Health and social protection in Transitional Asia: challenges and ways forward

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Introduction

A book on China, Cambodia and Lao PDR' health and social protection systems? These three countries differ in so many aspects that one can wonder about the reasons for gathering their experiences in one volume. If, nevertheless, we insist on doing so, it is because - apart from geographical proximity - these countries face a major common challenge: how to make a successful transition from a planned economy to a market economy.

Socialist countries did not all start their transition at the same point in time, nor did they proceed at the same speed and achieve equal success. However, for most of these former socialist countries the economic transition has led to more economic prosperity, and without any exception to a dramatic transformation of their societies. Whereas in recent times economic transitions have been, as a rule, mostly about expanding the property rights of individuals, in many countries economic transition has also led to the thorough reshaping of citizens' entitlements to social services such as education, health or housing. In many instances, this has not been for the better. Health status has not always kept up with rapid economic growth and health gains have not been distributed equitably.

While the market system has brought new opportunities for households confronted with illness, it has also created new risks, including a problematic access to quality health care and impoverishment due to health care expenditure (Meessen *et al.* 2003;Van Doorslaer *et al.* 2007). The rise of the cost of health care and the rise of the share of out-of-pocket payment in the total financing of health care in South-East Asia have been remarkable indeed. The current predicament of many rural households is obvious; they are mainly self-employed farmers and are therefore not covered by any form of social health insurance. Today, for the poorest of them, who are deprived of social networks and access to capital markets, foregoing treatment is too

often the practice they adopt. This is not always irrational: the rather loose regulation of many health care providers - and this is an understatement for the informal private sector - and the way they are remunerated induces perverse prescription behaviors. Lack of significant health improvement, even outright iatrogenic effects of irrational and unsafe therapeutic practices, despite very high spending is alas a possible outcome for many poor rural households.

China, Cambodia and Lao PDR differ greatly in terms of economic and human development, political leadership, health systems and culture (among many other aspects). In spite of these differences, their governments share similar challenges in terms of performance of the rural health system, its accessibility for the poor and the welfare risks for rural households. In the three countries, policy makers are actively addressing these problems and major initiatives are being launched. One can only welcome such political determination; this commitment will definitely constitute a key resource for improving the equity of the national health systems. However, knowledge gaps still abound. Policy makers are well aware of this situation and have developed close collaboration with 'knowledge brokers'. In Cambodia, China and Lao PDR, bridges have been built between health authorities and national and international researchers. The present book is a testimony to this common effort.

The POVILL project

Before outlining the content of this book in more detail, let us say a few words about its origin and nature. It presents the first and preliminary fruits of a multi-country collaborative project called POVILL ("Protecting the rural poor against the economic consequences of major illness: a challenge for Asian transitional economies", see p.549 for more information on the project or www.povill.com). It is a preliminary outcome in the sense that it mainly gathers preparatory work produced during the first year of the project by the consortium partners. Through the affiliation of the respective authors and the variety of national cases discussed, the book duly reflects the international character of the consortium.

The POVILL partners share the conviction that it will take a whole range of expertise and knowhow to understand and eventually break the vicious circle of poverty and disease. Building bridges between scientific

disciplines is sometimes more difficult than establishing international collaboration. Consequently, the POVILL project could claim early success in bringing together experts from disciplines as diverse as public health, health system research, public administration, economics, political science, sociology and anthropology. Besides the multidisciplinary character of the book, we hope that readers will also appreciate the pragmatic nature of most contributions. We believe that the potential public for such a collective undertaking goes beyond the academic world. We would feel honored if policy makers and social welfare program implementers found that ideas in the book were useful in development health systems that perform well in meeting the needs of the poor.

It is this concern for operational relevance that explains a very early choice of the POVILL consortium: not only to engage, but involve throughout all stages of research the different actors in charge of the design and implementation of health and social protection policies in the three countries. Therefore, we were happy that several of these actors responded positively and even enthusiastically to our offer to publish some of their studies and ideas. The diverse background and affiliation of the contributing authors (universities, think-tanks, institutes affiliated to ministries of health, international agencies, bilateral aid agencies, non-governmental organizations and social assistance implementers) can only enrich our understanding of the political, technical and operational obstacles and challenges to enhance access by the poor to effective health services.

Major illness in Asia

To some extent, the book reflects the structure of the POVILL project. Part 1 of the book sketches the knowledge gap on 'major illness' today in Asia. Henry Lucas *et al.* question key concepts that are popular today in the literature, such as 'health shocks', 'major illness' and 'catastrophic health care expenditure'. While significant progress has been made over the last years in the measurement of the welfare impact of illness, the knowledge base is still very incomplete. In order to design appropriate policies to protect households against the impoverishing consequence of illness, we need a thorough understanding of the multiple and complex pathways through which ill-health affects wellbeing. Research conducted so far on 'catastrophic health care expenditure' has remained quite silent on this process

dimension. Lucas *et al.* argue that other kinds of data collection are required. Their paper introduces the POVILL approach from this angle.

Shijun Ding *et al.* provide, to our knowledge, the first review of Chinese literature on major illness and coping strategies with respect to health shocks in rural China. A major challenge for the authors was the need for some cross-border reading, in terms of paradigms. As the POVILL project argues, the study of health shocks requires clear knowledge on both epidemiological situations and household livelihood. Their literature review provides clear evidence that Chinese scholars pay more and more attention to the link between illness and livelihood. However, many questions still require further investigation.

Health system and policy

The second part of the book is substantially larger. It pursues two aims: to provide general background information to readers not familiar with rural health systems in China, Cambodia and Lao PDR, and introduce a few research questions related to pro-poor health policy in the three countries. The second aspect is an emerging topic in the international literature. The international aid and scientific communities have recently become aware that proposing and documenting effective interventions is not enough. Strategies will bring change to the lives of the poorest only if they are correctly funded and implemented by governments. The political economy is rarely favorable to the poorest (Ridde 2008; World Bank 2003). Donors, international agencies, think-tanks and civil society groups have a role to play in getting pro-poor policies on the agenda.

Gerald Bloom *et al.* introduce again the similarities and differences between the three countries. While the three studied countries are at different stages in the formulation and implementation of their policies to improve access to health care and reduce the impoverishing impact on households of major illness, a common feature is their preference for demand-side approaches. This policy choice raises interesting questions. Bloom *et al.* report that the health policy processes have in fact been little studied so far. They show that the roles of stakeholder interests and and policy networks deserve much more attention. This sets the agenda for the POVILL team in charge of pro-poor health policy analysis.

The paper by Lijie Fang and Gerald Bloom offers, we believe, a nice entry (from a sociological perspective) to the situation of health services, and hospitals in particular, in rural China. The economic transition has completely reshaped the environment of rural hospitals. While many township health centers found it difficult to adapt to the new environment (characterized by the sharp decrease in public funding and the rapid rise of market forces in the allocation of medical human resources), some have managed to secure enough profit and social legitimacy, probably the two key conditions for survival as organizations in transitional China.

If the New Cooperative Medical Scheme (NCMS) and to a lesser extent the Medical Financial Assistance Scheme have received considerable attention as interventions both in Chinese and international journals, little has been said so far about the policy process and context in which these schemes were developed. In her paper, Yunping Wang discloses some of the forces and factors that have influenced the policy dynamics. Her discussion of how public concerns emerged and were translated into political issues and how later on in the process policy alternatives were chosen and legitimated, will certainly interest international readers. Her stakeholder analysis is also instructive on the tremendous societal changes occurring today in China and on the great awareness among Chinese scholars of the need for bold and generous policies; the latter include the participation of the rural population in the health policy process.

Cambodia and Lao PDR have many more characteristics in common than economic transition. In her paper, Kristina Jönsson highlights the constraints shaping public policymaking in the two countries and in the field of poverty reduction and health in particular. The role of external actors (donors, international agencies, bilateral aid agencies and non-governmental organizations) in the formulation, design and implementation of the health policy in these two countries is particularly striking.

This second part of the book ends with two background papers on Cambodia and Laos. In the first paper, Peter Annear, Maryam Bigdeli *et al.* review some recent developments in health care financing policy in Cambodia. The paper is insightful from various perspectives and provides good background knowledge of the health equity fund policy for readers not familiar with the strategy.

In Peter Annear, Kongsap Akkhavong *et al.*, the reader is introduced to the specific challenge that health equity in Lao PDR faces. That country

has to cope with specific constraints (e.g. remoteness of many population settlements, ethnic diversity, limited industrialization) and is still at an early stage of transition. The Ministry of Health is aware that its rural health system still requires consolidation and that equity necessitates decisive intervention, including in the field of health care financing. The paper, the authors of which are mostly foreign experts working in Laos, assesses the potential for and the tasks that lie ahead for the implementation of the HEF approach in the country. The paper is also the first one drawing on early evidence from the different pilot HEF programs launched in collaboration with bilateral agencies in recent years.

Social Health Assistance: scheme design and implementation

A core focus of the POVILL project is the study of schemes designed to enhance access by the poorest to health services. Our analysis is that the international research community has so far paid little attention to the specific needs of the poor in low- and middle-income countries. At best, agencies and scholars have documented the fact that user fees were a barrier impeding utilization of health services and advocated for exemption policies to the benefit of the poorest. A tenet of the POVILL project is that the poor face a multitude of specific barriers: distance, information, opportunity costs, stigma. Providing them with good access to services will require a holistic approach and interventions tailored to their specific needs. These solutions will include an entitlement to publicly funded packages, but also some specific active and, ideally, personalized support, which we propose to identify here as '*social health assistance*'. Implementing a social health assistance strategy does require specific expertise. The need for professional social workers has been overlooked so far in many countries. European history has also showed that poor people benefit from good coordination between medical professionals and social workers, and even more so when the national health system is still under construction (Nottingham & Dougall 2007).

Even .if they are not yet full-fledged social health assistance interventions, the Health Equity Fund (HEF) and the Medical Financial Assistance (MFA) are, we believe, programs deserving due attention by

scientists. The HEF experience in Cambodia has received growing attention these last years in international journals. The MFA program is less known outside China and still modest in terms of funding (if we compare it for example with all the efforts dedicated to the development of the new cooperative medical system), but one can regard the program as a first step towards the establishment of some kind of MEDICAID system in China. Moreover, there are interesting synergies between the MFA and NCMS systems, where the former are increasingly used to provide a subsidy for the premiums of the latter.

Targeting is a key component of social assistance programs. In their paper, Bruno Meessen and Bart Criel propose a framework which they hope could help policy makers at the stages of design and implementation of any targeted program. According to the authors, the framework could also contribute to less partial evaluations of such interventions (especially their success in terms of targeting). Future empirical work will reveal whether such frameworks can contribute to more informed evaluation, better intervention design, more careful implementation and eventually a better outcome for the targeted group. The framework is illustrated with an application to HEF in Cambodia.

The paper by Yuebin Xu *et al.* reviews the development of the Medical Financial Assistance program in rural China. The (health) policy process has followed the standard story in transitional China to a remarkable extent: first experimentation, then after observation of the first results, adjustment of the policy, formal adoption of the policy by the central authorities and eventually a quick scaling-up of the program (with substantial financing from the central government in order to set up the right incentives for local governments to adopt the policy). However, the process still gave a lot of discretion to local governments in terms of design and implementation. Besides the historical process, the authors report several elements pertaining to the funding and performance of the program. The limited financial resources have been a major constraint so far; managers have adopted rules such as thresholds, ceilings and low reimbursement rates to ration the limited resources. As a result, the assistance provided to beneficiaries is often insufficient to ensure full protection against the health shock. The authors report that authorities are aware of the failure of the MFA to reach the poorest of the poor and that many local governments are adjusting the schemes to reach the target group better.

Juying Zhang *et al.*'s paper completes our knowledge on the MFA program through the description and comparison of MFA schemes in four counties of the two provinces covered by the POVILL project, Hubei and Sichuan. The study confirms that while the central government has been very influential in policy formulation (especially in terms of assigning respective roles to the different administrations), local authorities, the officials in charge of counties in particular, have quite some leeway in design and implementation issues. The study evidences some of the limits of the scheme, including the rather narrow coverage (many poor are not entitled) and the too restrictive nature of the benefit package. Both are direct results of the current limited funding.

Bart Criel and colleagues provide another comparative paper, but across countries this time. The comparison between Belgium and Cambodia may look a bit bold to some, but the Belgian situation proves to be a nice eye-opener on possible tracks of actions for low- and middle-income countries. Let us maybe underscore three of their messages. An interesting observation from the comparison between Belgium and Cambodia is the different attitude towards stigma possibly attached to a means-test welfare program. This may have obvious consequences for scheme implementation. Secondly, the Belgian case illustrates the added value of versatile social workers in the personalized follow-up of individuals and households facing a situation of social exclusion. A third interesting lesson from the Belgian experience is the progressive shift in terms of role for the local social welfare agency. While the agency previously mainly focused on its provision of services and allowances, the emerging model is one of an agency playing also an active role in coordinating the multiplicity of (public and private) actors involved in the delivery of social support, i.e. it takes up a stewardship role. The potential benefit from a plurality of actors needs to be better acknowledged, especially in China and Lao PDR, where the civil society is still embryonic.

Scheme evaluation

The fourth part of the book deals with scheme evaluation. It is exclusively empirical and provides original results of field studies in Cambodia and Laos. The collection of five papers about health equity funds gives, in our opinion, a good overview of the policy debate taking place in Cambodia on

the HEF strategy, more particularly on questions related to eligibility criteria, entitlement procedure and benefit packages. The papers enrich also considerably the discussion about the measurement of the performance of HEF.

The pros and cons of pre-identification and post-identification have been debated at length in Cambodia for a while now. In pre-identification, households are identified before an episode of illness and granted an entitlement, equivalent to health insurance, valid for a given period, whereas in post-identification, the eligibility to the assistance is assessed at the point of use, usually the referral hospital. Three papers expand our knowledge of this contentious issue.

The first paper by Por Ir *et al.* reports the results of the socio-economic assessment of two samples of HEF entitled households and non-HEF entitled households in a province close to Thailand. The study reveals that after four years, the targeting achieved by the scheme is quite inaccurate: many entitled households are not poor anymore while many poor households are not covered by the scheme. Obviously, pre-identification can reach the target group only if it is frequently updated. Ir *et al.*'s study reports two main reasons for the observed discrepancy between the statutory status and the actual economic situation of the surveyed households. First, migration in and out of the village undermines the targeting implemented by schemes organized on a rather narrow geographical basis. Second, in Cambodia, as elsewhere in the world, poverty is a dynamic phenomenon. While there is indeed a core group of chronically poor households, for whom, the authors argue, pre-identification makes sense, there are also many households moving into or out of poverty. Post-identification is probably the best solution for them. Ir *et al.* leave several questions open. An empirical question, directly relevant to the operation of the schemes, is: to which extent is it possible to identify among the poor households those who will still be poor in a couple of years, i.e. the chronic poor?

Chean Rithy Men and Bruno Meessen report the results of a comparative study of the local perception of six different health equity funds. This study highlights the highly decentralized character of the HEF strategy in Cambodia. The differences in eligibility criteria are remarkable. This paper echoes quite well the one by Criel *et al.*: whereas confidentiality about enrolment status is perceived as very important in Belgium (mainly because of the stigmatizing character of targeted welfare programs), Cambodian HEF

operators and communities apparently do not perceive this as a crucial issue. A few possible explanations are put forward. Interestingly enough, the paper indicates that a whole research program may have been overlooked so far in Cambodia: the measurement of HEF performance from a community perspective.

Bart Jacobs and Neil Price take quite a different stance (compared with Ir *et al.*) in the debate about pre- and post-identification. We already owe several studies of the HEF in Kirivong district to this prolific pair of authors. In this new paper, they defend the view and provide evidence for their claim that pre-identification is more effective, on several metrics, than post-identification.

The fourth paper is proposed by the Cambodian 'Hospitals in Change' team. Part of a broader effort to document the performance of rural hospitals in Cambodia and China (see also Fang and Bloom), the paper by Bruno Meessen, Kannarath Chheng *et al.*, tries to assess the benefit-incidence of inpatient care and HEF assistance in six rural hospitals. In line with the approach of Ir *et al.*, the assessment rests both on principal component analysis and subjective assessment by surveyors. The confrontation of this paper with the one by Chean Rithy Men and Bruno Meessen raises an interesting question: what is the most legitimate method to assess the accuracy of a targeting program? As is common practice in many studies published so far, Meessen, Chheng *et al.* adopt the perspective of technocrats when making an assessment; their approach could seem rather obscure for people not familiar with multivariate statistical analysis. The other paper turns the problem upside-down and recommends that community perception is adopted. This discussion reflects, we believe, a major question neglected so far in Cambodia: to whom should the HEF operators be accountable: to external donors and the government or to local communities?

Nearly all publications so far about HEF have covered schemes that operate in rural areas. With their exploratory paper on health seeking behaviors and coping mechanisms in the slums of Phnom Penh, Maurits van Pelt and Guy Morineau open the door on the potential of HEF in an urban context. Obstacles abound (like the high mobility of the slum population), but their experience has proven that, quite surprisingly, community involvement is possible as well in urban settings. Yet, the core of the paper deals with something else: the extent to which HEF could succeed to protect

households' welfare, and more particularly prevent them from falling in a debt trap. In addition, the paper invites us to think of other proxies (than the threshold of 40% of available income to health care expenditure) for the measurement of livelihood impact of health care expenditure.

Finally the paper by Lamphone Syhakhang *et al.* brings us back to Lao PDR... and a few years ago. This paper reminds us of the challenge of developing effective solutions in extremely adverse settings. In Lao PDR, as poverty is highly correlated with remoteness, geographical targeting (i.e. the subsidized or even free provision of a service to the whole population of a given area) is probably the best strategy to reach the poorest. Yet, as evidenced by this study, the situation is so precarious in the country that even a basic strategy such as the provision of essential drugs by village health volunteers is difficult. This highlights once more that every policy requires a good design, careful implementation and a sustained commitment to improve the lot of the poor.

The purpose of the book is not to provide definite answers to the different questions touched upon by the different authors throughout the book. Hopefully, the POVILL project will help policy makers improve the existing schemes further. Social protection is a highly political issue and securing good entitlement for the poor may take several decades of political struggle. As a matter of fact, many countries in the world are still far from achieving the objective of universal coverage. The poorest set definitely specific challenges: they are rarely involved in the formal economic sector, their capacity to engage in contributory systems of social protection is very limited, and, crucially, their political representation in national political arenas is rather limited or downright weak. We deeply believe that the debate should not get bogged down in purely technical discussions; the political dimensions of poverty and poverty relief must be addressed as well. Researchers are also citizens.

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