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Equity in health systems financing in Cambodia: Roundtable discussion

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(Cambodian Health Equity and Financing Study)

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Background

- An essential component of Universal Health Coverage (UHC) is an *equitable* financing system.
 - ✓ Provides all people with access to needed health services
 - ✓ Ensures that use of these services does not expose the user to financial hardship
- How to measure progress?

Target of Universal Health Coverage

Direct Health SDG



- A:** Reduce the global maternal mortality ratio
- B:** End preventable deaths of newborns and children under 5 years of age
- C:** End current epidemics and combat communicable diseases
- D:** Reduce premature mortality from non-communicable diseases
- E:** Strengthen the prevention and treatment of substance abuse
- F:** Halve the number of global deaths and injuries from road traffic accidents
- G:** Ensure universal access to sexual and reproductive health-care services
- H:** Achieve universal health coverage
- I:** Reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

Indicators for measuring UHC

Achieving universal health coverage – has 2 indicators

- ✓ 3.8.1 – Coverage of essential health services
- ✓ 3.8.2 - Proportion of the population with catastrophic spending on health



Acknowledgement: Photo by GIZ Cambodia

Indicators for financial protection

	Indicator	Definition
✓	Catastrophic health spending	OOP health spending that exceeds a household's ability to pay
✓	Impoverishing health spending	Poverty due to OOP health spending
✓	Distress health financing	Borrowing to pay OOP for health care
✓	Benefit Incidence analysis (BIA)	Distribution of the benefits from health sector subsidies (according to need)
✓	Financing incidence analysis (FIA)	Distribution of the burden of health financing (according to ability to pay)

Financing incidence analysis (FIA)

Who pays for health care? To what extent are payments toward health care related to ability to pay (ATP)?

Steps:

- Compare the distribution of each type of health care payment as a share of household consumption expenditure across socioeconomics groups
- Combine all payment sources to determine the overall progressivity of the health financing system

Kakwani index is measure of progressivity. Twice the area between the concentration curve (health payments) and the Lorenz curve (ATP).

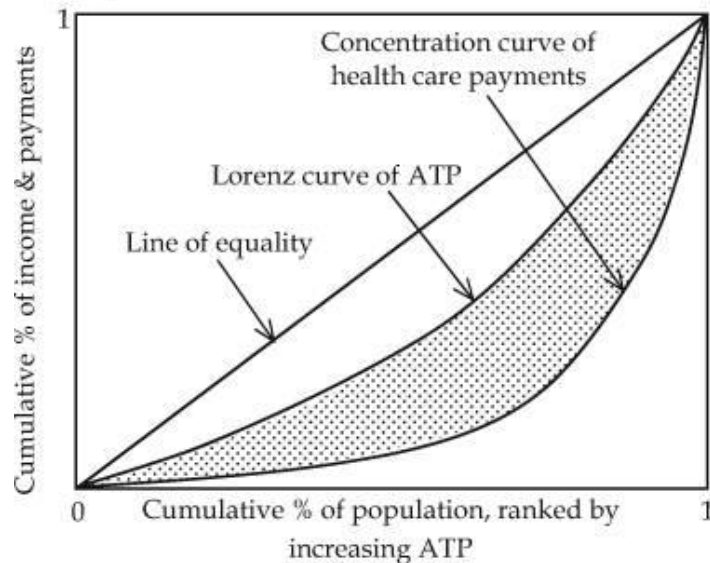
Progressive = high-ATP households pay a higher share of their income than low-ATP households (positive Kakwani index)



Assessing progressivity/regressivity

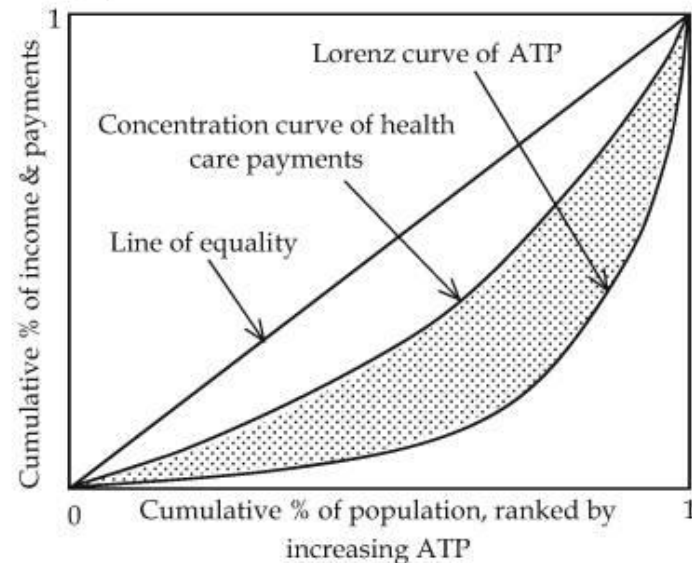
Progressive

- Lorenz curve lies above CC of health care payments
- *Kakwani Index*
 - Positive (+)



Regressive

- Lorenz curve lies below the CC of health care payments
- *Kakwani Index*
 - Negative (-)



FIA: Data

Data type	Data source
Household expenditure on health care	<ul style="list-style-type: none">• National Health Accounts• Cambodia Socioeconomic Survey (CSES) 2014
Tax rates	<ul style="list-style-type: none">• General Department of Taxation
Ability to pay	<ul style="list-style-type: none">• Cambodia Socioeconomic Survey (CSES) 2014

Benefit incidence analysis (BIA)

Who (in terms of socioeconomic status) receives what benefit from using health services?

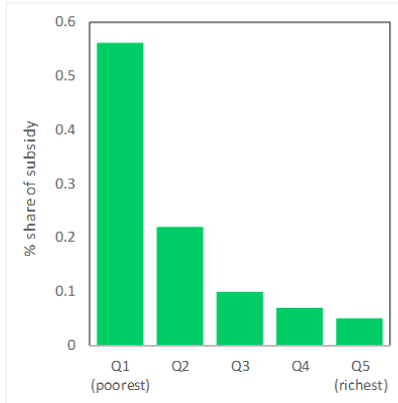
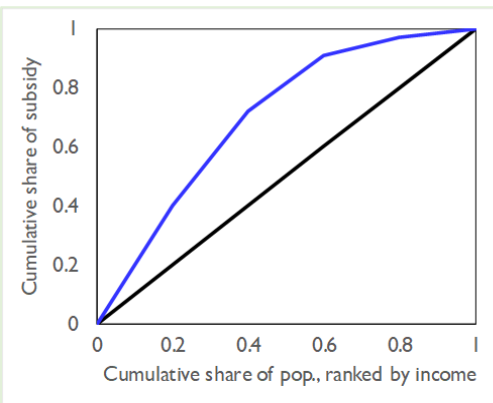
- 1) Rank population by living standards measure
- 2) Assess rate of utilization of different health services
- 3) Estimate unit cost of each type of service
- 4) Multiply utilisation rates for each service by the unit cost to obtain the subsidy
- 5) Compare against target distribution (e.g., population share or need)

Bar charts indicating the relative share of total benefits received by each socioeconomic group

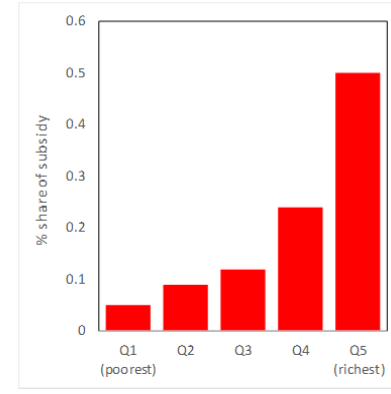
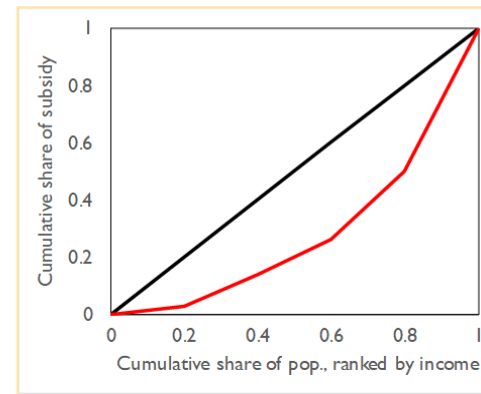
Concentration index indicates the extent to which healthcare benefits are concentrated in different socioeconomic groups (lies between -1 and +1)

Assessing pro-poorness

- *Pro-poor subsidy*
 - The share of subsidy received by the bottom $x\%$ of the population **exceeds** their population share ($x\%$)
 - *Concentration index*
 - Negative (-)



- *Pro-rich subsidy*
 - The share of subsidy received by the bottom $x\%$ of the population is **less than** their population share ($x\%$)
 - *Concentration index*
 - Positive (+)

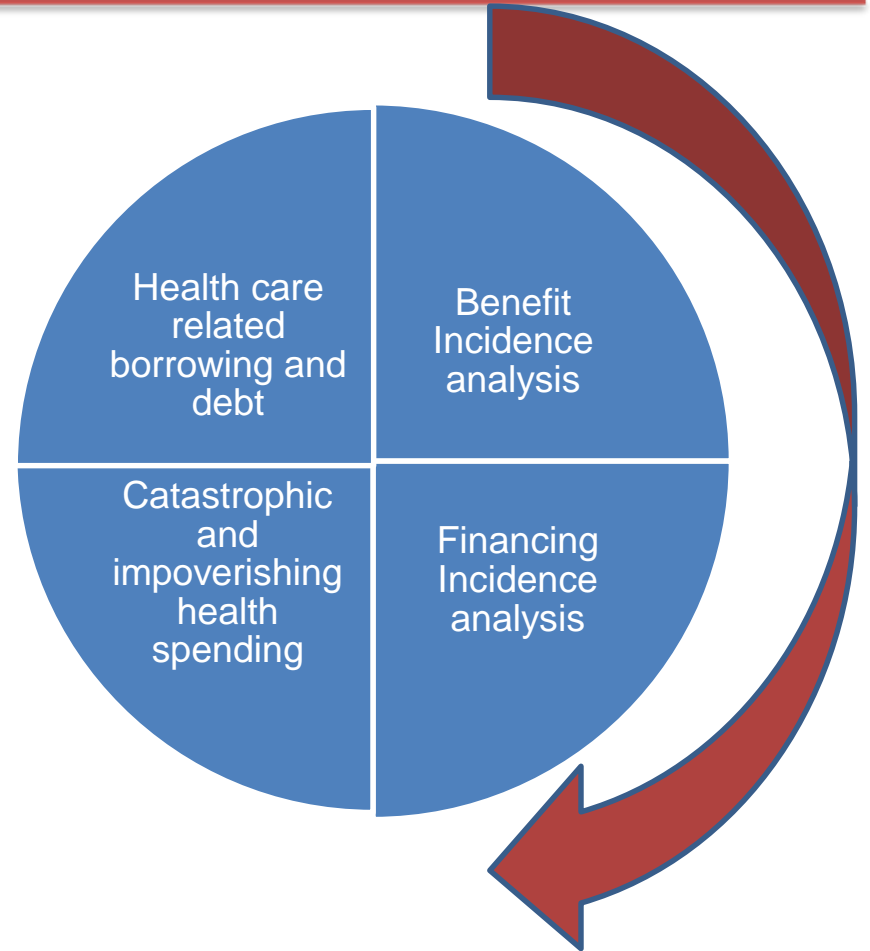


Data: BIA

Data type	Data source
Utilisation rates of different types of health services	<ul style="list-style-type: none">CHEF Household Survey (2016)
Living standards or socioeconomic status	<ul style="list-style-type: none">CHEF Household Survey (2016)
Unit costs of different types of health services	<ul style="list-style-type: none">National Health Accounts (2014), Annual Health Statistics Report (2012), Cambodia Demographic and Health Survey (2014).

Next...

- Present **evidence** on progress to UHC in Cambodia.
- Discuss **implications** for monitoring and evaluation of UHC.
- Future **research** agenda



Roundtable - aims

- Recap – key findings from presentations
- What do these results mean for UHC monitoring and evaluation?
 - Current activities?
 - Gaps in UHC evidence
 - Availability of routine data
 - Capacity for data collection and analysis
- Items for research agenda

Context

- Health care system in Cambodia is highly pluralistic
- Public health facilities, mainly health Centre's, play a dominant role in delivering preventive (maternal and child health) care
- Private providers, mainly private pharmacies and drug stores are responsible for a large share of outpatient care;
- Inpatient care is equally distributed between the public and private sectors

UHC monitoring & evaluation in Cambodia

- Many assessments of different elements of the health financing system in Cambodia
- Activities often dependent on donor funding
- Thus ad hoc, non-systematic and non-comprehensive approach
- Need for routine systematic M&E for UHC system

Key messages – Catastrophic & impoverishing health payments

- Cambodia has seen tremendous reduction of reported illness, financial burden, catastrophic expenditure incidence and impoverishments related to healthcare.
- This positive trend at national level masks increasing inequalities between the capital, other urban and rural areas.
- More resources (or attention) needed for the health sector in rural areas
- Expansion of health equity funds to 40-50% of the rural population



Key messages - Distress financing

- Distress financing, defined as borrowing with interest, is common in Cambodia where financial risk protection is limited;
- Poor and large households are at higher risk of distress financing, which can push them into heavy indebtedness and deeper poverty;
- Inpatient care and outpatient care with private providers also puts the user at higher risk of distress financing;
- HEF cannot effectively protect poor households from the risk of distress financing, as it can only lower but not eliminate their OOP;
- Need for more comprehensive and effective social health protection with max. population coverage for priority services and population at risk of distress financing:
 - continue direct subsidies for PHC and
 - further strengthen HEF and
 - expand SHI for curative care coupled with
 - supply-side efforts to improve quality of care and better regulations of private providers



Key messages – Who benefits from health spending? (BIA)

- The results clearly demonstrate that:
- Benefits from health spending in the public sector are generally distributed in favour of the poor and the distribution reflects the need for health services.
- Over 50% of total health expenditure and health care delivery remains in the private sector which distributes health care benefits in favour of the rich.
- Many poor Cambodians use private providers - a challenge that must be addressed if UHC is to become a reality.

Key messages – Who pays for the health system? (FIA)

- Overall burden of financing the health system in Cambodia is disproportionately borne by the rich through strongly progressive OOP payments.
- Progressive OOP spending is desirable in as much as the poor can still access the health services they need.
- Poor households in Cambodia still incur considerable costs in accessing health care, especially from the private sector.