HEALTH EQUITY AND FINANCIAL PROTECTION IN ASIA

POLICY BRIEF

HARNESSING INCENTIVES TO IMPROVE ACCESS AND FINANCIAL PROTECTION IN CAMBODIA

Cambodia has adopted a number of innovative healthcare financing arrangements in recent years that use incentives to encourage the provision and utilisation of essential health services. This policy brief summarises knowledge emerging from the HEFPA project on the impact of three financing schemes and highlights the significance of the evidence for health policy in Cambodia and elsewhere.

Q HOW CAN USER FEE EXEMPTIONS FOR THE POOR BE MADE MORE EFFECTIVE THROUGH COMPENSATION OF PROVIDERS?

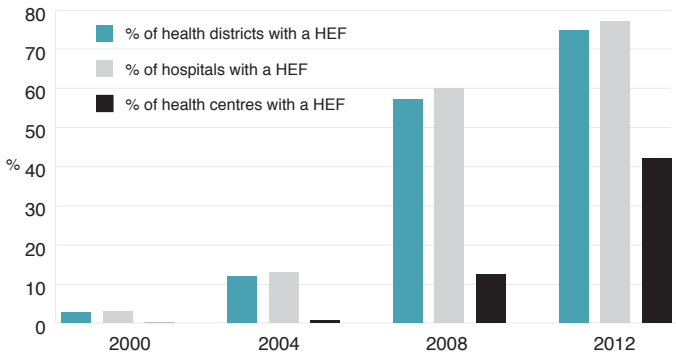
Scheme design: Cambodia has pioneered the use of Health Equity Funds (HEFs) to compensate public health facilities for user fee exemptions granted to eligible poor patients and subsidise hospitalisation-related transportation and food costs. They are mainly funded by donors but the government contribution is increasing. Management is entrusted to a third party, usually a national NGO. By 2012, HEFs were up and running in 48 (out of 79) health districts and in a further 12 districts the Ministry of Health operated a subsidy scheme that was largely similar, only without third party management and featuring a more restricted benefit package. Nearly half of the HEF schemes cover hospital services exclusively, while the others also cover care delivered at health centres.

HEFPA findings: A HEFPA study has revealed that HEFs reduce out-of-pocket (OOP) health spending by 35 per cent on average among households that make any payment.[1] The impact is larger for poorer households and for those mainly using public healthcare. While the effect is smaller and less significant for non-poor households, its extension to this group is consistent with the impact resulting not only from the direct subsidy to the poor, but also from a substantial contribution to the revenue of public facilities that improves the care on offer and attracts non-HEF beneficiaries.

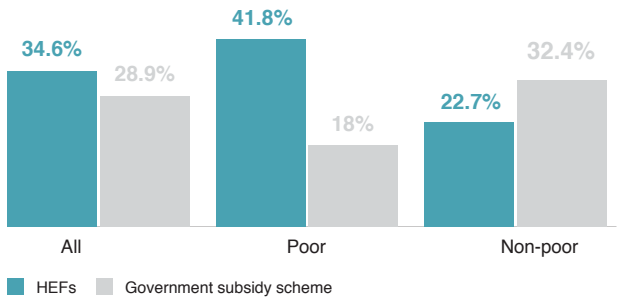
The government subsidy scheme also reduces OOP payments but the effect is less pronounced for the poor. By reducing payments for healthcare, both HEFs and the government scheme enable households to increase consumption of non-medical goods and services, but neither has any significant impact on health-related debt. HEFs reduce the probability of seeking care primarily in the private sector, but there is no significant effect on the use of public care, although this conclusion may reflect limitations of the data.

A prospective study that collected detailed utilisation data in two rural health districts shows that the introduction of HEFs to compensate health centres for user fee exemptions granted to poor patients had no significant impact on outpatient consultations at these facilities, and neither did it affect the propensity to opt for private providers or self-medication as a first choice of treatment.[2] Moreover, there was no significant effect on related OOP payments. The lack of effect may be attributable to the fact that consultation fees at health centres are very low. Perceived low quality of care offered and distance may discourage utilisation more than user fees.

COVERAGE OF HEALTH EQUITY FUNDS: 2000-2012



REDUCTION IN OOP EXPENDITURE DUE TO HEALTH EQUITY FUNDS/GOVERNMENT SUBSIDY SCHEMES



Q WHAT IS THE IMPACT OF INCENTIVES FOR REPRODUCTIVE HEALTHCARE?

Indicators of maternal and child health have improved dramatically in the last decade. While the causes are likely to be multiple, HEFPA findings indicate that a twin-pronged attack using both demand and supply side incentives may have contributed.

VOUCHERS FOR MATERNAL HEALTHCARE

Scheme design: Reproductive health vouchers are 100 per cent subsidies of maternal health services issued by a management agency – usually an NGO – to eligible pregnant women along with related information. Benefit packages vary, but all include safe motherhood services at health centres (antenatal care, delivery and postnatal care). Some also include family planning and safe abortion services. Some target poor women, but most do not. The provider uses the voucher to prove delivery of care and is compensated accordingly. Voucher schemes are fully funded by donors and had been implemented in 27 health districts by 2012.

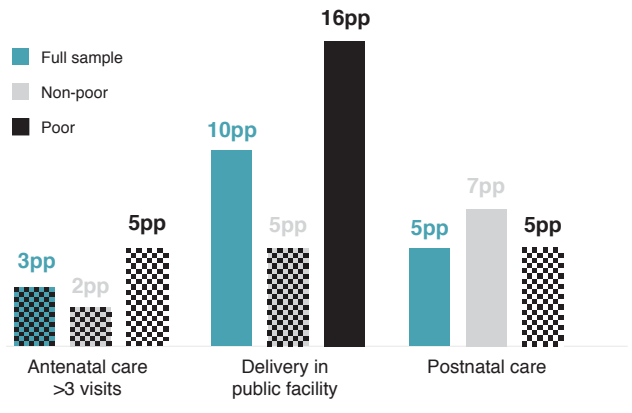
HEFPA findings: Analysis of the 2010 Cambodia Demographic and Health Survey data showed that vouchers increase the probability of delivery in a public health facility, mainly health centres, by 10 percentage points for all women and 16 percentage points for the poorest women.[3] The increase was mainly due to a shift from home delivery by traditional birth attendants. The effect of universal voucher schemes was found to be larger than that of those targeting poor women. Targeting seems unnecessary since poor women are more responsive to incentives to deliver in public facilities in any case. There is a positive effect of vouchers on postnatal care of non-poor women and universal vouchers have been shown to increase use of antenatal care, but only for poor women.

INCENTIVES FOR MIDWIVES

Scheme design: The Government Midwifery Incentive Scheme (GMIS) aims to boost institutional deliveries – and ultimately reduce maternal mortality – by offering cash incentives to midwives and other trained health personnel for deliveries attended in public health facilities; US $15 for a live birth in health centres and $10 in referral hospitals. Unlike HEFs and vouchers, GMIS was designed, funded and implemented nationwide in late 2007 by the Cambodian Government.

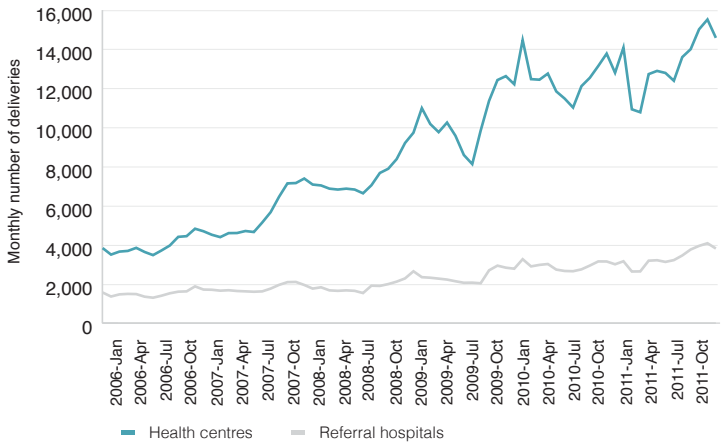
HEFPA findings: Deliveries in public facilities expressed as a percentage of expected births tripled from 19 per cent in 2006 just before GMIS started to 57 per cent in 2011. The increase was yet more pronounced for health centres. While the simultaneous nationwide launch of the scheme precludes the opportunity for a treatment-control comparison, detailed analysis of the trend suggests that GMIS may have boosted facility deliveries by 18 per cent during the first month of operation and by 15 per cent after 12 months.[4] Qualitative analysis also suggests that the introduction of GMIS together with other interventions to remove supply and demand barriers to essential maternal health services has led to considerable improvements in public health facilities and a steep increase in facility deliveries. However, several operational issues still need to be dealt with, including late and incomplete financial incentive disbursements and the absence of an effective monitoring system.

EFFECTS OF VOUCHER SCHEMES ON USE OF SAFE MOTHERHOOD SERVICES (IN PERCENTAGE POINTS)



Solid fields indicate statistically significant effects.
Poor = 40% poorest households based upon a wealth index

MONTHLY NUMBER OF DELIVERIES IN PUBLIC HEALTH FACILITIES: JANUARY 2006 – DECEMBER 2011



HOW THE FINDINGS WERE OBTAINED

Evidence on the impact of the three health financing interventions was obtained from the four HEFPA studies as follows:

(i) Data from the Cambodian Socio-Economic Survey (2004-2009) were analysed to identify the impact of HEFs on healthcare utilisation and out-of-pocket payments using a difference-in-differences (DID) strategy that compares changes in districts that acquired a HEF with those in districts that did not[1];

(ii) A prospective quasi-experimental (controlled before-and-after) study in two rural health districts, namely Sampov Luon (intervention area) and Thmar Koul (control area), was used to assess the impact of the HEF extension to health centres[2];

(iii) Analysis of the 2010 Cambodia Demographic and Health Survey covering births in the period 2005-2010 identified the impact of reproductive health vouchers on the use of safe motherhood services through a DID strategy comparing a) changes in districts in which vouchers were implemented, with b) those in districts that remained without vouchers[3];

(iv) The effect of GMIS was assessed by interrupted time series analysis of administrative data on deliveries between 2006 and 2011, supplemented with insights gleaned from in-depth interviews of key informants and focus group discussions[4].

Q WHAT LESSONS CAN BE DRAWN FOR POLICY?

Up to now, there has been belief but little or no proof that HEFs, vouchers and midwife incentives improve access to public healthcare in Cambodia. The HEFPA study confirms that vouchers do indeed increase utilisation of safe motherhood services. Giving women free access to maternal healthcare and ensuring that the facilities have the financial incentive to honour this entitlement serves to substantially raise institutional deliveries. Simultaneous nationwide roll-out of the midwifery incentives scheme makes it more difficult to establish its effect with the same degree of confidence; nevertheless, the circumstantial statistical evidence is consistent with a strong impact on deliveries in facilities and by trained health personnel. Furthermore, the demand and supply of reproductive healthcare does seem responsive to cash incentives.

The substantial reduction in OOP payments brought about by HEFs demonstrates that relieving providers from the responsibility to adjudicate entitlement to fee waivers and compensating them for lost user fee revenue can make nominal exemptions from user fees effective. But the lack of evidence of an effect on healthcare use suggests that fees are not necessarily the main barrier to utilisation of public facilities, in particular of health centres where fees are modest. In Cambodia, as in several other low-income countries, the private sector is preferred by the majority of the population, including the poor, for ambulatory curative care. This presumably reflects the inconvenience, unreliability or perceived low quality of the outpatient care offered by the public sector. Rather than designing elaborate schemes to exempt the poor from modest user fees, an alternative and arguably more appropriate policy response is either to correct the deficiencies in the public services, or engage the private sector in the provision of (partly) publicly financed care.

Contributing to the ongoing global debate on 'user fees or not', the HEF and voucher experiences in Cambodia suggest more feasible and effective alternatives to across-the-board user fee removal. Targeting the limited public or international resources to priority groups (the poor, women), the barriers they face (user charges but also transport, information, and accessibility) and priority services (hospital care, institutionalised delivery) may be the right strategy when budget constraints are tight. The feasibility of identifying the poorest is a constraint, but the evidence from the comparison of universal and targeted voucher schemes indicates that this is not necessary for all types of care.

Cambodia continues to be a pioneer in adopting innovative healthcare financing strategies tailored to low-resource settings. Its experience suggests that health financing has a key role in improving the performance of public health systems in this context. Consistent with the evidence emerging on the effectiveness of results-based financing, the HEFPA findings demonstrate that both patients and healthcare professionals respond to incentives. In line with evidence from elsewhere, the voucher and GMIS schemes suggest that financial incentives work particularly well for maternal health – for which procedures, and so prices, can be precisely defined.

In a resource-poor setting like Cambodia, where the health system is relatively weak, a package of interventions is probably the most pragmatic approach to follow in order to supply essential health services and remove barriers to access, including financial ones.

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PROJECT IDENTITY

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- **World Bank Development Research Group** http://econ.worldbank.org/

FURTHER INFORMATION

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