កិច្ចសហប្រតិបត្តិការ អាល្លឺម៉ង់
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Briefings for Health Financing Policy-Making in Cambodia - #5

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 language.

Mental Wellbeing among the Poor:

Do health equity funds protect them from stress and financial hardship?

KEY MESSAGES

- Stress related to health care costs is widespread, even among health equity fund beneficiaries.
- Health expenditure related stress is strongly associated with poor mental wellbeing.
- Although health equity fund (HEF) beneficiaries are entitled to free health care at public health facilities, the majority initiate care seeking at private facilities, incurring unnecessary and considerable expenses for services of unknown quality. As such, a considerable proportion of poor households still spend more than their monthly income on health care.
- Borrowing among poor households is widespread, including for health care, and related indebtedness is associated with stress and poor mental wellbeing, in turn negatively affecting physical health status.
- Coping mechanisms to service debts often include withdrawing children from school, which depletes human capital.
- To be successful, HEFs should also educate their beneficiaries and raise awareness about their entitlements under the scheme, associated rationales and potential financial consequences of care seeking at private health providers, including borrowing practices to cover health expenditures and their perverse consequences on livelihood and health.

Introduction – The mental dimension of health-related debt

Catastrophic spending and indebtedness due to health care needs are significant challenges for households in Cambodia. Health equity funds (HEFs) and strategies such as the Integrated Social Health Protection Scheme (ISHPS)[1] have been designed to enable affordable access to health care at public facilities for poor and vulnerable households, and prevent health-related financial hardship. But HEF schemes tend to be underutilised, and large numbers of eligible households still make out-of-pocket (OOP) payments for health care. The majority of these households resorts to borrowing to pay for these costs. Cambodians' heavy reliance on private health care is partly responsible for this.

When borrowing for health care, the poor typically utilise informal moneylenders with exorbitant interest rates. The poorest Cambodians can incur average annualised interest rates of 170% when borrowing money for health care. Such high rates put an extreme amount of stress on people and may affect their overall health; debt is a predictor of increased stress, depression, and worse general health status. The interaction between health care indebtedness and health status in Cambodia has received little attention to date, whereby this briefing note presents some of the latest evidence on this issue from four operational health districts (ODs) covered by social health protection schemes.

Evidence – When access to free public health care is not sufficient

From 2013-2014, Population Council and the National Institute of Public Health conducted a cross-sectional survey among poor households, all identified under the IDPoor programme, to measure utilisation of health care services in the ISHPS and 'standard' HEF schemes (non-ISHPS).[2] In this brief, the aggregated results for all poor households have been reported, as no statistically significant differences were found between the two groups on catastrophic expenditures, impoverishment and indebtedness status. As such, we present a situational analysis and broad findings on health expenditures and indebtedness, and their association with mental wellbeing and perceived physical health status of surveyed household heads.

Findings

The study found high levels of health care expenditures, and links between indebtedness and poor physical and mental health outcomes. Catastrophic health care expenditure was defined as households spending more than one month of income on health care related costs on a single episode of illness in the past five years. Individuals and households in study areas, in order to pay these costs, relied heavily on loans despite being eligible for free public health care. High indebtedness was associated with extensive strain on the physical, mental, and overall wellbeing of household members. The average reported monthly income of households was about USD 98, with USD 8 spent on health care. A high proportion of respondents (more than 90%) reported being ill at least once in the past year, with approximately a third being frequently ill.

[1] See "Briefings for Health Financing Policy-Making in Cambodia - #1. Extending Social Health Protection in Cambodia: How can health equity funds pave the way for universal health coverage?"

[2] The sample for this study comprised around 1,650 households, all identified as poor under the IDPoor programme over four operational health districts (ODs) in two provinces: Kampong Thom and Stong ODs in Kampong Thom province; Chamkar Leu OD in Kampong Cham province; and Moung Ruessey OD in Battambang province. Kampong Thom and Stong ODs were ISHPS areas (i.e., the intervention sites), and Chamkar Leu OD and Moung Ruessey OD were the comparison sites.

The study also found significant spending on health care. Results showed:

- 58% of households reported ever having catastrophic spending of more than one month's income on a health care episode in the past five years.
- Catastrophic health expenditures were 2.5 times higher than households' reported monthly income (USD 271 on average).

Approximately 61% of households relied on borrowing to cover the last catastrophic expenditure episode.[3] Of households that borrowed, 88% were required to pay interest. More than half of households that incurred debt could not pay off their loans within one year, and more than three quarters of these households had outstanding debt at the time of the survey. The average amount of outstanding debt was almost four times their reported monthly income (USD 369).

Households generally borrowed from informal moneylenders, microfinance institutions, and friends, relatives and neighbours. Findings suggest that household decision-making about where to obtain loans varied significantly by whether they were in ISHPS or non-ISHPS areas, which is likely due to the availability of microfinance services between areas.[4] The percentage of household that need to pay interest when taking loan was not different between the two geographic areas (ISHPS and non-ISHPS). Interest rates varied substantially between the type of lender (see Figure 1). Households that relied on informal moneylenders – including friends, relatives and neighbours – had to pay more than those borrowing from formal institutions (see Figure 2). A significant number of households had to pay very high interest rates, particularly when they relied on informal moneylenders, friends, relatives and neighbours (see Table 1).

Table 1: Average, minimum and maximum monthly interest rates, by type of lender.

Type of lender	Mean	Median	Minimum	Maximum	Share of households with interest rates of 10% and more
Informal moneylender	8.96%	5%	0.00%	60%	34%
Friend/Relative/Neighbour	7.23%	4%	0.00%	70%	26%
Microfinance institution	3.93%	3%	0.03%	50%	4%
Bank	3.39%	3%	1.50%	30%	2%
Other	2.92%	3%	0.00%	25%	2%

[3] For the purpose of this study, catastrophic expenditure was defined as expenditures on a single health event that are more than one month of household income.
[4] A significant difference in average interest rates was found between non-ISHPS and ISHPS areas; 6.6% and 4.1%, respectively.

Figure 1 : Source of loans, by type of lender.

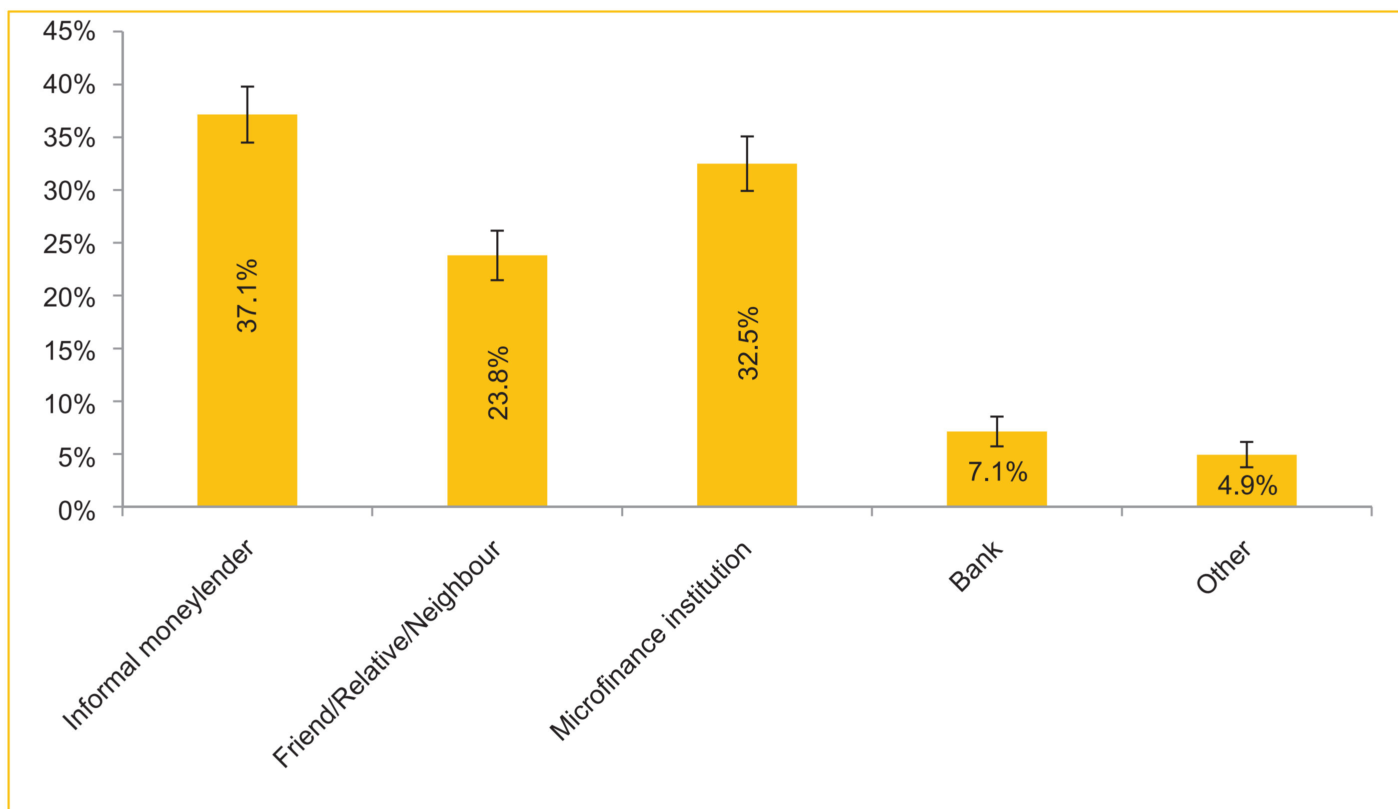
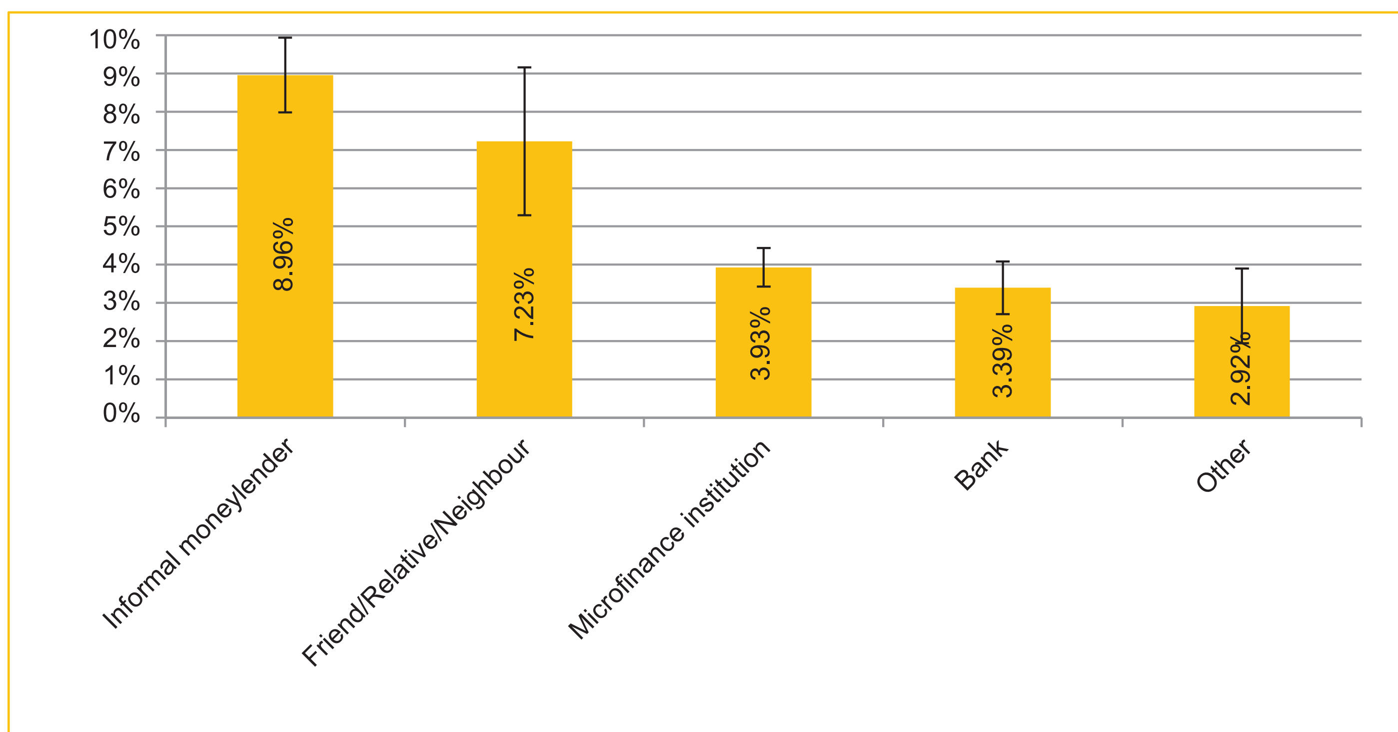


Figure 2: Monthly interest rates, by type of lender (in percent).

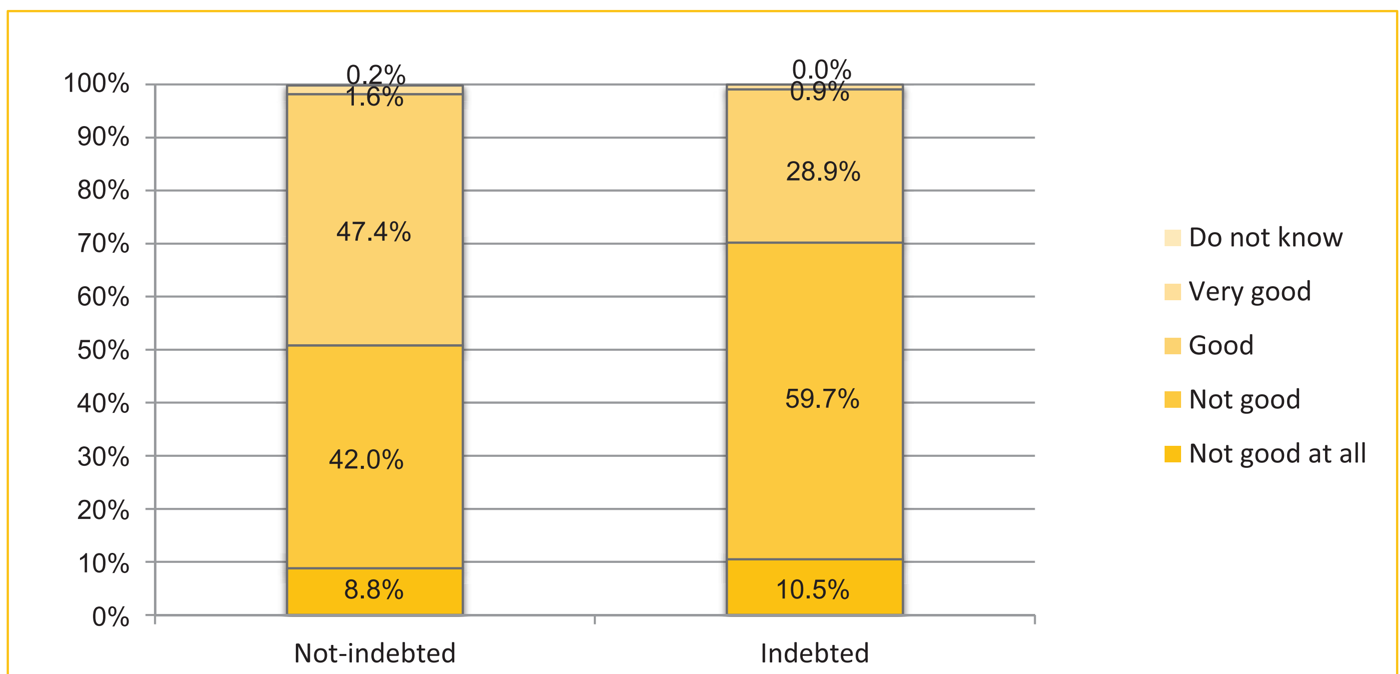


Families were found to employ various coping mechanisms to pay off their debt. 85.2% increased labour at work, and 20% reported that they sent children off to work. Furthermore, the relationship between the current amount of household debt and sending children to work was found to be significant: 29.3% of families who had debt above USD 400 sent their children to work, verses 17.3% of households with less than USD 400 in debt. No association was found between the amount of interest paid and other coping strategies.

The stress from health-related debt and expenditures was strongly related to mental wellbeing of the heads of households[5]. Over 65% of household heads reported either "not good" or "poor" mental wellbeing. Approximately 87% of household heads reported feeling stress within the last year due to large health care expenditures. Almost 77% of interviewees reporting poor mental wellbeing also experienced large health expenditures in the last five years, compared to 56% of interviewees with good mental wellbeing. Similar results were found for stress due to health-related debt. The level of stress also strongly correlates with mental wellbeing, with 46% of household heads reporting high stress due to health expenditures. The strong association between stress due to health-related expenditures and debt is consistent with the 'social causation pathway'. In this pathway, poverty conditions and associated financial stress cause poor mental wellbeing. Furthermore, it should also be acknowledged that poor mental wellbeing is likely to depress physical status and productivity.

In addition, results showed indebtedness to be significantly associated with reduced physical health. Considering that physical health effects of indebtedness may be driven by stress and mental heath status, and may take time to manifest, the study examined associations between incurred debt in the past and current physical health status. Results show that, among those who had ever taken out a loan in the past five years, 40% reported being physically ill frequently in the past year, versus 25% who had never taken a loan.

Figure 3 Perceived mental status and wellbeing among non-debted and indebted household heads.



[5] Household heads self-assessed their 'mental wellbeing' and 'level of sorrow' related to health care costs and debt. These terms were selected as the closest synonyms for the English terms and concepts of 'mental status' and 'stress'.

The findings on debt-related stress found that 77% of household heads felt stress due to outstanding debt over the last 5 years, and approximately 95% of household heads felt stress because of outstanding debt over the last year. The results, shown in Figure 3, provide preliminary evidence of the association between indebtedness and poor mental health outcomes.

They suggest:

- 60% of heads of indebted households reported their mental status as not good, compared to 42% of heads of non-debted households.
- Only 29% of heads of indebted households reported their mental status as good, compared to 47% of heads of non-debted households.

Conclusions and recommendations

This survey results show that health care spending and reliance on loans to cover these expenses is high in Cambodia, indicating that the problem of catastrophic expenditure and debt is significant for the poor population, despite their participation in programs such as HEF. The integrated ISHPS areas were seen to have more formalised sources for obtaining loans, with lower overall interest rates. As the poorest of the poor are the most likely to rely on informal lenders, this situation illustrates the need to improve social protection for health care, and to strongly regulate lending for non-business related loans.

When looking at health as the mental, physical, and social wellbeing of individuals, one can argue that HEFs alone inadequately address the health status of beneficiaries holistically, as their explicit focus is on physical aspects of health; i.e., the absence of disease. Our findings suggest that social health protection programmes should also address mental health stressors, and reduce debt to be effective; that is, to ensure financial protection of the eligible population. Incurring less debt for health care may lead to improved mental health status as well as physical health status, and thus improve socioeconomic wellbeing for Cambodians.

Given the findings from this study, we recommend the following:

- Focus on strategies that stimulate beneficiaries to utilise the free health care services they are entitled to.
- Educate and raise awareness on debt and borrowing, to ensure effective financial protection.
- Develop services to cope with poor mental and social wellbeing, in addition to the physical health of the poor.
- Support greater credit market regulation, to ensure Cambodians acquire loans through established, formal networks that do not exploit their vulnerability through exorbitant interest rates.
- Conduct longitudinal studies on mental health status and health care related indebtedness, and the impact on livelihoods in Cambodia.
- Conduct in-depth qualitative research, to provide context and meaning to observed trends in health status and health care related indebtedness.

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