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Inclusive healthcare and the political settlement in Cambodia

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ABSTRACT

Over the past 15 years Cambodia has made significant strides in expanding effective access to free healthcare for the poor, thanks largely to 'Health Equity Funds' (HEFs), a multi-stakeholder health-financing mechanism. HEF operators have helped expand access, incentivise health staff, and lobby on behalf of poor patients. However, despite their successes, they have been unable convincingly to address some of the deeper-seated problems of the Cambodian health system, such as under-resourced facilities, underpaid, poorly qualified staff and a burgeoning private sector. This paper explains this state of affairs as a product of Cambodia's 'political settlement', in which relatively successful multi-stakeholder initiatives exist as 'islands of effectiveness' in a sea of rent-seeking and patronage. While such islands may currently be the best solution available for the poor, the deeper problems are unlikely to be solved without a shift in the political settlement itself.

KEYWORDS

Politics; political economy; political settlements analysis; inclusive development; Cambodia; healthcare; Health Equity Funds

Introduction

Over the past 15 years, Cambodia has demonstrated an increased commitment to making health services inclusive by supporting the expansion of a variety of schemes that provide fee exemptions for the poor, notable among which are 'Health Equity Funds' (HEFs). HEFs are multi-stakeholder initiatives in which NGOs reimburse public health facilities for treating poor patients, using a combination of state and donor money. In contrast to many developing countries where the poor still have to pay 'under-the-table' fees for formally free services, HEFs have virtually eliminated this practice in Cambodia. They also contribute to improving the quality of care by providing cash incentives for staff and facilities, lobbying on behalf of poor patients, and monitoring health facility performance. Despite their manifest successes, HEFs have been unable thoroughly to address some of the deeper-seated problems of the Cambodian health system, including poorly paid and inadequately trained staff, under-resourced facilities and a burgeoning private sector poaching public patients and staff.

In the current paper, which should be read as a contribution to the literature on the political economy of developing country healthcare, we explain this state of affairs using a 'political settlements' framework developed at the Centre for Effective States and Inclusive Development at the University of Manchester (Hickey 2011, 2013, Levy and Walton 2013). We begin by sketching the framework and then employ it at both the national and sectoral levels to help us understand the evolution of health policy and outcomes. In a later section, we focus on HEFs, and explain how Cambodia's political settlement creates space for their success, while simultaneously constraining what they can achieve.

The study draws mainly on official documents and data, six focus groups with Cambodian and international researchers, NGO workers and development partners (FG1–6), eight interviews with

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expatriate health experts (E1–8) and eight interviews with Cambodian Ministry of Health officials and NGO staff (C1–8). The wider research of which this article is a part (Kelsall and Seiha 2014) also included 46 semi-structured interviews with health managers, frontline staff, local government authorities and NGO staff and volunteers at local level.

Political settlements analysis

In recent years, political settlements analysis has gained ground in development studies as an alternative to mainstream or new institutionalist approaches, by focusing on the deep power structures that underlie institutions and policies. A political settlement can be defined as, 'the balance or distribution of power between contending social groups and classes, on which any state is based' (Di John and Putzel 2009: 4), or 'a common understanding, especially among elites, about how power is organized and exercised' (DFID 2010). In recent years, the concept has been used to explain how societies transition from endemic violence to peace, and how the nature of the resulting settlement shapes their future growth trajectories (Di John and Putzel 2009, DFID 2010, Khan 2010, Parks and Cole 2010, Hickey 2011, Whitfield and Therkilsden 2011, Laws 2012, Laws and Leftwich 2014).

This paper is one of the first attempts to expand political settlements analysis beyond its normal preoccupation with stability and growth, and toward the issue of social provisioning (Parks and Cole 2010, ESID 2012, Sen 2012, Hickey 2013: 64). It is also one of the first attempts to extend political settlements analysis from the national to the sectoral level. As such, we draw on a framework developed at the Centre for Effective States and Inclusive Development at the University of Manchester, which is specialising in this field.

ESID classifies the diversity of the world's political settlements along two main axes. The first axis concerns the degree of competition in the political system. In 'dominant' settlements, it is very difficult to remove the leader or ruling party from power, while in 'competitive' settlements, this is much easier. The other axis concerns the degree of organisational or institutional complexity, for which the degree to which institutions are 'impersonal' or 'rule-governed' provides a proxy. In 'impersonal' settlements, Weberian legal–rational norms are adhered to, while in 'personalised' settlements, the opposite is the case (Levy and Walton 2013).[1]

The framework (see Figure 1) yields four basic types: dominant-personalistic; competitive-personalistic; dominant-impersonal and competitive-impersonal.

Dominant and competitive 'personalistic' settlements are likely to be predatory or clientelistic in nature, and consequently not very good at securing the public goods that typically underlie developmental progress.[2] Dominant and competitive 'impersonal' settlements are likely to be more successful in this regard, approximating, respectively, authoritarian developmental states and programmatic democracies on the 'doorstep' of advanced country status (Levy and Walton 2013).

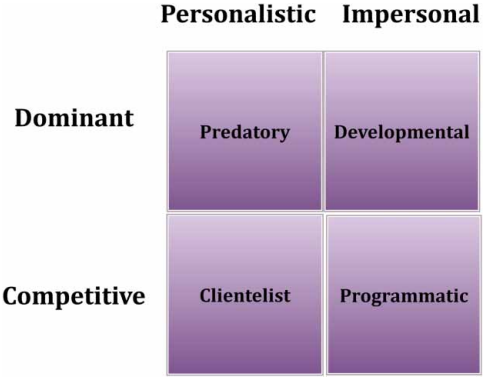

Figure 1. The ESID typology.

From this framework, Levy and Walton derive a number of hypotheses about service delivery. For example, they predict that dominant developmental states with hierarchical governance will produce effective outcomes, with multi-stakeholder governance possibly adding some value in respect of solving principal–agent problems, that is to say, securing the accountability of frontline service providers to their superiors, and, in democracies, to the public.[3] They also predict that multi-stakeholder governance can result in good performance under 'competitive clientelist' settlements, provided the external stakeholders are, among other things, well-connected politically. In contrast, they predict that hierarchical governance under dominant-predatory regimes will be ineffective, with multi-stakeholder governance unlikely to act well as a countervailing power (Levy and Walton 2013).

In this paper, we will argue that Cambodia is a dominant party system subject, intermittently, to strong competitive challenges; institutions are primarily personalistic, although some islands of rule-governed behavior can be found. This makes it a hybrid or 'in-between' case (Kelsall and Heng 2014, Kelsall and Seiha 2014). By melding the Levy and Walton hypotheses, we can consequently predict that, as a hybrid predatory-developmental dominant regime with a combination of hierarchical and multi-stakeholder governance, it will produce moderately effective developmental outcomes. As we shall see, this captures the history of inclusive healthcare in Cambodia, and in particular the phenomenon of HEFs, rather well. Another of way of thinking about this is to say that although significant developmental progress is possible in circumscribed areas, especially those with support from multiple stakeholders, outside these channels, provision of development-enhancing public goods and services is likely to be poor.

In the next section, we describe the evolution of Cambodia's hybrid political settlement.[4] In the subsequent section, we describe the political settlement in the health sector as similarly hybrid. We then argue that by melding the aforementioned Levy and Walton hypotheses, we can explain both the successes and limitations of HEFs.

The political settlement and healthcare in Cambodia

To understand the nature of poor people's access to healthcare in Cambodia today, we must return to the 1970s, when the country was devastated by civil war and the Khmer Rouge communist dictatorship. The Khmer Rouge were chased from power in 1979, when a group of Khmer rouge defectors, calling themselves the Kampuchean People's Revolutionary Party (KPRP), invaded the country with the support of the Vietnamese (Chandler 1991). They found health facilities in ruins and the health workforce virtually annihilated (Slocomb 2010, Keovathanak and Annear 2011). Quickly, the new rulers acted to establish a network of supporters who would act as a bulwark against continued assaults from a depleted but not defeated Khmer Rouge. There was a drive to recruit functionaries to the new state, but with the formal economy devastated and formal revenue-raising powers weak, this was done on the understanding that in addition to their meagre salaries, new recruits could use their positions to extract rents. By controlling access to the most lucrative of these, while turning a blind eye to petty rent scraping, the leadership, to the apex of which young Foreign Minister Hun Sen was rapidly ascending, was able to build a patronage-based state. As in most patronage systems, loyalty outweighed competence when it came to recruitment – a trend accentuated, no doubt, by the fact that many former, competent, officials had either fled or been murdered by the Khmer Rouge. Most ministries were consequently staffed by poorly qualified, underpaid staff who understandably devoted much of their time to moonlighting or extracting rents (Gottesman 2004).

Thus the political settlement of the 1980s featured a weak single party state, financially and militarily dependent on a neighbouring power, subject to strong insurgent challenges and dominated by a patronage logic. This provided the inauspicious context for the gradual reconstruction of the health service, using a combination of Soviet bloc aid and assistance from UNICEF and NGOs such as World Vision. Unsurprisingly, services remained rudimentary, reaching only around half the population (Grundy *et al.* 2009, Slocomb 2010, Keovathanak and Annear 2011).

After the fall of the Berlin Wall in 1989, Vietnam came under increasing pressure to withdraw from Cambodia. A peace deal was brokered with the help of the UN, and plans made for a transition to democracy in 1993. The KPRP renamed itself the Cambodian People's Party (CPP) prior to a contesting elections, which it lost to royalist party FUNCINPEC. Nevertheless, the CPP bullied its way into a power-sharing deal, and the next four years saw an arrangement in which Hun Sen and FUNCINPEC's Prince Norodom Ranariddh acted as co-prime ministers, with much of the business of government dominated by clientelistic competition for forestry rents. It was also a period in which international development partners assumed an increasingly important role in the political settlement and were given remarkably free rein to strengthen or create institutions such as the Ministry of Finance, the Council for the Development of Cambodia and to drive policy in the social sectors.

In Health, a number of major reforms were put in place with the aim of expanding and deepening services (Annear 1998, Barber *et al*. 2004, Grundy *et al*. 2009), giving birth to a system of Provincial Health Departments and Operational Districts (ODs), each having responsibility for a referral hospital and a network of health centres (Barber *et al*. 2004). Yet despite the increase in health infrastructure, effective access for the poor remained a problem. As we have seen, during this period Cambodia's rulers were engaged in an intense form of competitive clientelism, fighting for political ascendancy and survival, rendering healthcare issues of marginal importance. Central disbursements to local health organs were both low and unpredictable, giving health staff little incentive to work. One informant spoke of gleaming new buildings with no staff in them (E3), and where staff did work, under-the-table payments were rife. In 1996, the National Health Financing Charter (HFC) tried to address this situation by paving the way for the introduction of user fees, with exemptions for the poor (Ministry of Health 1996, 2003, 2006, 2008, Hardeman *et al*. 2004). By exempting poor people, however, the system created disincentives for health staff to treat them, so that the poor's effective access to healthcare remained low (Jones *et al*. 2012, National Institute of Public Health 2012).

In 1997, tensions between FUNCINEPC and the CPP spilled over into armed confrontation in the streets of Phnom Penh, forcing Norodom into exile. Hun Sen and the CPP consolidated their power in elections a year later, and although it still governed in coalition with FUNCINPEC – which held the health portfolio until 2008 – it was indisputably the senior partner (Le Billon 2000, Roberts 2001, Kelsall and Heng 2014).

The political settlement in Cambodia has changed little since that time. As sketched in Figure 2, it has been characterised by an inner circle of rent-seeking businessmen (often referred to by the honorific *oknha*), politicians, army generals and high-ranking technocrats, presided over by Hun Sen, and interlinked by a dense network of affinal ties. Rent-seekers have been gifted contracts and concessions, and in return have made kickbacks or donations to the ruling party (Hughes and Conway 2003, Un 2005, Jones *et al*. 2012, Kelsall and Heng 2014). The Prime Minister has taken great care to avert internal challenges by balancing party factions. In the meantime, technocrats have been given just enough latitude to nurture relatively competitive industries such as garments and tourism, which generate economic growth, mass employment, poverty reduction, and foreign exchange. The inner circle has been supported by an outer circle of development partners, the monarchy, clergy, business associations and pro-regime trades unions, and linked to subaltern groups via both programmatic policies and patronage ties, with the emphasis on the latter. Until recently, the social sectors were relatively marginal to this settlement, with Health typically footing the table of spending ministries (E7). The resulting vacuum has afforded development partners exceptional influence (E7).

As the regime has matured, the focus of its leaders has shifted from mere physical survival, to self-enrichment, to catching up economically and socially with larger, richer ASEAN neighbours (FG5, E7). The regime also has to win elections, by foul means or fair, receiving strong challenges in 2003 and 2013.[5] Connected to this, observers have noted a shift in governance tactics from coercion, which dominated early elections, to mass patronage (Un 2005). The Prime Minister has increasingly styled himself in the mode of generous benefactor, *a la* Prince Sihanouk,[6] and there has been a growth in parallel party-state structures to pool rents, dispense patronage and/or realise policy

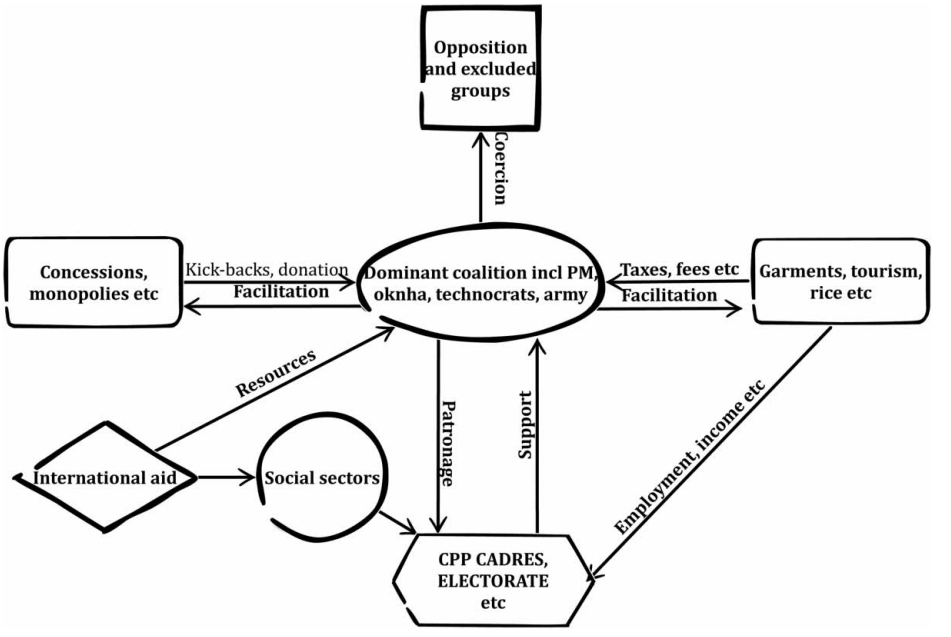

Figure 2. The CPP's growth and legitimation strategy.

goals. The rise of the Cambodian Red Cross, which pursues a number of high-profile campaigns in health and disaster-relief, is a good example. It is chaired by the First Lady, a trained midwife, and patronised by some of Cambodia's biggest businessmen (Craig and Pak 2011, Hughes and Un 2011, Pak 2011, Jones *et al*. 2012, Kelsall and Heng 2014).[7] Another good example is Party Working Groups (PWGs), which co-opt powerful officials and businessmen to make off-budget infrastructure investments in communes across the country (Pak 2011).

As security challenges have become less pressing, the government has devoted increased resources to the social sectors. General government expenditure on health increased from US$4 per capita in 2000 to US$7.2 in 2005 and US$10.3 in 2010.[8] Put differently, it rose from 8.7 per cent of government expenditure (1.3 per cent of GDP) in 2000 to 11.7 per cent (1.5 per cent of GDP) in 2005 and 11.5 per cent (1.3 per cent of GDP) in 2010. The number of hospitals rose from 79 in 2008 to 83 in 2013, health centres from 967 to 1024 and health posts rose from 107 to 121. The total number of health workers increased from 18,096 in 2008 to 19,721 in 2012. The state now funds around 60 per cent of the health budget from its own funds, up from around 30 per cent in 2005. The Prime Minister has signalled his support for a number of health campaigns designed by development partners and MOH technocrats, including reducing maternal mortality, child malnutrition and increasing access to health services for the poor (Jones *et al*. 2012).

The combination of increased health spending with high levels of donor influence has encouraged considerable innovation, experimentation and adoption of international models (C3, E4). For example, there has been a drive to introduce internal and external contracting into local health provision, as well as various new public management techniques (Keovathanak and Annear 2011). A significant minority of ODs are now semi-autonomous 'Special Operating Agencies' (SOAs), a model adapted from the British National Health Service in which a chain of performance-linked contractual relationships links national, provincial, district and facility health managers. There have also been a number of schemes aimed at increasing access. The most important, as we shall see below, have been HEFs (Annear and Ahmed 2012; Net and Chantrea 2012).

There have also been considerable improvements in health outcomes (Figure 3). Life expectancy at birth has increased from 57.5 years in 2000 to 62.6 years in 2010. Mortality rates, especially infant,

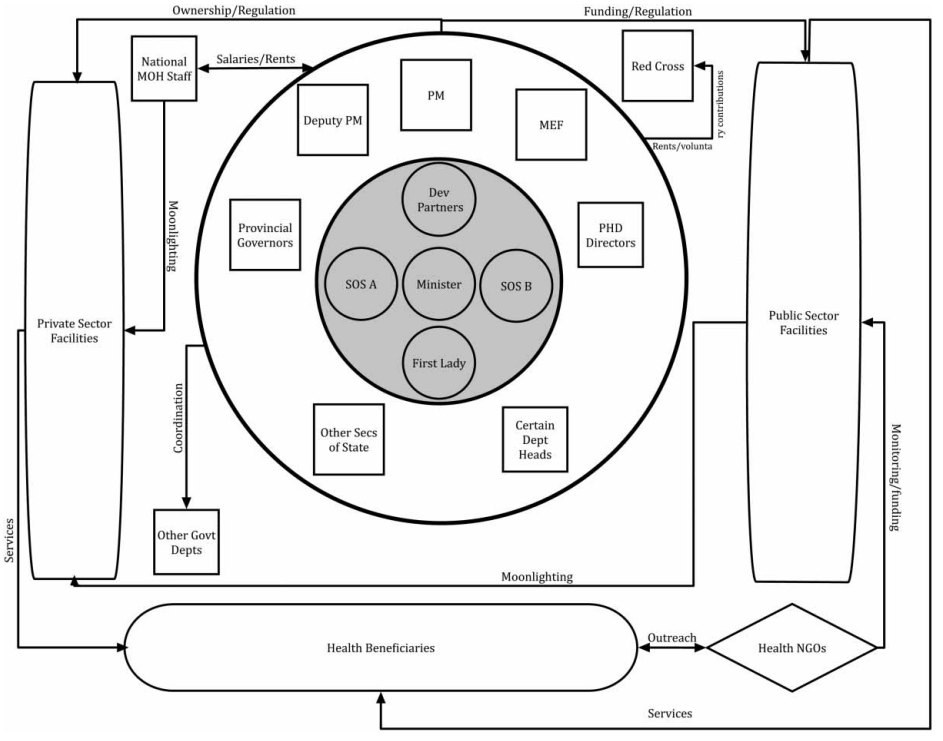

Figure 3. The sectoral political settlement in health.

and under-5 mortality, as well as the maternal mortality ratio, have dramatically declined. In consequence, MDGs 4 and 5 have already been met. As for MDG 6, malaria and HIV/AIDS seem well under control, with the record on tuberculosis, though still giving some cause for concern, improving (United Nations Development Programme 2014).

To explain this as an unequivocal triumph for the public health system would be premature, however. It is difficult to say to what extent the progress is attributable to more and better quality healthcare, or to rising economic growth, road-and-vehicle access, income, education and access to private medicine. Moreover, although the access of the poor to public health services has certainly improved, health progress has not been equally shared either geographically or by socio-economic group (Lane 2007, Annear *et al*. 2008, Asante *et al*. 2011, Jones *et al*. 2012, National Institute of Public Health 2012).

The political settlement in the health sector

As the regime has become more financially self-confident and increased its share of the health budget, so its employees have demonstrated an increased desire to take national ownership of health policy (E8). Whether or not this will result in more effective and more inclusive social provisioning, however, depends partly on the nature of the political settlement in the health sector itself.

Today, the Cambodian health service is formally structured as follows: The Minister for Health presides over eight Secretaries of State and 12 Under-Secretaries of State (these are known as 'policy-level' cadres), and three Directors General ('technical' cadres). Under all three Directorates are various technical departments, and under the Directorate General are the operational health facilities (Asante *et al*. 2011). While the Ministry's organogram gives the appearance of a Weberian-style bureaucracy, this does not capture the realities of power and decision-making on the ground. Although examinations for lower-level cadres have recently been introduced, and there are, as we

shall see, some long-standing islands or channels of rule-governed effectiveness, appointments and promotions are generally made on grounds of nepotism, financial contributions (the buying of offices) and only thirdly on competence. The result is a Ministry in which many staff are under-qualified for the posts they hold while other more qualified people are held back or encouraged to leave. Firing MOH staff is extremely difficult, since it requires an application to the Council of Ministers: non-performing staff are hardly ever sacked, merely, if anything, transferred (E2, E4, C5, C7).

Power relations are better represented in our map of the sectoral political settlement, above. In the inner circle of power is the Minister, Mam Bun Heng (a trained Doctor and former Secretary of State in Health), and networks around two current Secretaries of State (SOS A&B), discussed further below.[9] Development partners are also very influential, as is the First Lady, who despite not holding an official Government position, plays a key role as 'national champion' of maternal and child health issues (United Nations in Cambodia 2014). In the outer circle of power are other influential actors, but with less of a role in day-to-day decision-making. These include the Prime Minister, who takes an overall interest in health outcomes; the Ministry of Economy and Finance, which funds the majority of the health budget, and effectively sets limits on staff salaries; Provincial Governors, who deliver budget to Provincial Health Directors; a certain Deputy Prime Minister who owns a private teaching hospital with which national policy must align; plus a small number of other Secretaries of State and Health Ministry Departmental Heads.

Together, the inner and outer circle of elite actors comprises the *dominant coalition* in health (Figure 3). The dominant coalition pays the salaries of and extracts rents from more junior MOH staff, channels rents and 'voluntary' contributions to the CPP and Red Cross, funds and regulates public facilities, to some extent regulates private facilities (as well as having ownership stakes in them) and coordinates with other Government Departments. Private and public sector facilities deliver services to patients, and are to some extent monitored by Health NGOs, who also conduct outreach with health beneficiaries, as we shall see below. Most public sector health staff also spend a considerable amount of time moonlighting in the private sector.

It is easier to understand this if we think of the political settlement as an elite bargain in which both appropriating rents and delivering health outcomes are important. At the lower grades, salaries are insufficient to cover basic living expenses, driving actors to look for income earning opportunities on the side;[10] while at higher grades, most office-holders, having made sizeable financial contributions to acquire their offices, are under pressure to recoup their investments. Even in one of the more effective ministerial departments, we were told that of around 15 staff, only four or five actually worked; the remaining simply showed their face, donated a portion of their salary to their head of department and then pursued private activities (C5, C7). As for health outcomes, both development partners and the top leadership have demonstrated an interest in improving them, and have succeeded in forming alliances with like-minded actors internal to the Ministry, who strive to achieve their goals in the face of larger system dysfunctionalities. In practice, the balance between rent-seeking and health-seeking outcomes plays out through access to and control of two main resource flows controlled by two different Secretaries of State (Figure 4).

Secretary of State A is a pharmacist by training and an in-law of the Minister. Acting in concert with the Director General for Administration and Finance, these two men control the lion's share of Government funds that flow into the Ministry at national level, and in particular the procurement budget. This budget is highly opaque and presumed highly fungible (World Bank 2011), with much said to leak out via various forms of rent-extraction, and some rumoured to find its way into organisations closely linked to prominent political figures or their relatives. Although we could not verify this, it would be consistent with a tendency, seen in other areas, to use a combination of state and non-state resources to create parallel structures closely linked to the Prime Minister and his family. Developmental partners have complained vigorously about the procurement budget, but with little success (FG5, E7, C3, C7).

Donors put the majority of their funds, meanwhile, into the Health Sector Support Programme (which also receives contributions from MEF). Now in its second iteration (HSSP2), most of this

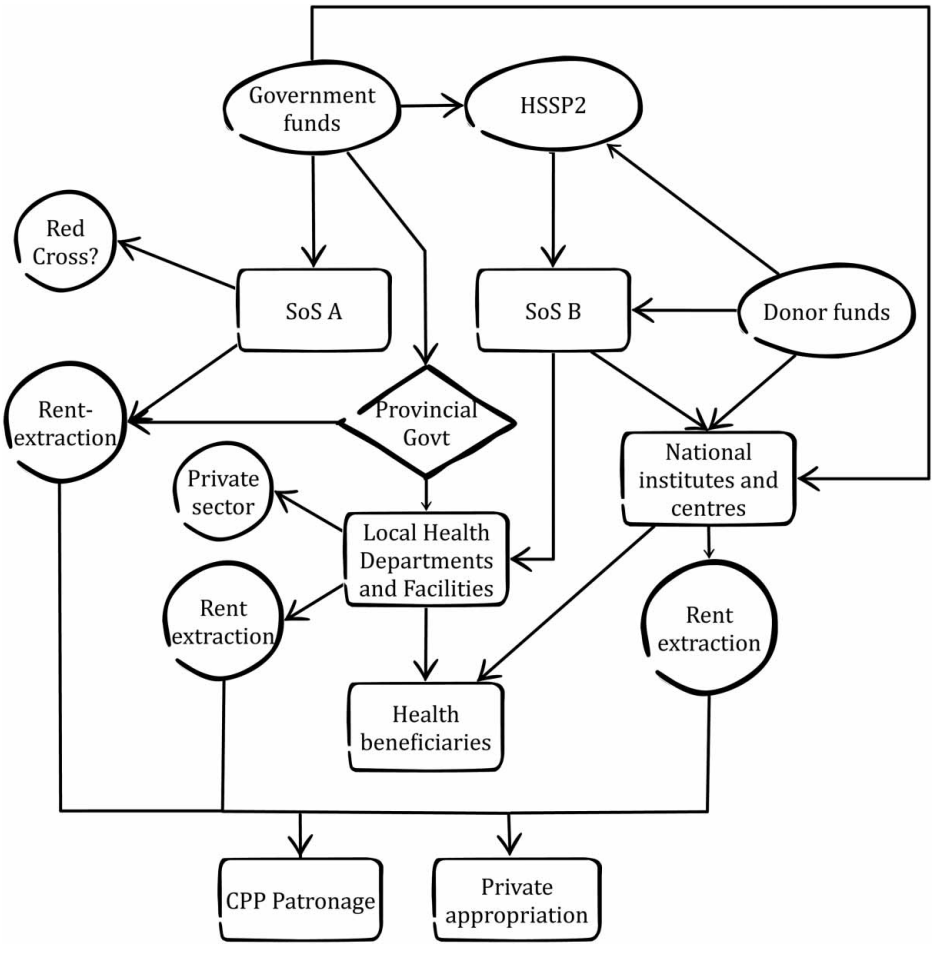

Figure 4. Resource flows in the ministry of health.

money goes to 'Service Delivery Grants' for SOAs and financial support to HEF benefit packages (see below).[11] This is administered through a Multi-Donor Trust Fund by a World Bank-funded Secretariat in the Ministry of Health, under the operational control of Secretary of State B. A technically skilled, results-oriented leader, B was one of the first doctors trained in Cambodia after the fall of the Khmer Rouge. He amassed considerable authority under the previous, FUNCINPEC, Minister, and is trusted by the current Minister, with whom he also shares a professional history, to manage donor funds and relations.

Thirty per cent of government funds also bypass the central level and flow into Provincial Treasuries, from where it is supposed to go to Provincial Health Departments, ODs and ultimately health facilities; but there is considerable leakage at each stage. Informants also spoke of other, smaller centres of patronage within the Ministry, all keen to grab a pot of resources. In 2013, for example, a scandal broke surrounding the use of monies from the Global Fund for Health to pay inflated prices for mosquito nets to companies from Singapore and Switzerland (Hruby 2013). There was also alleged to be considerable network-construction by individual Secretaries of State around the time of the election, each vying unsuccessfully to become the new Minister (FG5, E7, C5, C7).[12]

The basic contours of this bargain place some fundamental constraints on the ability of the state to supply inclusive healthcare. While relatively successful innovations in health equity flow, as we shall see below, from the network of Secretary of State B, these constitute but a channel of technocratic

effectiveness in a sea of personalised governance and institutionalised rent-seeking. Those rent-seeking pressures lead to the purchase of inappropriate or overpriced drugs and equipment, plus the emergence of an almost entirely unregulated and burgeoning private sector, owned and staffed by public sector workers. Indeed, the very presence of a large and opaque procurement budget makes it impossible to develop medium-term expenditure and budget frameworks, making rational budgeting and planning a non-starter. Lack of funds for training and low salaries mean that the competence and motivation of frontline staff are frequently low, with predictable consequences for the quality of care. This has hardly been alleviated by the emergence of private teaching hospitals producing inferior products (FG5, E7, C5, C7).

Partly as a result, Cambodia still encounters serious health challenges; one of the most pressing remains low overall utilisation of the public health sector (Grundy *et al*. 2009, Annear and Ahmed 2012, National Institute of Public Health 2012). Although representative statistics are hard to come by, it seems certain that large numbers bypass the public sector (National Institute of Statistics 2011, World Bank 2013a), which is of particular concern since private sector regulation is weak, and the quality of many private providers concomitantly low. One client survey conducted in Phnom Penh, found that '57% of consultations with private providers were potentially hazardous and only 32% met broad MoH guidelines' (Vickery *et al*. 2001). In a more recent study, the World Bank found problems throughout the sector, with 55 per cent, 60 per cent, 77 per cent, and 93 per cent of cases misdiagnosed in public facilities, private facilities, small private consultation rooms and the informal sector, respectively (World Bank 2014).

All of this can be explained by the fact that the political settlement's dominant tendency continues to be one of rent-seeking and patronage. Powerful elites are allowed either to pillage the state budget or leverage state authority to earn rents outside, provided they pour money into CPP patronage vehicles such as the Red Cross and PWGs. PWGs provide infrastructural investments such as roads, schools and a to a lesser extent health facilities, highly visible to and approved of by local electorates (Pak 2011). Providing for recurrent system costs or improving the quality of social provisioning, remains, however, a subordinate affair, left in the hands of development partners and a small group within the MOH, with some support from the Prime Minister and MEF (E3, E7, E8).[13]

Inclusive healthcare and HEFs

We now move to HEFs. HEFs are a purchasing mechanism that provides free healthcare to the poor, based on the principle of 'purchaser–provider' split. They are by far the most significant inclusive healthcare innovation in Cambodia, Cambodian health actors are proud of them and they have even attracted global interest (FG5, E1, E3). As of 2013, they covered more than two and a half million people in 51 out of the nation's 81 ODs, supporting more than a million health centre consultations and deliveries, and more than 300,000 hospital visits.[14] They are an example, we suggest, of a multi-stakeholder supported island of effectiveness, delivering real achievements within an otherwise unfavourable environment. As we shall see, they do so in part by creating structures of power and oversight that encourage frontline service providers to follow rules and policies with respect to treating the poor. In that respect, they create a space in the Cambodian health sector that we can locate, conceptually, as being further along the personal–impersonal governance axis than is the norm (see Figure 1).

Background

HEFs trace their origin to 2000, when the Urban Health Project, sponsored by WHO, Options UK and DFID, began to reimburse clinics for treating the poor in two Phnom Penh squatter settlements.[15] Around the same time, *Medicines sans frontieres* and UNICEF began a similar scheme in Siem Reap and Banteay Meanchey in the county's north-west (Hardeman *et al*. 2004, Annear *et al*. 2008, Por *et al*. 2010). As we saw in an earlier section, the schemes responded to a situation in which the introduction of user fees had boosted staff motivation and increased health service utilisation, but failed to address the needs of the poor (E3) (Barber *et al*. 2004). The Urban Health Project and *Medicines sans*

frontieres responded by devising a system for identifying the poor, then paying their fees through a third-party NGO (Jacobs *et al*. 2007).

The scheme proved popular and grew, with NGOs such as Health Net International, *Enfantset developpement*, UNICEF, the Swiss Red Cross and the Belgian Technical Cooperation[16] introducing them to a variety of districts (Annear *et al*. 2008, Por *et al*. 2010). Initially they were implemented with considerable flexibility and experimentation, attended by new innovations such as systems for pre-identifying the poor, support for transport and care-givers and community involvement in fund-raising; but all retained the principle of a third-party NGO fund manager that would reimburse user fees and also conduct community support activities (Annear *et al*. 2008, Jacobs and Price 2008).

Key decision-makers in the development community and the Ministry of Health were involved in the pilots from an early stage (E3) (Por *et al*. 2010). By 2003, HEFs had been included as part of the Government's Poverty Reduction Strategy and Health Strategic Plan (Por *et al*. 2010). In 2006, NGOs, international agencies and the Ministry of Health shared experiences at a National HEF Forum, followed in the same year by a drive to scale up and standardise HEFs in the National Equity Fund Monitoring and Implementation Framework (DFID 2014). In 2007, interest in HEFs skyrocketed as HEFO funding began to be routed through the Ministry of Health; the same year an interministerial Prakas decreed that the state health budget be used to support reimbursement of poor people's user fees (Annear *et al*. 2008, NA 2013). In 2010, the Prime Minister expressed his support for such schemes in an oft-referred to speech at the University of Health Sciences (FG5, E1, E3, C1, C3).[17] With high-level political backing, Government and development partners have vigorously expanded the schemes, aiming for nationwide coverage by the end of 2015. As of 2013, development partners funded 60 per cent of the costs of the scheme, and Government 40 per cent (E4).

How HEFs work

There are currently three HEF models operating in Cambodia, but by far the most widespread is the standard model on which we focus below.[18] Standard HEFs function as follows. Every three years, the Ministry of Planning pre-identifies poor households through its ID Poor scheme, and provides them an Equity card. This entitles them to free care at health centres and hospitals in Districts where a HEF is running. Every month, individual health facilities calculate the number of poor people treated, and submit a claim to their local Health Equity Fund Operator (HEFO), an NGO or CBO with a Ministry of Health contract to run the HEF in that District. The HEFO, using HSSP2 funds, then reimburses the health facilities based on a standardised 'case rate'.[19] The facilities devote 60 per cent of the funds to staff salary supplements, 39 per cent to running costs and remit 1 per cent to the Provincial Treasury.

In addition to performing these basic functions, the HEFO provides a number of supplementary services. It registers HEF patients at the hospital and into the MOH Patient Management and Registration System database; helps identify poor people at health facilities who for one reason or another lack an ID Poor card (see below); reimburses poor patient transport costs; provides food and care allowances; visits in-patients every day; advocates for poor patients who experience problems with their healthcare providers; and conducts community outreach and fundraising (USAID/URC N.d.).

Health facilities and HEFOs are monitored by University Research Co., LLC, an international NGO known as the Health Equity Fund Implementer (HEFI), funded by USAID. Every month in each OD, URC Monitors conduct document reviews in every hospital, three to five health centres and interview 40–80 households. In cases where mistakes are made or ghost patients found, deductions are made from the HEFO invoice. Once it has verified that the HEFO is doing its job, it certifies the monthly HEFO invoice and forwards it to HSSP2. It also provides technical assistance to HEF partners (USAID/URC N.d.), and in some districts, monitors the quality of care.

At local level, HEFs are overseen by Health Financing Steering Committees. HFSCs are a multi-stakeholder forum bringing together health officials, the HEFO and other government authorities. They assess the performance of the HEF, identify problems and recommend solutions, based on

monitoring data generated by the HFSC monitoring sub-committee, which every month randomly samples patients and interviews them about their experiences at the health centre, including such questions as whether they were greeted correctly, had to pay under-the-table fees, were satisfied with their treatment and so on. HEFI Technical Officers also sit on the HFSC, where they discuss the HEFI's monthly monitoring reports (Figure 5).

The HFSC also connects with MOH internal accountability systems. Under these, health facilities report to the OD Director, who reports to the Provincial Health Director, who reports to the Minister for Health. There is also a system of community participation in the management of health facilities, comprising multi-stakeholder Health Centre Co-Management Committees (HCCMCs) and Village Health Support Groups (VHSGs).

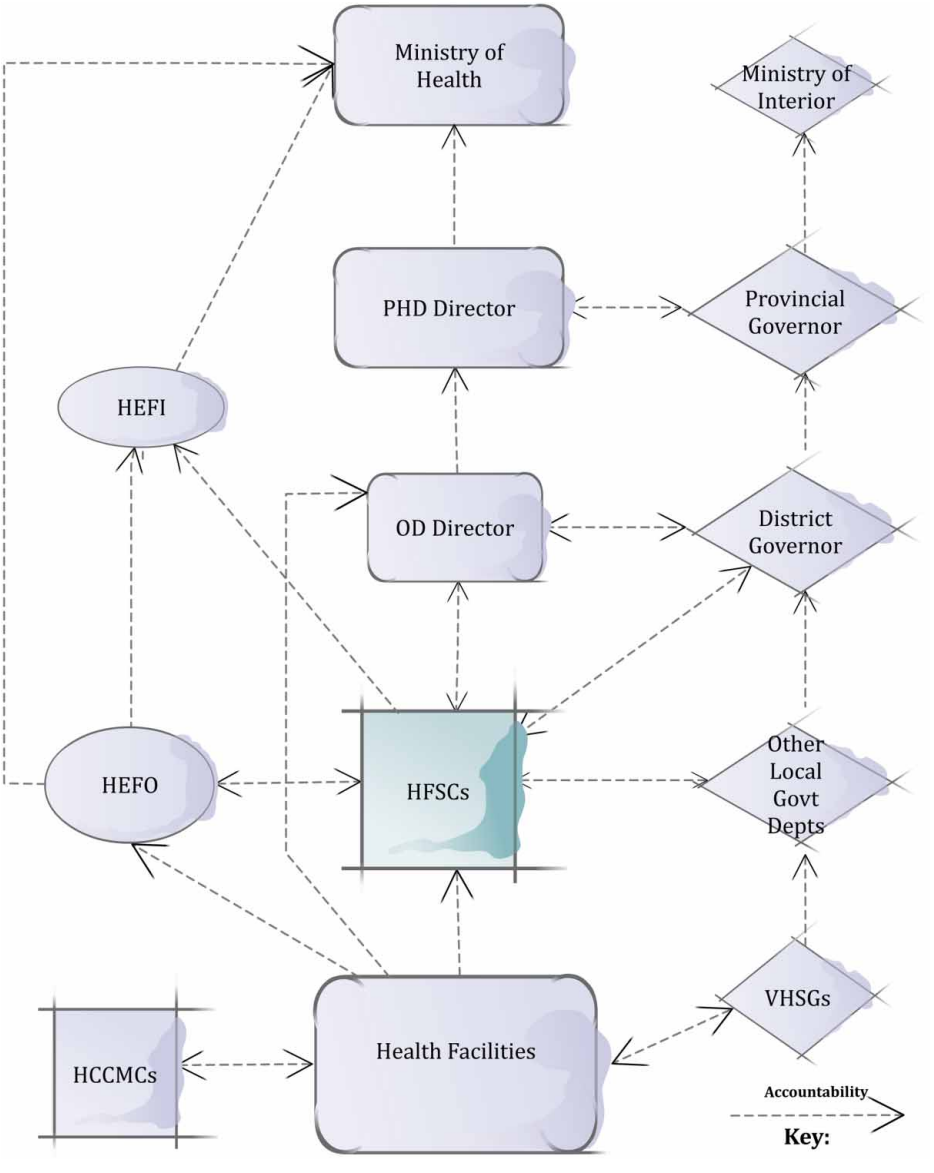

Figure 5. HEF governance arrangements.

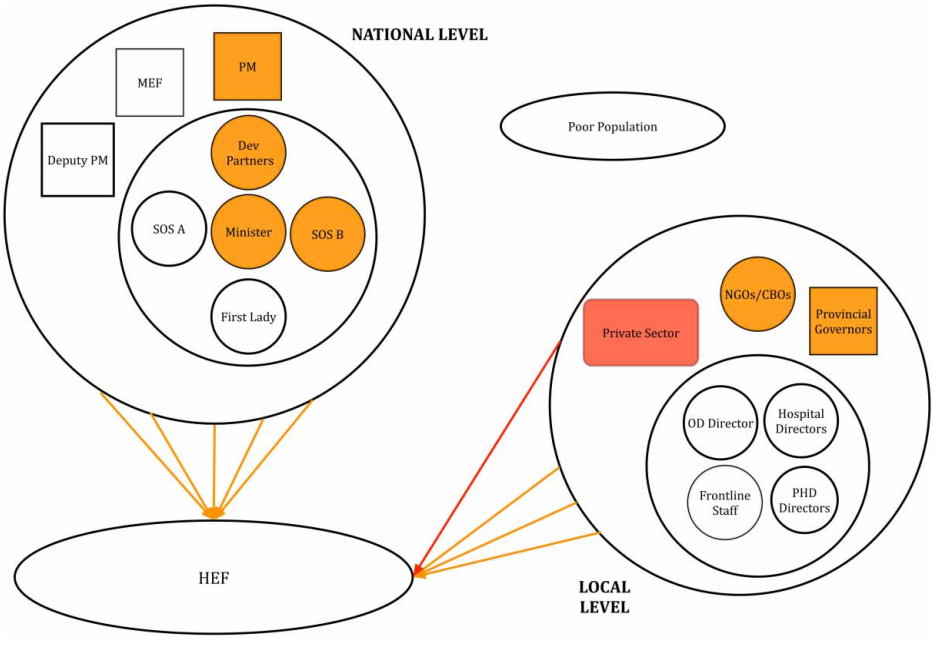

Figure 6. HEF interest mapping.

The interest-mapping below (Figure 6) illustrates how HEFs work in political–economic terms. Actors with an interest in HEFs are coloured in orange; those whose interests are negatively affected are in red; while those interests likely to be neutral or ambivalent are left white.

In the top left corner is the national dominant coalition in Health, and here we see that the Prime Minister, the Minister, Development Partners and the network of SOS B, who are all motivated at least to some extent by issues of performance legitimacy and health goals, have an interest in supporting HEFs. As discussed below, some SOS B actors may also receive financial benefits through their relationships with HEFOs, though this is difficult to verify (FG5, E1). The other actors in the dominant coalition may be ambivalent or neutral, but they are not seriously threatened by HEFs. In the bottom right of the picture is the dominant coalition at local level. Generally speaking, Provincial Governors have an interest in performance legitimacy, while Health NGOs/CBOs benefit financially from HEFs, so can be expected to support them. In contrast, the private sector loses patients because of HEFs, so is coloured red. The stance of PHD Directors, OD Directors, Hospital Directors and frontline staff meanwhile, is likely to be ambivalent. On the one hand, they are motivated to some extent by public health goals and are under some pressure from the national dominant coalition to perform. On the other hand, many own or work in private facilities, so experience a conflict of interest here. Finally, the poor population is represented in the diagram as white. Although it has an objective interest in HEFs, it will not necessarily realise this subjectively unless it is sensitised to the role of HEFs and the benefits of public healthcare generally. That said, there appears to be a sufficient balance of actors in favour of HEFs to suggest that they will be reasonably well-supported politically wherever they are; they are likely to work best, however, where conflicts of interest among key local level actors, together with the disconnectedness of the poor population, can be mitigated.

Successes and limitations

Studies have shown that where HEFs operate they are a significant force for inclusion, with the poor accessing public health services at a level higher than their weight in the population (as opposed to

around half that level in ODs without HEFs) (Annear *et al*. 2008). Further, they reduce household health-related debt and out-of-pocket expenditures, provide a significant source of additional revenue to health facilities, reduce under-the-table payments and help correct the under-utilisation of public health facilities generally (Flores *et al*. 2013, NA 2013: 22–25).[20] HEF advocates also claim that HEFs act as a powerful incentive to improving performance, helping ensure that facilities are always open with staff on hand, educating citizens about their rights to health and introducing internal and external monitoring systems that help improve the quality of care (E1). They have even been described as, 'the force driving the entire public sector' (E3).

However, HEFs are not a panacea. In total, 40–50 per cent of the poor never use the HEF (E4), with many poor patients preferring not to seek treatment or to seek it in the private sector (World Bank 2013a). Some of this may be down to 'cultural' preferences for superfluous injections, or reluctance to travel the distance required to public health facilities (Hardeman *et al*. 2004, Jacobs *et al*. 2007). More worryingly, it may be a result of the inability of HEFOs to raise awareness about the HEFs or to help raise public facilities to attractive standards (Hardeman *et al*. 2004). As we have seen, the nature of the political settlement both in health and nationally puts limits on the level and consistency of care the health service provides, which health NGOs cannot by themselves address (E3, C1).

Further, there is some evidence of unevenness among HEFOs in terms of cost-efficiency, ability to solve problems and local community involvement and outreach. HEFOs are contracted by the Ministry of Health, in an ostensibly competitive process with World Bank designed safeguards. However, more than one informant suggested that some are entwined in cosy, nepotistic relations with Ministry officials and consequently feel under little pressure to perform, doing the absolute minimum as per their terms of reference (E1, E3).[21] Ironically, the stringent safeguards applied by the Bank create a set of requirements for funding applications that militate in favour of large NGOs staffed by professional classes (E3, C1).[22]

Other poor people are excluded involuntarily. For example, studies show that the Ministry of Planning's ID Poor scheme captures only around 70 per cent of the poor. There is anecdotal evidence that Provincial Governors are under pressure to reduce the number of cards they distribute in line with falling national poverty figures, and also rumours that commune and village chiefs discriminate against poor households that support the opposition, an indication that at least some local CPP cadres continue to view ostensibly public goods such as healthcare as private or club goods to be allocated on patronage grounds.[23] Other anecdotal evidence has village chiefs selling ID Poor cards.[24] Although HEFOs identify many poor people through post-identification (a kind of safety net for the safety net), this situation is not ideal.

Another issue is that the scheme does not cover the large percentage of Cambodian households that sit just above the poverty line, who can still be flung into poverty by catastrophic health episodes (E3, C3) (World Bank 2013b). Another problem is that as the percentage of poor people in Cambodia decreases, so the unit costs of HEFs rise. Some, though by no means all, health actors in Cambodia see a closer integration of HEFs with Community-Based-Health-Insurance schemes as the solution (E3, E4) (Annear 2012).

Our own research into HEFs in four ODs suggested that the claims made for their success are largely justified (Kelsall and Seiha 2014: 23–32). The HEFs pay for free healthcare for large numbers of poor people, help incentivise health staff to treat them, have by and large eliminated under the table payments and contribute to raising awareness about the public health service. However, they are not able to surmount all the problems that afflict the Cambodian health sector. For example, we found that in two of the ODs where there was a very active private sector, partly owned by public servants, there was still considerable moonlighting and poaching of patients during normal staff hours. Moreover, we found that in two of the ODs run by a so-called 'top-down' NGO with close links to national health officials, the HEFO was not particularly diligent in maintaining its network of community volunteers. Further, HEFs worked best where they were combined with other multi-stakeholder-driven initiatives, for example SOAs, suggesting that a kind of doubling up of multi-stakeholder support may be necessary to help HEFs reach their full potential. Once again,

in terms of the ESID framework, SOAs, with their complex performance, monitoring and incentive arrangements, can be seen as an attempt to inject an added degree of organisational complexity and impersonality into an otherwise patronage-oriented institution. HEFs also worked better where there was strong local leadership in the health sector, the underlying determinants of which appeared, unfortunately, to be idiosyncratic (Kelsall and Seiha 2014). For example, the OD Director in Kirivong, our best-performing district, was also said to own a private practice, yet informants were unanimous that he did not allow public employees to work privately during normal hours. Whatever the underlying reasons, the combination of SOA incentive and monitoring arrangements, combined with committed local leadership, went a long way toward pushing local actors from HEF ambivalence to support (Kelsall and Seiha 2014).

Conclusions

The preceding sections used a political settlements framework developed at the University of Manchester to help illuminate the history of inclusive healthcare in Cambodia. In the 1980s, Cambodia's political settlement rested on a single party with strong Vietnamese support, experiencing significant challenges from guerilla forces and using patronage as the predominant means of securing its own cadres' loyalty. Health services began to be rebuilt after the devastation of the Khmer Rouge period, but coverage remained low. After the transition to multi-party democracy in 1993, the CPP shared power with FUNCINPEC, and the political settlement became characterised by intensely competitive clientelism. Health infrastructure expanded, but because health posts were often unmanned, effective access for the poor remained unsatisfactory. This was also a time, however, in which international donors, increasingly integral to the political settlement, began to carve out islands of effectiveness. After 1998, the CPP was able to consolidate itself, the security and revenue situations improved and increasing resources were devoted to healthcare. Nevertheless, the personalistic and predatory dimensions of the political settlement in the health sector have remained strong, with deleterious consequences for the level and quality of care. These consequences are less serious, however, in areas of health provision where development partners and other stakeholders have been able to ally with like-minded MOH staff and supportive politicians. We have illustrated this with respect to HEFs, which represent a relatively successful if incomplete solution to the problems poor people face when accessing free healthcare.

According to the ESID framework, given Cambodia's hybrid political settlement, some reasonably effective multi-stakeholder initiatives in service provision, as we see in the case of HEFs, are to be expected (Levy and Walton 2013). Indeed, they are probably the most that Cambodia and states with similar political settlements can hope for. This is because deeper-seated problems in service provision are unlikely to be resolved until the settlement's dominant tendency shifts from winning votes through predation-fuelled patronage, to programmatic public goods supply; and this shift is unlikely to take place until the dominant coalition senses that the existing way of governing cannot be sustained.

Interestingly, there are some signs in Cambodia that such a perception is growing. In the 2013 general election, the ruling party received a rude shock when large sections of an increasingly youthful electorate rejected its patronage appeals, and turned instead to the Opposition. Whether or not this will provide the incentive the leadership needs to try to change the nature of the political settlement, and whether it will result in support for even more inclusive and effective forms of healthcare, remains to be seen. While the Ministries of Commerce, Environment and Education have had dynamic new results-oriented ministers installed, there has, at time of writing, been no change in the Ministry of Health. Informal conversations suggest that this can be attributed to the durability of the nexus between the Minister, First Lady and the Red Cross. MOH thus appears to be behind the reform curve.

Some expatriate observers are concerned, and worry that HSSP2 and its funding for SOAs and HEFs somehow contributes to this situation, creating an unfortunate dualism in the Ministry, in

which the patronage-based and programmatic elements exist in symbiosis. This jibes with some recent writing on Cambodia that is fiercely critical of the dependency culture donor programmes seem to foster (Ear 2013, Strangio 2014). The implication, although not always stated explicitly, is that donor disengagement would force the Cambodian government to get its house in order. The argument certainly has an attractive logic; unfortunately, the empirical support for it is not strong. In fact, in other quasi-authoritarian political settlements characterised by high levels of patronage and informality, for example Zimbabwe in the 2000s, donor disengagement led not to better governance, but to increasing authoritarianism and even greater entanglement of the state in corrupt and criminal practices.

At the time of writing, the future of HEFs stands at a crossroads, with a new Health Financing Policy under construction. The Government, increasingly financially confident as we have seen, recognises HEFs as the largest and most important social welfare item in its budget, and an integral part of its National Social Protection Strategy for the Poor and Vulnerable 2011–2015. Unsurprisingly, it is uneasy about the pivotal role of international and national NGOs in the scheme, and is consequently looking at ways of bringing HEFs in-house (L16) (Flores *et al*. 2013).

HEFs are also seen as a part of a long-term series of stepping-stones to Universal Health Coverage, now on the political agenda in Cambodia (E7, C3) (Annear and Ahmed 2012). Whether this will take place through gradually expanding HEF benefits to other population categories, or by integrating HEFs with other forms of health insurance, remains to be seen.[25] A heated debate among health sector actors, all of whom have different ideas about and interests in the future of HEFs, is currently underway. One of the lessons of this study is that policy-makers should tread carefully, since it will be important not to overhaul too radically a reasonably effective health-financing model, before the underlying political conditions for a better replacement have emerged. At the same time, critics of the role of development partners in Cambodia's political settlement should perhaps acknowledge to a greater extent, the benefits that sustained donor engagement with a sector can bring.

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Notes

1. Indicators of where a settlement stands on the organisational complexity axis include: 'The extent to which *the rule of law* functions as an impartial, third party mechanism for resolving disputes among private parties, within the state, or between public and private parties; the extent to which *political parties* become formalised, and organised around programmatic platforms rather than the conferral of patronage to insider clients; the quality of *elections* – i.e. the extent to which they are competitive, free and fair; the extent of *openness* – i.e. the presence of rules (for example on freedom of information) and actors (such as the media) that ensure the open operation of civil society, and the transparent flow of information; and the extent to which the *public bureaucracy* – both the "central bureaucracy" and front-line executive agencies – functions in an ad hoc, personalised way or according to impersonal rules'. ESID (2013: 4).
2. 'Public good' being defined broadly here as any kind of good which, having positive externalities, will normally be undersupplied by private actors.
3. Levy and Walton define 'multi-stakeholder governance' as a situation in which, 'there is a politically salient coalition of external stakeholders that is working in concert with an organisation's management (whether through the

proactivity of the organisation's leaders or social pressures on the leadership) with a mutual interest in pursuing the organisations goals' (Levy and Walton 2013).

4. To build a picture of the political settlement, we began by conducting four focus groups to map the national political settlement (FG1–4), followed by a single focus group to map the sectoral political settlement (FG5).
5. The Opposition's 7-point policy-plan included a promise that, 'Poor people would receive free health care'.
6. Cambodia's former King, who abdicated the throne to lead his country to Independence.
7. In at least two of the health districts we worked in, national politicians had made high-profile donations to the health service.
8. WHO website – accessed on 18 November 2013 from http://apps.who.int/gho/data/node.country.country-KHM
9. The main outlines of Figures 3 and 4 were sketched out in our focus group FG5. Details were then corroborated and added to in interviews, especially E7, C5 and C7. We refrain from naming civil servants with a view to preserving their anonymity and protecting informant confidentiality.
10. A recent study of health professionals' remuneration made similar findings: Various Authors (2013).
11. Previously, a large proportion of HSSP funds went to health infrastructure projects (N1).
12. Note that one of our informants (C3) was skeptical of this account, but we believe it to be sufficiently corroborated.
13. And while development partners are generally a force in favour of delivering inclusive, quality healthcare, their role in the political settlement is not beyond reproach. They often suffer from fragmentation, have cumbersome procedures, high costs, objectives not necessarily aligned with local realities, rivalries, unpredictability, lack of mutual accountability and do not always deliver on their promises. Understandably, some of the more committed Cambodian health actors are desirous of reduced donor involvement and increased national control.
14. HEF Annual Data 2013.
15. A similar scheme run by MSF Holland in TmarPuk Referral Hospital may have come even earlier (E4).
16. BTC is a bilateral donor, not an NGO.
17. There is some debate over whether the PM referred specifically to HEFs or whether he made a vaguer statement about free healthcare for the poor. There is also some debate over why the PM chose to emphasise free healthcare at this point in time, with some suggesting that he was influenced by former Thai PM Thaksin Shinawatra, his one-time 'Financial Advisor'. Others have suggested that the PM was personally moved by a story he read in the newspaper. Whatever the case, HEF champions picked up the sentiment and ran with it.
18. The others are a government subsidy scheme (SUBO), and a scheme that integrates a voluntary health-insurance model for the non-poor with the standard model.
19. In some ODs, a proportion of the exemptions are paid by (mostly religious) community organisations.
20. In 2012, total HEF expenditure was USD 9,457,954, 85 per cent of which was spent on direct benefits to patients, (fees, transportation, food), and the rest on management and operational costs (NA 2013: 17). See also Annear and Bigdeli (2009), Jordanwood *et al.* (2009), Flores *et al.* (2013).
21. Part of this problem has been addressed via a move to output-based contracting, which now covers about 50 per cent of HEFOs (N1).
22. Other criticisms include the focus of HEFs on curative care, the implicit bias shown to hospitals over Health Centres, the upward pressure on health costs caused by HEFs' standard benefit package and transport costs (E3), ultimately borne by the nearly and non-poor.
23. Some of our local level interviews supported these allegations (LI4, L11, L26).
24. In interview, Ministry of Planning officials rejected these allegations, and explained to us how systemic safeguards prevent this (C4). Other informants told us that national-level MOP staff were often ignorant of what happens to their schemes on the ground.
25. There appear to be two main reasons for earlier resistance to UHC. One is the MEF's concerns about the fiscal implications, and the other is the belief that frontline MOH staff will not work unless incentivised via user fees.

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