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Briefings for Health Financing Policy-Making in Cambodia – #4

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.

The Transition to Universal Health Coverage in Cambodia:

It is about the poor… but not only.

Introduction – The challenge of transition

The Royal Government of Cambodia is aware of the challenges that direct and indirect health care costs represent for the population, and has supported and begun a number of social health protection (SHP) initiatives targeting different segments of the population, while working towards the ultimate goal of universal health coverage(UHC). The largest and most studied of these initiatives are health equity funds (HEFs). Cambodia has also initiated the establishment of social health insurance funds for workers in the formal sector, which are expected to begin in 2015. However, most of the population remains in the informal economy and is progressively moving out of poverty to a precarious 'near-poor' status. This group remains very vulnerable to economic shocks, which can push them back into poverty or hinder their economic progress through lost income or long-term debt.

In this briefing note, we look at the financial burden that health care puts on Cambodian families and the determinants (explanatory factors) that contribute to, or protect them from, catastrophic health spending. We conducted our analysis using the latest large-scale consumption surveys for which in country data is available – the 2004 and 2009 Cambodian socio-economic surveys (CSES). The evidence presented should guide decision-makers in setting priorities and policies in the transition to UHC.

Key messages

- Unmet need and the financial burden on families seeking health care decreased in Cambodia between 2004 and 2009.
- Equity in access to health care has improved. However, catastrophic spending and subsequent household debt to pay for health care remain high.
- Addressing these issues will require an initial focus on rural areas, hospital service coverage, chronic diseases, and long-term care of old people.
- Developing a comprehensive social health protection system to achieve universal health coverage in Cambodia requires the parallel regulation of the private sector.

Findings – Analysing the situation

This briefing note presents detailed results on out-of-pocket (OOP) and catastrophic health spending. It also looks at impoverishment as a result of this spending. The primary finding of this analysis is that the health and economic situation of households has improved rapidly. Over the period studied, incidence of illness decreased across all five economic subgroups (quintiles), from the poorest to the wealthiest households.

The unmet need for health care decreased at the same time as the percentage of ill people seeking medical care increased substantially, from 52.2% in 2004 to 68.6% in 2009. This shows that overall health care access has improved since 2004. This increased access was also seen among the poorest subgroup. Nevertheless, gaps between the poorest and wealthiest households were still substantial; more than 20% of the population in the two poorest subgroups did not seek care when ill, compared to less than 10% of people in the wealthiest economic subgroup.

As expected from the rapid economic growth experienced over the last decade, available household income and capacity-to-pay have rapidly increased between 2004 and 2009. OOP also increased, although less rapidly. Average monthly OOP per person, excluding transportation and associated costs for seeking health care, rose from KHR 4,970 in 2004 (USD 1.23; approximately USD 14.80 annually) to KHR 9,821 (USD 2.36; approximately USD 28.30 annually) in 2009. Not surprisingly, this increase in OOP was mainly among the wealthiest subgroup, although expenditures related to treatment of old people rose most rapidly.

However, the decrease of OOP as a share of household capacity-to-pay hides a rapid increase in actual health care costs. The average monthly spending per person seeking care rose from KHR 29,796 in 2004 to KHR 70,077 in 2009 (a 235% increase). Wealthier and older subgroups spent more on health care, as they also accessed health services more.

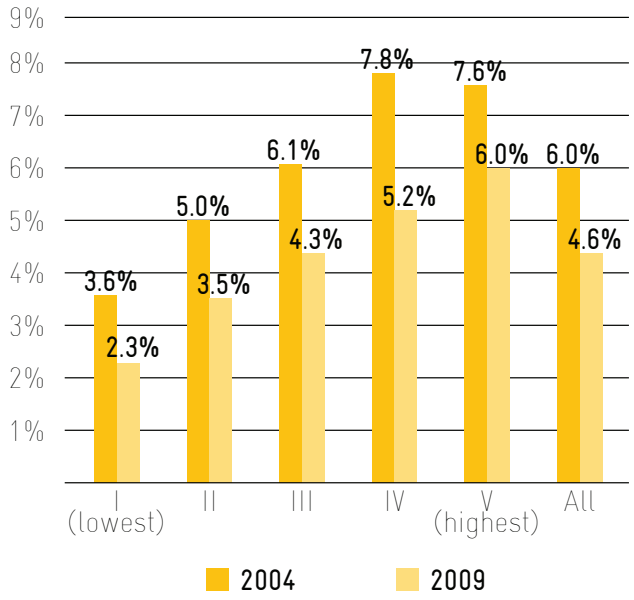
In addition, there was a significant decrease in catastrophic health spending rates, from 6.02% of all households in 2004 to 4.27% in 2009 (see Figure 1). Households facing indebtedness due to illness decreased from 5.3% to 3.8% over the same period. These reductions are primarily attributable to increased incomes across the entire population.

Overall, four factors primarily explain which households are more likely to spend money on health care, experience economic shocks from this care, and even contract debt to finance it: living in rural areas, hospitalising the patient, and treating old people and chronic diseases. Protective factors are higher education of the head of household, and living in a HEF-covered OD. Key explanatory factors in predicting and protecting households from health care spending, catastrophic expenditures and health care-related debt are summarised in Table 1.

Box 1: What is catastrophic health spending?

According to the World Health Organization, a catastrophic health expenditure (or spending) occurs when more than 40% of a household's remaining income after subsistence needs have been met (defined as 'capacity-to-pay') is spent on out-of-pocket health care costs. Such a situation frequently leads to poverty, or pushes households deeper into it.

Figure 1: Incidence of catastrophic expenditure on health in 2004 and 2009, in percentage of households. (Source: Cambodian Socio-Economic Survey (2004 and 2009) analysis)



Discussion – Policy implications

The CSES data analysis suggests that social health protection mechanisms, including HEFs, fee exemptions and micro health insurance schemes assist in protecting people from catastrophic health expenditures. However, it should be noted that the CSES analysis did not produce as much evidence regarding the impact of SHP mechanisms as expected, mainly because of the design of the survey. To better monitor the impact of SHP mechanisms and target those mechanisms, these survey tools should be reviewed.

The CSES analysis also indicates that when people who qualify for exemptions or live in a HEF OD spend money on health care, they are likely to spend more than other households. Also, households exempt from paying for public health care are also more likely to be indebted due to illness. These results seem unexpected, but HEFs and fee exemptions apply only to treatment at less expensive public facilities. Thus, if a household that benefits from a fee exemption or HEF spends money on health care, it will likely be in the more expensive private sector. And part

Table 1: Predictive/explanatory factors of household spending on health care (out-of-pocket expenditure, catastrophic expenditure and contracting debt for health care). (Source: Cambodian Socio-Economic Survey (2004, 2007 and 2009) analysis)

Explanatory factor	Dimension		
	Health care spending (OOP)	Catastrophic expenditure	Health care-related debt
Geographic			
Living in rural area	------	++++++++++++++++++	+++++++
Living in Phnom Penh	++++	0	0
Exemptions			
Fee exempt	0	0	++++++
Living in HEF OD	-	--	---
Household			
Having a large household	-	0	0
Head of household with primary education	0	------	----
Head of household with secondary education	----	----------	-------
Patient			
Patient under 5 years old	0	0	++++
Patient over 59 years old	+++++	++++	---
Male patient	----	0	0
Patient hospitalized	++++++++++++++++++	++++++++++++++++++	++++++++++
Patient treated for chronic disease	na	++++++++++++++++++++	+++++++
Economic			
Household above 2nd economic quintile (poorest)	+++++	++++++++++	0

Legend: (-) Less likely; (0) No difference; (+) More likely; (na) non available.

of the money spent on private care may have been saved by the family as a result of fee exemptions. This poses potential policy questions, as HEFs and fee exemptions are unlikely to reduce total out-of-pocket expenditures, but may contribute to price inflation (when reimbursements to public facilities trigger increased prices in private facilities) and increase debt related to consumption at private providers.

Conclusions and recommendations – Setting priorities in transition to UHC

The analysis of CSES data suggests that Cambodia is improving the equity of access to public health services while protecting the poorest households from financial burdens when seeking health care. Nevertheless, there are still a number of challenges that need policy interventions to further improve the country's social protection environment and secure its economic development. The significantly higher risk of debt and catastrophic health care expenditures in rural areas deserves special attention. Additionally, a rapid rise in health care costs and the subsequent financial burden pose a major threat to further economic progress. Improving all three dimensions of UHC (population, services and costs) is imperative, although changes must be prioritised. Decision-makers should use available evidence to focus on interventions that provide the highest returns on public investment. The evidence presented in this note highlights that rural areas, hospital services, and the needs of old people and those with chronic diseases should be addressed urgently.

The CSES analysis illustrates that all households in Cambodia are at risk of economic shocks when seeking health care, and that developing the SHP network is essential for maintaining the economic gains of the last decade without compromising equity. The draft health financing policy provides the vision and overall structure to achieve UHC. It also suggests a transitional strategy through expansion of existing SHP mechanisms such as HEFs and national social security funds (NSSF). In particular, NSSF implementation should be expedited, to secure social stability and productive labour forces.

In addition, the findings of this analysis further emphasise the strategic importance of private providers in the provision of health care in Cambodia, and also in securing SHP as a public service. The transition to UHC cannot rely only on the extension of SHP mechanisms that provide access to public facilities. A thorough regulation of the private sector is required to protect consumers. This will require reflection on key issues such as contacting, licensing, legislation of mispractices, accreditation and dual practices.

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