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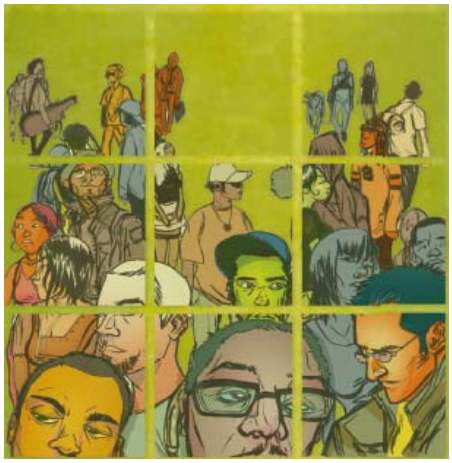
World Health Report (2010)
Background Paper, 42

HEALTH SYSTEMS FINANCING
The path to universal coverage

World Health Organization



A role for user charges? Thoughts from health financing reforms in Cambodia

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Introduction

There has been considerable debate recently about whether health services need to be free at the point of service to ensure equitable access. Cambodia is a low-income country where provision of and access to health services remain problematic despite substantial increase in government health expenditures in the past decade (1). User charges have been introduced in the public health sector since 1996 as part of overall health financing reforms to improve access to health services for the population, especially for the poor. We examine here how Cambodia has reformed its health financing system to ensure access without removing user fees (UF). The Cambodian experience suggests that, in resource-poor settings, carefully designed UF systems may positively benefit health service delivery, while negative effects of these systems on access of populations can be mitigated by viable alternatives such as targeted subsidies.

Rationale for introducing user charges

Until 1996, public health services were “free for all”. The low level of state funding and salaries of staff became major constraints to effective implementation of this policy. To earn a living, health personnel had to find alternative incomes, including private practices and/or charging informal fees in public facilities. Amounts of informal fees could be substantial and often had to be paid upfront even in emergency situations. It was estimated that about 45% of the facility revenues came from under-the-table payments (2). This practice obviously benefited individual staff, but not the health facilities nor the health system and was harmful to patients. Moreover, a growing number of NGOs supporting health service delivery throughout the country initiated unregulated financial participation schemes.

In 1996, the National Charter on Health Financing (3) was adopted. The Charter officially allowed implementation of user charges and financial participation schemes at facility level, thereby providing a legal framework to ensure minimum standards and pre-requisites, in a context where formal or informal fees were already charged in an unregulated manner. Since then, formal user fees have been gradually initiated in all

public health facilities throughout the country. In 2008, almost 100% of government health facilities had implemented UF schemes (1).

A few provisions in the Charter allow, at least in theory, oversight and ownership of UF schemes:

- At Community level: the Charter prescribes that UF should be established by Health Center Management Committees (HCMC), in which community participation should be ensured. The HCMC has the responsibility to set the UF at a level “affordable for the community” and which vary depending on the local context. This provision introduced a relative ownership of the community in the management and financing of their local health centers.

- At central level: schemes need to be submitted to MOH for approval. The allocation of UF revenues is established by government decree: 99% of income is kept at facility and spent for staff incentive (60%) and operational costs (39%). A 1% tax is levied by national treasury. The MOH is tasked to monitor income and expenditure from UF.

- At facility level: although basic salaries have increased, they remain below living wages and the incentive from UF is an important addition. Availability of immediate cash for recurrent cost is also an important improvement in health center and hospital management. Reports from the field indicate that these funds effectively supplement government budget, can be used in a more flexible and independent fashion by facility managers and increase their sense of responsibility.

In addition to the above provisions, the Charter also emphasized the necessity of granting exemptions to poor patients. Community participation in implementation and monitoring of the schemes was seen as a safeguard for effective implementation of the exemption system although no subsidies were clearly identified.

Finally, it is essential to put the Charter in the context of a larger set of reforms initiated in the late 1990's and early 2000. While the Health Coverage Plan established the distribution of infrastructure and staff, budget and administrative reforms aimed at addressing the constraints of state budget for health as the first and main source of funding for public health facilities. To date, hospitals and health centers heavily rely on their national budget allocation and there is a commitment from the government to sustain and even increase tax-funded support to health service delivery. As UF are not set at cost-recovery level, they are not intended to replace government funding for health.

Available evidence on the impact of user fees and exemptions

Revenues from UF totalled only US$ 6.9 million in 2008 and represented a per capita annual expenditure of US$ 0.52 (1). Despite their small share in the total health sector funding, UF have proven successful in achieving some of their intended objectives, especially at primary health care level.

An early assessment of the impact of UF in 2001 (4) shows that activity levels substantially increased as a result of improved staff attendance, better maintenance and supplies and improved management practices. The same assessment concludes that UF schemes also improved transparency in most facilities due to the necessity of accounting for the new cash income, while decreasing or eliminating unofficial payments in most rural areas. At health center level, the "low official fee levels, the readily accessible exemption schemes and the virtual elimination of unofficial fees" even contributed to increase access for the poor (4). Barber et al (2) confirm these findings and show that the introduction of UF controlled unpredictability of hospital fees, increased utilization of essential services and decreased hospital dependence on donor support. Akashi et al (5) report similar results at the National Maternal and Child Health Center in Phnom Penh. Wilkinson et al (4) however insist that the positive effect of UF is better observed at primary health care level compared to secondary and tertiary care. The necessity of keeping charges affordable for communities is not easily translated in fee schedules for more complex care. Community participation in facility management is also more theoretical for secondary and tertiary levels of care. Proximity of staff with the population

at health center allows more casual access to exemption schemes for poor patients, while a more formal screening process is necessary for hospital admissions. Other publications confirm that UF may have a potential risk of negative effect on access to care for more vulnerable populations in Cambodia (6,7). The same sources however orient policy makers towards more effective implementation of exemption arrangements within the context of the Health Financing Charter. Indeed, there is a general agreement that removal of UF in Cambodia may jeopardize the fragile balance of local health systems created by the Charter reform, but there is also concerns that exemption systems without proper subsidies are not effective. Cambodian policy makers therefore see a viable alternative in targeted subsidies for the poor channeled through Health Equity Funds (HEFs). The main purpose of HEFs is to reimburse facilities for services provided to poor patients. They also reimburse transport cost and provide food allowances for caretakers, and therefore address other major financial barriers to accessing health care (8). These barriers cannot be removed by the abolition of user charges. After an initial pilot stage, HEF have become the major pro-poor approach in health financing in Cambodia and the MOH has set an of objective national roll-out of these schemes by 2012. They are currently covering 65% of their target population (1). They demonstrate success in increasing access and utilization of underserved poor populations (6, 7,8).

Discussion and conclusions

In their comparison of removal of UF in Uganda and targeted subsidies in Cambodia, Meessen et al (7) stress that a pro-poor health financing policy is much more than a technical issue and should be put in the perspective of overall political and economic context. In Cambodia, user charges are supported by a strong budgetary and institutional government commitment, as demonstrated by the complete set of reforms initiated in the 90's and complemented by more recent provisions with regard internal contracting. However, there is a need to complete implementation of this set of reforms. User charges introduced a certain degree of output-based financing in a system which was mainly relying on inputs unrelated to performance (7). Health Equity Funds used this opportunity to introduce more effective purchasing of services for the poor (8). Consistently, a more

efficient allocation and use of current tax-funded health budget should be possible through programme based-budgeting and results-based financing arrangements. More recent reforms in the context of decentralization introduced internal contracting within the public administration and should be effectively used as an avenue to channel both domestic and donor funding with the essential objective of performance and equity in health service delivery. In this context, UF can play an important role in the overall health financing system without deterring access. Their negative impact on access to health services for the poor can be mitigated by targeted subsidies.

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