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Briefings for Health Financing Policy-Making in Cambodia – #1

This series of policy briefs intends to support and inform decision-makers in Cambodia on key issues related to health financing and social health protection. These briefs are not scientific papers, but rather summarise evidence and technical concepts that decision-makers may consider in their discussions. – All briefs are available in Khmer and English.

Extending Social Health Protection in Cambodia:

How can health equity funds pave the way for universal health coverage?

Introduction – The future of health equity funds

Out-of-pocket expenditures on health are a major challenge for Cambodia's population; they cause indebtedness and impoverishment across all population groups, and pose considerable barriers to accessing health care, especially for poor and vulnerable groups such as old people, people with disabilities, the near-poor and people with unreliable work. To address these challenges, Cambodia's current draft health financing policy foresees the development of social health protection (SHP) schemes targeting different segments of the population. Currently, health equity funds (HEFs) are the most widespread SHP scheme in Cambodia.

HEFs target 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 not meeting the strict national poverty criteria are excluded from HEF benefits even if specific risk factors, such as chronic disease, would justify their inclusion. In addition, HEF schemes face a major challenge as the costs per beneficiary rise. This is due to smaller pools of potential beneficiaries, resulting from decreasing poverty and higher benefit reimbursement rates. Extending the role of HEF schemes beyond their current focus on the poorest members of society would address those concerns.

Key messages

- Making social health protection (SHP) available to all Cambodians is necessary to reduce catastrophic and impoverishing health care spending, promote social cohesion and ensure sustainable socioeconomic development.
- Health equity fund (HEF) schemes provide a platform to extend SHP for the informal employment sector, and contribute to achieving universal health coverage.
- Voluntary enrolment in HEF schemes can:
  - Extend SHP population coverage;
  - Target unsalaried (informal) workers and their families;
  - Improve equity and reduce the burden of disease by directing public funds to high-risk or needy households;
  - Empower members to demand better quality of care in public health facilities;
  - Contribute to improving the equity and efficiency of HEF schemes.
- Voluntary enrolment in HEF schemes is mainly attractive for low-income and high-risk households because of the benefits package on offer.
- Voluntary enrolment in HEF schemes is a self-targeting approach, effective at channelling public subsidies to people that have graduated out from poverty, are at high-risk of falling back into poverty and actually demand public health services.
- HEFs and voluntary enrolment in HEF schemes are transitional strategies towards universal health coverage.

Rationale – Moving towards universal health coverage

Unaffordable costs for health care keep families in poverty and reduce productivity in time of illness. SHP schemes that pre identify poor households can mitigate the negative effects of high health care spending for the poor. But, current SHP schemes in Cambodia do not provide a way to protect households when their economic situation improves and they are no longer eligible for social assistance. Even if no longer extremely poor, these near-poor households are still vulnerable to the effects of health care costs and economic shocks.

Not only do they risk falling again into poverty once without the protection of a SHP scheme, but their potential of economic productivity is hampered. Today, the majority of the Cambodian population is in this situation. Moreover, unpredictable and recurrent out-of-pocket health care costs put all but the wealthiest households at risk of catastrophic expenditures and impoverishment. This is especially true in rural areas, where limited access to cash makes households more prone to rely on high-interest credit or asset sales to overcome economic shocks.[1]

In an emerging SHP system, it is difficult to initially cover all segments of the population. Thus, it is rational to develop parallel SHP schemes, each focusing on a certain population group, such as the formal or informal sector populations. However, establishing several SHP schemes at the same time implies fragmentation of resources (financial pools) and burden (risk pools) and imposes managerial and administrative challenges. Building on existing schemes is a better way to reduce this fragmentation. This is also the approach suggested in the draft health financing policy, which foresees three dedicated SHP funds. In the long term, these funds will be harmonised and connected by equalisation mechanisms. One of the funds, the National Social Health Protection Fund (NSHPF) will target the poor and informal sector populations. Today, HEF schemes cover most of the poor, and could be transitioned into NSHPF. This transition could happen incrementally, to match the growth of available economic and national budgetary resources in Cambodia.

One way to begin this transition of HEFs would be to accommodate voluntary enrolment in HEF schemes for all Cambodian households, through pre-payment of affordable contributions. This buy-in into existing HEFs would improve the funds' cost efficiency and strengthen their purchasing power, increasing their ability to influence the quality of public health services. Under such arrangements, a HEF would become an integrated SHP scheme, with single fund and risk pools and a single operator. This would help the resulting SHP scheme to target public resources to households at risk of high health care spending and that are willing to use public health services. Contributions from voluntary members would complement funding from public subsidies, but these contributions cannot be expected to recover the full costs of services.

1 See also "Briefings for Health Financing Policy-Making in Cambodia – #4. The Transition to Universal Health Coverage in Cambodia: It is about the poor... but not only."

Proposed Reforms – From health equity funds to integrated social health protection schemes

Advantages of integrated SHP schemes

Integrated SHP schemes could make use of existing HEF structures, standards and administrations to improve:

- **Efficiency**
  - Increased 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 costs;
  - Voluntary contributions complement public subsidies;
  - The cost burden for dealing with complications at public facilities is reduced by enabling timely access to health services for people at high risk or with greater health care needs.
- **Equity**
  - Integrated SHP schemes provide protection for the poor as well as other vulnerable households that are at high risk of catastrophic health care spending;
  - All people in the catchment area have access to an SHP mechanism;
  - All scheme members receive financial support to access health services on the same basis, thereby potentially reducing stigmatisation and discrimination against the poor by health service providers;
  - Households with higher risks or 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 purchasing power of the scheme by improving its negotiating capacity for quality health services. Moreover, voluntarily enrolled households are more demanding and have well-articulated expectations about the product they are purchasing.

Considerations of design

An integrated SHP scheme includes full subsidisation of benefits for the poor, as in HEF. However, it gives voluntarily enrolled households access to the same medical benefits, once they buy into the scheme. Specifically, an integrated SHP scheme:

- Provides an identical health SHP card or booklet to all members (both voluntary enrolled 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 groups (such as pagodas, mosques, and churches) in the programme's promotions, voluntary enrolment and service feedback mechanisms;
- Provides all members, with the same essential medical benefits package, although the poor continue to receive additional transportation and food aid as with the current HEF schemes.

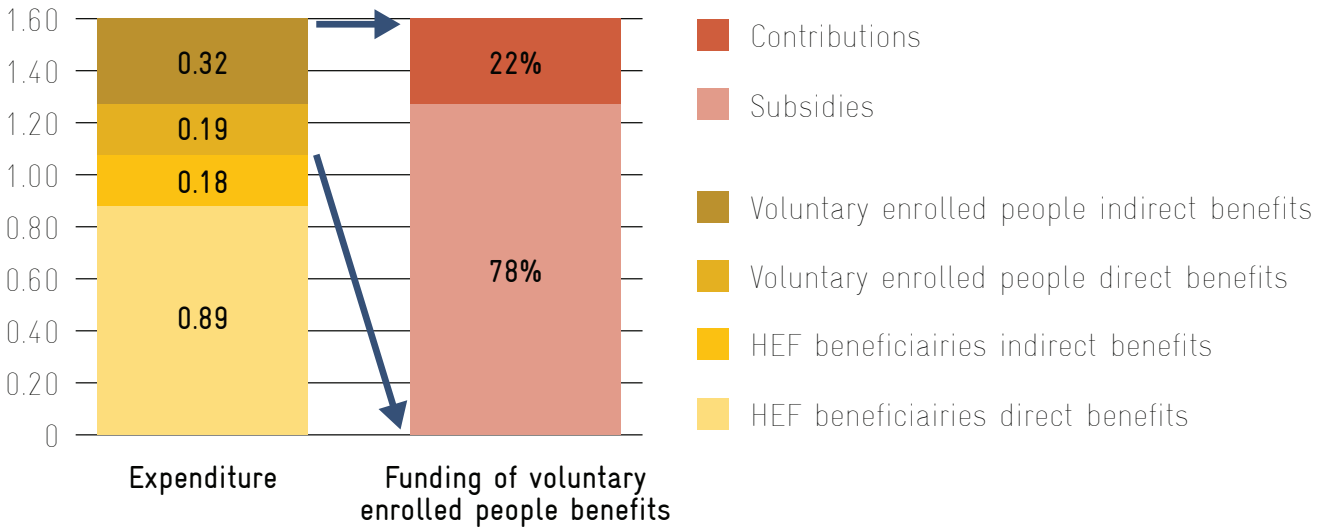
Integrated SHP schemes are a social assistance and protection mechanism that combines targeting of the poor and self-targeting of vulnerable households. Contributions of voluntary members are affordable prepayments that are not expected to recover the full costs of the benefits. Thus, applying conventional commercial insurance concepts to assess the cost-effectiveness and sustainability of SHP mechanisms would be misleading, especially since the aim is to promote timely and predictable access to public health services using subsidies. The concept of social security implies increasing equity by redistributing public resources to households with higher risks and health care needs – the kind of people that private insurers would exclude, or charge very high premiums, based on their risk profile. Embracing at-risk populations for inclusion in integrated SHP schemes is in line with the constitutional right of all Cambodians to access health care, and is a strong mechanism to help the public health system move toward universal health coverage (UHC).

Evidence from pilot schemes

Evidence from selected integrated SHP schemes operating in the operational health districts (ODs) of Kampot, Kampong Thom, Angkhor Chhum and Thmar Pouk, shows the potential of the integrated SHP scheme approach, namely:

- Increased utilisation rates of both poor and voluntary enrolees, which are both above the national average in those ODs.
- Improved perceptions of the quality of services, indicated by increased utilisation. In the integrated SHP schemes in Kampot and Kampong Thom ODs, client surveys conducted at regular intervals show an increasing level of satisfaction and expectation with services.
- Feedback by poor households indicates a decreased perception of discrimination by providers, which indicates improvement of equity.
- In Thmar Pouk OD, where the management and direct costs of services are subsidised, a total coverage of over one third of the OD population was achieved, with voluntary enrolment of more than 50%. This happened at a modest annual cost of USD 1.60 per capita.
- In Kampot and Kampong Thom ODs, engaging pagodas, mosques and churches to mobilise and oversee the distribution of funds for additional benefits for the poor (i.e., transportation and food allowances) fosters community participation. These faith-based organisations, together with commune councils and village chiefs, also assist with outreach activities for preventive services and scheme promotions.

Figure 1: Integrated SHP scheme expenditures and funding of voluntarily enrolled people's benefits in Kampong Thom operational district in 2013, in USD per capita per year, and percentage.



- In 2013, the costs to cover voluntary enrolment in Kampong Thom OD were USD 0.52 per capita annually, 22% of which was covered by voluntary members' contributions. Thus, adding voluntary enrolment to the existing scheme only requires public subsidies of USD 0.41 per capita. This is a reasonable figure, considering that the cost of fully covering poor households was only USD 1.07 per capita in 2013. Figure 1 shows the expenditure and revenue structures of the Kampong Thom OD scheme, and funding of voluntary enrolment.

Conclusions and recommendations

Realising the vision of the draft health financing policy will require an incremental approach to ensuring coverage of the informal sector, and voluntary enrolment in existing HEF schemes should be one of the first ways to accomplish this. Voluntary enrolment in HEFs, through integrated SHP schemes, is a sound strategy to extend SHP coverage of public health services to the near-poor and vulnerable households. Economies of scale and scope should be realised, offsetting the continuously increasing costs per beneficiary that potentially undermine the sustainability of existing HEFs.

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

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