REVIEW OF MECHANISMS TO IMPROVE EQUITY IN ACCESS TO HEALTH CARE, CAMBODIA

Draft report

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July 16th 2002
The DFID Health Systems Resource Centre (HSRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HSRC is based at IHSD’s London offices and managed by an international Consortium of seven organisations: Aga Khan Health Services Community Health Department, Kenya; CREDES-International, France; Curatio International Foundation, Georgia; IDS (Institute of Development Studies, University of Sussex, UK); IHSD (Institute of Health Sector Development, UK); IHSG (International Health Systems Group, Harvard School of Public Health, USA); and the Institute of Policy Studies, Sri Lanka.

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Author: Andrea Crossland and Tim Conway, July 2002
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ADD</td>
<td>Accelerated Development Districts</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>APS</td>
<td>Approved Provider Scheme</td>
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<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>BSS</td>
<td>Behavioural Sentinel Survey</td>
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<tr>
<td>CCC</td>
<td>Co-ordinating Committee for Cambodia</td>
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<td>CDC</td>
<td>Communicable Disease Control OR Commune Development Committee</td>
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<tr>
<td>CDRI</td>
<td>Cambodian Development Resource Institute</td>
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<td>CFDS</td>
<td>Cambodia Family Development Services</td>
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<tr>
<td>CFR</td>
<td>Case Fatality Rate</td>
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<td>CHSPP</td>
<td>Contracting for Health Services Pilot Project</td>
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<td>CoCom</td>
<td>Co-ordinating Committee (of the Ministry of Health)</td>
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<td>CPA</td>
<td>Complementary Package of Activities</td>
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<tr>
<td>CRC</td>
<td>Cambodian Red Cross</td>
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<td>CSES</td>
<td>Cambodia Socio-Economic Survey</td>
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<tr>
<td>DBF</td>
<td>Department of Budget and Finance (MoH)</td>
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<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
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<tr>
<td>DG-H</td>
<td>Directorate General for Health (MoH)</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DOTS</td>
<td>Directly-Observed Treatment Short course (TB)</td>
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<tr>
<td>DPHI</td>
<td>Department of Planning and Health Information (MoH)</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme of Immunisation</td>
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<tr>
<td>FBC</td>
<td>Feedback Committee (of Health Centre)</td>
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<tr>
<td>FC</td>
<td>(health facility) Feedback Committee</td>
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<td>FTVS</td>
<td>Fast-Track Vulnerability Screening</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HC</td>
<td>Health Centre</td>
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<td>HCMC</td>
<td>Health Centre Management Committee</td>
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<td>HFA</td>
<td>Height-For-Age</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HISB</td>
<td>Health Information System Bureau</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSRG</td>
<td>Health Sector Reform Group</td>
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<td>HSSP</td>
<td>Health Sector Support Programme</td>
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<tr>
<td>IBN</td>
<td>Impregnated Bed Nets</td>
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<tr>
<td>IHSD</td>
<td>Institute for Health Sector Development</td>
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<td>INGO</td>
<td>International Non-Governmental Organisation</td>
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<tr>
<td>ICSW</td>
<td>Indirect Commercial Sex Worker</td>
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<tr>
<td>ISC</td>
<td>Integrated Supervisory Checklists</td>
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<td>JHSR</td>
<td>Joint Health Sector Review</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MEF</td>
<td>Ministry of Economy and Finance</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoP</td>
<td>Ministry of Planning</td>
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<tr>
<td>MPA</td>
<td>Minimum Package of Activities</td>
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MTEF  Medium-Term Expenditure Framework
n.a.  not available
NCHADS  National Centre for HIV/AIDS, Dermatology and STDs
NGO  Non-Governmental Organisation
NHFC  National Health Financing Charter
NHS  National Health Survey
NIS  National Institute of Statistics
NIPH  National Institute for Public Health
NLI  National Level Indicators
NPAR  National Programme of Administrative Reform / National Public Administration Reform
OD  Operational District
ODA  Overseas Development Assistance
p.a.  per annum
PAD  Project Appraisal Document
PAP  Priority Action Programme
p.c.  per capita
PEM  Protein-Energy Malnutrition
PHC  Primary Health Care
PMU  Project Management Unit
PHD  Provincial Health Department
ProCoCom  Provincial Coordinating Committee(s)
PRSP  Poverty Reduction Strategy Paper
RGC  Royal Government of Cambodia (1994-)
RH  Referral Hospital
SEDP  Socio-Economic Development Plan
SESC  Socio-Economic Survey of Cambodia
SRC  Swiss Red Cross
STD  Sexually-Transmitted Disease
SWAp  Sector Wide Approach
SWIM  Sector-Wide Management
TB  Tuberculosis
UNFPA  United Nations Fund for Population Activities
UNICEF  United Nations Children’s Fund
UHP  Urban Health Project
VDC  Village Development Committee
WB  World Bank
WFA  Weight-for-Age
WFH  Weight-for-Height
WHO  World Health Organisation

Currencies

US$1 = c. 3,900 Cambodian riel
UK£1 = US$ 1.42
1. Executive summary

1.1 Background

1. There are important two-way causal relationships between poverty and ill-health in Cambodia. The structural weaknesses of the sector (both demand-side and supply-side) mean that the vast majority of total annual health spend is in the form of out-of-pocket expenditure by households. Health expenditure, particularly on serious (e.g. emergency) treatment at a hospital, accounts for a major proportion of total household spending. A single inpatient hospital visit can account for more than total normal annual non-food household expenditure. As a result, households are either forced to forgo treatment, or to take crisis actions (selling productive assets, taking out loans at high interest rates) in order to afford health care. These crisis actions can force non-poor households into poverty, and the poor into absolute destitution.

2. In a response to these problems, the World Bank-ADB-DFID Health Sector Support Programme (HSSP) contains as one of its objectives the provision of mechanisms to increase the ability of poor households to obtain access to affordable quality health care. This report reviews experiences to date with pilot pro-poor health financing schemes in Cambodia, focusing in particular on the use of equity funds to compensate health facilities for the provision of exemptions from user fees to poor patients.

1.2 Review of experience with pro-poor health financing

3. Existing documentary evidence with regard to the results of pro-poor financing arrangements are reviewed for four pilot schemes, namely:

- the five contracting schemes supported by ADB;
- the “New Deal” initiated by MSF, CFDS and UNICEF in the referral hospital in Sotnikum District, Siem Reap;
- the use of referrals from community Health Rooms in the Urban Health Project in Phnom Penh; and
- the exemption scheme and equity fund introduced with Swiss and Cambodian Red Cross support at Takeo hospital.

The key features of each approach are described and their strengths and weaknesses compared.

1.3 Options for identifying the poor

4. Drawing on the experience of the four pilots, the report identifies and compares practical mechanisms for identifying the poor – that is, for determining who will be considered eligible for equity fund-backed user fee exemptions. The approach adopted should be accurate in distinguishing the poor from the non-poor; cost-effective; flexible, picking up changes in household status over time; efficient in terms of the time required to determine eligibility; and respectful of the patients. The following emerge as options:

**Identification by local leaders or local representative bodies**

5. Village chiefs, Village Development Committees, achars, or new health-specific community participation bodies (Health Centre Management Committees and/or Feedback Committees) could be involved in drawing up village lists of poor households. These lists are passed to the Referral Hospital; each household on the consolidated list receives a certificate, signed, stamped and dated by whatever local institution or institutions were involved in the decision-making
process. This form entitles them to exemption. The method of identification can either be formal (using their knowledge of the families in the village, those involved assign them to the category of poor or non-poor on the basis of a simple checklist of household characteristics supplied by the equity fund managers) or informal (the decision-makers come to a subjective but consensus judgement about who is and is not poor). Ensuring that the method works and is not abused (used to provide access to free treatment for the friends and relatives of the decision-makers) is in part a matter of involving a variety of actors rather than just, for example, the village chief; and in part a matter of spot checking and monitoring by Health Centre or equity fund staff.

Community-based identification.

6. Participatory methods – group wealth ranking – provide a very accurate way of identifying the poor at the village level. However, if done properly this can be very time-consuming, both for the village participants but particularly for those who facilitate the exercise. Alternatively, identification can be somewhat accelerated if groups of villagers are given a standardised list of household characteristics taken to denote poverty and asked to sort households into those which do and those which do not meet these criteria. As with the former approach, lists of eligible names are submitted to the RH, and the eligible families are given a certificate which they present when they need treatment.

7. The two options described above involve classifying the entire population within an RH catchment area as either poor or non-poor. This has the great advantage that there is no need to then determine eligibility when a patient presents him or herself for treatment: if they have a certificate and their name is on a list of previously identified poor families, they receive free treatment, and the facility invoices the equity fund for reimbursement. Staff do not need to spend time determining eligibility before they begin treatment, and patients need not hesitate about going to seek treatment out of fear that they will not be eligible. Pre-identification is however an extremely labour-intensive exercise. An alternative is to identify the poor as and when they need medical attention and present themselves at a health facility.

Identification during referral at the Health Centre

8. Identifying the poor may be best done at the local Health Centre. Experience has shown that staff at this level feel confident about their ability to identify the poor, largely on the basis of their personal knowledge of the patient’s circumstances. Each Health Centre in the RH catchment would be given an annual quota of fee-exempt referrals that they are allowed to make to the RH; these numbers would be reported monthly to the RH equity fund, which would ensure that individual HCs did not over- or under-refer. The main disadvantage of this approach is that people experiencing a medical emergency may need to go straight to the RH, without presenting themselves at the HC for consideration for fee exemption. If this problem can be resolved in a reasonably satisfactory manner then this approach, while far from perfect, seems to be the best available at present.

Identification at the Referral Hospital

9. Both the Sotnikum and Takeo equity fund pilots have to date relied upon identifying the poor when they seek treatment at the referral hospital. The drawbacks to this approach are as follows:

- The poor may not seek treatment at the RH because they are uncertain as to whether they would qualify for exemption and so do not want to risk spending money and time on transport to the hospital without any guarantee of free treatment;
- The staff at the RH have little or no knowledge of the circumstances of the patient, so must attempt to determine eligibility with a questionnaire. It does not seem too hard for the non-poor to anticipate what answers will lead them to be classified as poor and therefore eligible for free treatment, and to tailor their answers accordingly.

**Geographical targeting**

10. When there is a high correlation between location and poverty, it may be quicker and more cost-effective to classify everyone from a poor area (village, commune, HC) as poor and therefore eligible for exemption. The efficacy and equity of this approach depends critically upon the degree to which location is indeed a good proxy for poverty. If however there are significant numbers of non-poor in "poor" villages – or, more importantly, a large number of poor in "non-poor" villages – then the method is of limited value. It is also necessary to devise some means of determining at the point of treatment whether the patient does, as claimed, live in a poor village.

**Targeting by categories**

11. Certain medical or social categories – for example, the pregnant, young children, or those suffering from TB – may be treated without user fees as a matter of policy, either on economic, social or public health grounds.

12. If the poor are to be identified by a defined list of characteristics (rather than through the holistic consideration and group consensus of wealth ranking or the single-criterion approach involved in geographical or categorical targeting), there are several ways in which eligibility criteria may be chosen. Criteria may be derived by conducting regression analysis on the SESC national sample survey data, which will reveal which household characteristics are the best predictors of poverty. Alternatively, a baseline sample survey of health and socio-economic status, conducted in HSSP target Districts at the outset of the programme, may be used to yield more regionally specific indicators of poverty. (In monitoring the impact of the contracting pilots, the ADB used an innovative technique which assigned household variables a value as a poverty indicator that was based on the natural log of the inverse frequency with which it occurred during the sample survey: that is, the fewer households possessed a given item, the greater the weight assigned to that variable as a predictor of non-poor status.) Finally, targeting indicators of poverty may be derived from participatory exercises, often most productively organised as a facilitated discussion around a group wealth ranking exercise.

**1.4 Institutional and financial arrangements for pro-poor health care**

13. Identifying the poor is only the first stage in making pro-poor health financing work. Chapter Five addresses a number of practical issues relating to the division of rights and responsibilities between stakeholders in the provision of affordable health care.

**The financing and management of equity funds**

14. In pilot schemes conducted to date, equity funds have been managed by an NGO (typically a Cambodian NGO operating with the support of an international NGO), using donor funds. It is likely that external finance and non-governmental capacity will continue to be required in the medium term. However, HSSP pilots should strive to reduce expensive expatriate inputs as and when it is feasible to do so, and by this and other means to reduce the costs of administering equity funds. One of the objectives of the HSSP should be to develop capacity and institutional arrangements which would allow Government or low-cost Cambodian
private providers (commercial and not-for-profit) to take over the roles currently played by donors and international NGOs.

15. Similarly, it is unrealistic to expect equity funds to be able to operate without external finance in the near future. Nonetheless, the HSSP partners should make a conscious effort to phase in part-contributions from the Government and/or the community. One possibility is to assign a percentage of user fee revenue to the equity fund: in other words, to institute a local redistribution function, so that those who can afford to pay for health care help to subsidise the treatment of those who cannot. This raises potential problems, but the feasibility should be investigated further.

16. One underlying question, which to a certain extent precedes the design of equity fund arrangements, is how to set the balance between the level of user fees and the rate at which exemptions are granted. For any given desired sum of revenue that is to be raised from user fees, policy makers may in theory choose between setting high fee rates, but granting many exemptions, or (as in Takeo hospital) setting fees low, and thus granting only a few exemptions. Neither is obviously superior. Getting this balance right will involve more detailed work by a health finance or health economics specialist, drawing on research into what people with different levels of income would be willing to pay for given services.

Local capacity and the location of HSSP-supported pilots

17. User fee and equity fund pilots have so far been located in Provinces in which capacity in the public health sector has been strengthened through the prolonged engagement of foreign aid organisations. Piloting HSSP schemes for pro-poor health financing in Districts and Provinces that have not benefited from this kind of cumulative improvement in basic capacity entails a higher risk of failure. The current HSSP Aide Memoire states that pilots will be conducted in between four and eight Districts, including two in “remote, poor and low-performing” Districts in Ratanakiri and Prey Vihear. Piloting in poor Districts is obviously desirable from a targeting point of view. However, there is a risk that if the HSSP approach fails in these “difficult” Districts, the approach is discredited, even though it may be feasible and valuable in areas where administrative capacity has already been improved through earlier reforms. It is thus recommended that HSSP pilots are conducted not only in Ratanakiri and Prey Vihear but also in a selection of the more densely populated central and southern lowland plains Provinces in which government capacity is greater.

Full or partial reimbursement

18. Facilities, particularly hospitals, should be fully reimbursed for treating the poor: any less than this, and staff will have a strong incentive to treat the rich in preference to the poor. This is not to say that the equity fund, and thus ultimately HSSP, has to be the one to pay the full sum: it is quite reasonable that some patients receive a partial exemption but are expected to pay the balance from their own pocket. Offering a mix of full and partial exemptions does however introduce added complexity, and increases the scope for confusion or abuse.

Reimbursement of fees exempted or flat rate sum

19. Under the UHP, Phnom Penh health facilities proposed that the project should reimburse them at a flat rate for services provided to patients who were exempted from paying user fees. The UHP rejected this, on the grounds that this created the possibility for providers to treat exempted patients less well than fee-paying patients in order to open up a profit margin between actual cost of treatment and fixed rate of reimbursement.
Monitoring and evaluation

20. The schemes supported by HSSP will still be in the form of a variety of pilots. Good monitoring is thus essential, both to generate lessons which can be rapidly fed back into modifications to pilot design and to hold all the institutional stakeholders involved accountable for proper and effective use of funds. Monitoring needs to involve both reporting upwards to Government (PHD and MoH) and HSSP donors, and reporting downwards to the intended beneficiaries. Key questions will focus on who gets exemptions, whether the poor are achieving improved access, and how well the pilot arrangements serve the referral hospital and the equity fund management.

Alternatives to equity funds

21. Equity funds provide the main focus of this report, as they appear to be better suited to the circumstances currently prevailing in Cambodia. Looking to the future, however, the Government and donors should begin to explore the possibilities of using microfinance (health insurance, affordable loans to cover health costs, and instant access cash savings) as an instrument of health financing. These instruments can help both to ensure that the poor can obtain access to health care, but also to allow the non-poor to smooth their spending on health care, reducing the chance that sudden large health expenditures will force households into costly coping strategies which will push them into poverty.

1.5 Recommendations for design and management of HSSP pilots

Identifying the poor

22. Identifying the poor at the referral hospital when they require treatment is not ideal: it is likely to be inaccurate much of the time, as the respondent will often be able to anticipate the answers which will result in him or her receiving an exemption; and it may be distressing for the patient and / or his or her carers to have to answer questions when they are in need to treatment. For a poor individual, not knowing in advance whether or not he or she will qualify for an exemption can be a powerful deterrent to seek hospital attention. Pre-identification of the entire catchment population as either eligible or not eligible is however a major undertaking.

23. It seems on balance that, if HSSP is to be used as an opportunity to experiment with promising approaches which have not previously been piloted in Sotnikum, Phnom Penh or Takeo, three variants are worth investigating.

- The first involves a system of identification at the point at which a patient receives a referral from an Health Centre. Each HC can be given a quota of referrals it is allowed to make in a given year, and monthly targets, supervised by the equity fund and / or the OD or PHD, to keep them on track.
- The second approach is to identify the poor prior to the need to seek treatment. As mentioned above, this requires a considerable investment of time. Two different approaches can be trialled in different pilots: in the first, a quick, rough-and-ready identification of village-level poor is drawn up by consensus between the village chief, VDC (if any), achars and the village’s two FBC delegates (again, if they exist), in a meeting facilitated by HC staff.
- In the second pilot area dedicated to testing pre-treatment identification of the poor, a streamlined, half-day group wealth ranking exercise is conducted in each village. Assuming that each HC serves around 25 villages, each HC will have to allocate at least 12 working days to produce rankings for all their catchment communities. To minimise disruption to the normal duties of HC staff, this identification phase should be spread over a couple of months: it would be worth starting the process in the pre-project phase, particularly as...
the HC staff will need at least a few days of training before they can conduct the rankings.

24. None of these approaches are perfect, but they are all much preferable to a lack of exemptions. Each in different ways seem to strike a more appropriate balance than any of the alternatives – including RH-based identification - and to merit pilots in order to investigate their feasibility.

The location of pilots

25. Pilots in low-capacity remote Districts in Prey Vihear and Ratanakiri should be balanced with pilots in Districts which have greater capacity, and where it will not be necessary to undertake equity fund piloting and basic capacity-building simultaneously. Institutional roles and responsibilities will need to be adapted to different circumstances in different Districts: there will not be a workable one-size-fits-all solution. In the low capacity Districts it may be necessary to contract two different NGOs, one to manage the equity fund and one to work with the OD and RH to improve capacity in financial and personnel management and M&E.

Further research on revenue incidence and burden

26. More work needs to be commissioned in order to establish what is the appropriate rate at which to set user fees and the frequency of exemptions, drawing on research into willingness and capacity to pay for different socio-economic groups.

Financing

27. In at least one of the pilots, HSSP should attempt to secure commitments for MoH and the RH user fee account to provide contributions – even if largely symbolic – to the equity fund. Unless convincing reasons are presented to the contrary, reimbursement of actual posted fees is preferable to reimbursement on a flat rate.

Monitoring and evaluation

28. MoH should have primary responsibility for monitoring and evaluating attempts to develop workable models of affordable health care for the poor: involving other ministries seems likely to entail more costs than benefits. The PHD should be given a major role as intermediary between pilot Districts and the core MoH institutions (DPHI, NIPH, DBF): apart from anything else, it is at the Provincial level that comparisons can be made between outcomes in HSSP pilot Districts and outcomes in non-HSSP “control” Districts. It is important that M&E systems report information up to MoH and the HSS donors (using routine HMIS and periodic spot checks and evaluations), but also that M&E systems include participating facilities and communities as both sources and consumers of performance information.

1.6 Recommendations for future work during the course of the HSSP

29. HSSP policy-makers and planners should be clear that, while their primary objective is to ensure that the currently poor can obtain access to health care, they should also be aiming to prevent poverty by helping non-poor households to smooth their health expenditure. Over the course of the HSSP programme staff should investigate and pilot the development of savings, loans and insurance schemes which will help the non-poor and the non-destitute poor to smooth health expenditure. These initiatives will however need to be pursued in the context of microfinance sector experience and reform, requiring an active dialogue with actors outside the health sector.
2. Purpose and background

2.1 The Health Sector Support Programme

Over the course of 2000 and 2001 the World Bank, ADB and DFID began, more or less simultaneously, to embark on planning major commitments to the Cambodian health sector as part of their new medium-term country planning. Over the course of several missions and ongoing negotiation between the three donors and the Royal Government of Cambodia, it has been agreed that the four partners will co-finance the Health Sector Support Project (HSSP). The HSSP’s overall objective is to support the GOKC health sector program and sector reform process, within the context of a Sector Wide Management Approach, by strengthening the sector capacity to: i) manage resources efficiently and ii), deliver services with focus on quality and affordability. Ultimately, it aims to improve the health status of the Cambodian people, especially of the poor. The project’s specific objectives are to:

- improve health sector management capacity and program performance;
- develop affordable quality health services, particularly of primary health care and first referral services in rural areas;
- increase the utilization of health services, especially by the low-income groups; and
- control or mitigate the effects of infectious disease epidemics and of malnutrition, with emphasis on the poor.

This study was commissioned by DFID’s Health Sector Resource Centre (HSRC) in order to review experience to date with pilot projects that have focussed upon providing accessible and affordable health care for the poor.

2.2 Country background

Cambodia is still recovering from the devastating events of the 1970s. The country is extremely poor: as of 2000, gross national income p.c. was estimated at US$260 p.a., 36% of the population lived below the national poverty line of $0.5 / day, and life expectancy was around 54 years. With much of the educated population killed during the 1970s and the education system functioning at a very low level since 1979, both technical and management capacity in the public sector is extremely limited. Severely underdeveloped transport infrastructure acts as a constraint on economic development and hinders access to health and education facilities. The vast majority of the population are subsistence-oriented farmers heavily dependent upon low-input rainfed rice cultivation for food security and income. Water control infrastructure is minimal, exposing the population to risks of floods or droughts (and sometimes both in the same year). The rural population, and the rural poor in particular, have traditionally relied upon common property resources (forests, ponds and rivers) to supplement their food supply and income: these common property resources are coming under pressure as the population grows and powerful groups stake claims to land and natural resources for commercial development. Financial markets are underdeveloped, which means that it is hard for most of the population to obtain access to loans at anything other than extremely high interest rates.

In November 1999 the financing was agreed as follows: ADB would provide a preferential loan of US$35 million; DFID would provide a grant of about US$22 million; IDA would provide a preferential loan of US$35 million; and the RGC would provide about US$7.5 million. However, the World Bank loan component has since been cut back to $25m and, at the request of the Government, the ADB loan has been reduced from US$35m to US$20m. The project is thus currently estimated at about US$74.5m.

2.3 Health care provision in Cambodia: structures and financing

Despite very low levels of income and total household expenditure, out-of-pocket household spending on health care is high (US$29 p.c. p.a., much higher than the average for countries with Cambodia’s level of income). This is in large part because state spending on health is extremely low ($2.67 p.c. p.a. in 2000). If total health expenditure from all sources is analysed, it is found that household out-of-pocket spending accounts for 82% of the total, with donors and NGOs funding 14%, and the MoH paying for a mere 4%.

Much of this out-of-pocket household expenditure is on private sector treatment, particularly in the form of self-treatment with drugs obtained from private pharmacies. However, household or out-of-pocket expenditures are also incurred when seeking treatment from the public sector. Most MoH staff receive a monthly wage in the order of $15, which is not enough to live on. This resulted in a pattern in the 1990s in which public health staff would levy informal charges for treatment, despite the fact that health care was in theory free at the point of service. These informal charges were not only typically high but also unpredictable, as staff would often ask for whatever they thought the patient could pay. This combination meant that seeking health care, particularly for a serious medical condition, could push a non-poor family below the povety line, and a family which was already poor into utter destitution. The people who escaped having to pay for public health services were, ironically, the rich, who were socially and politically influential.3

As the charges levied in government clinics and hospitals were variable and illegal, they did not constitute a predictable infusion of funds into the health service, and did little if anything to improve the quality of care. The combined effect of high fees and poor, brusque service from undertrained, underpaid, demoralised staff battling with a lack of equipment and drugs was to deter people from using the public sector, resulting in severe underutilisation and mounting inefficiencies in public health care facilities. The private sector offered (and sometimes still does offer) a more responsive and courteous service, and allows customers to purchase drugs and treatment on credit. However, private practitioners are often poorly trained (although as some are moonlighting MoH employees, the overall difference is not always very pronounced) and heavily dependent upon drug sales to make a profit, which leads to pronounced over- and mis-prescription. Private health care is thus poor quality for money, being both expensive and rather ineffective.

Since 1993 a number of MoH reforms, designed and carried out with the assistance of donors and international NGOs, have sought to address the multiple and interlocking problems of public sector health care. Access of the population to a standardised set of basic services was improved through a Health Coverage Plan and Operational Guidelines. Of critical importance has been the recognition, in the National Health Financing Charter (NHFC) of 1996, of the need for cost-sharing to finance the public health service to an adequate level. The funds allocated centrally to health care are extremely low: the MoH budget amounted to just $2.67 p.c. p.a. in 2000, far below what WHO recommends is necessary to provide a basic public health service in a low income country4. Much of this total government spending never trickles down to primary health care service providers, with losses at each stage of transfer between Ministry of Finance, Ministry of Health, the Provincial

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3 World Bank 1999 pp. 60, 102. This relates to findings from a national sample survey in 1997, when most institutions had yet to introduce the formal user fees or exemption policies mandated in the 1996 NHFC.

Governor, the Provincial Health Directorate (PHD), Operational Districts and the health facilities.

2.4 Health and poverty

The rationale for the current health finance reforms – the centrepiece of which is the introduction of formal, standardised and predictable user fees for services provided – is thus that it is essential for facilities to obtain additional income to supplement what they receive from the centre. With these additional funds they can afford to pay staff better salaries which (in combination with better supervision and performance management) will hopefully lead to better motivation and service quality; they can also afford to pay non-salary costs (drugs, petrol, equipment, buildings, etc.). And in theory the users of public health services do have the capacity to pay, as indicated by the remarkably high rates of out-of-pocket household expenditure on health. If some of the discretionary household expenditure which is currently spent on rather ineffective (and sometimes actively dangerous) private sector treatment could be captured in the public sector health budget then it could be directed to policy-led improvements in services.

However, there is also a need to not only capture an increasing share of household spending on health in the public sector but also to progressively reduce the amount that households have to spend. The very poorest households simply cannot afford modern health care, and will do without essential treatment, making do with traditional treatments, either self-administered or provided by traditional healers. Other households, and poor households in particular, can only afford to meet the high costs of health care with difficulty. Table 1 provides 1997 affordability ratios for different types of health services for different wealth groups: for households in the poorest quintile, a single inpatient hospital treatment cost on average more than the entire sum spent on non-food goods and items in a year.

Table 1 Affordability ratios for health services by consumption quintile

<table>
<thead>
<tr>
<th>Health service category</th>
<th>Consumption quintile</th>
<th>Nationwide average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>poorest</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>All public providers</td>
<td>42%</td>
<td>62%</td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>109%</td>
<td>113%</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>36%</td>
<td>49%</td>
</tr>
<tr>
<td>Commune clinic / HC inpatient</td>
<td>53%</td>
<td>445%</td>
</tr>
<tr>
<td>Commune clinic / HC outpatient</td>
<td>33%</td>
<td>36%</td>
</tr>
<tr>
<td>Annual non-food spending p.c. p.a. (riels)</td>
<td>91,190</td>
<td>141,220</td>
</tr>
</tbody>
</table>


When a single inpatient visit can cost more than is normally spent on all non-food expenditures in a year, it is obvious that health costs can often only be met through drastic measures: by selling productive assets (e.g. land or draft animals), dipping into limited savings, and / or borrowing money, typically at immiserating interest rates5. Health care thus constitutes a significant causal factor in the explanation of poverty in Cambodia, forcing non-poor households down below the poverty line and

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forcing already poor households to the point of destitution. Studies by both the Health Economics task force and Oxfam GB have found that health costs, particularly the high costs associated with the treatment of medical emergencies, are a significant factor in the emergence of landlessness. Less costly household expenditures for health care would free up money for productive investment and other forms of consumption; a better standard of health care would result in a healthier, more productive active population more attractive to foreign investors.

2.5 Ensuring that poverty does not preclude health care, and that health care does not cause poverty

There is thus a need to ensure that people are not deterred from seeking treatment because of the cost; and that, if they do seek treatment, the cost does not push them into poverty. In the short to medium term the best way to achieve this is to provide exemptions from user fees for patients who are deemed to be poor. On its own, however, the enforcement of exemptions may create undesirable effects. The problem is not particularly pronounced at the health centre level, in part because the fees for services at this level are low and in part because staff are willing to grant exemptions. Wilkinson et al concluded that “Low official health fees, and the virtual elimination of unofficial fees are increasing access for the poor at the health centres…All but the very poorest people report being able to afford the amounts commonly charged…In contrast to hospitals, exemption schemes at health centres are generally well publicised and exemptions are provided quite readily”6.

The problem is more pronounced at the higher levels in the health system (Referral Hospital and above), where real costs and the consequent user fees are significantly higher. Facilities will be reluctant to treat the poor if they cannot obtain payment for the services provided; the poor will not be treated, or will be treated last, or provided with a lower quality of care than that provided to fee-paying patients. Facilities that do treat the poor will be penalised compared to those that refuse to do so; facilities in poor catchment areas will be underfunded compared to those in richer areas. In practice, most hospitals go out of their way to hide from patients the fact that they in theory offer exemptions (which they are obliged to offer, according to the provisions of the 1996 NHFC)7. It is thus essential that some mechanism is found by which to reimburse facilities for treating the fee-exempt poor. It also addresses the second part of the problem, which is to ensure that health costs do not force the currently non-poor into the ranks of the poor. Different mechanisms are required for each. To date, the mechanism by which development actors in Cambodia have attempted to ensure access for the poor is through equity funds. Financed by donors and typically managed by NGOs, these compensate health facilities for treating poor patients who pay no user fees. This report reviews the experience with user fees and exemptions in a number of hospital-level pilot projects, and lays out the options for further development of the equity fund approach; it also addresses briefly the possibilities for other arrangements (micro-insurance, savings and loans) by which individuals and households, not necessarily the poor, can smooth the impact of health funding.

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7 ibid pp. 48-9.
2.6 The institutional basis for collective solutions

The solution of health and other development problems require an element of collective organisation and public action (defined broadly, to include actions both by the state and by organised civil society). In this light, it is worth briefly summarising the strengths and limitations of civil society (“community”) and state (political and administrative structures) as potential actors in the provision of pro-poor health care.

Community

Cambodia is overwhelmingly (at least 85%) rural in character. Outsiders (both national elites and foreigners) often assume that “traditional” agrarian society is characterised by strong local level (“community”) identities and organisations. While these may exist in Cambodia, it would be a mistake to assume they are ubiquitous or even common, or that they can provide a solid basis for collective pro-poor action at the local level. The characterisation of Khmer society as “loosely structured” may be explained in large part as the legacy of a political history which has since 1970 been characterised by violence, displacement and authoritarianism, and which has eroded the basis for trust and belief in the effectiveness of social sanctions against rule-breaking. In the interest of historical accuracy, however, it should be noted that observers of Cambodian rural society in the 1950s and 1960s also drew attention to the individualistic nature of “traditional” social life and noted the absence of the kind of community identity and organisation seen in many other agrarian societies.

Cambodian village society is not entirely lacking in organisational structures above the level of the family: as in most countries, there exist traditional funeral associations, the members of which agree to pay a small sum (e.g. 500 riel) to the family of another member who dies. There are also tontines, in which members bid at regular intervals for a pot of money: the individual who bids highest wins the pot for that round. Permanent, stable, multi-functional and inclusive village-level organisations of the kind often assumed to exist in rural communities are however very rare in Cambodia. In the words of a French study of rural Cambodia in the 1950s, the phum, conventionally translated as village, is no more than an administrative unit, “only a grouping of houses in particular geographical conditions”.

Government and external actors such as NGOs and donors should therefore be careful when proposing a central role for “community” in the identification, design, management or targeting of development policies or programmes. This is relevant given that community may indeed have to assume an important function in the identification of the poor for the purposes of health fee exemptions. Community-based targeting and activities are certainly possible, but may require an investment of a considerable amount of time, thought and resources to be made to work. Using communities should not be assumed to be an easy solution to development problems.

Urban communities may be something of a special case again. While there is little systematic research on the subject in Cambodia, there is an impressionistic case, backed up with findings from other countries, that poor urban communities are fairly fluid, with families moving into and out of an area over a short space of time. This reduces the social knowledge that households have of their neighbours, and reduces somewhat their ability to identify rich and poor from among their members. A “community”, if defined in functional terms as the catchment population served by a

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9 Delvert 1961 p. 213.
primary level health or education facility, will also be larger in an urban area, as a more dense population enables service providers to take advantage of economies of scale which are not feasible in sparsely populated rural areas. If an urban health clinic typically serves a larger population than a rural health clinic, this attenuates the ability of the clinic staff to identify poor clients on the basis of personal knowledge.

On the other hand, it is worth noting that urban populations have to obtain on a commodified basis goods or services (e.g. drinking water supply or sewerage, fuelwood, or building materials) which rural households can source individually and free as “rent from nature”. This, arguably, creates incentive for collective action over issues of goods or service provision, and therefore makes collective action and mobilisation around community issues more likely.

**Government and governance**

Relations between state and civil society in Cambodia reached a nadir under the Khmer Rouge government, which sought to destroy any basis for identity and organisation other than the party-state-nation collectivity of the Ongkah (“Organisation”). But patterns of governance in Cambodia have always been authoritarian and marked by a structural tendency towards patronage and the use of public office for personal gain. Transparency and accountability are limited and the checks upon the abuse of power are present in theory but largely absent in practice. Formal democracy has been re-established, with two national elections (in 1993 and 1998) and one round of Commune elections (in 2001). Unfortunately however the complex web of ancillary arrangements and values which give substance to these democratic forms – e.g. institutional checks and balances between executive, legislative and judiciary; a free and mature press serving a literate and politically informed population; stable party structures based on ideology rather than patronage and faction; acceptance of the concept of a loyal opposition; and the presumption of legal channels rather than force as the means of resolving disputes – is largely lacking. Expectations and values may be starting to change, but the process can be expected to be long, slow and uneven. These practical limitations should be borne in mind when considering the potential roles of administrative or elected actors in the provision of pro-poor health care10.

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3. Review of experience with pro-poor health financing pilots

As mentioned in the Background, exemptions from user fees work reasonably well at the primary, health centre level. There are several reasons for this. Firstly, the health centres serve a small catchment, so there is a chance that the patient is personally known to the health staff in the centre, who will be in a position to know whether he or she is indeed genuinely poor. Secondly, there seems to be a degree of empathy felt by Health Centre staff for the poor. Thirdly, the costs involved in treatments at this level are smaller than those at hospital level, given that the treatments are more basic.\(^\text{11}\)

Another reason why equity funds are primarily an issue for hospital level rather than health centre level care is that patients arriving at hospital may have had to pay transport costs, and may have to stay in the hospital, thus incurring food costs. Patients presented at the health clinic will by contrast typically have come a shorter distance and be treated as outpatients; even if admitted for overnight treatment they are physically closer to home and can be brought food by family or other relatives.

The central challenge is thus to find a way to make user fee exemptions and other financial arrangements for the poor work at the hospital level, where medical and non-medical costs are higher and facility staff are less well placed to judge eligibility. This section reviews the experience to date with four schemes which attempt to compensate facilities for the income lost through exemptions, by paying the facility all or part of the user fee for patients who are deemed to qualify for exemption.

This chapter provides basic background information on a number of pilots, which have attempted to improve the accessibility and affordability of health care through efficiency and performance reforms, the setting of appropriate user fees, equity funds, and pre-payment schemes. The following chapters then review how the various schemes have addressed the two problems of determining eligibility and managing finances, and the strengths and weaknesses observed in different approaches.

3.1 Asian Development Bank Pilot Contracting Projects

As a component of their Basic Health Services Project, the ADB experimented with contracting the management of health services to non-governmental entities (in this case, international NGOs) in order to improve efficiency, cost-effectiveness and the quality of care. This Contracting for Health Services Pilot Project (CHSPP) experimented with both contracting-in (in which contracted organisations managed health staff who remained MoH employees) and contracting-out (in which the contractors had full responsibility for the delivery of District health services, directly employing District health staff and assuming full management authority). Contracting in was piloted in three Districts and contracting out in two Districts; a further four Districts were taken as a control. Baseline data (household and facility) was collected in early 1999 and compared to findings from a final survey in 2001. The findings were generally positive: government health services in the contracted Districts were of a better quality, more cost-effective, and more equitable, with a significant reduction in the out-of-pocket expenses paid by the poor. Services were provided at a cost of $4.5 p.c. p.a.. While this is significantly higher than the level of expenditure feasible in the "normal" health service (and excludes expenditure through national programme channels, which makes the basis for comparison

somewhat false), it is still relatively low-cost, and as such an interesting model to consider for scaling up.

Of the five project districts, four did not employ user fees, so that health services were available to the whole district population on a non-targeted basis. The fifth contractor in Peraing District, Prey Veng Province managed the health project with a user fee and a ban on local private health service. Exemptions for the poor were not used but it was noted that the fees were ‘low’.

Table 2 The results of ADB experiments with contracting arrangements

<table>
<thead>
<tr>
<th>Management model</th>
<th>Operational District</th>
<th>User fees?</th>
<th>Percentage change among the poorest 50% of households in terms of Utilisation of District public health facilities for curative care</th>
<th>Average private out-of-pocket health expenditure p.c. p.a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting-in</td>
<td>Peraing</td>
<td>Yes</td>
<td>+ 1,536%</td>
<td>- 40%</td>
</tr>
<tr>
<td></td>
<td>Kirivong</td>
<td>No</td>
<td>+ 716%</td>
<td>+ 36%</td>
</tr>
<tr>
<td></td>
<td>Cheung Prey</td>
<td>No</td>
<td>+ 161%</td>
<td>+ 36%</td>
</tr>
<tr>
<td>Contracting-out</td>
<td>Ang Roka</td>
<td>No</td>
<td>+ 2,631%</td>
<td>- 77%</td>
</tr>
<tr>
<td></td>
<td>Memut</td>
<td>No</td>
<td>+ 512%</td>
<td>- 61%</td>
</tr>
<tr>
<td>Control</td>
<td>Preah Sdach</td>
<td>No</td>
<td>+ 257%</td>
<td>-11%</td>
</tr>
<tr>
<td></td>
<td>Kamchay Meaw</td>
<td>No</td>
<td>- 14%</td>
<td>- 12%</td>
</tr>
<tr>
<td></td>
<td>Bati</td>
<td>No</td>
<td>+ 605%</td>
<td>- 33%</td>
</tr>
<tr>
<td></td>
<td>Kroch Chhmar</td>
<td>No</td>
<td>- 32%</td>
<td>+ 132%</td>
</tr>
</tbody>
</table>

Source: adapted from Keller and Schwartz 2001 p. 51.

There are two lessons to be drawn from the ADB pilots. The first, and less immediately useful, lesson is that management-led improvements in efficiency and effectiveness (achieved in this case through contracting – particularly contracting out) can result in significant equity gains, with major reductions in the average annual out-of-pocket health expenditure of the poorest half of the population, and a resulting dramatic increase in their usage of public health facilities for curative care. This is a valuable finding, but of somewhat limited use, as in four out of five of the contracted Districts these gains were achieved with a model of health care that was free to all at the point of service, i.e. did not charge user fees. This was only possible with donor funding, managed by the INGOs.

The second lesson which might be taken from the ADB experience in the fifth contracted District (Peraing) is that better health delivery and reduced health expenditure for the poor can be achieved even when user fees are applied across the board, i.e. there are no exemptions (although the fees were apparently kept low). Furthermore, Peraing - the only District which did introduce user fees - was one of the three which followed the contracting-in model, which was generally found to be hard to make work (although still more successful than the normal MoH arrangements operating in the control Districts). In assessing the (not inconsiderable) achievements of this pilot, therefore, it should be borne in mind that universal user fees may yield more dramatic results when coupled with a more effective (contracting-out) management model. The implication is, as in the four other contracted pilot Districts, that significant improvements in access and reduction in costs can be achieved through basic efficiency reforms, without targeting the poor.
(i.e. no user fee exemption) – although, once again, the achievements were underpinned by the injection of ADB financing and INGO capacity.

3.2 Sotnikum “New Deal”

The New Deal experiment launched in Sotnikum District, Siem Reap Province in 2000 was premised as an attempt to break the vicious cycle of underpaid (and therefore poorly performing) health staff and poorly performing, under-utilised (and therefore under-funded) health services. Staff are promised better pay in return for providing a better service. The pilot included both Sotnikum referral hospital and the Health Centres that serve it.

Part of the Sotnikum New Deal involved the introduction of higher user fees, particularly at the hospital level, as part of the push to increase staff pay. This in turn necessitated the introduction of an effective exemption policy to ensure that the poor could maintain – or improve – their access to public health services. It was judged that it would be counter-productive to ask the facilities themselves to be simultaneously i) rigorous in charging higher, standardised user fees and ii) scrupulous in the often time-consuming task of identifying the poor for exemption. A purchaser-provider split was introduced, with an NGO assigned responsibility for identifying the poor and managing an equity fund to pay for their exemptions. MSF sub-contracted the operation of the equity fund to a local NGO, Cambodia Family Development Services (CFDS).

Patients arriving at the hospital – or their relatives – can apply for exemption from user fees. In practice, health staff refer “visibly poor” patients to CFDS, whose staff are on call at the hospital 24 hours a day in order to establish eligibility through an in-depth interview. Food and transport costs can also be included in the financial assistance to the poor after eligibility is verified. CFDS does not reveal the criteria it uses, on the grounds that if known these will enable the non-poor to falsely report their circumstances in such a way as to qualify for exemption. The hospital, managed by MSF, is fully reimbursed (i.e., receives 100% of the user fee cost) from the Equity Fund for every admission and inpatient treatment of every fee-exempt patient. In the first year of operation, 10% of admissions (around 20 individuals per month) were exempted; the exempted user fee revenue which CFDS reimburses to the hospital (amounting to $232 per month) accounts for 71% of the total payouts of the equity fund, with the next biggest set of payments (17%) made in order to reimburse poor patients’ transport costs.

It has been documented that although 15% to 20% of the patients have been supported by the Sotnikum equity fund, up to 30% to 40% of the population in the catchment area is likely to be eligible. In other words, up to half of the very poor have not accessed the equity fund, despite being eligible to do so. There are a number of possible explanations:

- The poor have been on average more healthy than the rest of the population (which seems unlikely);
- They do not believe that the services provided are valuable;
- They do not know the equity fund exists, and so do not seek medical attention when ill, or seek what they perceive to be cheaper treatments (self-treatment, traditional or non-traditional private sector treatment);
- They know that the equity fund exists but are concerned that they will be rejected as eligible for fee exemption on arrival;

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• They do not know that the fund will pay transport costs, and are detered by these costs rather than (or as well as) the treatment costs;
• They are detered from seeking treatment in the public health care system for some other reason (possibly an impression of brusque or demeaning treatment from health staff);
• They are unable to leave their family, especially young children, alone at home, or are unable to take time away from farming, income-generating activities or employment;
• Distance and therefore travel security is a concern, especially at night; or
• They do not have a family member to accompany them.

It is clear that there is a range of factors, including non-financial factors, that limit access to health care for the poor. At the present there is little understanding of the relative importance of these factors. This is an important gap in our knowledge about the relationships between wealth and access to health care. Investigation is needed into the Sotnikum health service catchment area to determine the community’s health knowledge, concepts and practices, focusing in particular on whether they are aware of the exemption system and, if they have used it, their experience of it in practice.

Description of the characteristics of the patients receiving fee exemption would be very useful but was unfortunately not available. Information such as age, sex, diagnosis on admission and final diagnosis would enable analysis of disease, condition or seasonal trends, which would help in the production of annual plans and the design of public health interventions. It also would be of interest to know if the fee exempt patients were admitted with diseases associated with poverty, such as malaria, waterborne diseases and malnutrition. Once again, health education and preventive interventions could follow up with regard to any high-risk diseases identified in the district.

The Sotnikum experience provides a useful source of lessons for HSSP. However, it must be borne in mind both that Siem Reap province is generally wealthier than the Cambodia average (although there exist pockets of pronounced poverty); and that it is amongst the upper ranks of Cambodian provinces in terms of per capita receipt of ODA, with the result that capacity in provincial and sub-provincial government is higher than in, for example, Ratanakiri. Planners need to exercise caution in transplanting lessons from Siem Reap to other provinces which are poorer and have not benefited from such a prolonged and, relatively speaking, intensive application of external assistance.

3.3 Phnom Penh Urban Health Project

The DFID-funded Urban Health Project (UHP) was designed with a Health Services for the Poor component which aimed to provide improved primary and secondary health care for the capital’s poor. Two health rooms were established in Phnom Penh, one in Tonle Bassac District and one in Boeung Kak District, as a more accessible first point of contact between the poor and the public health system. These health rooms provide early (and thus more efficient) primary curative and (to a lesser extent) preventative care, and refer more serious cases to other facilities (the two health centres which sponsor the health rooms, or the Municipal Hospital).

The equity fund, managed by the project, reimburses the referral provider (i.e. the health centre or hospital) with 70% of the posted user fee for MPA or CPA services provided to those referred from the health rooms. The average provider reimbursement is just under $20 per referral. An economic evaluation of the Health Services for the Urban Poor Component of the UHP concluded that the equity fund
had helped to prevent poverty, by helping people to avoid the need to sell assets or take out loans in order to pay health costs, and by helping them to get treated early, rather than risk the condition worsening (at which point treatment would be more expensive and less likely to succeed). However, it is important to note that the fund’s benefits exclude the payment of expensive treatments.

There is also a fear that because referral service providers are reimbursed for only 70% of the cost of referral services – that is, they make less income from health room referrals than from other patients – patients who arrive by referral from the Health Rooms and who have their costs paid by the UHP equity fund will receive treatment after, and to a less high standard than, patients who pay the full user fee. This concern would seem to be borne out by some of the utilisation figures. The average inpatient stay of referred patients is 12.2 days compared to 3.6 days for non-referred inpatients, suggesting that a longer stay may be used by facilities as a way to increase the cost even though minimum or no treatment is carried out in the last few days before discharge. Alternatively, it could imply that the very poor who are receiving support from the Equity Fund may have been in need of longer term treatment for illnesses that have been ignored in the past due to their inability to pay.

A detailed analysis of inpatient records could explain the reason for the long inpatient stay and examine the quality of inpatient care given. Overall, however, it would seem that there is a strong case for equity funds to reimburse 100% of the user fees that are foregone by facilities treating fee-exempt patients.

Another issue that arose concerned whether reimbursement of facilities should be based on posted user fee prices for the treatments provided or at a flat rate. The facilities were keen to see a flat rate reimbursement. This raised the possibility that health staff might provide less expensive treatment to user fee-exempt patients; and was rejected by the project accordingly.

The identification of the poor and/or vulnerable for fee-exempt referral to the clinics or the hospital was carried out by health room staff using a short questionnaire form, the Fast-Track Vulnerability Screening (FTVS). Revised a few times over the course of the project, the FTVS checklist appeared to be quite accurate at distinguishing the poor from the non-poor. However, there are reports of clients being coached by staff in how to answer so as to qualify, or of village leaders, MHD staff or even UHP staff seeking to reverse determinations. Apparently, by September 2001 there were only two cases in which health room clients requested equity fund assistance and were refused. Given this, it would seem that the time spent administering the checklist cannot easily be justified. The component evaluation recommended that all residents of the catchment areas be considered poor or vulnerable, and therefore qualifying for fee-exempt referral. The value of such an approach – essentially, an geographical targeting approach - depends on two judgements: firstly, whether the residents of these two areas are indeed generally poor (the evaluation concluded yes, other studies characterise them as containing a mix of low- and mid- or high-income groups) and secondly whether it would be possible (and any easier than using FTVS) to determine whether a patient was indeed a resident of the target communities, and therefore qualifying for equity fund assistance.

However, this may be because staff destroy the FTVS forms of those who are not found eligible – although it has been repeatedly stressed that they should not do so.
3.4 Takeo Provincial Hospital
The Swiss Red Cross has since 1997 worked with the MoH and WHO to develop an effective system of health financing and management in Takeo hospital. The combination of good quality of service and low user fees has resulted in high utilisation, even drawing in paying patients from neighbouring Kampot Province. Employees of the hospital earn bonuses roughly seven times their basic government salary and evidence suggests that informal fees are no longer levied. Because the official fees are quite low, many even among the poor can afford to pay. The problem is that the very poorest cannot afford even these low fees; and, since the hospital grants very few exemptions or discounts (only 2.8% of clients in 2000), most of these truly indigent patients simply could not obtain access to hospital care. Recognising the problem, the hospital established an equity fund in October 2000, with funding from the Swiss Red Cross. This will improve the ability of the very poor to obtain access to the hospital's services, but as the total fund size is quite small (budgeted to cover only 5% of total patient costs in 2001), there is still likely to be effective rationing of services for this group.14

4 Analysis of options: how to identify the poor
Some of the options for improving the financial accessibility of health care for the poor do not necessarily involve targeting, such as setting the level of user fees so that the poor (if not the poorest) can afford to pay. It is also important to remember that there is more than one way that the provision of affordable quality health care can contribute to poverty reduction. One way to reduce poverty is to prevent the currently non-poor from falling into poverty. Part of the overall goal of HSS should therefore be to ensure that, wherever possible, the non-poor too are protected from very high costs associated with emergencies and serious illnesses that might push them into poverty.

Nonetheless, the majority of financial access-oriented policies and programmes do involve a measure of targeting – whether for user fee exemptions backed by equity funds, or for concessional access to loans – and must accordingly find a methodology and set of institutional arrangements by which health providers can identify the poor. The identification mechanism has to be:

- accurate, minimising both types of targeting error (ie errors of exclusion – denying services to some of the poor who should be eligible - and errors of inclusion – in which some among the rich obtain free or subsidised services intended for the poor);
- cost-effective, so that the costs of administering eligibility criteria do not outweigh the savings achieved through targeting;
- flexible, so that those who were non-poor but fall into poverty can access health services;
- efficient, so that health staff and patients are not burdened with excessively time-consuming eligibility tests
- respectful, so that patients qualifying for free treatment are not humiliated or stigmatised in the process.

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Several options are available for consideration. This chapter explores each in turn, addressing what would need to be done to make it work, and highlighting the strengths and weaknesses of each approach. They are grouped into four categories: those which seek to have a comprehensive list of the poor defined in advance so that the poor can receive fee-exempt treatment without the need to undergo eligibility testing; those that require eligibility testing at the point at which treatment is sought; a third category – geographical targeting - which can be seen as a hybrid, as the basis for eligibility is determined in advance, but there is one test (place of residence) which is needed to confirm eligibility at the point at which treatment is provided; and, finally, targeting by characteristics (which does not require individual eligibility tests). In each case, it is necessary to consider who makes the selection; how the selection is made (whether it involves a formal and standardised eligibility questionnaire, or whether it is a matter of informed judgement); and when and where eligibility is determined: if it is determined before and away from the point at which treatment is provided, this requires efficient, timely and corruption-resistant arrangements to communicate eligibility to the facility and the equity fund.

It is important that this is clearly seen as a preliminary, theoretical exploration of the issues on paper: there will be unconsidered factors which will emerge as approaches are implemented as pilots. The final paragraphs of this chapter summarise the options and make recommendations as to which is chosen, and which are considered for future piloting.

### 4.1 Approaches which establish eligibility before the need to seek medical treatment

The attraction of establishing eligibility in advance of a patient’s need to use health services is that it simplifies the process of treating the condition. Medical staff can spend their time on diagnosis and treatment without the need to first administer an eligibility test; and the patient does not have to worry about whether or not he or she qualifies for exemption. Two possible approaches are identified.

#### Identification by local leaders or representative bodies

The simplest approach to the *ex ante* classification of those households / individuals who are eligible for health fee exemption is to ask the lowest levels of the government structure – the chief of the village (*phum*) or, in the case of large or scattered villages in which the village chief may not know every family, the chief of the group (*krom*) – to simply state which villagers he (chiefs are almost always male) considers poor. The problem is that village chiefs vary considerably in capability and probity. Some have been elected (albeit typically a long time ago), while many have been simply appointed. In some villages the chief is respected and trusted, while in others villagers complain that he is illiterate or drunk. In the worst cases village chiefs are guilty of stealing villagers’ land or channelling the benefits of development projects to themselves, their relatives and friends. This is made easier, and more likely, when the village chief is a relative or friend of Commune officials. On balance, simply asking village chiefs to identify the poor is not a satisfactory solution, as it is likely to perpetuate the situation described in the Poverty profile, in which the great majority of those found to receive exemptions from health user fees were from the wealthiest – and most influential – quintiles, rather than from the poorest.

An alternative to the village chief is the elected Village Development Committee or VDC. The VDC story is somewhat complex. At one point in the mid-1990s VDC formation was championed by a minor Ministry as a national programme. This

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universal programme of VDC creation failed for a variety of reasons\textsuperscript{16}, with the result that functioning VDCs are concentrated in a small number of provinces in which major donor programmes have used VDCs to foster local, participatory development. They do seem to have performed reasonably well in the provinces in which UNDP and other donors supported Seila through the CARERE II programme: but in many other cases they exist merely on paper. It may be worth involving VDCs in selection of the poor in areas in which CARERE has built capacity, particularly in the north-west (Pursat, Battambang, Banteay Meanchey and Siem Reap)\textsuperscript{17}.

A third alternative is to use the achars, the Buddhist laity who assist in organising celebrations (bons), either those connected to the wat or those associated with civic life such as weddings. Achars are respected, generally middle-aged or elderly men, who act as intermediaries between villagers and monks, and are typically entrusted with raising and spending money for celebrations or wat-construction. Giving achars a role substantially beyond their traditional remit is an uncertain endeavour, which will need to be carefully trialled to see if it is worth embarking on a large-scale pilot: but it certainly worth considering.

Fourthly, it may be possible to use the local community bodies that have been set up specifically to provide participation in the planning and delivery of health services (see Box). Early findings on these bodies suggest wide variation in quality and effectiveness, but on balance considerable promise: user fee income is two-thirds higher in HCs which have a functioning HCMC and three-fourths higher in HCs with a functioning FBC than in HCs which lack either\textsuperscript{18}.

\begin{table}[h]
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\begin{tabular}{|c|c|}
\hline
\textbf{Box 1 Community participation in health: HCMCs and FBCs} & \\
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The MoH Guidelines for Operational Districts and the NHFC both endorse this principle of community participation in HC management and user fee administration. Two different types of body have been created for this purpose: Feedback Committees (FBCs or FCs) and Health Centre Management Committees (HCMCs). HCMCs are supposed to have three members drawn from the HC staff, plus an elected representative from each of the communes served by the HC (which averages four). The FBCs are larger, with the ideal being the full staff of the HC, plus one male and one female elected representatives from each village served by the HC (average fifteen). A typical FBC would thus contain around 37 members, which is too large for effective decision-making but effective for the exchange of information. & \\
\hline
\end{tabular}
\end{table}

Finally, it might be worth involving all of these parties – village and group leaders, the VDC, the achars and the FBCs / HCMCs – collectively in a selection meeting. This does not guarantee that a powerful village chief will not force through a biased selection of respondents, but it does make it slightly harder to do so\textsuperscript{19}. FBCs could play a crucial role at both an initial stage (allocating each village a set number of poor households which they are allowed to nominate, reflecting population size and perhaps, more controversially, some consensus on the relative wealth of different

\textsuperscript{16} It appears to have been perceived within Government as a party partisan move; the Ministry in question lacked the resources to implement the plan for VDC formation at a national level without external assistance; and the plan cut across and was cut across by autonomous efforts donor efforts to create VDCs in selected provinces as part of local governance reform and area-based planning.

\textsuperscript{17} On VDCs, see Joint Health Sector Review 2001 Health behaviour and equity report p. 15-16; Biddulph 1996; Conway 1999, 2001.

\textsuperscript{18} Joint Health Sector Review 2001 Health behaviour and equity report p. 15.

\textsuperscript{19} On a minor point, it should be noted that the “community” that is served by an achar is not always congruent with the “community” of the administrative phum. As the role of the achars is defined largely in relationship to a local wat, and a wat may serve several villages or just part of a village, the relationship of achars to the phum is somewhat fuzzy.
villages) and at a final stage, collating village lists of poor individuals to pass on up to the RH and the equity fund managers.

This leaves the issue of how the identification of those who qualify for fee exemption is communicated to health staff or equity fund administrators at the RH level. The list of all eligible individuals should be passed from the village to the equity fund administrators at the RH. Rather than introduce a new and untried reporting channel by which villages pass these lists directly to the RH, the village chief should either i) include the list with the basic statistics (number of families and individuals, male and female, widows, etc.) which he is required to collect and pass to the Commune every quarter; or ii) supply the list to the HC, which would then submit it to the OD along with the next routine HMIS report. Fee-exempt households should be given corresponding certificates, signed, dated and stamped by the village chief and whatever other local figures (e.g. VDC or achars) were involved in the selection process.

Community-based identification
Alternatively, the poor may be identified by the community in which they live, as villagers can be expected to know the relative wealth and poverty of their neighbours. There is a range of possible approaches by which a community could identify the poor.

- Firstly, they could use conventional wealth ranking. This involves recording the names of every head of household in the community; putting each household onto a card; and then asking villagers, either individually or in a group, to place each household card along a continuum from poorest to richest. This provides the basis for grouping households into different wealth categories.

There are advantages to wealth ranking. If done properly, it can be extremely reliable: group exercises reduce the ability of respondents to purposively represent their own household or those of friends and relatives as poor, and averaging scores across several exercises should further minimise distortions. Generally, it is found that the scores given to particular households in different exercises are highly correlated – that is, there is a high degree of consensus within a small community about who is and is not poor. It reduces the need to design, pre-test and apply a lengthy household questionnaire; and solves the problem that poverty, in the form of household asset characteristics taken as proxy indicators, takes different forms in different locales.

Respondents are free to choose the number of piles / categories they use. Categories are numbered from 1 (poorest) upwards, and given a standardised score out of 100 by dividing the category number by the number of categories used and multiplying by 100. The exercise is repeated with other individuals or groups, and the standardised scores from each exercise are averaged to give a mean standardised score for each household. These average scores are ranked, and cut-offs chosen in order to define wealth categories. The cut-off points can be chosen either to create categories with equal numbers of households – e.g. quintiles of the population of households – or on the basis of natural breaks in the ranking of households, where a big gap in the scores of households sequential in the ranking serve to separate categories of households within which households have a similar average score For the original presentation of wealth ranking methodology, see Grandin 1988; for a worked example from Cambodia see Conway 1999.

For example, in an economically undifferentiated, remote village largely dependent upon wet season rice cultivation, area of rice land, ownership of draft animals, or months by which own-harvest rice supply falls short of self-sufficiency may be key indicators; in a fishing village it may be ownership of an outboard motor or nets; and so on. People living in the community internalise these complex and locally-specific considerations when they classify households during the course of wealth ranking, in a way that would be hard and time-consuming to achieve with a household survey instrument.
However, it is not to be seen as an easy option. It is important to ensure that the list of households is complete – that recent arrivals in a community, often settled on its physical limits, are not left off. To the extent that there exists a real social community in which people know their neighbours (an essential requirement for wealth ranking), its borders may not always be congruent with those of the official administrative unit of the village (or phum). The most important problem, however, is that the ranked score which is obtained is a relative rather than absolute measure of wellbeing, and as such not comparable between communities. A household with an average standardised score of 60 in Village A may be considerably poorer or wealthier than a household with the same score in Village B; or, to put it another way, if the poor are defined as the bottom 25% of households in any village, the definition will include some relatively well-off households in richer villages, and exclude some poor households in poorer villages. This may be acceptable as a low-cost method of determining equity fund eligibility, and may constitute a significant improvement on the existing situation, but it is not ideal. NIPH and GTZ have been testing the viability of community-based wealth ranking as a means of identifying the poor22: the findings from these pilots should be incorporated into any HSSP plans.

- Alternatively, communities could be given a short and simple set of criteria and asked to identify their poor on this basis, using their knowledge of each household's characteristics (assets, landholdings, etc.). Once again, while this information could be obtained in theory by sitting down or walking the village with the village chief, it would be better collected as a group exercise, to minimise the chances of false reporting, for completeness (in terms of coverage of all households in the village), and for transparency. The characteristics chosen should (obviously) be those which serve as good proxies for poverty; they should also, preferably, be tangible (e.g. material used to roof house; possession of bicycle; etc.) rather than dependent upon calculation or reporting (e.g. area of land owned, months without own-harvested rice, etc.).

While this method would seem, unlike wealth ranking, to offer an absolute rather than a relative scale – that is, would seem to result in the same definition of the poor being used in every village in the OD area – it is actually less absolute, and less fair, than it seems. This is because there are genuine variations in the nature of poverty (as defined by its proxy indicators, such as key assets) between different locales (see the previous footnote). Landlessness may be used to define poverty and eligibility for equity fund-financed health treatment, and result in a reasonably accurate separation of the poor from non-poor in most villages; but in roadside or market villages might result in the false classification of wealthy households which make a living from trade or milling rice amongst the list of the eligible poor.

Apart from a choice of method, it is necessary to address the practical logistics of the identification exercise: how often it will be conducted, by whom, and how the poor, once identified, are enabled to claim.

It is important to recognise that participatory exercises take time and impose a burden on both the community members who participate and the village and commune officials, health staff, and donor or NGO staff who facilitate or oversee the process. Thought should be given to when participatory identification exercises should be held so as to maximise the number of people present in the village and minimise the burden that participation imposes. Harvest periods should obviously be

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avoided, but other more locality-specific seasonal variations in labour demand should also be taken into consideration as far as possible. Accessibility may also be an issue (large areas may be inaccessible apart from by boat in the wet season).

The question of who is involved in the identification exercise is important. In the future, it may be possible for community group identification exercises to be organised and facilitated by village chiefs (and/or in large villages the chief of the sub-village group or krom) or the elected VDCs. In the short- to medium-term, however, it does seem necessary that people from outside the community are involved in explaining, facilitating and monitoring the process, so as to ensure that it is carried out in the same way in different communities, and not abused. Different categories of outside stakeholders who might be considered include:

- Staff of the elected Commune Development Committee (CDC), HC staff, or the HCMC; both will know and be known to many of those participating and can hopefully explain the rationale and process of the exercise in terms which are accessible to the audience;
- OD staff - who will be managing the services provided under the equity fund, and so have an interest in seeing what characterises their poor patients, and getting a feel for which communities are poorer than other;
- PHD staff, who once again should get a feel for how the process is administered;
- The staff of the organisation contracted to manage the equity fund – which may be a donor, an international NGO, a Cambodian NGO, or an office within the OD or RH.

Community identification of the poor is time-consuming. If it involves a number of wealth ranking exercises in each village, it will probably take a day per community. For this reason, it does not seem feasible to involve staff above the HC level in each and every exercise23 - although in the longer term donors, including HSSP, could consider providing funds to support an Equity Fund Eligibility Unit at the RH, with perhaps two staff employed almost full-time to facilitate village identification exercises on a rolling basis throughout the year. If extra staff resources are not made available at the OD level, however, it will simply not be feasible for staff from at this level or above to attend every exercise. Instead, identification exercises will have to be led by HC staff, with members of OD, PHD, donor and NGO staff attending a small sample of the exercises in order to supervise the process, ensuring that it is conducted in a fair and standardised manner.

This places a lot of responsibility on the staff of the Health Clinics, the lowest level of the health system. Time would have to be invested in training them in the techniques and attitude necessary to conduct a successful community identification exercise. Alternatively, the responsibility for conducting community identification exercises could be located outside the health sector, with the Commune: identification of the poor is, after all, of critical importance for development activities in other sectors such as education. The problem here is that the Health Coverage Plan, by redrawing Health Clinic catchment boundaries so that they contain roughly equal populations, has disconnected the administrative unit of the HC from the political unit of the Commune. The problem is not insurmountable – all that is needed is for Communes to have lists showing which villages belong to which HC, and forward the results of

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23 An HC is intended to serve some 10,000 people. Assuming an average household size of five, this amounts to 2,000 households. Villages vary considerably in size, but can be assumed to average around 80 households. On this basis, a HC serves some 25 villages. If identifying the poor takes a day in each village, conducting identification exercises throughout an HC catchment area will take over a month of staff-days – and with perhaps 10 HCs serving each OD, it would take 250 working days to attend every exercise in an OD.
different village poverty identification exercises to the appropriate HC accordingly – but it does introduce complexity and the likelihood of delays and mistakes.

The frequency of reappraisal also needs to be considered. This will necessitate a trade-off between accuracy – ideally the list of those qualifying for exemption / equity fund receipts would be updated frequently so as to capture any changes in household status – and available resources of staff time and money. Given that the process of identification is so time-consuming, it is proposed that each identification is valid for two years. To spread the burden, the eligibility-identification exercise could be conducted on a rolling basis, with half the villages within an HC catchment conducting an identification / eligibility exercise in the first year, the second half conducting the exercise in the second year, the first half of the villages revisited in year three for a reappraisal, and so on.

The means by which eligibility is proven when treatment is sought would be much the same as in the village leadership-led identification described above: the community-determined list of eligible names would be drawn up, signed, stamped and dated by the village chief, the HC staffmember present, and perhaps a number of witnesses, and then submitted to the RH. Eligible villagers would subsequently receive certificates to present when they sought treatment.

4.2 Approaches which establish eligibility when medical treatment is sought

If establishing eligibility in advance of the need to claim it is attractive because it relieves both patient and medical staff of the need to administer tests when treatment is needed, it does also constitute a much greater net cost, as everyone is tested (and periodically re-tested), rather than just those who require treatment. The following approaches rely upon establishing eligibility for equity-funded treatment at the point at which treatment is needed.

Facility-based identification at point of first contact and referral (at the Health Centre)

As described in the analysis of user fees by Wilkinson et al, Health Centre staff are reasonably confident of their ability to distinguish the poor from the non-poor, and reasonably willing to grant exemptions on this basis: and reviews conclude that exemptions are largely reflective of need. One possibility is therefore that responsibility for determining eligibility is delegated to HC staff at the point at which they refer patients onwards to the Referral Hospital.

There are however a number of considerations which complicate the process.

- Firstly, this approach would require that all patients who are granted exemption obtain access to the RH only via the HC: in a medical emergency, however, it may be necessary for the patient to go directly to the hospital.
- Secondly, the exponential difference in user fees at HC and RH level changes the incentives: RH staff are willing to exempt indigent patients from the very small charges levied for clinic services (typically 500-2,000 riel - although cases were reported of patients being exempted from a 10,000 riel fee for assistance with delivery), but exempting patients from the 100,000 or 500,000 riel fees for surgery in the hospital demands more serious thought. Finally, there is the fact that while HC staff clearly have the right to determine fee exemptions for HC services (as they pay the price for these exemptions), their right to exempt patients from RH fees is more complex, as they do not have to pay the price. A institutional separation of the fee-charging service provider and the exemption-
granting equity-fund manager is of course seen as desirable: it is for example the rationale for the NGO management of the Sotnikum equity fund. However, in the model proposed the exemption-granting body (the HC) is not the body which manages the exemption fund: the HC has little incentive to be rigorous in granting exemptions only to the poor, making it hard to control equity fund expenditure, or to prevent unnecessary over-treatment at the RH level (as seen in the Phnom Penh UHP, in which health room staff seem to have been largely undiscriminating in granting exemptions).

One solution to the latter problem would be to take the funds available annually in the RH equity fund, estimate an average reimbursement cost for each exempt patient, and on this basis allocate to each HC within the RH catchment an annual quota of fee-exempt referrals they are allowed to make, broken down into monthly target figures. Health Centres would have to report on how many fee-exempt referrals they made in monthly HMIS reporting, and OD and PHD managers would have to scrutinise these figures and reconcile them with the figures for fee-exempt referrals received from each HC, obtained from the RH; they would then advise HCs which were either dramatically under-using or dramatically over-using their referral powers. (Some month-on-month variation in the level of fee-exempt RH referrals is to be expected, given seasonal variations in disease incidence.)

This system is not perfect. It assumes that each HC will have the same number of poor people needing fee-exempt hospital treatment in a given year. (This could be refined if the number of exemptions a Health Centre was able to make in a given year was weighted by catchment population – which is recorded – and / or, in a more sophisticated approach, by some factor which reflects perceived difference in the level of poverty between different HC catchments.) The proposed system of HC quotas for fee-exempt referrals also assumes that the rate at which patients fall seriously ill is predictable and consistent throughout the year. It thus raises the possibility that a HC hit by a run of illnesses amongst poor patients in the last month of the year will have fully used its quota of RH exemptions and be unable to refer new patients.

An variant approach to ensuring that HCs effectively manage the demand for a finite supply of RH fee exemptions is to grant each Centre an annual allowance of money for exemptions – which cannot be used for other purposes – and require that they use this to pay a nominal, fixed contribution to the equity fund per patient referred to the RH for fee-exempt treatment.

The actual mechanism of referral would also have to be determined. Probably the easiest system would be for the HC to give fee-exempt patients or their carers a certificate to submit to the equity fund management staff at the RH. These certificates should be signed, stamped and dated by the Health Centre staff making the referral, and include the name of the patient and a brief description of their condition, to limit the possibilities for fake reproduction or transfer of certificates. Certificates should be numbered sequentially and the name of the patient entered against the certificate number on a list of referrals held at the Health Centre. Many HCs now possess a short-band radio: the HC call-sign could be included on the certificate, so that equity fund administrators who had reason to doubt the validity of a certificate could call up the HC to check that the referral had indeed been made.

A monitoring and supervision system would be very important to ensure that the system was not abused.
Facility-based identification at the point of service (at the Referral Hospital)

Both the Sotnikum New Deal and the Takeo hospital scheme identified the poor at the point at which they presented themselves at the hospital for treatment. Those presenting as patients for treatment are subject to an eligibility test – in the form of a questionnaire about household characteristics – which may qualify them for exemptions. In Sotnikum, the criteria that determine eligibility are kept secret so as to prevent the non-poor from qualifying for exemptions intended for the poor.

One of the big disadvantages is that those needing consultation or treatment may not know in advance of the existence of exemptions, with the result that they do not bother presenting themselves for treatment at the hospital. This could be addressed if the HCs and others promote awareness of the equity fund – emphasising that it will pay the costs of the poor. Alternatively, the poor may know that exemptions are given but, if they do not know the criteria or trust the selection process, may not be confident of receiving exemptions - and so, once again, may decide not to take the risk of spending money on transport if they feel they risk being turned down. This is obviously more likely to happen if the eligibility criteria are kept secret.

A secondary but nonetheless serious drawback of using a questionnaire at the hospital to determine eligibility is that it takes time and is both distracting for the health staff and distressing for the patient or those accompanying him or her.

Identifying the poor who are eligible for exemptions at the referral hospital at the point at which they present for treatment is the only approach which has been attempted so far. It is however clearly not ideal. As HSSP pilots begin to attempt to scale up and make more sustainable efforts to provide affordable health care, serious thought should be given to the alternatives to hospital-based identification.

4.3 Approaches which require a mix of pre-identification and eligibility testing at point of treatment

Geographical targeting

If a given area is deemed significantly poorer than the average it may be less expensive and less time-consuming simply to classify everyone from that area as poor, rather than administer an individual eligibility test. This was the approach recommended in the evaluation of the Phnom Penh UHS – based largely on the conclusion that the time and cost involved in administering the FTVS approach to testing individual eligibility was not justified by any cost-saving targeting benefits, as very few were ever rejected. Clearly, the validity of a geographical approach to targeting depends upon the degree to which it is possible to i) find spatial concentrations of poverty for which place of residence does clearly stand as a good proxy for household poverty and ii) determine with a high degree of reliability whether or not a given patient does indeed live in the defined area of eligibility. The targeting accuracy of the approach (that is, its ability to exclude the non-poor and include the poor) obviously increases with an increasingly fine-grained geographical analysis: in other words, geographical targeting which identifies rich and poor villages is more accurate than geographical targeting which distinguishes rich and poor Communes or HC catchments. Classifying a large number of small locations is however far more of a burden in terms of time and administrative costs than classifying a smaller number of larger areas.

Geographical targeting is obviously most valuable in RH catchments in which there appears to be clear geographical concentrations of poverty – that is, where there is a
reasonably high degree of consensus regarding what villages (ideally, what communes or HC catchments) are significantly poorer than others. If geographical targeting is to be used, it might be possible to use participatory methods in order to identify poor, fee exempt communities. HC staff (or alternatively the HCMC or FBC for a Health Centre) would be required to classify the villages in their catchment as poor or non-poor. On its own, however, geographical targeting is likely to be a very blunt instrument. The free treatment of a minority of rich individuals in villages classified as poor may be acceptable; but some mechanism will still be needed to identify the (almost certainly numerous) poor individuals who live in rich villages. Given the need to have an individual test for these cases, careful consideration should be given as to whether the administrative savings to be made from partial geographical targeting outweigh the costs. The effectiveness of geographical targeting also depends heavily upon being able to determine where an individual lives when he or she presents themselves for treatment.

4.4 Targeting by categories

Certain groups can be allotted free medical care on the basis of social or medical condition rather than income level. This is often based upon a public goods argument: treating these conditions is a matter of public health policy, with social benefits as well as individual benefits. The Kantha Bopha Hospitals provide free health and surgical services to children (although this is a high cost hospital sustained by foreign aid, and therefore hard to take as model for replication in “normal” Cambodian circumstances). The Emergency Hospital similarly treats people with war-related injuries. Certain hospitals, mainly in Phnom Penh, which receive support from International NGOs are able to run hospice-type wards for HIV/AIDS patients, but admission is limited compared to the number who need HIV/AIDS care. Nationwide, patients presenting with leprosy and TB are supposed to be treated without payment as a matter of policy. There is also a strong case for making antenatal care free as a matter of policy.

4.5 Eligibility criteria: designing a questionnaire form to identify the poor

Identifying the poor by wealth ranking or by geographical targeting does not require a formal list of criteria. Identifying the poor by village-level leadership or HC staff may require some simple formal criteria, or may be based on an informal but holistic awareness of the circumstances of different households. Identification at the referral hospital however will require a fully formalised checklist or questionnaire.

A formal questionnaire may thus be required for two of the potential approaches: village-level identification by local officials or representative groups using formal criteria, and identification at the RH by health or equity fund staff. These two approaches call for different types of form. In the case of village-level identification, the criteria can be tested by observation or knowledge (e.g. of housing materials, or of assets owned). At the referral hospital by contrast staff have no knowledge of the patient’s circumstances, and no way to ascertain these apart from on the basis of the patient’s answers to questions.

Choosing what questions should be on this questionnaire can be approached in various ways. To adapt the points made at the start of the chapter for the particular circumstances of formal, questionnaire-based identification, such a method of identifying the poor must be:

- accurate (that is, it must include the great majority of the poor and exclude the great majority of the non-poor);
- flexible enough to pick up local particularities in the manifestation of poverty while establishing an objective, universal standard for the meaning of poverty
throughout all 23 provinces (so it does not include those deemed poor in Kandal, who would be deemed non-poor in Koh Kong);
- verifiable by the observer – that is, not subject to opportunistic responses by households who may believe that their identification as poor may bring benefits and answer accordingly;
- respectful of the patient;
- and, above all, relatively quick and simple to use, so as to minimise the burden on both the patient and the individual (facility staff or equity fund administrator) who is applying the test.

Alternative methods exist for identifying the poor on the basis of a questionnaire. Perhaps the ideal would be to take the household characteristics found to be the best predictors of poverty (that is, the characteristics which correlate best, singly or in combination in a multiple regression analysis, with over household poverty). For this purpose, the large scale national Socio-Economic Survey of Cambodia (SESC), analysed in the 1999 MoP / World Bank Cambodia Poverty Assessment, might be taken as the source. Unfortunately however several of the characteristics which correlate highly are not readily determined in a short questionnaire (the SESC form is extremely long and time-consuming to administer). It is also important to try to incorporate indicators of poverty which are specific to the agro-ecological and socio-economic circumstances of the locality (referring here to the OD served by the RH), which may not necessarily be the same as those which emerge from the national sample survey.

An alternative approach is to use a variant of the method that was developed to track service utilisation by the poor in the ADB-financed piloting of contracting arrangements. This involved developing an index of 8 key household characteristics or household assets (see Box), in which the weight assigned to the presence of a given indicator was the natural log of the inverse proportion of households that possessed this asset: in other words, the fewer households had a given asset, the higher its value. A frequency distribution of total household scores was used to define socio-economic status quartiles (Keller and Schwartz 2001: 13, 10).

**Box 2 Household characteristics / assets used in ADB socio-economic status (SES) scoring**
- Roof of permanent material (brick, cement, metal or a combination of these)
- Bicycle
- Radio
- Motorcycle
- Television
- Oxcart
- Boat with outboard motor
- At least one cow or water buffalo

An initial HSSP baseline survey of socio-economic and health status (which would be used for general monitoring of impact on health outcomes, not just for establishing eligibility criteria) would identify the most important five to ten household characteristics associated with poverty in the OD served by the HSSP-supported RH. These would then be used to produce a simple questionnaire.

The third option is to conduct participatory exercises in a sample of villages within the OD, to see what characteristics communities regard as reliable indicators of poverty. Such an exercise is best facilitated in the context of a wealth-ranking exercise: having
grouped village households into wealth categories, the researchers would ask the group present what (in terms of housing characteristics, assets, demographics, etc.) distinguishes the poorest groups.

Annex 1 presents preliminary draft eligibility forms for rural and urban hospitals, based upon characteristics which experience and poverty studies suggest will be good indicators of poverty. Whatever method is used to choose eligibility criteria for the questionnaire instrument, however, it is hard to see how staff at the RH can reasonably hope to judge the accuracy of the self-reported circumstances of the patient. It is relatively easy for the non-poor applicant to guess what responses will lead to them being classified as poor and qualifying for exemption, and to respond accordingly. Further discussion with the staff of CFDS and MSF in Sotnikum to see how they attempt this task, and what degree of success they think they achieve, would be very rewarding.

4.6 Summary
To date, only the third and fourth of the possible approaches to identifying the poor outlined above – namely, individual means testing at the point of first contact and referral (Phnom Penh UHP) and at the point of service delivery in the RH (Sotnikum) – have been piloted and evaluated. Pilots have however varied in which body they have assigned responsibility for determining eligibility. In Sotnikum, responsibility was contracted to an NGO; in Phnom Penh it was determined by primary care facility staff. However, geographical targeting has been recommended as preferable to means testing in Phnom Penh, on the grounds that all residents of the two slum districts concerned would be either poor or at risk of becoming poor if faced with substantial health costs.

The following table summarises the key points about each of the possible ways of identifying the poor.
### Table 3  Summary of advantages and disadvantages of alternative approaches to identifying the poor

<table>
<thead>
<tr>
<th>Approach</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Approaches which attempt to establish eligibility in advance of need for treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.1 Eligibility established by local leaders</td>
<td>• Relatively straightforward, low cost and quick</td>
<td>• May be subject to manipulation</td>
</tr>
<tr>
<td>A.2 Eligibility established by community through wealth ranking</td>
<td>• Reliable</td>
<td>• Relativistic: definition of poor in one village different from that in another, therefore geographical inequalities</td>
</tr>
<tr>
<td></td>
<td>• Reflects local differences in the nature of poverty</td>
<td>• Time-consuming, for community and staff</td>
</tr>
<tr>
<td><strong>B. Approaches which attempt to establish eligibility in advance of need for treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.1 Eligibility established at referral (HC)</td>
<td>• HC staff can make eligibility judgement relatively quickly and easily, minimising burden to staff and patient</td>
<td>• Requires patients to obtain RH treatment via HC: not appropriate in an emergency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires rules and supervision to control exemptions and equity fund costs</td>
</tr>
<tr>
<td>B.2 Eligibility established at treatment (RH)</td>
<td>• In an emergency, patients do not have to present first at HC for referral</td>
<td>• Without personal knowledge of patient, eligibility test is formal. To work, must be detailed (time-consuming, potentially distressing) and basis for judgement must be kept secret; and is still likely to result in some false inclusions and some false exclusions</td>
</tr>
<tr>
<td><strong>C. Approaches which require a mix of pre-identification &amp; eligibility testing at point of treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.1 Geographical targeting</td>
<td>• Once poor areas identified and patient’s place of residence established, determination of eligibility is quick and simple</td>
<td>• Process of identifying poor areas may be complex, or time-consuming, or inaccurate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requires an ability to confirm place of residence when a patient presents for treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Broad-brush: will include some rich who live in poor areas and, without complementary measures, will exclude poor who live in rich areas</td>
</tr>
<tr>
<td><strong>D. Targeting by categories</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.1</td>
<td>• For categories based on medical condition, determining eligibility is simple</td>
<td>• Only certain groups can be targeted in this way; many of the poor do not fall into simple, readily verified categories</td>
</tr>
</tbody>
</table>
5. Institutional and financial arrangements for pro-poor health care

Identifying the poor in a cost-effective and timely way is obviously only the first hurdle that must be overcome to make an equity-funded exemption scheme work. There is a further set of issues to be resolved concerning the management of the equity fund: who runs it, where it obtains its financing, how it makes reimbursements to the health provider, and how it is monitored. This chapter attempts to address these questions, even if only in summary form; it also looks briefly at the possibilities for alternatives to equity funds.

5.1 The financing and management of equity funds

The Background chapter above laid out the basic issue which this report aims to address, namely that of reducing the cost burden of health care for the poor while ensuring that the public health system obtains the funds it needs to meet essential expenditure (and in particular to pay a living and motivating wage to health staff). To expand on this, what is needed is a health financing system which:

- Enables the poor to obtain access to quality health care at an affordable cost;
- Ensures that the facility has funds to pay staff and non-staff costs;
- Ensures that the facility has an incentive to treat poor patients – or at least, does not have an incentive not to treat them;
- Does not create incentives for over-treating or over-charging the poor; or, if such incentives cannot be eliminated, incorporates effective monitoring and meaningful sanctions in order to deter such distortions;
- Is realistic, in that the PHD and MoH have the capacity, and incentive, to monitor effectively;
- Is cost-effective, i.e. does not entail excessive administrative costs;
- Contains provision for the MoH to gradually increase its contribution to what is, after all, a core responsibility.

Simultaneously reconciling all these criteria is probably not possible. However, some arrangements emerge as superior to others.

Management responsibility for equity funds

At present, responsibility for managing equity funds rests largely with NGOs. The primary reason for this is that if the manager of the equity fund is the same as the provider of services there is a strong incentive to overtreat, providing unnecessary services in order to obtain extra user fee-replacement funds (half of which go to support staff supplements). However, NGOs – particularly international NGOs (e.g. MSF, which backed CFDS in Sotnikum, or Swiss Red Cross, which backed the CRS in Takeo) – have relatively high salaries.

In the medium term, it is hard to see there being a viable alternative to NGOs as contracted independent managers of HSSP-supported equity funds. The private sector in Cambodia does not yet appear to be sufficiently developed for professional private-for-profit contracting companies to assume responsibility for equity fund management: this was the experience of ADB, which received no Cambodian expressions of interest when it invited bids for the contracting pilots. Indeed, they received no tenders from Cambodian NGOs: the five pilot Districts were contracted out to four INGOs (one being allocated responsibility for two Districts). The ADB
evaluation notes that with a “baby boom” of graduates emerging from university, there is a potential for rapid development of private sector capacity in the health sector, given the right policies and skill-building opportunities. Over the lifetime of the HSSP, however, it seems likely that NGOs will continue to play a dominant role in managing equity funds. The challenge will be to achieve cost efficiencies, progressively reducing the number of expatriate staff required to provide advice and oversight to professional Khmer staff.24

**Local capacity and the location of HSSP-supported pilots**

This report has reviewed the experiences of three projects which used equity funds (Sotnikum New Deal, Phnom Penh UHP, and Takeo hospital); and one which did not use an equity fund but achieved substantial improvement in utilisation and substantial decreases in out-of-pocket costs through externally financed management reforms, sometimes without and sometimes with across-the-board user fees (the ADB Contracting pilots). All of these pilots have involved:

- Relatively well developed pre-existing local management capacity, both in the general administration and in the planning and management of health services at the PHD, OD and HC levels. In Phnom Penh, Takeo and Siem Reap facilities largely conform to the Health Coverage Plan (i.e. Health Centres provide the MPA and Referral Hospitals provide the CPA). These comparatively strong Provincial and sub-Provincial structures reflect the cumulative influence of a number of donors who have provided funding and advice in these Provinces over numerous years.

- The commitment of quite substantial inputs of external financing and a reasonably large amount of (expensive) staff time from senior advisors, whether donor or NGO, in order to make the equity fund work.

If HSSP is to develop more low cost equity fund solutions which better reflect the “normal” situation in Cambodia, many of the parameters will change. The HSSP pilots will to a certain extent be trying to achieve more with less. In this context it is important to choose suitable locations for these pilot schemes. At present, HSSP documentation suggests that the World Bank-funded component will support the development of user fees and associated equity fund arrangements in the one or two “remote, poor and low-performing” Districts in which Bank-financed HSSP contracting arrangements are piloted, plus two to six other Districts.25

There is a danger that HSSP over-reaches itself in attempting to achieve improvements in efficiency and effectiveness while simultaneously starting up in two Provinces which have historically not received much aid and which are indeed “remote, poor and low-performing”. The equity fund arrangements piloted under the HSSP should realistically be seen as graduated steps along a continuum: in selecting areas in which to pilot equity funds or any other pro-poor health financing schemes. It is important that the pilots are given a chance to perform in a variety of contexts: the “two to six” other Districts should include at least some in areas with a higher capacity. Otherwise, if they are attempted only in Ratanakiri or Prey Vihear and fail, it will be hard to say if it is because the approach and design is fundamentally flawed, or if it was simply not suitable for these contexts with extremely limited capacity to plan, budget, monitor or management the health system. There does seem to be a considerable consensus behind this position: MediCam has recommended that equity funds could be established “in all Operational Districts where quality of care and management are present to support them.”26

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24 Keller and Schwartz 2001 pp. 11-12.
26 MediCam 2002.
Financing
At present, equity funds are financed with donor money. This is not going to be a feasible solution in the long term or at a national scale. If equity funds are to have a major role to play in addressing health-poverty links – whether alone or in conjunction with pre-payment / health insurance / health loans arrangements – then there needs to be an effort to generate a Cambodian revenue stream. This will not be achieved within the period of HSSP funding, but the Programme can at least begin to work towards this, or at the very least avoid creating systems which will later make it harder for communities or the Government to take on the task.

One option is that equity funds receive money from the MoH. Ensuring access to health for Cambodia’s poorer citizens is after all a core responsibility of Government: it is important that the Government is encouraged gradually to assume this role. An MoH contribution also has the advantage of creating an MoH incentive to monitor the probity and performance of equity funds. At present, however, the funding available will be extremely small. The whole rationale for user fees is that the funds received by facilities from MEF / MoH are totally inadequate to provide a decent basic health service, and so must be complemented by revenue raised local from health service users.

Another option is that resources for equity funds are raised through cost-sharing, that is, are raised locally. The formula for the division of user fee resources could be modified so that a proportion of the money goes towards a facility-based equity fund. This may not be popular with staff. User fee revenue is currently split so that 1% goes to MEF, 49% to augment the salaries of facility staff and 50% to pay for non-salary facility costs. Any user fee revenue which is taken to fund an equity fund therefore involves a cut in the money available to meet salary or no-salary costs. The contribution to the equity fund should definitely not come from the salary component. Even if taken from the non-staff cost component, however, there is a danger that staff will, correctly, see this solution - paying the costs of fee exemptions from fee revenue rather than a separate donor fund - as a net loss of total revenue, and possibly as no different from and no better than treating the poor for free without equity fund compensation. But if non-donor funding of equity funds is to develop this is, realistically, the only way to it. In the short to medium term, the sums flowing out from the centre are so small and unreliable that locally generated funds will have to be used.

For the medium term at least donors will need to continue to be the primary funder of equity funds. A realistic goal would be to gradually build up contributions from other sources to complement donor funding. The division of user fee revenue should be changed by an amendment in the NHFC so that 50% goes to support staff costs, 44% to non-staff facility costs, 5% to the facility’s equity fund and 1% to MEF. MoH meanwhile should assume responsibility for paying a contribution to equity funds. How exactly this is arranged would need to be the subject of further research by a health economics / health finance specialist who understands the situation in Cambodia. It could take the form of a flat rate grant to each equity fund (simple, therefore less subject to rent-seeking and leakage); or in terms of matching existing funds to a set proposition, perhaps topping up by 10% whatever equity fund revenue is raised by donors and user fees.

The other possibility is that equity funds are raised and managed by communities. Given that a sense of community identity or a belief in the obligation of the rich to help the poor are not particularly pronounced in Cambodia, it seems unlikely that rich households will willingly contribute to funding a scheme intended to pay the health
costs of poor households. In urban areas however there may be some mileage in requiring large employers to make a contribution towards the equity fund of a local hospital.

Estimates from the Swiss Red Cross in Takeo suggest that $8,000 p.a. “seed money” is needed to make a referral hospital equity fund work. The Takeo pilot, however, is notable for granting very few exemptions, and (at least in the beginning) for not actively publicising the fact that exemptions were available. If HSSP equity funds are to provide exemptions to a larger proportion of the client population, costs may be considerably higher. A comparison of the costs of the various schemes in existence – including Sotnikum and the UPH – would help establish broad budget estimates for HSSP pilots. The effort should be to improve on the cost-effectiveness of this first generation of pilots (which used considerable inputs of donor and NGO expatriate expertise, and therefore had a high cost structure); while being realistic, and providing the schemes with enough to work, including allowances for learning over the first few years.

**Balancing revenue incidence and burden**

There is an important question relating to the level at which user fees are set, and the frequency with which exemptions are granted. Broadly speaking, for any given desired level of user fee income there is a choice between setting user fees low and granting few exemptions, and setting them higher but granting more exemptions. Getting this balance right is complex and will almost certainly require adaption to local circumstances. The following table summarises the advantages and disadvantages of each approach. Putting figures to these broad scenarios will require the inputs of a health economist.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Advantages / opportunities</th>
<th>Disadvantages /risks</th>
</tr>
</thead>
</table>
| Relatively high user fees, relatively large number of exemptions | • Eligibility criteria do not have to be as rigorous as exemptions are less tightly targeted  
• Encourages a larger population to use the public health sector, drawing them in to contact with preventative health care messages and improving cost-efficiency | • If targeting is not accurate, poor face very strong cost barriers to care  
• Tertiary health costs can be very high: even those in the top one or two quintiles could be forced into poverty if they alone are expected to finance an equity fund and so absorb the cost of supplementing salaries and other operating costs  
• The base for user fee revenue becomes narrower, therefore more precarious, especially if  
• The rich defect from the public health service to the private sector because of the high user fees |
| Relatively low user fees, relatively small number of exemptions | • Broader and therefore more sustainable revenue base  
• Lower fees reduces risk that fee-paying non-poor (or poor mis-classified as non-poor) will be impoverished by them  
• Larger proportion of patients paying their own user fees increases the patient-side pressure for quality and value-for-money improvements | • Requires very narrow targeting, which may be time-consuming, expensive and / or distressing to the patient  
• May stigmatise those who receive exemptions, as they will be a small minority |
**Full or partial reimbursement**

Facilities should be fully renumerated for treating poor patients: any arrangement which results in a hospital receiving less income for treating a poor patient than a non-poor patient creates a dangerous incentive for the hospital to not treat the poor, or to treat them last, or less well. In reimbursing facilities only 70% of the posted user fee cost, the UHP found many facilities refused to treat Health Room referrals, and the three facilities which did accept referrals were unhappy and modified their treatment in various ways. Even if it were to prove possible to force facilities to treat user fee-exempt patients equally, the effect of only partially compensating them would be to punish financially facilities in poor areas relative to those in richer areas. By paying the full 100% of the exempted user fee cost, the Sotnikum equity fund avoided this problem.

This does not necessarily mean that the equity fund always needs to pay the full cost. It would be possible to offer partial as well as full exemptions, so long as the patient then paid the balance. The advantage of this approach is that it allows for a graduation of assistance: those who can afford to pay something towards their treatment do so, which frees up more funds with which to offer full exemptions to the truly indigent. If designed carefully, partial exemptions can also create an incentive for the patient to try to keep costs down; channelled through a collective consumer feedback mechanism such as the Health Centre Feedback Committee, this can create a demand-side pressure for value for money. The Health Economics Task Force review of user fees suggested there was “a strong case for supporting an exemption scheme which would provide partial exemptions for the majority of the estimated 36% poor in a province, and full exemptions for the absolutely destitute”\textsuperscript{27}.

The drawback is that to offer a graduated range of exemptions requires a more complex decision-making procedure, increasing the administrative burden on whatever stakeholders (community, local leaders, facility staff or separate – probably NGO – equity fund manager) is given responsibility for identifying the poor. It also makes the collection of money a little more complex: rather than having a simple choice between collecting the full sum from the patient, or filing the treatment as one which is to be claimed from the equity fund, the medical staff must do both (process part payment from the patient and file an invoice to be claimed from the equity fund).

**Reimbursement of fees exempted or flat rate sum**

Reimbursement should be for actual user fee prices, not a flat rate. Reimbursing facilities at a flat rate for patients who qualify for equity fund support creates an incentive for facilities to under-treat poor patients in order to preserve and maximise a margin between treatment cost and reimbursement income.

**5.2 Monitoring and evaluation**

The evidence base upon which to evaluate the feasibility of pro-poor health financing arrangements is still fairly narrow: this report reviews briefly three equity funds that are known to exist (Sotnikum New Deal, Phnom Penh UHP and Takeo hospital), one set of contracting arrangements which have resulted in improved but untargeted service delivery (ADB), and one pre-payment scheme (GRET in Kandal: see below). Any HSSP-supported pro-poor financing approach will therefore take the form of one or more pilots, while attempting to scale up so as to reach a wider poor population and greater cost-efficiency. Given the experimental nature of these approaches, it will be particularly important to have in place a monitoring and evaluation system.

\textsuperscript{27} Wilkinson et al 2001 p. 51.
which will allow both direct stakeholders (communities, facilities, MoH, NGOs and HSSP donors) and others in the sector to obtain a comprehensive picture of the successes and failures of the approaches adopted.

Performance indicators and evaluation criteria

This system should allow comparison of different pilot approaches with regard to certain core issues. The key questions in monitoring the implementation and outcomes of pro-poor health financing pilots include:

- Who is getting the exemptions? This first set of questions involves talking to a sample of fee-exempted patients, and assessing whether they are rich or poor (or fall into another category which qualifies for exemption); the sample frame in this case is the list of patients who have been treated who have been exempted from health fees, and for whom the equity fund has reimbursed the facility.

- Are the poor receiving better access to more affordable quality health care? Do they receive treatment at the referral hospital when ill? If not, why not? Is it because they don’t know about the existence of exemptions? Is it because they don’t know what the criteria are, and therefore do not want to spend money and time getting to the facility if they may not be able to receive free treatment? If the poor do receive free treatment, is it of the same standard as that received by those who pay the user fee? How is the total spending of the poor on health changing: are they spending less, are they switching from the private to the public sector for their health care needs, are health care-induced crisis sales or debts becoming less common? This second set of questions involves sampling from the catchment communities that serve a referral hospital, talking to the poor in particular, and will require a mixture of quantitative (sample survey) and qualitative (individual and group discussion) research skills.

- How well are the financing arrangements working? Do staff feel happy with them? Is there a perception that paying a small percentage from the user fee revenue into the equity fund results in a loss to the staff (if this approach is adopted)? Does MoH pay the amount it is meant to pay, when it is meant to pay it? Is there any evidence of over- or under-treatment of patients who are exempted from fees? (This will involve a rigorous comparison of cost-per-case records for user fee-paying and exempted patients.) If pre-payment or health insurance schemes are used, do members feel that the benefits justify the costs? Are members following the rules of the scheme, or making their own idiosyncratic arrangements with the administratrs of the scheme? If the latter, do these modifications threaten the equity or sustainability of the scheme, or are they sensible adaptations that should be incorporated into formal policy? Do members find the contributory mechanism appropriate? (are the premium payments a burden? Do members find a monthly or an annual payment preferable? Do they need the flexibility to over- or under-pay at certain times?) This third set of questions will need to focus on the facilities, the equity fund managers, the PHD and MoH, and will need to involve a health economist.

Institutional responsibilities for M&E

Monitoring will need to involve a variety of stakeholders. The PHD should have a significant role: as the level which must supervise and plan and budget for the Referral Hospitals that will operate the equity funds, the PHD has a clear stake in monitoring the progress of the schemes. It also provides a channel by which to feed findings up into debates within the MoH (in which the Department of Planning and Health Information (DPHI), National Institute for Public Health (NIPH) and Department of Budget and Finance (DBF) will be key stakeholders)\(^{28}\). However, the

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\(^{28}\) One option considered is to locate responsibility for the management of equity funds and / or other pro-poor health financing instruments with a ministry other than MoH. The Ministry for Social
PHD will require some external assistance, channelled through HSSP, in order properly to fulfil this role. If it is anticipated that pro-poor health financing arrangements will be piloted in no more than eight Districts (see Local capacity and the location of HSSP-supported pilots above and World Bank 2002), this should not be an excessive burden on the HSSP management structures.

Routine monitoring of the equity funds and exemption policy should be incorporated within HMIS monthly reporting. Indicators would include the number of exemptions granted and brief details of the breakdown of exemptions (by age, sex, ethnicity, initial diagnosis, diagnosis on treatment, etc.).

Monitoring of exemptions and equity fund operation by the PHD and MoH through the HMIS establishes accountability upwards, to senior health sector planners and managers. It is highly desirable to complement this with "downward" accountability to the intended beneficiaries of these policies. This could be achieved through periodic (perhaps quarterly or half-annual) special sessions of FBCs, in which staff from the RH and the organisation (probably NGO) that runs the equity fund would visit each HC in their catchment and report on the functioning of the exemption scheme and the equity fund mechanism.

Once a year, following one round of these consultations, there should be a workshop held at the RH at which representatives from each HCMC can exchange perspectives on how the scheme is working. This would also provide an opportunity for front-line RH staff – the nurses, pharmacists and doctors who have to treat patients, invoice for exemptions and supplement their salary with user fees and equity fund reimbursements – to provide their perspective on the operation of the scheme. (As an incidental benefit, it would also expose RH staff to the perspectives of the communities and the HCs from which their poor patients hail.) PHD staff and HSSP programme staff should attend and facilitate these RH-level workshops, which should be timed to report their findings as an input to the HSSP annual review29.

5.3 Alternatives to equity funds

Besides the equity schemes discussed above, there are several approaches to ensuring the affordability and accessibility of health services for the poor, which have been largely neglected to date in Cambodia but seem to merit further consideration. It is worth noting that most studies concur that equity funds should be used as an interim measure, as a means by which donors can help to ensure to protect the poor from the effects of health expenditure while more comprehensive and sustainable solutions (pre-payment schemes or health loans) are developed. It is also worth noting that in many cases these approaches, while complex, are not significantly more problematic than equity funds30. Both equity funds and health insurance schemes, for example, require carefully designed procedures and management policies in order to control costs.

Welfare, Labour and Rehabilitation, for example, might be considered a suitable manager, given that the provision of affordable health care is to large degree about social protection (which covers both poverty alleviation and poverty prevention). This is, on consideration, not recommended. Little is known about the capacity of this Ministry, either in general or in the particular context of managing health equity fund pilots. It is not clear that the complexities of dividing responsibilities (in terms of accountability to Government and to HSSP donors) between the two ministries outweigh any advantage that might accrue from involving MWLR.

29 On proposals for M&E framework for the HSSP, see World Bank 2002 pp. 31-2; Conway and Beckerleg 2002.

30 Joint Health Sector Review Health sector financing report p. 30. A March 2001 review of the UHP experience concurred, noted that “Setting up an equity fund can be as challenging as establishing a health insurance scheme” (UHP 2001 p. 4).
Pre-payment arrangements / health insurance

There is in theory a strong logic for health insurance, allowing Cambodians to buy protection against the impoverishing effects of serious illness. Community members pool risk by paying contributions to a fund which will pay out in the case of the need to pay for defined forms or sums of health care. These arrangements could be made pro-poor if they include provisions to pay the premiums of the poor, either directly or from equity funds. This can also, at least in theory, have a governance effect, by facilitating the development of a collective consumer demand mechanism, exerting discipline on health providers to provide a better quality of care for a better price.

In practice however there are a number of barriers to making such schemes work. Part of the problem is economic: given that most Cambodians have very little money, the premiums paid to an insurance scheme have a considerable opportunity cost. People may prefer to invest their limited funds in productive assets, or in general purpose savings (gold, pigs, etc.) which can be mobilised in order to meet a variety of eventualities, rather than tied up in a scheme which will only respond to a health crisis. The ability to pay may also vary considerably on a seasonal basis, in which case schemes which require a regular contribution will not be suitable. Related to this, however, is an institutional problem: if people lack trust in collective arrangements then they will not be willing to pay the premium, for fear that the money they invest will be stolen or mismanaged so that when they come to need treatment it will not be able to pay out, and their payments will have been wasted. The problem is not unique to Cambodia: it has been hard to establish health insurance in most low-income countries. As discussed in the background, there is however an argument that the problem may be more than usually pronounced in Cambodia, which has traditionally not been noted for collective organisation. Experience with attempts to create in Cambodia village-level collective organisations (e.g. for managing irrigation or credit) have often faced considerable difficulties in maintaining rule-based governance, which has often eroded their sustainability. On the other hand, a study for GTZ has concluded that there are some promising opportunities for the development of community-based health insurance in Cambodia. The various sources of evidence need to be collated and reviewed carefully.

The main threat to insurance schemes comes from covariant risk, that is, risk which when it strikes affects many people at once, forcing major payouts which may bankrupt the fund. Insurance schemes become stronger as they acquire more and more diversified members, which reduces the likelihood that a given covariant risk will affect the majority of the members. Small schemes are thus particularly vulnerable to covariant risk: if all twenty members in a village scheme are afflicted with dengue fever simultaneously then the scheme will be unable to pay for treatment for all, and the scheme will collapse. The conundrum is that in a weak regulatory environment, people may only be willing to trust their savings to a small-scale, local scheme, in which they know those who hold the funds. The logical way to proceed is to federate small scale schemes. International experience, however, strongly suggests that small scale community-based insurance schemes are extremely hard to set up, demanding a major commitment of time and resources; and that scaling up is difficult and takes a long time to develop.

Given this, it is perhaps unsurprising that there has been only limited experimentation to date with pre-payment or insurance schemes. The French NGO GRET has

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32 Daubert et al 1996.
operated a Phnom Penh-based prepaid health care plan serving Kandal since 1999. The premium (initially 3,000 riels p.c. p.a. but later increased to 6,000 riels p.c. p.a.) entitles members to fixed cash benefits for a specified set of conditions (death, critical surgery in the torso, caesarian delivery, delivery with forceps and suction, normal delivery, emergency transport to hospital for critical surgery). Phnom Penh-based medical teams also regularly visit the homes of scheme members to provide consultations for a nominal fee (500 riels per child, 1,500 riels per adult), with drugs priced moderately and free follow-up visits. The scheme is currently still quite small: after one year it covered 167 enrolled families (711 individuals) in seven villages in two Districts. At this stage premiums covered only a fraction of the schemes costs, with the balance met from donor funds34.

MSF is also reported to have considered “pregnancy insurance” for use in connection with the Sotnikum New Deal. Under this scheme, pregnant women would pay a premium which would cover all pregnancy-related health costs, including delivery by a trained midwife and referral by ambulance to a hospital with surgical facilities in the event of an obstetric emergency35.

In the light of this experience, it may be more productive to look to employment-based insurance schemes, particularly for factory workers. This will not be easy, and covers only a proportion of the (urban) poor population, but may provide the basis for larger and more diversified social insurance schemes at some point in the future.

Pre-payment or micro-insurance schemes will not be of use to the very poorest, who cannot afford to make insurance payments: this group will continue to rely on equity fund-backed exemptions. But in the long term, for the remainder of the poor and non-poor, they will provide a valuable contribution to poverty prevention, ensuring that those who have some capacity to pay can smooth their health expenditure. There should be provision for flexible contributions, with the ability to skip payments or over-pay depending on the seasonal availability of cash. Entitlement to benefits will obviously need to reflect this flexibility: it may be that while members are encouraged to pay a set sum every month, they are also allowed a limited number of months in which they do not pay; or are provided with a minimum annual total which they have to meet, so that they can overpay in some months in order to compensate for under-paying in other. Alternatively, flexibility in contributions could be clearly related to benefits, with the maximum payout determined by the total number of months in which contributions have been made, or (in order to maintain the incentive to continue contributing) the number of months in the current year in which contributions have been made. The risk-pooling function could be expanded by combining health insurance with insurance against other risks; and / or by combining insurance services with other microfinance functions (savings and loans). This involves working outside the boundaries of the health sector, and engaging with the evolution of microfinance policy and institutions.

**Savings and affordable loans**

Another possibility is to use micro-finance to help the poor meet their medical expenses. In part the problem of high medical costs is one of consumption smoothing: while the size of expenditure required for emergency health treatment is obviously the key problem, it is exacerbated by the fact that it is required at such short notice, meaning that the poor can only raise money by taking out informal sector loans at very high interest rates or selling productive assets to raise money. If there were opportunities to borrow money at an affordable interest rate and pay the

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35 Ibid.
cost of medical treatment back over an extended period then it might be possible for
the sick to pay public sector user fees or private sector health costs without the need
for drastic measures which will push them into, or deeper, into poverty.

In Cambodia as in many other countries, donor- and NGO-supported credit schemes
have often attempted to restrict the uses to which loans are made, insisting that
borrowers use the loan for productive rather than consumption purposes. This is
seen as necessary to ensure that the loan can be repaid, and the scheme sustained.
There is however a good case for providing loans which allow the borrower to meet a
short-term need for cash without selling productive assets, taking informal loans at a
punishing interest rate, or cutting back on another aspect of consumption (e.g. food
or children’s education). Credit schemes can overcome the difficulties inherent in
making consumption-related loans, but it takes careful design.

Finally, there is also an argument that a simple savings scheme may be of value in
improving the ability of the poor to access health care and absorb the cost of that
treatment. In the absence of cash savings, the poor use livestock or other assets as
savings. An instant access, interest-bearing savings account could help the poor to
regularly set aside small quantities which could provide a buffer for some health
costs.

As with micro-insurance, it is desirable that health loans or savings for health costs
are not pursued in isolation but as part of a portfolio of microfinance products
(including, at the very least, general purpose savings and loans for both productive
purposes and for other, non-food consumption purposes). This will require
consulting with actors who have considerable experience in the microfinance sector.

Deferred payments
One of the main reasons cited for preferring the private sector over the public is that
private sector providers will provide treatment on credit. As noted above, it is in large
part the lumpiness of major health payments that is problematic for Cambodians: if
they were able to spread payment over a reasonably long period then it might be
possible for them to pay without the need to resort to crisis measures such as selling
assets (e.g. land) or taking out loans. Seasonalities in household income are
unfortunately often exacerbated by seasonalities in illness, so that many people fall ill
in the season in which they have the least money available. For those who do not
qualify for exemptions, HSSP should seriously consider including in at least some of
the pilot schemes a provision for flexible or deferred payment of RH health costs.36
These groups must be required to pay some fraction (maybe 10%) of the user fee at
the point at which they are treated, but may be granted an extended period (perhaps
nine months) over which to pay it off. It may be necessary to charge interest on the
amount due (in which case it should be charged at a rate no higher than the average
for NGO credit schemes, around 2% per month), or to define a period beyond which
interest will be charged or a fixed penalty sum added.

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### Annex 1 Preliminary forms to establish patient eligibility

**A. Form to establish eligibility for equity fund support (Rural)**

<table>
<thead>
<tr>
<th>Demographic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphan and Abandoned children under 15 years of age (Child lives in a state, NGO orphanage or nutrition centre.)</td>
<td></td>
</tr>
<tr>
<td>Number of children in family under 14 years of age (5 or more)</td>
<td></td>
</tr>
<tr>
<td>Age over 60 years.</td>
<td></td>
</tr>
<tr>
<td>Disabled (war/non war disability)</td>
<td></td>
</tr>
<tr>
<td>Mine / UXO injury (old or new injury)</td>
<td></td>
</tr>
<tr>
<td>Demobilized soldier (male/female with ID card)</td>
<td></td>
</tr>
<tr>
<td>Prisoner (male, female or child)</td>
<td></td>
</tr>
<tr>
<td>Street child (peri-urban)</td>
<td></td>
</tr>
<tr>
<td>Street family (peri-urban)</td>
<td></td>
</tr>
<tr>
<td>Monk or Nun</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Land</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Landless (no chamkar nor rice land)</td>
<td></td>
</tr>
<tr>
<td>Resettlement or Settlement land (during past 5 years)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>House walls and/or roof made of plastic/ cloth</td>
<td></td>
</tr>
<tr>
<td>No electricity</td>
<td></td>
</tr>
<tr>
<td>Temporary shelter in a Buddhist Wat</td>
<td></td>
</tr>
<tr>
<td>House plot has severe seasonal flooding</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of pregnancy (5 or more)</td>
<td></td>
</tr>
<tr>
<td>Immunisation coverage child (no booster)</td>
<td></td>
</tr>
<tr>
<td>Immunisation coverage maternal (none or no booster tetanus)</td>
<td></td>
</tr>
<tr>
<td>Chronic illness (as defined: e.g. leprosy)</td>
<td></td>
</tr>
<tr>
<td>Communicable Disease (Fulminatory)</td>
<td></td>
</tr>
<tr>
<td>Mine/UXO injury (old or new injury)</td>
<td></td>
</tr>
<tr>
<td>Pregnancy:</td>
<td></td>
</tr>
<tr>
<td>Eclampsia (at any period during pregnancy and delivery)</td>
<td></td>
</tr>
<tr>
<td>Placenta praevia</td>
<td></td>
</tr>
<tr>
<td>Obstructed Delivery</td>
<td></td>
</tr>
<tr>
<td>Multiple births</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Water Sanitation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited year round access to potable water (1+ kilometre to water source)</td>
<td></td>
</tr>
<tr>
<td>No access to a family toilet</td>
<td></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>No transportation (No bicycle/motorbike/ox or horse cart/boat)</td>
<td></td>
</tr>
<tr>
<td>Distance in km to nearest Commune Health Centre (5+ kilometres)</td>
<td></td>
</tr>
<tr>
<td>Distance in km to nearest year round road (1+ kilometre)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Occupation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour on other peoples agriculture/rice land</td>
</tr>
<tr>
<td>Male Head of Household migrates to other areas for work. (Include seasonal migration)</td>
</tr>
<tr>
<td>Female Head of Household migrates to other areas for work (includes seasonal migration)</td>
</tr>
<tr>
<td>Family adults unemployed looking for work.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Finance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family adult members not eligible to apply for credit.</td>
</tr>
<tr>
<td>Family is paying back credit debt (Collateral used: land/house paper/title)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exemption Number</th>
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<tbody>
<tr>
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**Comments:**
A. Form to establish eligibility for equity fund support (Urban)

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<tr>
<td>No electricity</td>
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<tr>
<td>Temporary shelter in a Buddhist Wat</td>
</tr>
<tr>
<td>Living on Public Land (squatters: roadside, public parks, alleys, rooftop settlements etc.)</td>
</tr>
<tr>
<td>Resettlement or settlement site. (moved to area during past 5 years)</td>
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**Annex 2 Terms of Reference**

Preparation of the Cambodia HSS - Mechanisms to improve equity in access to services and protect the poor

Draft – 11 February 2002

**Background**

DFID with the World Bank, Asian Development Bank and the Government of Cambodia are preparing to implement a joint programme, The Health Sector Support Programme (HSSP). The HSSP has three main components:

- ‘Improving the provision of health services especially for low income groups’ aims at increasing the accessibility and affordability of primary health care and first referral services including the Minimum Package of activities to be delivered by health centres and the Complementary Package of Activities to be delivered by referral hospitals. In order to ensure the accessibility and affordability of both packages the following will be financed: civil works; medical equipment; development and piloting of a maintenance system; pharmaceuticals; a quality assurance programme; training and fellowships; development and piloting of innovative financing schemes; development and piloting of arrangements to protect the poor; monitoring of access and affordability of services for the poor.

- The Health Sector Reform and Improvement component aims to: (i) strengthen the MoH management responsibilities, (ii) strengthen health administration at decentralised levels, (iii) develop human resources.

- Support to technical programmes addressing public health priorities. The programmes include: TB, malaria and dengue, HIV/AIDS and STDs, nutrition and safe motherhood.

A number of activities for increasing accessibility by the poor are being considered. These include: equity funds that pay fees for identified poor patients; pre-payment arrangements, including provisions to pay premiums of low income groups from equity funds; lending money to the poor to pay the contribution to cost recovery in public health services or the cost of services rendered by private health sector. Another component planned that will contribute to protecting the poor is an exemption programme associated with the cost recovery scheme: the poor will be exempted from paying for immunizations, ante-natal and post-natal care, impregnated bed-nets and hammock-nets care and contraceptives.

Social development consultants are required to review the options for ensuring accessibility of services to the poor, and to make recommendations concerning the design and management of pro-poor schemes, including equity funds, within HSSP.

**Key tasks**

Review of work on: a) the relationship of income/poverty to access to health services and, b) the performance of equity funds, exemption schemes and other mechanisms piloted in Cambodia with a view of improving access by low income groups to health services.

Review in detail the various criteria and measures used to define and identify poor individuals and households in Cambodia. Identify the strengths and weaknesses of these measures.
Analyse the structure of Khmer village politics and assess the ways that village level political processes/community participation may exclude or protect the poor. A number of questions should be addressed:

- What existing village level social mechanisms could be developed through the HSS to alleviate the effects of catastrophic illness (including emergency obstetric and hospital-based care) on low-income households?

- What existing village level social mechanisms could be developed to improve access for poor families to primary health care?

- To what extent could these social mechanisms be applied in HSS-supported provinces throughout Cambodia?

- What similar social mechanisms, in terms of access to health care, could be developed in poor urban neighbourhoods?

Identify and assess the range of possible arrangements for managing schemes to improve access for the poor by a) community based committees; b) NGOs or c) health centre/Hospital staff, or d) a combination of these.

Make recommendations, with the economist, on the approach(es) to be supported in HSS.

**Output**
A report containing the following sections:

- Review of the strengths and weaknesses of various arrangements to increase affordability and accessibility of services to the poor that have been considered, piloted or are operating in Cambodia;
- Recommendations for the design and management of schemes to increase accessibility and affordability of services for the poor through the HSS;
- Recommendations on any further work required in planning and pre-project stages.

This report may be integrated with the report of the economist working on this issue. In any case, the consultants are expected to come up with shared recommendations on how HSS should address the access issue.

**Skills required**
Two consultants have been identified for this task:

- Andrea Crossland will carry out the in-country work, working with the World Bank economist (Howard Barnum).
- Tim Conway will provide initial briefing on HSS thinking and progress to date, and provide technical comments on the proposals developed.

**Timetable**
Ms Crossland will work for up to 15 days in Cambodia, including as part of the WB-led mission starting on 18 February. Tim Conway will provide inputs to briefing before 18 February, and review the recommendations from the work and provide comments on these.