

Originally, contributions from voluntary members were collected monthly through home visits and during village information sessions. Although this was very convenient for scheme members, it was very costly for the operators and enabled families to regularly opt in and out of the scheme

<sup>2</sup> The original contribution rates set by GRET-SKY were regressive by family size, and capped above nine household members. This incentivised families to join during the promotion phase. To remove this incentive, contribution rates were adjusted, with large families paying contributions on a per-member basis, and minimum household rates applied to families with 5 household members (the average household size in Cambodia).

<sup>3</sup> This is an average figure; the actual price paid varied depending on the number of individuals in a household.

rather than being encouraged to provide prepayments for significant periods of time.

In Kampong Thom OD, AFH therefore introduced incentives for longer enrolment periods, with a particular focus on new health centre catchment areas. This was relatively successful in some health centres, with almost 30 percent of voluntary members choosing to make longer term payments as of the end of 2011. The majority of voluntary members, however, still paid on a monthly basis.

In Kampot OD, longer enrolment periods were also introduced in the second half of 2011, with the aim of promoting yearly or periodic payments wherever possible (with a minimum period of three months). Given the difficulties of persuading existing voluntary members to switch to a new payment regime, this initiative also seems to have contributed to the high dropout rates reported above. However, this strategy was successful in Kampong Thom and other schemes across the country, showing advantages in retention and reduced administrative costs in other schemes in the country.

## Subsidy management

Direct medical costs for poor members in both ODs were paid for by HSSP2 and reimbursed to health facilities in line with the actual expenditures for services. Between March 2010 and March 2012, the disbursement of funds to both schemes by HSSP2 was problematic at times, with some significant delays. The funds from HSSP2 also covered transport vouchers, food allowances and a portion of staff costs.

There was initially a delay in the operationalisation of the scheme in Kampong Thom OD, as negotiations regarding the coverage of direct medical costs at the health centre level and establishment of a memorandum of understanding with all supporting stakeholders took considerably longer than planned.

Figure 3: Scheme membership in Kampot OD, Q1 2008 – Q2 2012.

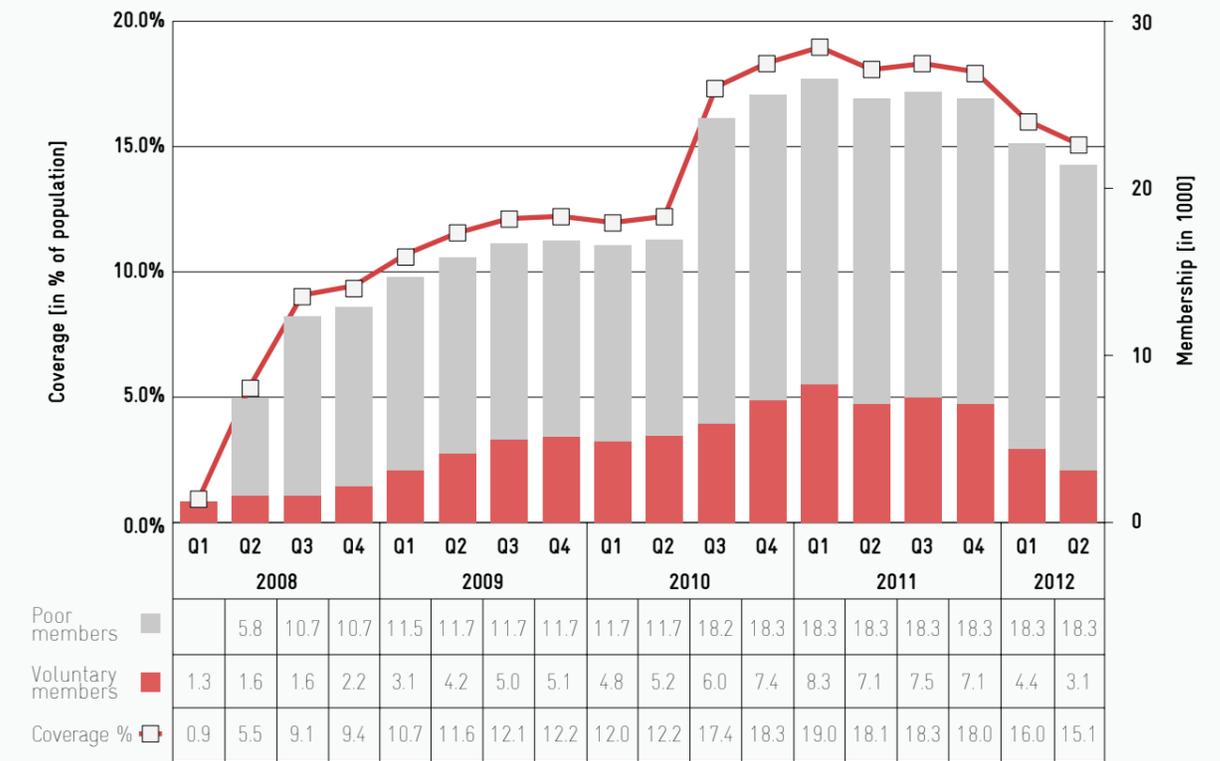


Figure 4: Scheme membership in Kampong Thom OD, 2008 – Q2 2012.



## Community funds for non-medical benefits

Faith-based organisation committees played an important role in mobilising resources from communities. Some commune councils also committed part of their limited financial resources to support scheme implementations. Different means of resource mobilisation were used to generate funds, alongside donation boxes placed in pagodas and commune council offices. Seed funding for the committees was provided by the Australian Government through GIZ.

In Kampot, the amount of funds raised between 2010 and March 2012 by all committees was KHR 28,985,000 (approximately USD 7,246). This cumulative amount was deposited in a bank account and used to subsidise around 10% of transport and food allowances for health centre and hospital services for poor members. A notable achievement of the scheme was that by the end of 2011, nine commune councils were making regular contributions to the pagoda funds.

In Kampong Thom, community resource mobilisation started in August 2010. By March 2012, a total of KHR 8,803,000 (approximately USD 2,201) was collected by the committees. Unlike in Kampot OD, the principal committees in Kampong Thom contributed a fixed amount towards the costs of transport vouchers to health centres (both food and transport allowances for hospitals were covered by HSSP2). Overall, the trend in contributions was somewhat downward, but nonetheless it remained an important method of ensuring the active engagement of faith-based organisations in the scheme.

## 2.3. Purchasing

The schemes in both ODs provided a substantial portion of the revenues of health centres and provincial referral hospitals. In Kampot, despite the scheme's limited coverage (16% of the population), it provided 55% and 35% of health centre and provincial referral hospital revenues, respectively, through the third quarter of 2011. In Kampong Thom, the corresponding figures were 43% and 58%, respectively. In both cases, this indicates that the operators had some leverage with health providers, enabling them to address any problems and ensure the quality of services. It also suggests that the supply-side subsidies from the government became more effective and pro-poor.

## Utilisation of health services

In Kampot OD, there was an overall increase in contact rates at health centres by ISHPS members during the period of operation. The average annual contact rate per person at health centres increased from 2.07 in 2008 to 3.14 in 2011 among voluntary members, and from 0.4 in 2008<sup>4</sup> to 1.35 in 2011 among poor members. The utilisation rates of both groups were considerably above the national average contact rate, which in 2011 was 0.7 for all health facilities.

At the provincial referral hospital, voluntary member utilisation averaged 0.12 in 2010 and 0.092 in 2011. For poor members, the contact rate was 0.072 in 2010 and 0.04 in 2011. Despite the later declines – and as with health centre utilisation – contact rates for both groups remained well above the national average. Scheme members also used public health facilities in the OD much more than non-members.

Significantly, the higher utilisation of public health services by scheme members constituted a considerable proportion of the total number of patients and workload for the health facility staff: 39% for health centres and 35% for the hospital.

In Kampong Thom OD, the utilisation of health centre services by scheme members was relatively high in 2011, at 2.19 contacts per person for voluntary members, and 1.06 for poor members. Similar to the situation in Kampot, the utilisation rates of both groups were well above the national average. The stabilisation of utilisation rates among voluntary members may be attributed to the ceiling in monthly transfers in the new provider payment mechanism, which intended to reduce unnecessary supplier-induced demand or gaming opportunities for providers that were paid on a fee-for-service basis in 2010.

At the hospital level, utilisation rates for inpatient care in 2011 were 0.10 among voluntary members, and 0.09 among poor members. A financial analysis showed that there was no difference in the average value of the services provided to voluntary members and poor members.

Any comparison between group utilisation rates should be made cautiously because of how case-mix and denominators were built. However, utilisation rates suggest that the scheme was successful at targeting higher risk families and increasing utilisation over time.

<sup>4</sup> Integration of poor households started in May 2008.

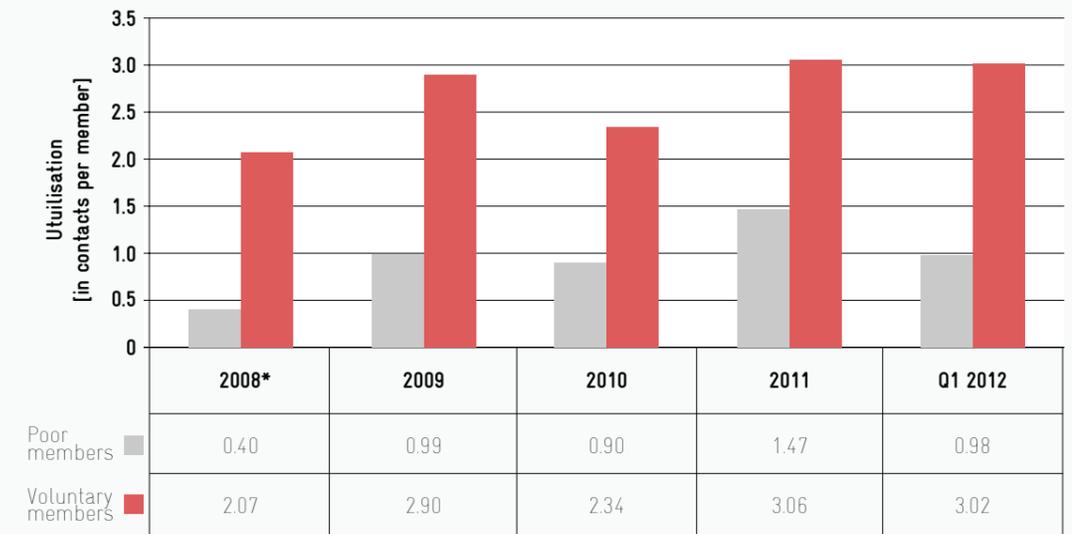
## Transport vouchers for health centres

In Kampot OD, transport vouchers were distributed beginning in June 2010, and provided to all poor families leaving more than 1km away from the affiliated health centre. By March 2012, a total of 11,855 poor scheme members had made use of the vouchers, for a total cost of USD 13,295. The introduction of the transport vouchers

for health centre services correlated with a substantial increase of 64% in utilisation of health services among these members (Figure 5).

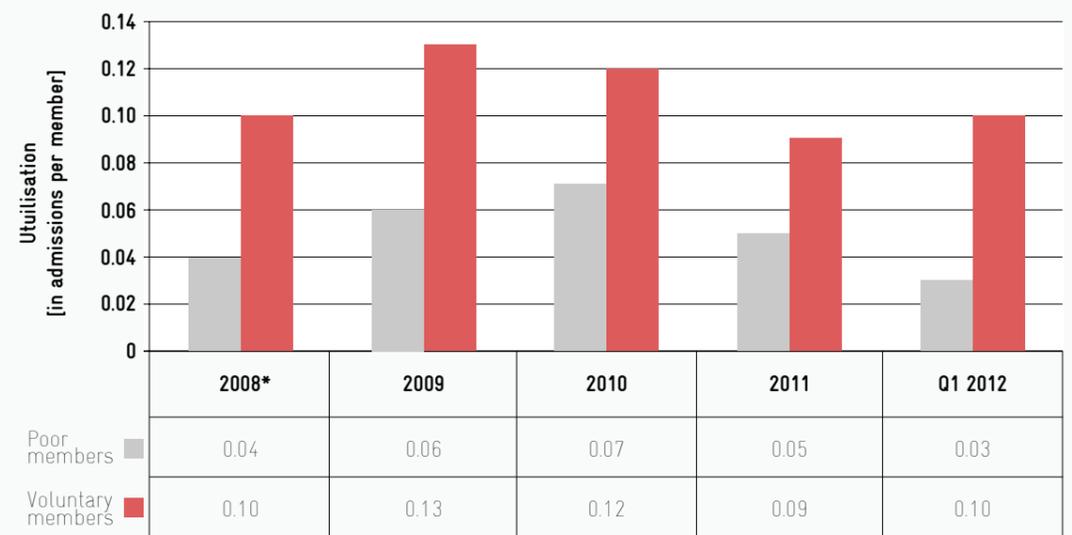
Initially, a substantial percentage of poor members made use of this support (Figure 9). Thereafter, the usage fluctuated, and finally decreased drastically to 2.8% in March 2012, when the benefits were phased out amid

Figure 5: Health centre utilisation rate of ISHPS members in Kampot OD, in average number of contacts per person per year, 2008 – Q1 2012 (annualised).



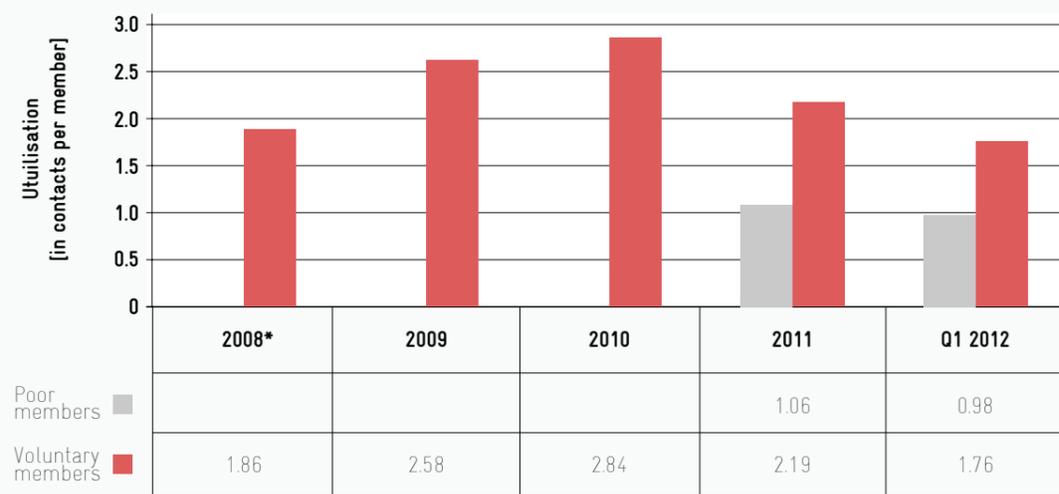
\* Estimated from total contacts as hospital and OPD/IPD ratios in 2009; 8 months only

Figure 6: Hospital inpatient utilisation rate of ISHPS members in Kampot OD, in average number of contacts per person per year, 2008 – Q1 2012 (annualised).



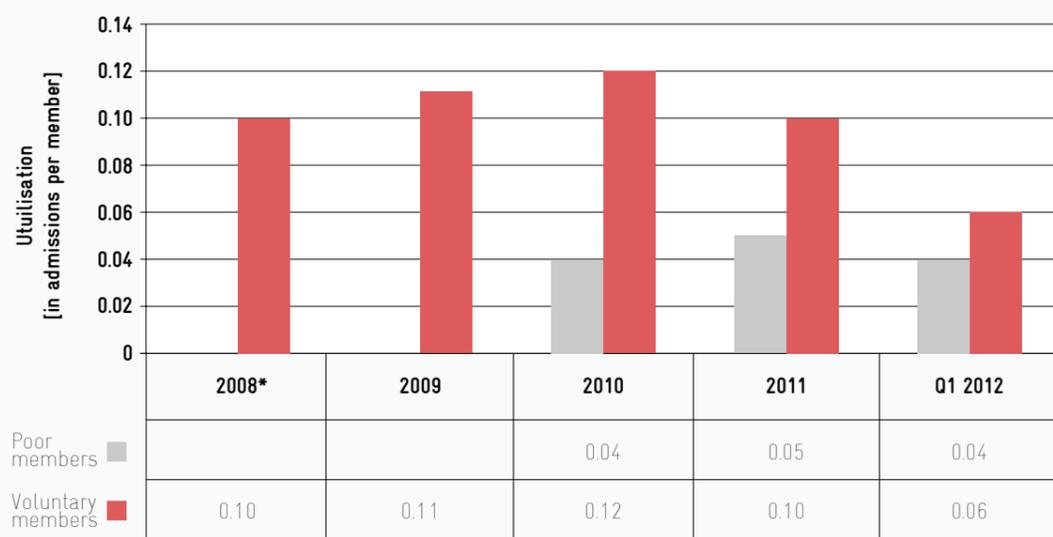
\* Estimated from total contacts as hospital and OPD/IPD ratios in 2009; 8 months only

Figure 7: Health centre utilisation rate of ISHPS members in Kampong Thom OD, in average number of contacts per person per year, 2008 – Q1 2012 (annualised).



\* Standalone micro insurance data.

Figure 8: Hospital inpatient utilisation rate of ISHPS members in Kampong Thom OD, in average number of contacts per person per year, 2008 – Q1 2012 (annualised).



\* Standalone micro insurance data.

managerial difficulties of the operator. At that time the operator was dealing with delays in the funding of services from MOH/HSSP2, and had been informed of the discontinuation of their management contract.

The average annual cost of transportation to access health centres for poor members was USD 0.41 per poor scheme member, and USD 1.12 per visit. This cost is relatively low, especially when considered at the population level: USD

0.054 per capita. Thus, this approach was a cost-effective way to improve the health status of poor households, by reducing the delay in utilisation of primary health services and, when necessary, a timely referral to hospital-level care.

In Kampong Thom OD, between January 2011 and March 2012 a total of 35,489 poor members used transport vouchers, for a total cost of USD 64,323. The average annual cost of transport benefits to access health

Figure 9: Use of transport vouchers for health centres and health centre utilisation rates by poor scheme members in Kampong Thom OD, 2008 – Q1 2012.

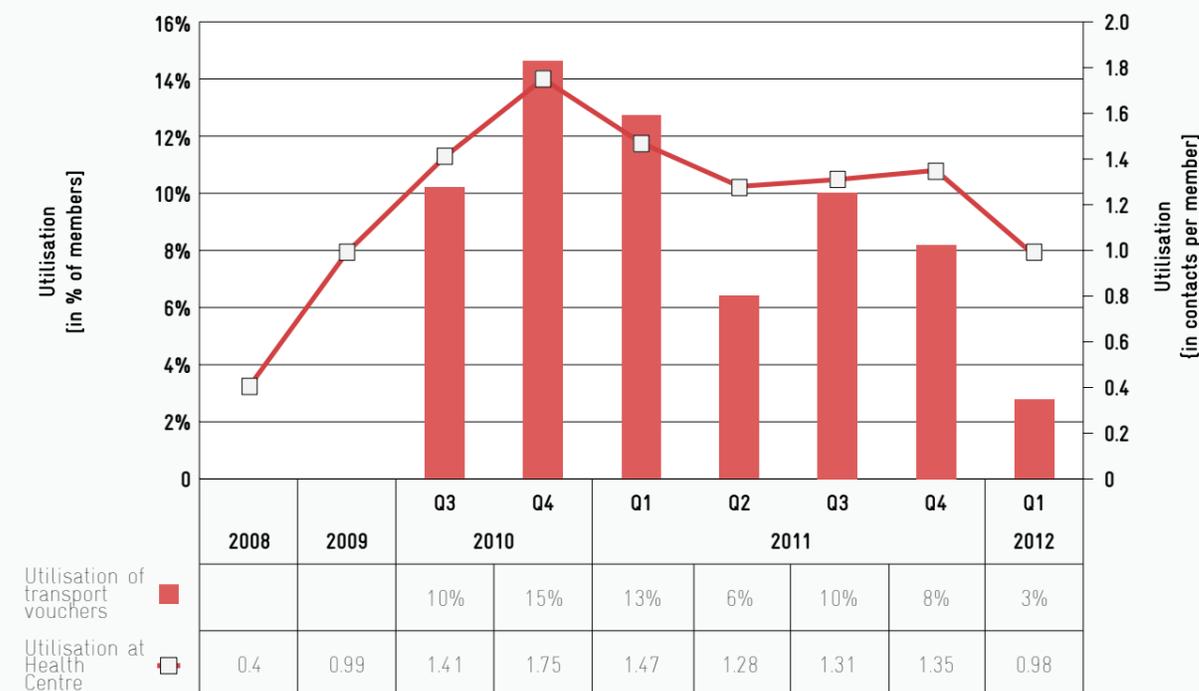
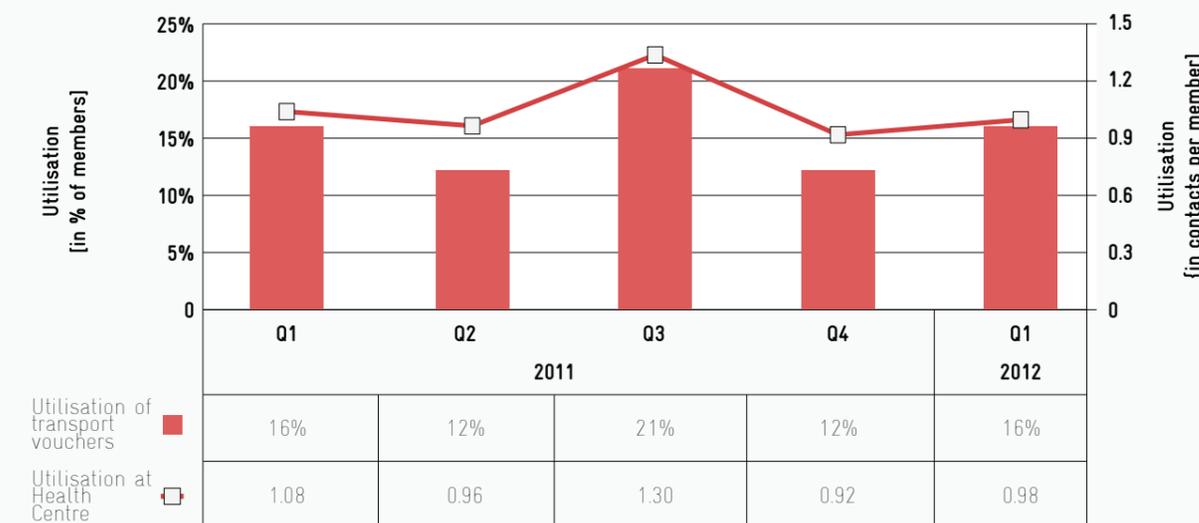


Figure 10: Use of transport vouchers to health centres and health centre utilisation rates by poor scheme members in Kampong Thom OD, Q1 2011 – Q1 2012.



centres for poor members was USD 1.10 per poor person (and USD 1.79 per visit)<sup>5</sup>, or USD 0.29 per capita. This cost was higher than the Kampong Thom figure. Among other reasons, this was due to the remoteness of villages in this

OD – higher cost per visit; some villages are 30 kilometres away from the nearest health centre. The higher poverty rate in Kampong Thom province also explains in part the higher per capita expenditures comparison with Kampong

<sup>5</sup> Vouchers were only provided to households leaving at least 2km from health centres.

An evaluation of the voucher scheme after one year of implementation found that the contact rates at health centres by

poor members had increased significantly in the overwhelming majority of villages, with particularly significant increases in villages located more than 8km from a health centre. Overall, 50% of the vouchers distributed to poor members were used, although only 1% of members used all the transport vouchers provided.

An evaluation of the scheme in Kampot OD found that while the transport vouchers were an important factor to allow poor households to access health centres, there were several issues with the vouchers (both in terms of operation and design) and in some cases transportation remained difficult. Specific findings included:

- Some scheme members reported they had either not received the intended transportation reimbursement when they arrived at the health centre, or they were concerned they would not receive it if they went.
- Some scheme members, especially those who lived farther away from the central part of the village, said that the value of reimbursement was not sufficient to cover the cost of the journey. It seems that the official distance used to calculate the value of the transport vouchers – which is in fact the distance from the centre of the village to the health centre – applied only to certain households. As some of the villages were quite spread out, some families lived farther away from the health centre, and the cost of transport was considerably higher.
- In order to receive the reimbursement, it was necessary to visit the health centre when the access facilitators were in attendance. Under the scheme, however, access facilitators were present at health centres only in the morning. Poor scheme members who went to the health centres later in the day were generally not (or found it difficult to be) reimbursed for transport.
- While reimbursement of transport costs took place retroactively, after receiving services at the health facility, transport costs normally had to be pre-financed (that is, before or upon arrival at the health facility).

### Transport and food allowances at hospitals

In Kampot OD, transport was also supported for referrals from the health centres to the provincial referral hospital. A total of 8,114 patients received this benefit between January 2010 and March 2012, with total costs of USD 24,814. The average annual cost per poor scheme member was USD 0.60 (USD 3.06 per admission/visit), or USD 0.079 per capita. Food allowances were also provided

to 2,157 poor members, for total costs of USD 9,596, at an annual cost per member of USD 0.23 (USD 4.45 per admission), or USD 0.03 per capita.

In Kampong Thom OD, all hospitalised poor scheme members received food allowances during their hospital stays. Funding for the transport and food allowances at the hospital level came from HSSP2. Since these costs were not covered through the scheme, data on these components is not available and cannot be reported here.

### Safe motherhood grant

The safe motherhood grant was in operation from 2008 to mid-2011 in Kampot OD, and from 2007 to mid-2011 in Kampong Thom OD.

In Kampot OD, a total of USD 3,717 was transferred through the safe motherhood grant in 2010. Among the 172 women originally enrolled, 135 were active participants (with 79 complying partially, and 40 fully completing all activities). In 2011, 454 pregnant women received the first payment, and 467 received the second payment. From 2009 to 2010, a 36% increase in enrolment for the grant took place: 34% among voluntary members and 39% among poor members.

In Kampong Thom OD, a total of USD 6,199 was provided through the safe motherhood grant between January 2010 and March 2012. Two hundred and four women received the first payment, and 215 received the second payment.

The safe motherhood grant can be clearly associated with an increase in utilisation of health services for deliveries. During its period of operation, the proportion of scheme member deliveries that were attended by trained health personnel at facilities increased from 45% to 59% in Kampot OD, and from 26% to 38% in Kampong Thom OD. The grant was also a factor in encouraging retention of voluntary members in the scheme; in Kampot, for example, voluntary members who registered for the grant remained in the scheme twice as long as those who did not. The grant motivated expectant mothers to progressively attend the required number of check-ups and seek advice when needed, and contributed to increased awareness of the importance of pregnancy follow-ups, examinations (e.g., for pregnancy complications and HIV/AIDS) and immunisations. The grant thus had a behaviour change and educational aspect which went beyond its primary

objective. Participant satisfaction with the care and staff behaviour at the health centres was high, although there were complaints about hospital services.

### Funeral grants

In the event of death, all scheme members in Kampot also received support for the transportation of dead bodies to their homes, and a contribution towards funeral costs. A total of USD 10,820 was distributed for 42 death cases in 2011, and USD 1,918 for 18 cases in the first quarter of 2012. In Kampong Thom OD, as for the transport and food allowances for inpatient treatment, funding for this benefit was provided by HSSP2 and cannot be reported here.

# Conclusions

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Voluntary enrolment in ISHPSs could be one of the first ways to progressively achieve coverage of the informal sector in Cambodia, as part of the vision of the draft health financing policy. Public subsidies can be targeted to households with higher risks and needs for public services by self-targeting. ISHPSs are a sound strategy to extend social health protection to the near-poor and vulnerable households, as well as to sustain and improve services for poor households. They allow the realisation of economies of scale and scope, offsetting the continuously increasing costs per beneficiary that potentially undermine the sustainability of existing HEFs. Further analysis of the cost structure and utilisation of the ISHPS schemes is still needed to assess their comparative or complementary advantages compared to other interventions such as individual HEFs, or vouchers for priority services. However, the contributions of voluntary members have been proven to empower and complement public funding. Thus, ISHPS may be a cost-effective way to increase utilisation of public facilities that continue to have additional capacities.

In particular, the ISHPSs in Kampong OD and Kampong Thom OD have several features that were beneficial:

- The involvement of local religious and administrative authorities in the schemes was advantageous to their effective implementation, especially in relation to health centre services. These local institutions took responsibility for the health of the poor in their areas and facilitated access to health centre services. They were also important for the organisation of scheme promotion and outreach activities in villages. The population trusts the religious leaders, and their involvement in the dissemination of information and promotion of voluntary enrolment was a highly effective approach to create trust in the scheme.
- Transport vouchers for the poor were an effective way to reduce barriers to accessing health centres among households that otherwise would face difficulties dealing with the cost of transport. The limit of one voucher every six months was very cost-effective, compared to the average reimbursement for other benefits from the scheme. Community stakeholders, especially respected religious authorities, can play a role in mobilising resources for such benefits, but also in reducing abuse by signalling that these resources

are owned by the community and therefore should be appropriately used.

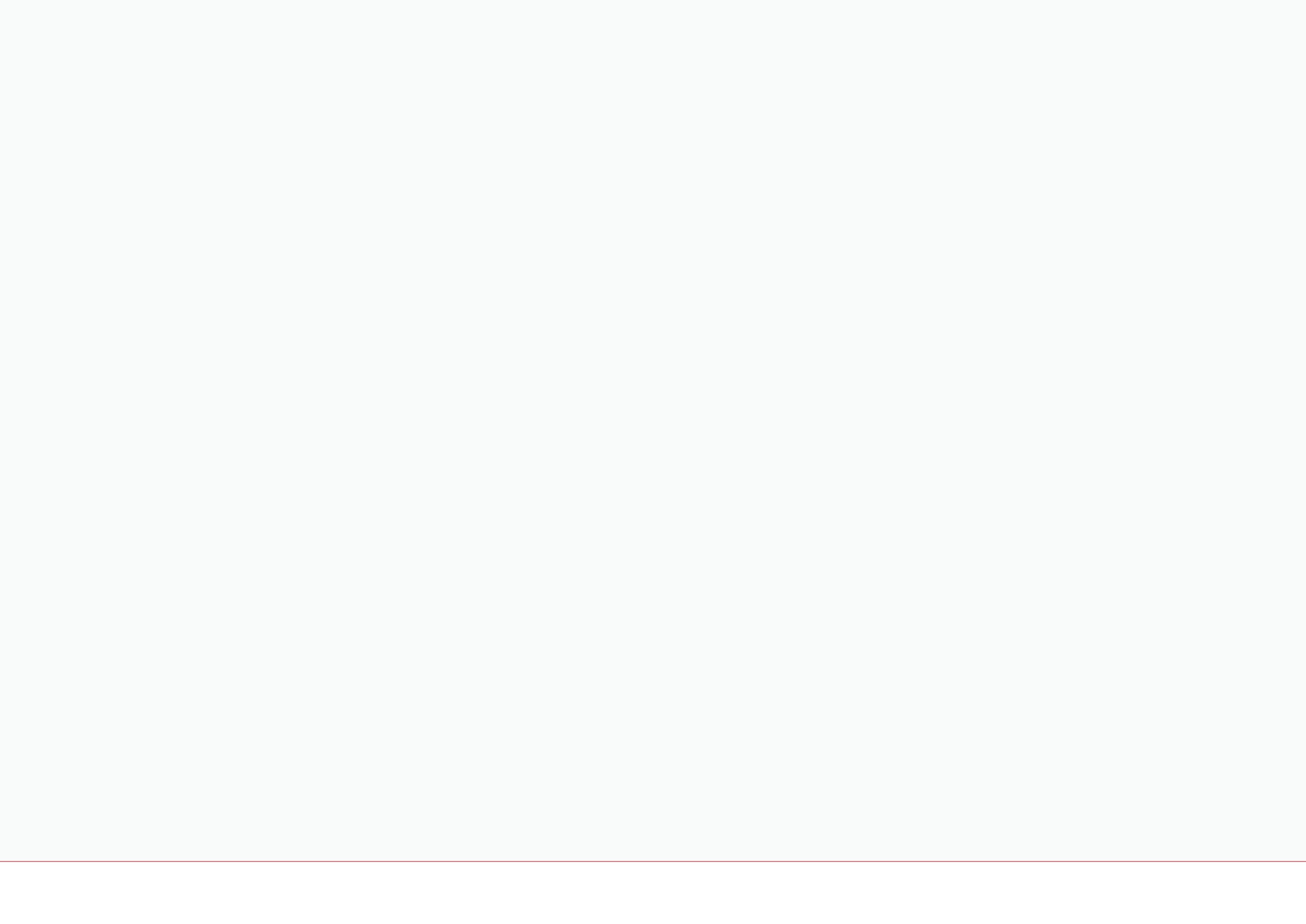
- The placement of access facilitators in health centres and hospitals was useful in assisting with and ensuring access to services, and in increasing health staff presence at health centres.
- The safe motherhood grant, with its conditions, contributed to an increase in health service utilisation for deliveries. Aside from increasing awareness and compliance with pregnancy check-ups, it also served as a way to encourage retention of voluntary members in the scheme.

In addition, the following lessons were reaffirmed during the course of ISHPS implementation:

- Good relations at the Provincial Health Department and OD level are crucial, as trust has to be built to ensure public health personnel support the scheme. It is therefore important to put a strong emphasis on interpersonal and communication skills when selecting staff for the schemes.
- Being able to provide a quick response to problems related to management or service delivery provides a positive atmosphere which contributes to the success of the scheme. Quality improvement (through quality improvement committees, plans and activities) – with sufficient support from implementing partners – is an important aspect of a successful scheme.
- Contracts with all parties involved in the scheme need to contain clear commitments and deliverables – ideally with performance- and satisfaction-based provider payment mechanisms, well designed monitoring and evaluation mechanisms, and effective sanctions in case contractual targets are not met.
- Ongoing communication by scheme operators, from the provincial to the national level, accompanied by regular feedback from national-level staff, is critical for preventing any issues from escalating and damaging the long-term development of the scheme. These include issues of provider performance, as well as challenges in scheme promotion and retention of voluntary members.

- The fragmentation of management contracts and funding sources for scheme benefits is likely to result in diseconomies and delays in the provision of benefits, which in time damages the trust of beneficiaries in the schemes.

Cambodian policy-makers should thus consider ISHPSs as a strategy for scaling up social health protection coverage. As with any new policy, it is important to assess the merits of this incremental strategy, keeping in mind the ultimate objective of advancing universal health coverage while prioritising those who are most vulnerable and in need of medical services.





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