HEALTH FINANCING EQUITY AND UNIVERSAL COVERAGE IN CAMBODIA: PROGRESS AND CHALLENGES

POLICY BRIEF
2018

INTRODUCTION

Health care in Cambodia has witnessed significant improvements in the last two decades. Even so, access to quality health care remains problematic, particularly for the poor and people who live in rural areas. The government has pledged support to the goal of universal health coverage (UHC) and is reforming the health financing system to align with this goal.[1] UHC means ensuring people have access to the health services they need at an affordable price.[2] An essential component of UHC is an equitable financing system that distributes health care benefits (public subsidy for health) according to need and the burden of financing health care according to ability-to-pay (ATP).[3] Using a system-wide approach, this project assesses how health care benefits and payments are distributed across the Cambodian population.

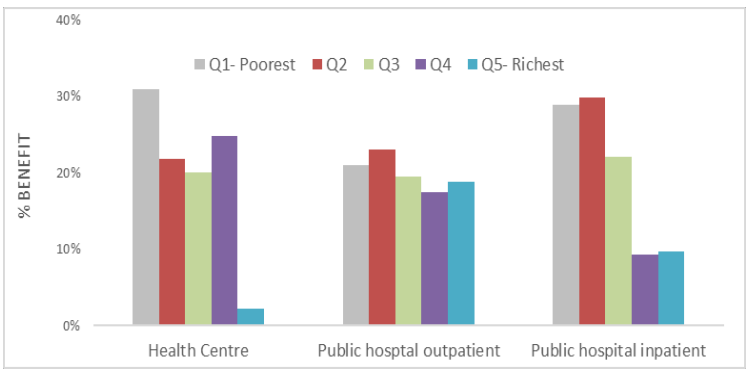
Q WHO BENEFITS FROM (GOVERNMENT) HEALTH SPENDING IN CAMBODIA – THE POOR OR THE RICH?

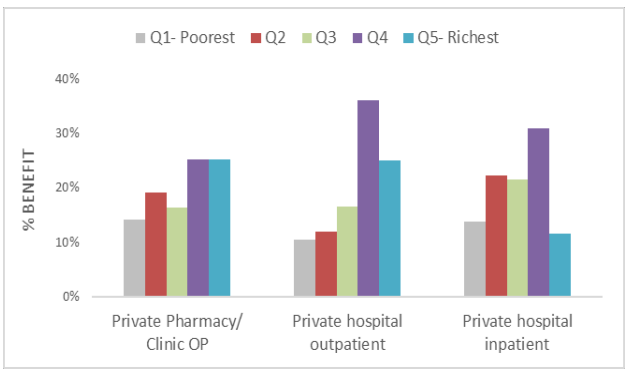
Approach: Benefit incidence analysis (BIA) was employed to assess who gains the most from government investments in the health sector – rich or poor. A nationally representative survey of 5000 randomly selected households was carried out to gather information on utilisation of various types of health services, the costs incurred for using these services, and socioeconomic status of households. Unit costs for different types of services were estimated using health expenditure and utilisation data from the Cambodia National Health Accounts, the Annual Health Statistics Report 2012, and the 2014 Cambodia Demographic and Health Survey.

Preliminary findings: Health care benefits (defined here as public subsidy for health care) at the primary care level were distributed in favour of the poor, with about 32% of health centre subsidy going to the poorest population quintile.

The benefits associated with public hospital outpatient care were quite evenly distributed across all wealth quintiles, although the concentration index (CI) of -0.059 suggests a moderately pro-poor distribution. The benefits from public hospital inpatient care were substantially pro-poor with a CI of -0.276. In contrast, the private sector, was significantly skewed towards the rich, who received 26% and 29% respectively of the benefits for private clinics and pharmacies and private hospital outpatient care. Private hospital inpatient care was mildly pro-rich. Relative to need, the distribution of total benefits in the public sector was pro-poor while the private sector was relatively pro-rich. **Looking across the entire health system, health financing in Cambodia benefits the rich although the public sector remains largely pro-poor.**

FIGURE 1. DISTRIBUTION OF HEALTH CARE BENEFITS FOR PUBLIC AND PRIVATE HEALTH SECTOR



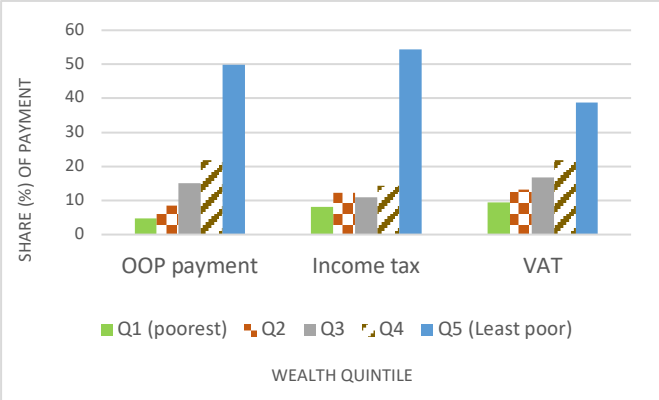


HOW IS THE BURDEN OF FINANCING THE CAMBODIAN HEALTH CARE SYSTEM DISTRIBUTED ACROSS THE POPULATION?

Cambodia spends around 6% of its GDP on health. In 2014 the total health expenditure (THE) was about US$1 billion or US$70 per capita.[4] Public sector spending accounts for nearly 48% of THE while the remaining 52% is allocated the private sector.[5] There are three main sources of finance for the health system – government (through taxation), donor funding, and out-of-pocket (OOP) payment. Government funding constitutes about 20% of THE and comprises both direct (40%) and indirect (60%) taxes. Donor funding accounts for 20% of THE, while OOP payments make up the remaining 60%.[6] Donor funding was excluded from this analysis as the incidence of this does not fall on Cambodian citizens.

Approach: Financing incidence analysis (FIA) was used to assess how the burden of financing health care in Cambodia is distributed across socioeconomic groups. Data from the Cambodia Socioeconomic Survey (CSES) 2014[7] were used. Household *per adult equivalent consumption* expenditure was used as a proxy for income.[8] To determine who bears the greater share of health financing burden, the concentration curves of the various financing sources were compared with the Lorenz curve of income to determine if one dominates the other.[9] The Lorenz curve provides a graphical representation of income or wealth distribution.[9] Dominance tests were conducted to ascertain whether any differences between the concentration and Lorenz curves were statistically significant. Finally, we assessed the relative progressivity of each financing source using the Kakwani Index (KI). The KI has values ranging from −2 to 1; a positive value indicates the rich bears the greater share of the health financing burden and a negative value the opposite.[10]

Preliminary findings: For two of the three sources of finance - income tax and OOP payment - the greater proportion of the financing burden was borne by richer Cambodians (Table 1). Value-added tax (VAT) was the only source of health finance in Cambodia for which the burden was more on the shoulders of the poor than the rich. VAT had a negative KI of -0.044 and a high concentration index (CI) of 0.290. Income tax constituted only a small proportion of total tax revenue in Cambodia (about 4%) and the rich contributed relatively more to this than the poor. This may be partly due to the large number of Cambodians who do not earn income exceeding the national tax threshold of 800,000 riels per month in 2014. The minimum wage was around $100 per month.[11] Households might have also understated their income in the socio-economic survey. OOP payment for health care remains problematic in Cambodia despite our finding that the poor do not generally spend OOP for health in excess of their ATP. The Health Equity Fund (HEF) - a national scheme designed to improve financial access to health services for the poor - may have, to some extent, protected the poor from OOP payment. **Overall, the rich in Cambodia bear the larger share of the health financing burden compared to the poor, although the poor still face immense difficulties in paying for health care.**



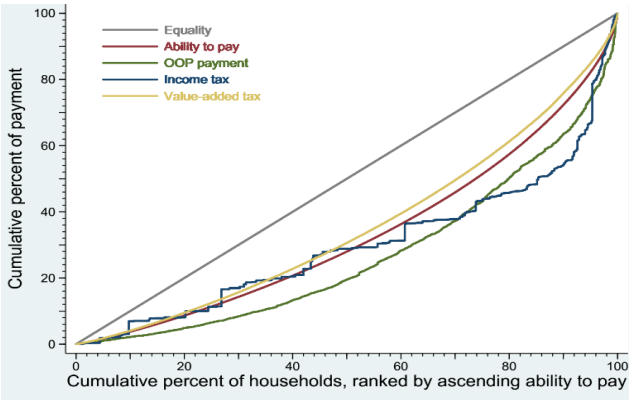


Table 1. Inequality indices for health financing sources in Cambodia

	Financing source			Total
	OOP payment	Income tax[a]	VAT[a]	
THE share (%)	76.0	9.6	14.4	100
GC, point estimate (SE)	0.334*** (0.0037)			
CI, point estimate (SE)	0.460*** (0.019)	0.403*** (0.096)	0.290*** (0.004)	0.430
KI, point estimate (SE)	0.126*** (0.035)	0.069 (0.118)	-0.044*** (0.003)	0.096

* P<0.05, ** P<0.01, *** P<0.001. GC= Gini Co-efficient; CI= Concentration index; KI= Kakwani index.

WHAT ARE THE DETERMINANTS OF 'DISTRESS' HEALTH FINANCING IN CAMBODIA?

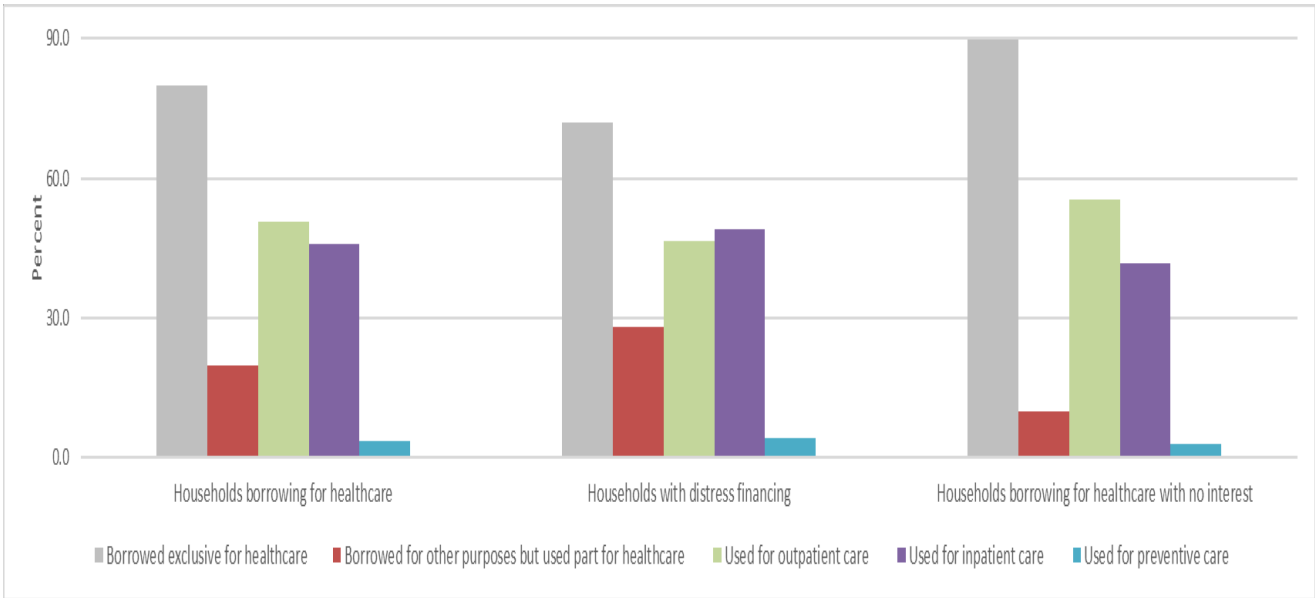
Borrowing to pay for health care is a common coping strategy for many households in Cambodia and other LMICs, especially where social health protection is limited or non-existent. "Distress health financing" refers to borrowing with interest, a form of financing that can push households into heavy indebtedness and exacerbate the financial consequences of their health care use. As part of this study we investigated distress health financing practices and its determinants among Cambodian households.

Approach: Multivariate logistic regression was used to determine factors associated with distress health financing. The same household survey conducted for the BIA was used for this analysis.

Preliminary findings: Around 28.0% of households using health care in Cambodia borrowed money to pay for the costs of that care, with 55% of these households subjected to distress financing. The median loan was US$125 (US$200 for loans with interest and US$75 for loans without interest). Approximately 51.0% of health care related loans were to pay for the costs of outpatient care, 45.8% for inpatient care, and 3.6% for preventive care. The average period for repayment of the loans was 8 months. However, about 78% of households were still indebted from loans taken in the 12 months preceding our survey. Distress financing was strongly associated with household poverty. The poorer the household the more likely it was to borrow, fall into debt, and be unable to pay off the debt. Being a member of the HEF was not a full protection against distress financing. Other determinants of distress financing were household size, use of inpatient care, and outpatient consultations with private providers or with both private and public providers.

Credit: GIZ Cambodia

FIGURE 2. HOUSEHOLDS HEALTHCARE BORROWING PRACTICES



WHAT DO THESE RESULTS MEAN FOR HEALTH FINANCING POLICY IN CAMBODIA?

Taken together, the above results clearly show that although Cambodia has come a long way in terms of improving access to health services, there is a lot still to be done, especially if the UHC dream is to become a reality.

- While the distribution of total health care benefits in the public sector is largely *pro-poor*, those in the private sector remain *pro-rich,* driven largely by a strong *pro-rich* distribution of private outpatient care. Given the large proportion of Cambodians that seek health care in the private sector, it is vital that the government pay specific attention to this sector, particularly in terms of regulation – the sector is highly unregulated, and nobody can attest to the quality of services it provides. If the quality of health care is low, this may subject patients to unnecessary and expensive care which may in turn pushes poor Cambodians further into poverty.
- The overall burden of financing the health system is disproportionately borne by the rich through a substantial OOP payment. The rich spending more OOP on health is desirable in as much as the poor can still access the health services they need and are not priced out of the health market. In Cambodia, although the greater part of the financing burden is borne by the rich, poor households still incur considerable costs in accessing health care, and this sometimes serves as a trigger for distress financing which pushes people into heavy indebtedness and deeper poverty. Households that seek care from private providers were found to be more susceptible to distress financing compared to those that sought care only in the public sector.
- Collectively, these results send a clear message that the level of financial risk protection currently offered to poorer households under the HEF and through other financing mechanisms targeting the poor is not sufficient to achieve the degree of financial risk protection necessary to move Cambodia towards UHC.
- In order to ensure effective financial risk protection, Cambodia should establish a more comprehensive and effective social health protection system that provides maximum population coverage and prioritises services for populations at risk of distress financing, especially poorer and larger households.

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