



CAMBODIA: Health Care for the Poorest Through the „Health Equity Fund“

Institut für
Entwicklung
und Frieden



INEF

UNIVERSITÄT
**DUISBURG
ESSEN**

Offen im Denken

Ways out of extreme poverty, vulnerability
and food insecurity (AVE)

06B **GOOD
PRACTICE
SERIES**

Frank Bliss

Health Care for the Poorest Through the „Health Equity Fund“ in Cambodia

This article deals with the Cambodian Health Equity Fund (HEF), which, in a modified form since 2000, has enabled around three million people classified as extremely poor, i.e. around 20% of the country's total population, to receive free health care at various levels. The service financed by the HEF starts with the services of local health centres and extends from district and provincial hospitals (Referral Hospitals) to special treatment in the capital Phnom Penh.

The surveys carried out in 2017-2018 by the Institute for Development and Peace (INEF), University of Duisburg-Essen, within the framework of a study in a total of 28 health facilities and among numerous actors in their environment confirm the positive effects of the HEF-supported care system on poor patients. On the one hand, many people who could not afford any medical care before are now visiting the state institutions for treatment purposes. On the other hand, the services offered there have improved significantly compared to earlier years. This is also due to the fact that part of the payments from the HEF (60%) goes to the staff, whose motivation is significantly increased in this way.

In particular, mothers-to-be (e.g. free births in qualified health facilities) and women with small children benefit from comprehensive aftercare, which also includes nutrition counselling and thus addresses the problem of widespread malnutrition in Cambodia, especially among children.

One challenge remains the fact that a large part of Cambodia's population is vulnerable (including the extremely poor, this is around 55%), so that a solution must also be found for people living just above the poverty line to enable them affordable access to health services.

Cambodia, health promotion, social security, poverty reduction, food security

Project background

Before a first HEF was introduced in 2000 to provide free health care for poor population groups, Cambodia was characterised by a considerable degree of arbitrariness in the provision of medical care. According to a report by the Medicus Mundi network (Switzerland), health workers at the time received wages of only USD 10-20 per month, which of course did not cover their living costs in any way. This had the consequence that the income had to be improved „under the table“ (cf. Schenker 2000). Accordingly, the motivation of the staff and thus also the quality of the services in the state institutions often depended on the level of the „voluntary“ financial contributions of the patients. Those who were poor and could not afford this money received no or only very poor medical care.

In the first years after the introduction of the HEF, the quality of the health services paid for by the fund for the poor improved selectively. But the overall budget was low and only a few institutions were included in the system at all. Between 2008 and 2018, however, the budget and the number of



beneficiaries increased sharply, especially since medical services have been available to all people identified as poor in Cambodia since 2015/16.

Goals and activities of the HEF system at a glance



The HEF is a core component of a larger programme, the Cambodia Health Equity and Quality Improvement Project (H-EQIP), which will cost a total of USD 174.2 million over five years until 2021. The aim is to increase the efficiency of the national health system in general, with a view to providing care for poor population groups in particular (cf. World Bank 2016). At USD 94.2 million, the Cambodian state is by far the largest contributor to the programme, which also points to its strong ownership. The World Bank contributes USD 30 million and coordinates external support. German development cooperation is contributing USD 15 million to a donor package totalling USD 50 million, to which South Korea and Australia are also contributing.



This objective is to be achieved above all by increasing the number of available health centres, which at the same time are intended to improve the quality of their services. In general, the use of the centres by people with ID Poor status, i.e. people who can be supported by HEF, is to be significantly increased. This, in turn,

should ensure that significantly fewer households than before are driven into poverty by health expenditure.

As a core element of the programme, the HEF is to distribute USD 70 million over five years in reimbursing expenses for poor patients in the health centres, the state district and provincial hospitals and a specialist hospital in Phnom Penh, according to a fixed scale. The beneficiaries must first have received a status confirming their social situation and, associated with this, an identity card as part of an identification process for poor households, the „ID Poor Procedure“ (cf. Bliss / Hennecke 2018). In addition, persons in need without this ID card can also receive free services within the framework of a special admission procedure in state hospitals.



The reimbursement amounts received by the health care institutions for HEF-supported persons are low, but always at the upper limit of the tariffs set by the state institutions for self-paying patients. They are billed individually, the invoices are submitted monthly to an inspection agency in Phnom Penh, and then are approved for payment by the latter. It is important for the functioning of the system that 60% of the amounts invoiced to the HEF, and also of the income from the self-paying patients, goes to the staff of the health facilities. The remainder is mainly used for the maintenance and operation of the health centres and hospitals, thus supplementing the rather scarce basic funds that the state allocates to the facilities each year.

Country background and project integration

Today, due to considerable economic growth (above all in the textile industry) in Cambodia, only 13.5% to 17% of people are extremely poor according to national criteria, depending on the source (cf. ADB 2017 for 2014, CIA 2018 for 2012, both estimates). When multidimensional poverty criteria are used (in addition to income, e.g. access to good nutrition, health care, education), the proportion rises to more than one third. In addition, an even larger proportion is vulnerable, i.e. has less than twice what is considered the poverty line. Accordingly, about 55% of the country's population must be regarded as poor and/or vulnerable (cf. UNDP 2017).

As in the fight against poverty, Cambodia is also showing success in the area of food security. Between 2000 and 2010, the percentage of children under five years of age who were underweight fell from 38% to 28.3%, while the proportion of emaciated children fell from 16.8% to 10.9% over the same period (see UNICEF 2017). However, in all areas these trends lag behind the improvement of social indicators. According to the statements of the numerous interviewees, socio-cultural as well as historical reasons, such as the high importance of rice during the genocide of the Khmer Rouge (1975-1979), are the reasons for this gap between income development and hardly increasing nutritional quality.



The complete collapse of the health care system, which was painstakingly rebuilt after 1979, can also be traced back to the reign of terror of the Khmer Rouge. State structures were developed only very hesitantly, so that until about 2000 mainly private health services were used. These were often of doubtful quality, but were usually easier to reach than the few state offers, which

also had a bad reputation because the staff were demotivated and often could not be reached even during core working hours due to the necessary secondary jobs.



This is where the H-EQIP or its predecessor programme with its HEF financing component came in. On the one hand, it was necessary to significantly improve the accessibility of state health facilities for all sections of the population, which has been achieved and will continue to be achieved above all by expanding the network of health centres to cover the entire population. On the other hand, the quality of the health care system was to be significantly improved and confidence in the institutions strengthened.

Project impacts achieved so far

ID Poor status actually entitles the families or individuals concerned to free health services throughout the country. These include all local health centres and the state district and provincial hospitals. In addition, treatment in particularly severe cases is provided in one of the country's seven specialist hospitals in Phnom Penh. A second study carried out by the Institute for Development and Peace as part of its own research on the ID Poor identification system (Bliss/Hennecke 2018) confirmed that the treatments were indeed free of charge and that, with a few exceptions, the bribes paid as a prerequisite for medical quality and empathy towards the patients had completely disappeared.

In addition to the direct costs for the treatment of the sick or injured, the HEF also compensates for travel costs to the health facilities and accompanying persons who look after the sick can receive a daily allowance. If someone dies during treatment in a

health centre or hospital, their relatives also receive a funeral allowance. Against the background of the isolation of many rural areas and the resulting high transport costs, the HEF's contribution to the travel costs to the hospitals is particularly important. This makes it easier for many seriously ill people to choose between the tedious journey to the state health centre and hospital or to a private clinic – possibly just a quack business – which may be easier and cheaper to reach. As a result, the number of HEF-sponsored patients in district and provincial hospitals in particular has risen sharply.

Women are much more strongly represented than men in the use of services based on ID Poor status; they particularly benefit from health services within the framework of the HEF and here again from the relatively comprehensive pre- and post-natal care as well as obstetrics itself provided by the midwives of the health centres and hospitals. In some institutions, the number of births accounted for by the HEF considerably exceeds the number of self-payers.



H-EQIP and above all the HEF have significantly improved the equipment of the facilities and thus the quality of the services offered as well as the motivation of the health personnel, although there is still considerable scope for further improvements (cf. more detailed report on this good practice: Bliss 2018). Perhaps even more important, however, is the motivation of the staff, which has naturally increased due to the formula of 60% bonus direct payments from the HEF reimbursements. Even if the same applies to the bills of self-payers, the HEF has increased the amount of paying (or paid) patients to an extent that bonuses have become a relevant part of income today. In some centres they may only be symbolic amounts, with USD 5

additional income to the basic income of USD 150 per month for nurses. In some hospitals, however, these bonuses also amount to USD 50 to 100 per month, often more than a third of the state salaries.

Conditions for success and challenges

The most important prerequisite for the significant improvement of health services for extremely poor population groups is the willingness of the Cambodian government to commit itself to the nationwide implementation of the HEF and to bear most of the costs from the national budget. In this way, a national system could be created instead of the series of patchwork-like and in some cases even overlapping special programmes that were usually found elsewhere. The available reports (ADRA 2016, World Bank 2016) and the survey of key stakeholders in this study show that the performance of HEF has become increasingly effective, at least in recent years.

An important contribution to reducing poverty and improving the living conditions of poor families is the fact that people who do not have current ID Poor status can also benefit from the HEF benefits through subsequent identification in hospitals. This instrument takes into account the fact that there are many households in Cambodia that live just above the poverty line. For those affected, even relatively modest health expenditure would lead to indebtedness and, as a rule, to long-term impoverishment.



The sharp rise of poor people making use of health services in recent years is not only due to the fact that they receive free medical care, but also to the improved quality of care and the significantly improved reputation of state personnel. In this respect, the formula of

providing 60% of revenue to staff in the form of bonuses has proven to be particularly effective. In addition, these bonuses are distributed relatively equitably within a minimum of 60 points (cleaning staff) and a maximum of 100 points (director), thus substantially improving the medium and lower-end incomes of nursing staff.

A challenge to the social security system via the HEF remains, however, in view of the question of how to deal with the vulnerable households in Cambodia, which exist alongside the approximately 20% people with ID Poor status. These form a further 35% of all households, many of which are „near poor“, i.e. living just above the poverty line – and currently have to pay for medical services out of their own pockets. Should the target groups of the HEF be expanded here or would a general health insurance system, which is based on income in the medium term, be the more cost-effective solution for all in terms of contributions?



Conclusions for development cooperation in general

► Even in a country located at the lowest limit of the „middle income“ status, a social security system, as introduced nationwide by the HEF for all persons classified as poor, can be established and financed. In the special context of Cambodia with a total of up to 55% poor or vulnerable people, however, opportunities would have to be sought to expand the basis of the persons supported at least into the group of vulnerable population groups or the „near poor“.

► The accessibility of medical services for the extremely poor also includes promoting physical access to them, i.e. enabling those affected to be transported to

the nearest health facility that offers appropriate care for the case and, if necessary, to pay for this transportation. Where this is necessary, i.e. where the medical system does not provide care by way of first aid, the support of an accompanying person by the health system (in Cambodia in the form of daily or meal allowances) represents a small but important contribution to ensuring that poor people have the opportunity to benefit from health service.

► Bonus systems or money transfers to health care facilities based on performance according to fixed quality criteria can be a very good way to increase not only the technical and medical quality but also the motivation of health care personnel and thus make the system significantly more attractive for potential patients. What is important here is that the bonuses should be allocated as fairly as possible to those involved who bear the burden of the services, as is the case in Cambodia, where this takes place in a way which is transparent and overall apparently exemplary.

► A system of social security that offers pregnant women and women with new-borns from poor households comprehensive and continuous access to pre- and aftercare is a good way of positively influencing the food security of the critical first thousand days of life for children through counselling services. In any case, this institutional anchoring is more suitable than project-related nutrition counselling for mother and child, i.e. often spatially selective and almost always limited in time. It can also reduce maternal mortality and combat malnutrition.



Literature

- ADB. Asian Development Bank (2014): Cambodia. Country Poverty Analysis 2014. Manila.
- ADB. Asian Development Bank (2017): Poverty in Cambodia <https://www.adb.org/countries/cambodia/poverty> [4-2019].
- ADRA. Australian Development Research Award (2016): National coverage and health service utilization by Health Equity Fund members, 2004-2015. ADRA Report 31.
- Bliss, Frank (2018): Gesundheitsfürsorge für die Ärmsten: Der „Health Equity Fund“ (HEF) in Kambodscha. Institut für Entwicklung und Frieden (INEF), Universität Duisburg-Essen (AVE-Studie 11/2018, Wege aus extremer Armut, Vulnerabilität und Ernährungsunsicherheit).
- Bliss, Frank / Hennecke, Rosa (2018): Wer sind die Ärmsten im Dorf? Mit dem ID-Poor-Ansatz werden die Armen in Kambodscha partizipativ und transparent identifiziert. Institut für Entwicklung und Frieden (INEF), Universität Duisburg-Essen (AVE-Studie 9/2018, Wege aus extremer Armut, Vulnerabilität und Ernährungsunsicherheit).
- CIA. Central Intelligence Agency (2018): World Factbook Cambodia. Washington <http://bit.ly/1pIAsH7> [4-2019].
- KoC. Kingdom of Cambodia (2014): National Strategic Development Plan 2014-2018. Phnom Penh.
- Schenker, Margit (2000): Kambodscha: Die Bevölkerung trägt die Gesundheitskosten. *Medicus Mundi Schweiz Bulletin* 79, Dezember 2000.
- UNDP. United Nations Development Programme (2017): Human Development for Everyone. Human Development Report 2016. New York.
- UNICEF. United Nations International Children's Emergency Fund (2017): <https://www.unicef.org/cambodia/> [4-2019].
- World Bank (2016): Health Equity and Quality Improvement Project (H-EQIP). Project Appraisal Document. Report No: PAD1647. Washington.

Images

1. Specialist doctors in a provincial hospital,
2. Map of Cambodia (Source: based on project documents),
3. Well-visited patient admission in a rural health centre,
4. Aftercare includes regular weight check-up for the babies,
5. Vaccination of a new-born child in a health centre,
6. Paediatric department in a Referral Hospital,
7. One of the few specialist departments for premature babies in Siem Reap,
8. Admission of HEF patients to a Referral Hospital,
9. The Khmer-Soviet Friendship Hospital in Phnom Penh also admits HEF patients,
10. Nutritional counselling with UNICEF teaching material in a health centre,
11. Discussion with the team of a rural health centre.

All images © Frank Bliss 2016-2018.

Project characteristics*

- B4 – Processing intensity by research team
- G1-G2 – Gender identification
- P2 – Participation
- A1 – Target group identification

* For explanation see Good Practice Handbook or www.inef-reachthepoorest.de

Previously published in the Good Practice Series:

- AVE Handreichung zur Good-Practice-Reihe
- 01 Kenia: Mitunguu Smallholder Irrigation Project
- 02 Kambodscha: Das Kommunale Landtitelprogramm für indigene Bevölkerungsgruppen
- 03 Kambodscha: Schulspeisung mit lokaler Beschaffung. Das "Home-Grown School Feeding Project" des World Food Programme
- 04 Kenia: Der Selbsthilfegruppen-Ansatz in Kitui
- 05 Kambodscha: Verbesserung der Ernährungssicherung ehemals landloser und landarmer Haushalte

INEF - Research Project

The research project aims to develop recommendations for state development cooperation. The aim is to identify measures that can better reach extremely poor, food-insecure and vulnerable population groups.

We examine the interdependencies of extreme poverty, vulnerability and food insecurity in order to identify both blockages and success factors for development cooperation.

Based on literature analyses and surveys of professional organisations at home and abroad, successfully practised approaches ("good practices") are to be identified and intensively analysed within the framework of field research. In addition to a socio-cultural contextualisation, the gender dimension is consistently

taken into account throughout. The local investigations focus on the participation of the affected population in order to capture their perception of the problems and ideas for solutions..

We initially conduct our research in Ethiopia, Benin, Kenya and Cambodia.

The project is funded by the German Federal Ministry for Economic Cooperation and Development (BMZ) under the special initiative "One World – No Hunger".

Authors of the series

Prof. Dr. Frank Bliss
Prof. Dr. sc. pol. Tobias Debiel
Dr. rer. pol. Karin Gaesing
Jana Herold, M.A.
Anika Mahla, M.A.

Editor

Institut für Entwicklung und Frieden (INEF)
Universität Duisburg-Essen

Layout

cMore.MEDIA
Lucy Yang

© Institut für Entwicklung und Frieden 2019

Lotharstr. 53 – D-47057 Duisburg
Tel: +49 203 379-4420 – Fax: +49 203 379-4425
inef-sek@inef.uni-due.de
www.inef-reachthepoorest.de
www.inef.uni-due.de
ISSN: 2512-4552