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Overcoming Barriers: Health Equity Fund in Cambodia

By Bruno Meessen and Por Ir

In low-income countries, user fees have been promoted as a strategy to tap more resources to public health facilities. But they may also constitute a barrier limiting utilization of public health services by the poor. The barrier is particularly critical for hospital care as the technicality, intensity and duration of the care delivered to an inpatient often leads to significant costs. Moreover, most of the population has no hospital in its immediate vicinity. Transportation cost also constitutes a heavy burden for the poorest.

To tackle this equity problem, most governments have decreed that the poor should be treated for free. The existing evidence shows that waivers and exemptions through regulation, in most cases, do not work: few poor can benefit from it and many beneficiaries are not the poorest. As an organization, why would the hospital accept to bear a cost without compensation? Indeed, every poor patient leads to more medical and paramedical work, more drug consumption, more catering and more troubles. On the other hand, fees are just one of the many costs for the patients. The poor traditionally live far from hospitals. In order to benefit from free medical care, they have to cover other costs such as transport. Moreover, there may be a lot of uncertainty about eligibility for waivers and exemptions. The poorest may then decide to stay at home foregoing the treatment, or seeking inappropriate care. There is also a problem at the facility level. If the hospital staff has some freedom to decide whom to waive, one can expect that people with some formal or informal connections with the hospital will manage to be among the beneficiaries. Social capital is not an attribute of the poorest.

The Health Equity Fund experience in Sotnikum, Cambodia

Sotnikum Health District is a poor rural area, with around

220.000 inhabitants. It is divided into 17 health areas, each of them having one public health center. The district hospital is in the small town of Damdek. It provides the full complementary package of activities foreseen by the national policy: internal medicine, pediatrics, obstetrics-gynecology and surgery.

In 1999, the Ministry of Health, Médecins Sans Frontières, and UNICEF agreed on a common approach to boost the activities in the health district. They introduced a new scheme, called the 'New Deal,' which establishes strong incentives for the hospital and health center staff to deliver quality health services to the population. Income collected through user fees was expected to finance an important part of the motivational scheme. There was however an obvious risk that the poorest would not benefit from the improvement in the service delivery. In order to avoid the pitfalls discussed above, the three partners decided to review the mechanisms dealing with hospital access.

First, a special fund was established. Both international agencies agreed to commit to an earmarked funding for enhancing access by the poor to the hospital services, the so-called Health Equity Fund (HEF). Straight from the start, it was decided that the HEF should cover all the costs the poor have to overcome to access hospital care: the user fees, the transportation cost, items for facilitating their hospital stays and some social care if necessary.

The next question was whom the HEF should be entrusted to. Both international agencies were not interested in managing it: they did not feel to have enough expertise in this domain; they were expensive and non-sustainable solutions. The other option was to entrust the HEF to the hospital itself. But some conflicts of interests were expected. In a model where a hospital staff manage such a fund, there are some perverse incentives: the most lucrative strategy for the hospital is to spend the fund, as quick as possible, in paying their own user fees, whatever the profile of the beneficiaries. Incentives for targeting the poorest and for addressing external barriers are then limited.

Henceforth, the decision was to subcontract the management

of the HEF to a local social welfare non-governmental organization (NGO). Several benefits were expected from that choice. First, one could expect some expertise and commitment to care for the poorest from this type of organization. The expertise was necessary to be able to identify correctly the beneficiaries but also to tailor the assistance. The commitment was necessary to be responsive to the needs of the poorest, including defending their rights and dignity during their stay in the hospital. Second, the local NGO was a low-cost and sustainable option. Thirdly, sponsors were concerned for enforcing some accountability mechanisms upon the fund manager (e.g. observation of leakage to non-poor should be sanctioned). Subcontracting to an agent potentially replaceable (managing a HEF has a low entry cost, there are quite a lot of local NGOs in Cambodia) was perceived as a way to guarantee actual benefit to the poorest.

Quite some freedom was given to the local NGO in the development of the strategy for recruiting, identifying and assisting the poor. Experience has permitted to progressively design the best organizational set-up. Initially, a single employee was based in an office in the hospital compound. One year later, a second person was hired to improve presence in the hospital, follow-up of supported patients and information sharing at community level.

The recruitment of candidates for assistance was based on three ways: (1) referral by the hospital cashier who found that the patients could not pay for the admission fee and those with referral letter from the community; (2) active recruitment in the wards by the NGO welfare worker (some patients are able to pay the admission fee thanks to the assets they have sold or the debts they have taken before coming to the hospital); (3) spontaneous applicants who have heard in their community about the existence of the HEF.

Identification is done at the hospital through interviews by using a set of questionnaire. The interviews focus on information about food security, ownership of land and productive assets, housing, occupation, household size and structure, as well as social capital. Physical appearance, including clothing, often

gives an indication of socio-economic status. The ‘target group’ of the HEF consists of the extremely poor, as well as the poor who risk falling into extreme poverty. No fixed criteria for eligibility are used, as poverty has many dimensions that are difficult to measure. Some room is left for subjective judgment by the welfare worker.

Judgment indeed matters: first to entitle or not the candidate, second, to tailor the assistance package according to the specific needs of those who have been entitled.

The level of financial assistance is indeed determined on a case-by-case basis, from partial payment of the admission fee to full coverage of the total cost of hospitalization, including transport, food and basic items. Presence of the social worker in the hospital compound allows frequent visits in the ward. If necessary, the support can be readjusted.

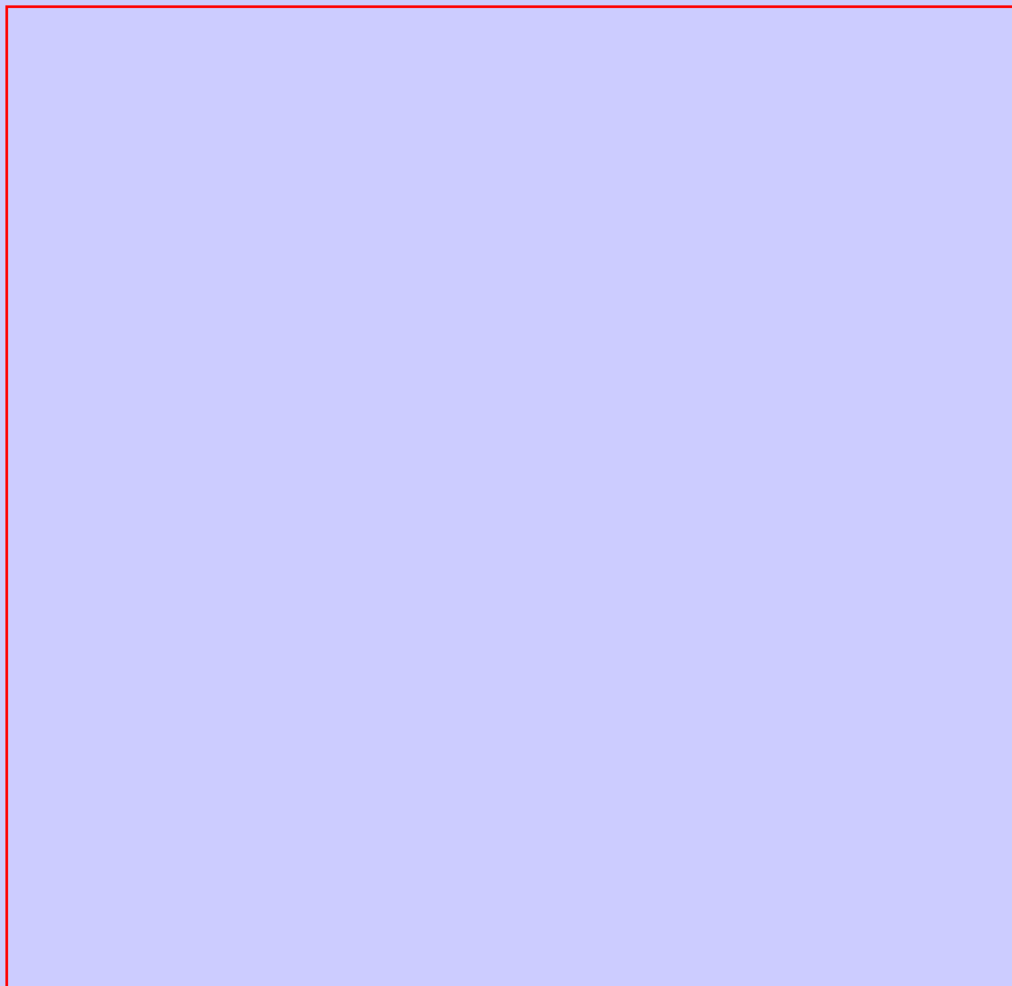
Results

In Sotnikum hospital, the HEF assisted his first patient in September 2000. After four years, it has become an important building block for the good performance of the health system.

As shown in Figure 1, the HEF has turned the hospital into a real pro-poor health facility. On average, 40 percent of hospital inpatients received some assistance. Monitoring has constantly confirmed that beneficiaries were actual poor. Leakage to non-poor is not an issue. If there is any problem, it is one of under-coverage.

The breakdown of the HEF expenditure shows that administration costs, including management, identification and social follow-up, are under control (Figure 2). An important share of the fund goes back to the hospital through the user fees. This is of course a strong incentive for the hospital staff to provide good services to poor patients. It is important to notice that the transfer in kind to the assisted patient is much more than what is paid by the HEF. Indeed in Cambodia, a part of hospital costs are covered by the government or the donors through input financing (salaries, drugs, equipment and

buildings). By paying on average US$11.5 for a poor patient, the HEFs give him an access to a benefit of more than US$48.



Lessons learned

In Sotnikum, the introduction of a HEF managed by a local NGO appeared to effectively improve access to hospital care for the poor. As long as the services delivered in the hospital are meeting the standards, one can expect a significant health outcome for the beneficiaries.

During the first year, the HEF may have mainly reduced the cost of care for people who had already chosen to access care. The years after, the steep increase in utilization indicates that a considerable number of the ‘new’ patients were from poor households who would not have sought care at the hospital without financial support. It is important to note that in the Cambodian context most of a household’s health expenditure takes place outside the public sector, often spent on poor quality treatment by informal private practitioners. Therefore, in terms of poverty prevention, the greatest potential of the HEF does not seem to lie in financing expenditure in the public sector, but in preventing unnecessary expenditure in the private sector, by encouraging the use of adequate public health services.

The scheme has some limitations. A better coverage would be achieved if the poor got entitled for assistance before the episode of illness (e.g. through a ‘poor card’). Uncertainty on eligibility and assistance would then be removed. Some experiments with such an approach are going on in Cambodia. Another observation has been that welfare workers were quite keen on being very specific in their targeting (avoid the leakage to non-poor) but quite reluctant to deliver proximity social care to the poorest, a kind of retreat into administrative tasks.

The HEF model may be relevant to settings other than Cambodia. Similar approaches are being developed in China and some countries of Africa. Subcontracting to NGOs is probably not a necessary condition, but the purchaser-provider split is. Donor money can be helpful for the pilot stage, but the HEF model is very possible with public money. It allows the government to kill two birds with the same stone: (1) target the poor; (2) develop its public health system. For the ease of targeting, it is important to acknowledge that the model will probably be easier to implement in countries where socio-economic differentiation is increasing. In regions stricken by general extreme poverty, very low user fees (or no fees at all) are probably still the best approach.

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