

Briefings for Health Financing Policy-Making in Cambodia – #3

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.

Access to Public Health Services:

Why do eligible households not make use of health equity fund benefits?

Introduction – Health equity funds in Cambodia

The costs associated with using health services pose a major challenge for Cambodia's poor. This led to the emergence of a number of social health protection (SHP) schemes targeting poor households, the most widespread being health equity funds (HEFs). HEFs cover both poor households' health care costs at public facilities and direct non-medical costs such as transportation and food (for hospital inpatients and care-takers). The geographic expansion of HEF schemes is a significant development towards universal health coverage (UHC). Nevertheless, careful analysis of utilisation data among HEF beneficiaries raises questions about the extent to which beneficiaries actually make use of the scheme in case of sickness.

Key messages

- While health equity funds (HEFs) enable access to public health services at minimal costs for the poor, many eligible households do not use public health providers and incur unnecessary costs at private practitioners.
- Reasons for not using HEF services relate mainly to misconceptions about their entitlements, especially timely provision of sufficient social benefits, highlighting the need to:
 - Monitor the adequacy of non-medical benefit provisions, together with a reconsideration and reassessment of their worthiness;
 - Raise awareness among beneficiaries of their benefits and entitlements when seeking care.
- Other barriers relate to perceptions concerning discrimination at public health facilities.
- Old people in particular face a range of barriers that are not yet considered when accessing public facilities.



Rationale – Low utilisation despite free access to health care

HEF schemes have successfully increased access to health care for the poor, making public health services more equitable. As of December 2013, HEFs have been established in 52 of the country's 81 operational health districts (ODs) and cover approximately 2.4 million of the poorest people. Despite the large geographical, population and service coverage of HEFs, utilisation remains low with only one million consultations at public health facilities in 2012 (722,000 at health centres and 284,700 at hospitals). Evidence from individual schemes also suggests that a significant proportion of eligible households do not fully use HEF services. Many pre-identified households that have access to HEF benefits have never used the scheme. This is also true in areas with high overall utilisation rates among the poor and good quality public health services, such as in Kampot OD where a HEF has been operating since 2008.

The particularity of the Kampot scheme is that it also provided transport benefits for all poor members to health centres till March 2012. Transport vouchers were given to households on a base of 2 visits per household member per year. Utilisation and distribution of these vouchers were managed and monitored by faith-based organisations. Moral hazard, i.e. misuse of the benefits, was so minimised. Utilisation of services by the poor increased subsequently. Despite the high utilisation rates and extensive benefits package of the scheme, about a fifth of pre-identified eligible households reportedly never made use of their entitlement to fee-free care from 2008–2012. While there is ample literature on general access barriers to health services by the poor in Cambodia, much less is known about the possible causes of non-utilisation by those entitled to free care under HEF schemes. To address this evidence gap and inform possible reforms in HEFs, a study was commissioned by the Cambodian Ministry of Health (MOH), with the support of the Cambodian-German Social Health Protection Project, to assess the barriers to utilisation among non-users of the scheme in Kampot. Analysis of the scheme's database was performed, while in-depth interviews and focus group discussions were held with beneficiaries who rarely or never made use of their eligible HEF services. This briefing note is based on their responses.

Findings – Barriers to health equity fund services

The findings of the study in Kampot can be presented according to three main categories:

- Scheme-related factors – benefits package, design and operations;
- Supply-side factors – health care provision by public facilities;
- Demand-side factors – intrinsic factors influencing HEF beneficiaries' demands for services and benefits.

Scheme-related barriers

The cost of accessing health care remains a barrier despite the extensive transport reimbursement scheme which covers up to two visits to health centres per household member per year. Transport allowances to health centres are administered using vouchers, which members can exchange for cash with the scheme operator stationed at the health centre every morning. The main constraints to this arrangement brought up by beneficiaries were:

- Fear of not receiving the benefit;
- Insufficient reimbursement to cover actual transport costs;
- Absence of scheme operators in the afternoon to pay the transport allowances;
- The need to pre-finance transport costs.

At the hospital level, HEF beneficiaries that were hospitalised received food allowances (also for one caretaker) in addition to the transport allowance. The main constraints deterring poor people from using these services concerned:

- Fear of not receiving the benefit;
- Insufficient reimbursement to cover actual incurred costs.

In summary, even rare incidences of incomplete provision of allowances damage trust and deter poor households from utilising the scheme's services and benefits.

Supply-side barriers

Concerning public health services, the main barriers relate to the availability of care, staff behaviour, and the perceived quality of treatment:

- **Availability:**
 - Absence of health centre staff during work hours;
 - Long wait times (compared to private clinics);
 - Restricted operating hours, especially during the evening and at night (unlike private clinics and home-visiting doctors, who are available at these times).
 - Distance to the public health facility.
- **Staff behaviour:**
 - Inappropriate staff behaviour, especially at hospitals;
 - Discrimination against scheme beneficiaries (compared to paying patients).
- **Perceived quality of treatment:**
 - Ineffectiveness of medicines at health centres, and prescription of the same medicine for different ailments;
 - Inadequate medical examinations and equipment;
 - Limited variety of medicine, and lack of intravenous medication;
 - Inability to receive specific medicine upon request.



In summary, provision of injections or particular medicines upon request at private facilities was often mentioned as a reason for HEF beneficiaries to seek care at private providers. In the absence of regulatory mechanisms, private providers are inclined to follow patients' treatment preferences (regardless of whether they are medically justified) or even to promote inefficient or harmful care.

Building on those preconceptions, mistrust of public health facilities dominates among poor households. This mistrust is sufficient to deter beneficiaries from using HEF benefits and seeking care from private providers. This is rather surprising, as local private providers often also provide care at public facilities. This dual practice creates a perverse cycle, as this mistrust directly benefits the private activities of public health staff.

Demand-side barriers

Issues that had to do with the unique situations of beneficiaries are complex, and range from geographic access to social and cultural issues, including:

■ Geographical access:

- Difficulty arranging transportation, especially in more remote villages;
- Inability to travel, particularly for older beneficiaries.

■ Leaving work and home to go to the public health facility:

- Inability/unwillingness to take time off work;
- Need to take care of children or other household members;
- Reluctance to stay in the hospital for treatment, due to lack of caretakers.

■ Non-use of the scheme booklet in public health facilities:

- Beneficiaries forgetting to take their insurance booklet in emergencies (which functions as their scheme access card).

■ Concerns about utilising public health services:

- Worries about health staff complaining that scheme beneficiaries come too often;
- Concerns about not receiving treatment when presenting their booklet (as opposed to paying for the service).

■ Attitudes toward health problems and treatment:

- Reluctance to share one's illness with others, including health staff, family and community members;
- Tendency to delay treatment seeking.

In summary, concerns regarding travel costs to public providers result in delaying care seeking or even foregoing health care, despite transport and food allowances. Weak social solidarity networks also make it difficult for HEF beneficiaries, particularly old people, to seek HEF benefits as there is a general reluctance to rely on assistance from others, be them community or family members. Mobility limitations also reduced the demand for HEF services, especially in the case of disabled and old people for whom the transport allowances were insufficient or inappropriate for their needs. In all these cases, purchasing drugs in local shops or seeking services at nearby private providers was considered more convenient, thereby reducing the potential positive impact of the HEF scheme.

Conclusions and recommendations

Even with the health care and support services provided by HEFs, there are still barriers deterring poor people from seeking health care at public providers. Some of these barriers have to do with the design and operational arrangements of the schemes, while others are related to the responsiveness, quality and acceptability of public health services. Other barriers relate to the perverse incentives created by the dual practices by public health sector staff. However, the evidence from this study also suggests that those barriers disproportionately affect more vulnerable groups. This is especially the case for old people, who have low demand for HEF services because of a lack of solidarity networks. Removing these barriers will require revisions to the benefits package and HEF scheme operations, but also changes to dual practices in the public health sector and local community networks. Specific recommendations to reduce such barriers include:

- Closely monitor the provision of non-medical benefits and establish rapid complaint response mechanisms, to improve the trust of HEF beneficiaries in scheme services.

- Review transport allowances for preventive and curative care for poor people living in remote villages and people with specific transport needs, such as old people and people with disabilities.
- Consider cost-effective alternatives to transport allowances, such as strengthened community outreach or local transport arrangements.
- Regular and community-based awareness-raising for the poor on their entitlements under HEF.
- Overall awareness-raising for the general population on patients' rights and providers' rights, in collaboration with local authorities.
- Link patient satisfaction mechanisms to public provider supervision and payment mechanisms.
- Establishment of community mechanisms to collect, relay and follow up with members' complaints and mistrust of public health providers.
- Review the direct benefits package and services for vulnerable groups, and train health providers to address the specific expectations and needs of those groups.
- Address the dual practices of public health providers.
- Regulate health advertising and develop specific awareness-raising materials for HEF beneficiaries on appropriate treatment protocols and harmful practices, especially polypharmacy (use of multiple medications) and inappropriate intravenous therapies.

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Social Health Protection Project
GIZ Project Office at NIPH, P.O. Box 1238
#2, Street 289, Phnom Penh, Cambodia
Tel: +855 23 88 44 76
Fax: +855 23 88 49 76
Email: info@giz.de
Internet: www.giz-cambodia.com

Cambodia office PO Box 1238, Phnom Penh, Cambodia
Tel: +855 23 884 476
Fax: +855 23 884 976
Email: giz-kambodscha@giz.de

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Editors Adélio Fernandes Antunes and Bart Jacobs
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