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Impact of health financing policies in Cambodia: A 20 year experience

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ABSTRACT

Improving financial access to services is an essential part of extending universal health coverage in low resource settings. In Cambodia, high out of pocket spending and low levels of utilisation have impeded the expansion of coverage and improvement in health outcomes. For twenty years a series of health financing policies have focused on mitigating costs to increase access particularly by vulnerable groups. Demand side financing policies including health equity funds, vouchers and community health insurance have been complemented by supply side measures to improve service delivery incentives through contracting.

Multiple rounds of the Cambodia Socio-Economic Survey are used to investigate the impact of financing policies on health service utilisation and out of pocket payments both over time using commune panel data from 1997 to 2011 and across groups using individual data from 2004 and 2009. Policy combinations including areas with multiple interventions were examined against controls using difference-in-difference and panel estimation.

Widespread roll-out of financing policies combined with user charge formalisation has led to a general reduction in health spending by the poor. Equity funds are associated with a reduction in out of pocket payments although the effect of donor schemes is larger than those financed by government. Vouchers, which are aimed only at reproductive health services, has a more modest impact that is enhanced when combined with other schemes. At the aggregate level changes are less pronounced although there is evidence that policies take a number of years to have substantial effect.

Health financing policies and the supportive systems that they require provide a foundation for more radical extension of coverage already envisaged by a proposed social insurance system. A policy challenge is how disparate mechanisms can be integrated to ensure that vulnerable groups remain protected.

1. Introduction

Improving financial access to services is an essential part of extending universal health coverage (UHC) in low resource settings. Strategies typically incorporate a number of elements including boosting overall funding, increasing the proportion of funding channelled through pooled funding (particularly publicly funded insurance mechanisms), diverting spending to services known to be effective and ensuring equitable financial access (Moreno-Serra and Smith, 2012; Kutzin, 2013).

Development of UHC in Cambodia requires action across each of these elements. Although total spending on health care at around 6% of GDP (World Development Indicators, databank.worldbank.org/) in Cambodia is about average by South-East Asian standards, much of this is un-pooled spending on medicines and other private services. Public funding remains at around 20% of total funding on health and penetration of private insurance is low. Contact with the formal health sector remains low (around 0.5 visits per capita), reflected until recently in the limited use of essential services such as skilled delivery care: until around 2010 only around half women attended a health facility, although the latest DHS shows an increase to 80% (National Institute of Statistics DGfH, 2015).

In recent years, health financing policy has focused on reducing the barriers to utilising services particularly amongst the most vulnerable. Ultimately the intention is to develop a comprehensive

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system of social protection based on social health insurance. Current policy in Cambodia attempts to ameliorate the effects of financial barriers to service access by targeting resources at "the poor and groups with special needs" (Government of Cambodia, 2013). Policies implemented include formal user fee exemptions, health equity funds run by government and development partners, vouchers and community based health insurance. Impact and qualitative studies suggest they have a generally positive impact on access to services particularly by the poor including: equity funds (Flores et al., 2013; Noirhomme et al., 2007a; Dingle et al., 2013) and vouchers (Ir et al., 2010; Poel et al., 2014) and performance funding (Soeters and Griffiths, 2003a; Van de Poel et al., 2015). Using data from the Cambodia Socio-Economic Survey, we add to this evidence by: 1) examining how the initial decision to formalise user fees affected spending; 2) how the effect of policies have built up over time; 3) how interactions between policies magnify or diminish the impact of policies. Following previous studies, we utilise the gradual roll out of policies across the country to facilitate a comparison between the policy effect on individuals in intervention areas and similar individuals in control areas. By reviewing evidence from other studies combined with a consideration of the impact of all main policies using a regularly collected dataset, we provide a consolidated overview of the main financing changes over the last 20 years.

The article is arranged as follows. In the next section we describe the evolution of health financing policies in Cambodia. This is followed by a description of the methods and data used to assess the impact of policies and policy combinations on both use of public health services and health spending per capita. Results are then described followed by a discussion of these in the context of policy goals and in comparison to findings of other studies.

1.1. Health financing policies in Cambodia

A series of health financing policies designed to improve financial access to health services, particularly amongst the poor, have been rolled out across the country since 1996 (Table 1). Initially these had the intention of bringing greater transparency and more stable funding to the public health system. Latterly they have addressed the low use of services, particularly amongst the poor.

Much of the evidence on the impact of user fees is based on case studies of districts and individual facilities combined with cross sectional analysis of the impact of charging on health seeking behaviours. There is some evidence that formalisation when implemented with clear rules, strong management and waivers for the poor can reduce unpredictability over payment and increase utilisation of services (James et al., 2006). User fees bring funding into a facility that can be used flexibly to improve services including incentives to staff. A positive impact on utilisation was reported by early case studies in Takeo district and a maternal care referral facility (Barber et al., 2004; Akashi et al., 2004). There is also considerable evidence of the negative impact of user fees. Qualitative studies found that exemption rates for health services have often been low, applied haphazardly and benefited those with connections to staff rather than the most vulnerable (Khun and Manderson, 2008). It is suggested that formalisation has contributed to increased levels of health spending which often lead to accumulated household debt following episodes of ill health (Van Damme et al., 2004; Health Economics Task Force, 2000). Fees may initially have caused patients to seek services in private rather than public facilities which later encouraged an increase in the price charged in the private sector (Jacobs and Price, 2004).

To mitigate the rising cost of care use of services particularly amongst the poor, the government with support and advice from international agencies has introduced a series of financing mechanisms. The need for these mechanisms is motivated by the formalisation of user fees. Arguably these other mechanisms can only be made to work once unofficial fees have been eliminated.

The mechanism that has had greatest coverage is the health equity fund (HEF) mechanism which was introduced with financial support from development partners and technical support from international NGOs from 2000. By 2009, the population of almost 50% of communes was covered by an NGO or Government financed equity fund. HEFs are held by facilities and contribute to the costs of treatment, transportation and food for patients and carers. Most early research produced case studies of schemes in particular areas.

Table 1
Health financing policy roll out in Cambodia.

Year of Implementation	Details	Communes included						
		1997	1999	2004	2007	2009	2011	% of total by 2011
1996	User fees: Fees are set by facility committee and approved by Ministry of Health; 99% of revenue is retained in facility; facilities must establish exemption policy for the poor; some high priority services should be provided without charge.	38	195	867	1325	1395	1357	84%
1998	CBHI: This is a not-for-profit, voluntary insurance scheme selling low-cost policies to community members. The insured and family are entitled to use defined health services at contracted public health facilities. CBHI reimburses the cost of services consumed by its members.	0	1	12	70	140	310	19%
1999	Contracting: This includes contracting-in, contracting-out, and special operating agency arrangements within the health sector aimed at delivering a range of different clinical and support services, including cleaning, catering and management.	0	100	279	256	164	565	35%
2000	Health Equity Funds (Donor-funded): A social-transfer mechanism designed to remove financial access barriers to public health facilities received by the poor through reimbursement of fees from a third-party payer, mainly local NGOs. Pre- or post-identification are used to identify those who are entitled to get health free services at the point of use. The third party reimburses the cost of such services to facilities on a monthly basis.	0	1	74	146	586	482	30%
2007	Voucher schemes: Vouchers given to pregnant women to cover 2–4 ANC visits, delivery and post-natal care, transportation costs and fees for referral to hospital. Some schemes are universal and some target only poor women.	0	0	0	54	345	545	34%
2008	Health Equity Funds (Government-funded): A Government funded subsidy whereby public health facilities provide services free of charge to poor patients financed through a transfer from the national budget. The schemes are managed directly by operational districts (ODs) and Hospitals.	0	0	0	0	210	259	16%