Barriers to access and the purchasing function of health equity funds: lessons from Cambodia

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Problem High out-of-pocket payments and user fees with unfunded exemptions limit access to health services for the poor. Health equity funds (HEF) emerged in Cambodia as a strategic purchasing mechanism used to fund exemptions and reduce the burden of health-care costs on people on very low incomes. Their impact on access to health services must be carefully examined.
Approach Evidence from the field is examined to define barriers to access, analyse the role played by HEF and identify how HEF address these barriers.
Local setting Two-thirds of total health expenditure consists of patients' out-of-pocket spending at the time of care, mainly for self-medication and private services. While the private sector attracts most out-of-pocket spending, user fees remain a barrier to access to public services for people on very low incomes.
Relevant changes HEF brought new patients to public facilities, satisfying some unmet health-care needs. There was no perceived stigma for HEF patients but many of them still had to borrow money to access health care.
Lessons learned HEF are a purchasing mechanism in the Cambodian health-care system. They exercise four essential roles: financing, community support, quality assurance and policy dialogue. These roles respond to the main barriers to access to health services. The impact is greatest where a third-party arrangement is in place. A strong and supportive policy environment is needed for the HEF to exercise their active purchasing role fully.

Une traduction en français de ce résumé figure à la fin de l'article. *Al final del artículo se facilita una traducción al español.* الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Introduction

The Cambodian public health-care system is financed through a national budget, donor funding and user fees. However, two-thirds of total health expenditure consists of patients' out-of-pocket spending at the time of care, mainly for self-medication and private services. Van Damme et al.[1] found that the proportion of health expenditure in the private sector may be considerably higher than in the public sector. Private sector attracts most out-of-pocket spending – due to a lack of trust in public services and poor quality resulting from low public funding – but user fees remain a barrier to access to public services for the poor. The right to implement user fees at government facilities was approved by the 1996 National Health Financing Charter. While implementation of official user fees helped to control under-the-table payments,[2,3] it also deterred poor patients from seeking care.[3] The approved user-fee exemption system has been inadequate in the absence of appropriate subsidies.[3,4]

Pro-poor purchasing

To fund exemptions and address the problem of access for the poor, decentralized health equity funds (HEFs) emerged in 2000 as third-party payers for impoverished patients in which a fund is managed at district level by a local agent. Identified poor patients receive reimbursement for transport and food costs and free care at government health facilities. Facilities are reimbursed monthly by the HEF scheme for foregone user fees.

The functional framework developed by *The world health report 2000* identifies four main health financing roles – revenue collection, pooling, purchasing of services and provision of health care.[5] The Report defines purchasing as "a process by which pooled funds are paid to providers to deliver a specified or unspecified set of interventions". According to this functional framework, HEFs can be identified as a purchasing mechanism, as illustrated in Fig. 1. Early pilots of HEFs already emphasize their "potential to represent the poor for whom [they] purchase health care".[6] In practice, HEF schemes use subsidies pooled at district level to purchase public health services for the poor. Today, these subsidies come from both donor and government funds.

We examine here the mechanisms by which HEFs exercise their purchasing function and look at the benefits and outcomes in terms of increased access for the poor. We first identify the determinants of access that need to be addressed by a purchasing mechanism such as an HEF. Then we define the essential roles of an HEF scheme and how these roles contribute to overcoming access barriers for the poor. Our analysis uses data from our own study of HEF beneficiaries and fee-paying patients, combined with key informant interviews, in one urban and one rural location.[7,8] We also use evidence from the field provided by earlier studies. Lessons learned are summarized in Box 1.

Barriers to health services

Table 1 codifies the main barriers to access to services for the poor in five main categories. This builds on previous work

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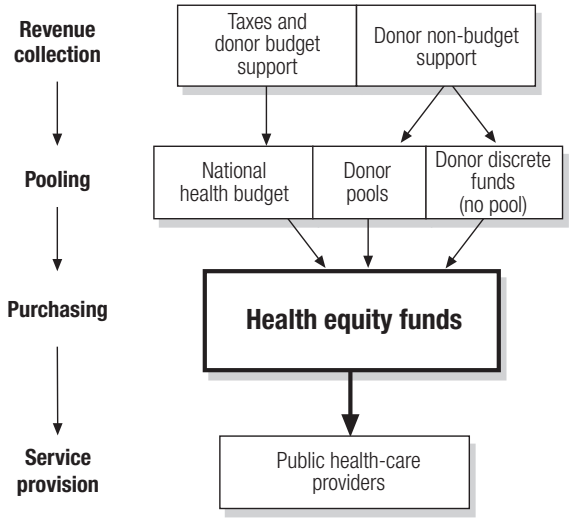
and findings from the first phase of our study.[7] Hardeman et al.[6] define four major constraints to equitable access: financial, geographical, informational and intra-household. Likewise, Jacobs & Price.[9] refer to information paucity and lack of community engagement as major barriers. For the purpose of our analysis, we retain five main categories of barriers to access, as illustrated in Table 1 and summarized as follows:

i) physical barriers including distance but also means of transport, restricted opening hours at facility and possibility of encountering long waiting times;
ii) financial barriers including direct and indirect financial costs, informal charges and the opportunity costs of seeking health care;
iii) quality of care, which may be subjective and related to patients' expectations but includes also objective conditions such as clinical skills of staff, availability of drugs and equipment and the functioning of the referral system;
iv) knowledge of users, which represents an access barrier when there is lack of information on available services, lack of confidence in facilities and staff and lack of community participation mechanisms;
v) sociocultural barriers including constraints related to gender or age, beliefs and cultural preference (e.g. for home care).

Addressing access barriers

The HEFs have successfully met their objectives by raising utilization of public sector services and increasing access by the poor.[7,8] Several studies in rural and urban settings have demonstrated the positive impact of HEFs on financial access to health services.[6,9,10] The *Strategic framework for equity funds*,[11] a policy paper published by the Cambodian Ministry of Health in 2003, defines the role of HEFs as financing, community engagement, quality assurance and policy dialogue.

Fig. 1. **Health equity funds as a purchasing mechanism in the Cambodian health sector**[a]



[a] HEFs receive funding from bilateral or multilateral donors as well as government budget. They are used to purchase health services for the poor at public facilities. Some also reimburse transport, food and funeral costs.

We looked at the *financing role*. The second phase of our study showed that, depending on the type and location of the facility, up to 28% of HEF-funded patients now using health facilities did not attend public facilities before having an HEF card and that the majority cited financial constraints as the reason. Using a different methodology, this confirms findings by Noirhomme et al.[10] and other studies.[6,9,12] These data confirm that the financing role of HEFs addresses the unmet health-care needs of poor families. Jacobs et al.[12] showed that HEF coverage of transport and user fee costs did not guarantee free care and that patients still incurred debt, presumably to shoulder indirect costs. Our findings showed that, while HEFs do not provide total financial protection, they may increase the opportunity for discretionary use of money. Among our study population, up to 36% of HEF patients in the rural area still borrowed money for the current episode of care, in addition to older debt. In the urban area, borrowing for the current visit was much less among HEF beneficiaries (4%) than among non-beneficiaries (17%).

Reduced levels of adverse debt and greater awareness of financing arrangements appear to be improved where HEF agents have an active presence in the community, engage beneficiaries in poverty identification and provide strong HEF management. Participants in focus group discussions in our study identified the main source of community information, awareness and empowerment as the HEF agent, with a stronger impact when the agent employed community liaison officers. This reflects the *community role* of the HEF.

Regarding the *quality assurance role*, we observed that there was no perceived difference in treatment received by HEF and non-HEF patients. Our study confirmed that HEF patients did not face stigma, were rarely charged unofficial fees (thanks to procedures put in place by HEF schemes) and that HEFs helped to improve overall quality of care. Noirhomme et al.[10] confirmed that contracting arrangements adopted by HEF schemes ensure accountability of health-care providers and set quality standards.

HEFs have played a positive role in building partnerships between the public sector, civil society and nongovernmental organizations. We refer to this as the *policy dialogue role*. Stakeholders in Cambodia recognize the success of HEFs in: (i) innovation through initial pilot schemes; (ii) provision of

Box 1. **Lessons learned**

Health equity funds contribute to reducing inequity, increasing access for the poor and building a system of social protection, more so when their purchasing function is fully and effectively managed. Their impact is optimized when a third-party arrangement involved a community-mandated organization active both at facility and community level that engaged in policy dialogue. Local government authorities could also be effective fund holders if their capacity to exercise effective purchasing were developed.

Table 1. **Ability of health equity funds to address access barriers**

Access barriers	Addressed	HEF roles			
		Financing	Community	Quality assurance	Policy
Physical					
Distance	No				
Means of transport	Partly	Yes – transport costs			
Waiting time	Yes			Yes – control at facility	
Financial					
Direct and indirect formal costs	Yes	Yes – user fees, transport and food			Yes
Informal charges	Yes	Yes – user fees, transport and food		Yes – control at facility	
Opportunity costs	No				
Quality of care					
Perceived quality	Yes			Yes – control at facility	Yes to all, especially dialogue for a regulatory and monitoring framework
Uneven clinical skills	No				
Staff attitudes	Yes			Yes – control at facility	
Maintenance of facilities	Yes	Yes – income for facility			
Equipment and material	Partly	Idem – not valid for capital investment			
Drug availability	Partly	Idem – local purchase only			
Regulatory mechanisms	Partly				
Public–private dual practice	Partly				
Knowledge of users					
Confidence in public facilities	Yes		Yes to all, active presence in the community, pre-identification		Yes, policy dialogue at community level
Information on available services	Yes				
Knowledge of user fees and other schemes	Yes				
Uncertainty about informal charges	Yes				
Understanding of community participation mechanisms	Yes				
Sociocultural barriers					
Intra-household constraints such as age or gender	Long-term impact		Yes to all. Active presence in the community, post-identification, community participation in pre-identification		Yes, policy dialogue at community level
Preference for home care	Long-term impact				
Preference for traditional healers	Long-term impact				
Seasonal ability to pay	Partly				

HEF, health equity funds.

evidence; and (iii) knowledge brokering to attract attention of policy-makers on poverty and equity in access to health services (Ir & Bigdeli, unpublished observations, 2007).

Table 1 indicates the degree to which HEF roles have addressed the identified access barriers, either fully, partially, not at all or only in the longer term. The financial barriers are addressed almost immediately (except for opportunity costs) through reimbursement of user fees, transport and food. Sociocultural barriers may be affected only in the longer term after several years of implementation with the further development of trust in public services and community networks. By providing additional facility revenues and establishing formal contractual arrangements, HEFs have addressed those quality-of-care issues that can be affected by demand-side initiatives; they also have improved patient information and knowledge by active presence in and ongoing dialogue with the community. In these ways the HEFs have

reached their objectives as a pro-poor purchasing mechanism.

The policy challenge

HEFs contribute to reducing inequity, increasing access for the poor and building a system of social protection, more so when their purchasing function is fully and effectively managed. Their impact is optimized when a third-party arrangement involved a community-mandated organization active both at facility and community level and engaging in policy dialogue. The third party role has been exercised by independent nongovernmental organizations, local HEF committees or local social institutions such as Buddhist or other faith-based organizations.[9] Local government authorities could also be effective HEF fund holders if their capacity to exercise effective purchasing is developed.

HEF coverage now includes more than half of all health districts in Cambodia. However, their financing role remains the one predominantly recognized by policy-makers. Many stakeholders within and outside the government advocate for a larger HEF mandate with the objective of promoting equity in access to improved quality of care (Ir & Bigdeli, unpublished observations, 2007). They call for a strong and supportive policy framework where the roles of HEF are recognized and used within an effective and equitable social health protection system.

The experience with HEFs introduces an additional element to the functional analysis in *The world health report 2000*. HEFs highlight the need for targeted and subsidized access to health services for the poor. While the report includes within its framework the need to cross-subsidize the poor within risk-pooling arrangements, it gives less attention to the need for direct subsidies where the poor are excluded from the risk pool. Cambodia's HEFs provide a good example of how this might be achieved, with direct benefit to poor and vulnerable populations. ■

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Résumé

Obstacles à l'accès aux services médicaux et fonction d'achat des fonds de financement de la santé : enseignements provenant du Cambodge

Problématique Le montant élevé des dépenses et des participations financières à la charge des usagers et l'absence de financement des exemptions pour ces dépenses limitent l'accès aux services de santé pour la population pauvre. Des Fonds de financement de la santé (Health Equity Fonds, HEF) sont apparus au Cambodge en tant que mécanismes stratégiques d'achat servant à financer ces exemptions et à réduire la charge liée aux soins médicaux pour les personnes à très faibles revenus. Leur impact sur l'accès aux services de santé doit être examiné de manière approfondie.

Démarche Les éléments provenant du terrain sont examinés pour identifier les obstacles à l'accès aux services, analyser le rôle joué par les fonds HEF et déterminer comment ils aplanissent ces obstacles.

Contexte local Deux tiers des dépenses de santé totales correspondent à des débours à la charge des patients au moment des soins, résultant principalement de l'automédication et du recours aux services de santé privés. Si le secteur privé est à l'origine de la plupart des dépenses de santé à la charge des patients, les participations financières à la charge des usagers restent un obstacle à l'accès aux services publics pour les personnes très pauvres.

Modifications pertinentes Les fonds HEF ont amené de nouveaux patients dans les établissements de santé publics, répondant ainsi à une partie des besoins en soins médicaux insatisfaits. On n'a observé aucune stigmatisation à l'égard des patients soignés grâce aux fonds HEF, mais nombre d'entre eux ont dû encore emprunter de l'argent pour accéder aux soins.

Enseignements tirés Les fonds HEF constituent un mécanisme d'achat dans le cadre du système de santé cambodgien. Ces fonds exercent quatre rôles essentiels : financement, soutien aux communautés, assurance de la qualité et dialogue politique. Ces rôles répondent aux principaux obstacles à l'accès aux services de santé. L'impact des fonds est maximal lorsqu'un dispositif impliquant une tierce partie est en place. Pour que les HEF exercent pleinement et activement leur fonction de mécanisme d'acquisition, un environnement politique solide et favorable est nécessaire.

Resumen

Barreras al acceso y función de compra de los fondos de inversión en acciones para la salud: enseñanzas de Camboya

Problema La elevada cuantía de los pagos directos y los honorarios pagados por los usuarios y las exenciones de cobertura limitan el acceso de los pobres a los servicios de salud. Los fondos de inversión en acciones para la salud (FIAS) surgieron en Camboya como un mecanismo de compra estratégico utilizado para financiar esos pagos no reembolsados y reducir el gasto sanitario que deben costear las personas con ingresos muy bajos. Es necesario estudiar detenidamente el efecto de esos instrumentos en el acceso a los servicios de salud.

Enfoque Se analizan los datos obtenidos sobre el terreno para describir las barreras al acceso, analizar la función desempeñada por los FIAS y determinar cómo abordan éstos dichas barreras.

Contexto local Las dos terceras partes del gasto sanitario total corresponden a pagos directos realizados por los pacientes en el momento de recibir atención, principalmente cuando se automedican o acuden a la medicina privada. Si bien el sector privado absorbe la mayor parte de los pagos directos, los honorarios cobrados a los usuarios siguen obstaculizando también el acceso a los servicios públicos por parte de las personas con muy bajos ingresos.

Cambios destacables Los FIAS favorecieron la llegada de nuevos pacientes a los centros públicos y permitieron así cubrir

algunas necesidades sanitarias que no estaban atendidas. No se observaron problemas de estigmatización de los pacientes beneficiados por los FIAS, pero muchos de ellos aún tuvieron que pedir dinero prestado para acceder a la atención de salud.

Enseñanzas extraídas Los FIAS son un mecanismo de compra empleado por el sistema de atención de salud de Camboya que cumple cuatro funciones esenciales: financiación, apoyo comunitario, garantía de la calidad y diálogo normativo. Dichas funciones corresponden a las barreras principales al acceso a los servicios de salud. El impacto logrado es máximo cuando entra en juego un acuerdo con terceros. Se requiere un entorno normativo sólido y propicio para que los FIAS revelen todo su potencial como instrumento activo de adquisición.

ملخص

الحواجز أمام الإتاحة ومهمة شراء الخدمات من صناديق العدالة الصحية: دروس من كمبوديا

المشكلة: إن ارتفاع المدفوعات والأجور من جيوب الناس والمستفيدين مع وجود إعفاءات غير ممولَّة تحد من إتاحة الخدمات الصحية للفقراء. وقد ظهرت صناديق العدالة الصحية في كمبوديا لتكون آلية شراء استراتيجية تستخدم لتمويل الإعفاءات ولخفض عبء تكاليف الرعاية الصحية على ذوي الدخل المنخفض جداً. وينبغي دراسة تأثيرها على إتاحة الخدمات الصحية دراسة متأنية.

الأسلوب: تمت دراسة البيِّنات المستمدَّة من الميدان للتعرُّف على الحواجز أمام إتاحة الخدمات مع إجراء تحليل لدور صندوق العدالة الصحية وكيفية تصديه لهذه الحواجز.

الموقع المحلي: إن ثلثي مجمل النفقات الصحية تعود إلى المصروفات المدفوعة من جيوب الناس وقت الرعاية، وهي توجَّه بشكل عام إلى الشراء الذاتي للأدوية أو إلى الخدمات المقدمة في القطاع الخاص. ورغم أن القطاع الخاص يجتذب معظم المصروفات المدفوعة من جيوب الناس إلا أن الأجور التي يدفعها المرضى تبقى حاجزاً أمام الحصول على خدمات القطاع العام من قِبَل الأشخاص ذوي الدخل المنخفض جداً.

التغيرات ذات الصلة: لقد جذب صندوق العدالة الصحية مرضى جداً إلى مرافق القطاع العام، مما أدَّى إلى تلبية بعض الاحتياجات في الرعاية الصحية التي لم تكن تلبَّى من قبل. ولا يشعر المرضى المستفيدون من صندوق العدالة الصحية بأي وصمة، إلا أن الكثير منهم لايزال يقترض المال للحصول على الرعاية الصحية.

الدروس المستفادة: إن صندوق العدالة الصحية أحد آليات الشراء في نظام الرعاية الصحية في كمبوديا. ولهذا الصندوق أربعة أدوار أساسية: التمويل، والدعم الاجتماعي وضمان الجودة والمحاورة السياسية. وتتصدَّى هذه الأدوار للحواجز الرئيسية للحصول على الخدمات الصحية، ويكون التأثير على أشده في المواقع التي تتوفر فيها تدابير من قِبَل طرف ثالث. ولابد من وجود بيئة سياسات داعمة وقوية لصندوق العدالة الصحية حتى يتمكن من أداء دورٍ فعال في شراء الخدمات بشكل كامل.

References

1. Van Damme W, van Leemput L, Ir P, Hardeman W, Meessen B. Out-of-pocket health expenditure and debt in poor households: evidence from Cambodia. *Trop Med Int Health* 2004;9:273-80. PMID:15040566 doi:10.1046/j.1365-3156.2003.01194.x
2. Barber S, Bonnet F, Bekedam H. Formalizing under-the-table payments to control out-of-pocket hospital expenditures in Cambodia. *Health Policy Plan* 2004;19:199-208. PMID:15208276 doi:10.1093/heapol/czh025
3. Jacobs B, Price N. The impact of the introduction of user fees at a district hospital in Cambodia. *Health Policy Plan* 2004;19:310-21. PMID:15310666 doi:10.1093/heapol/czh036
4. Wilkinson D, Holloway J, Fallavier P. *The impact of user fees on access, equity and health provider practices in Cambodia* [WHO Health Sector Reform Phase III Project Report]. Phnom Penh: Cambodian Ministry of Health/Health Economics Task Force; 2001.
5. *The world health report 2000: health systems, improving performance*. Geneva: World Health Organization; 2000.
6. Hardeman W, van Damme W, van Pelt M, Ir P. Heng Kimvan, Messen B. Access to health care for all? User fees plus a Health Equity Fund in Sotnikum, Cambodia. *Health Policy Plan* 2004;19:22-32. PMID:14679282 doi:10.1093/heapol/czh003
7. Annear P, Wilkinson D, Rithy Chean M, van Pelt M. *Study of financial access to health services for the poor in Cambodia* [Research report phase 1]. Phnom Penh, Canberra & Melbourne: Ministry of Health Government of Cambodia, Cambodian office of the World Health Organization, AusAID and RMIT University; 2006.
8. Annear P, Bigdeli M, Chhun Eang R, James P. *Study of financial access to health services for the poor in Cambodia* [Research report phase 1]. Phnom Penh, Canberra & Melbourne: Ministry of Health Government of Cambodia, Cambodian office of the World Health Organization, AusAID and RMIT University; 2007.
9. Jacobs B, Price N. Improving access for the poorest to public sector health services: insights from Kirivong Operational Health District in Cambodia. *Health Policy Plan* 2006;21:27-39. PMID:16293700 doi:10.1093/heapol/czj001
10. Noirhomme M, Meessen B, Griffiths F, Ir P, Jacobs B, Thor R, et al. Improving access to hospital care for the poor: comparative analysis of four health equity funds in Cambodia. *Health Policy Plan* 2007;22:246-62 PMID:17526640 doi:10.1093/heapol/czm015
11. *Strategic framework for equity funds: promoting access to priority health services among the poor*. Phnom Penh: Ministry of Health, Government of Cambodia; 2003.
12. Jacobs B, Price N, Oeun S. Do exemptions from user fees mean free access to health services? A case study from a rural Cambodian hospital. *Trop Med Int Health* 2007;12:1-11.