Improving access to and use of Reproductive Health Services by the poor and vulnerable in Cambodia

The Potential Role of Vouchers

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Despite an economic growth of around 9% over the past decade, the health situation of Cambodians remains poor and inequitably distributed among different socio-economic groups. With a per capita GDP of USD 818 in 2008[a] the country is still considered a low-income country. Eighty per cent of the total population of 13.4 million live in rural areas, largely relying on agriculture. One third of the population – mostly in rural areas – live under the national poverty line of half a dollar per day[b]. Whereas child health indicators did improve over the past 10 years, neonatal mortality and the maternal mortality ratio have remained high and stagnant.

Table 1 Maternal and child health related indicators

Indicators	CDHS 2000	CDHS 2005	CDHS 2010
Children 12-23 months fully vaccinated (%)	40	67	79
Use of modern contraceptive method (%)	19	27	35
Antenatal care at least once by trained personnel (%)	38	69	89
Deliveries in health facilities (%)	10	22	54
Deliveries assisted by trained personnel (%)	32	44	71
Exclusive breastfeeding	11	60	74
Total fertility rate	4.0	3.4	3.0
Infant mortality per 1,000 live births	95	66	45
Under 5 mortality per 1,000 live births	124	83	54
Maternal mortality ratio per 100,000 live births[c]	437	472	462

Source: CDHS Reports 2000 and 2005, and the Preliminary Report of the CDHS 2010

Iatrogenic impoverishment in Cambodia

Poverty correlates with ill-health, creating a vicious circle: poverty breeds ill-health and ill-health often exacerbates poverty. Serious illness not only causes suffering and death, but also has an important financial cost. Direct out-of-pocket payments for treatment and illness-related income loss can make a non-poor household poor, and push a poor household into destitution[1]. There is substantial evidence to show that ill-health is a major cause of impoverishment – iatrogenic impoverishment – especially in countries where social health protection systems are underdeveloped[2, 3].
In Cambodia access to services is hampered because of supply-side issues, but also demand- side barriers are noted, such as financial barriers impeding beneficiaries to seek and make use of essential services[4]. More than two thirds of the relatively high total health expenditure is direct out-of-pocket payments (USD 35 per capita, 2007). A number of studies showed that many poor households in Cambodia lost their land and went to heavy indebtedness because of illness[5-7].

Reducing financial barriers: improving access to care

To tackle some of the barriers to skilled care, especially in the domain of child and maternal health, the Cambodian government developed a National Social Protection Strategy for the Poor and Vulnerable. The Strategy highlights a number of interventions to protect households from impoverishment because of catastrophic health costs. The Strategy includes social health insurance for salaried workers and civil servants, community-based health insurance for the informal sector, and user fee exemptions.

Also under the Strategy, Health Equity Funds (HEFs) for the poor are promoted. Generally such funds are designed to remove financial barriers in accessing

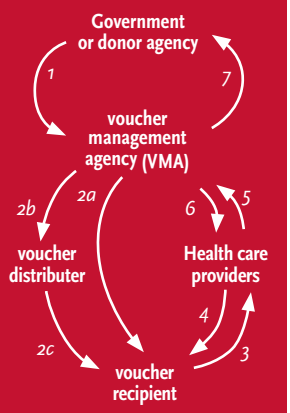

Figure 1:
Organizational structure of a voucher programme.

1 Government or donor agency establishes a voucher management agency (VMA) and transfers funds to the VMA

2 VMA produces vouchers and distributes them to the target population, either:
2a directly by itself, or
2b through a third-party voucher distributer, who
2c offers them to the target clients

3 Voucher recipient selects a provider and takes the voucher to the provider of choice (and redeems the voucher for a pre-specified service or product)

4 Provider accepts voucher and delivers service or product

5 Provider returns vouchers received to VMA (with any necessary documentation)

6 VMA pays the service provider a contracted amount for each returned voucher

7 VMA monitors program and reports outcomes to the funding agency

Source: PSP-One (2006)[9]

public health services at hospital level, and in some cases – as in Cambodia – also at primary health care level. In most HEF schemes the management fund is entrusted to a third party, usually a national NGO that is supported and monitored by international NGOs/ donors. In a few cases the Ministry of Health operates equity funds, but so far these have been less successful. Beneficiaries of the fund are identified within the community, when seeking services at the facility, or a combination of both. At the health facilities, the eligible poor patients receive full or partial support from the HEF for the cost of user fees (mainly hospital user fees), plus transport costs and other related costs during hospitalization. Since the first pilots in 2000, the number of health funds has increased significantly. As of April 2010, there were 57 HEF schemes being implemented in Cambodia. Evidence from several studies suggest their effectiveness based on data showing improved access to public hospital services by the poor, and reduced out-of-pocket payments and health care-related debts, preventing iatrogenic impoverishment among poor rural populations.
As Health Equity Funds, vouchers are a social health protection mechanism where subsidies from government or donor agencies are used to stimulate demand for priority goods or services from under-served population groups. Subsidies go directly to the consumer in the form of a voucher that the consumer redeems when demanding the goods/services from a public or private provider, either free of charge or at a reduced price[8,9]. Figure 1 presents the organizational structure of a voucher programme, illustrating the different steps in a generic (health) voucher programme.

Increasingly in many low-income countries vouchers are being introduced for promoting access to and use of reproductive health services. Evaluations of such programmes are showing positive results[9-13].

Potential benefits and pitfalls of voucher schemes

Vouchers can effectively target poor and/or vulnerable populations. As vouchers reduce financial barriers to care, they potentially increase the utilisation of priority health services. When the voucher is distributed, information regarding the relevance of the service is provided, and this can further increase the use of the services. The voucher itself transfers purchasing power to the beneficiaries and this may have an empowering effect on them. On the supply-side, the voucher scheme can positively influence the quality of health services. Generally, vouchers are easier to administer than other demand-side subsidies.
However, health vouchers also have some limitations. In the absence of an effective monitoring system they are susceptible to fraud or abuse. Establishing a voucher programme, including a rigorous monitoring system, can be technically complex and costly. However, once developed, a voucher programme is relatively easy to run and costs come down.
Generally, vouchers are introduced to remove financial and other barriers to priority health services. As such, the schemes are instruments in tackling important public health problems, such as maternal mortality.

Differences between HEF and vouchers

HEF and vouchers are both social health protection mechanisms with many similarities (see table 2 for a comparison of HEFs and vouchers). However, there are also important differences, the most striking ones being: 1) type of services covered and level of facility: HEF covers all services mostly at hospital level, vouchers cover specific priority services at all facility levels, 2) targeting: vouchers actively inform, promote and invite the beneficiary to use a particular service, while HEF covers the service once the beneficiary decides he or she needs the service, 3) administrative: the voucher itself serves as monitoring instrument, while HEF has a staff member at each facility to collect the information and to check for abuse and fraud.

Experience with voucher schemes in Cambodia

Since 2007 the Ministry of Health has implemented vouchers for maternal health services targeting poor women in three rural health districts in Kampong Cham province, with support of the Belgian Technical Cooperation. It was set up to complement the existing Health Equity Funds in target districts, and to increase the use of antenatal and postnatal services at public health centres and to promote skilled attendance at birth. Evaluations of this scheme, using routine data, focus group discussions and key informants interviews, were conducted at the end of the first and second year of implementation. The findings demonstrated a strong potential of vouchers to complement other interventions to overcome demand-side barriers of access to skilled birth attendance for poor pregnant women in rural Cambodia [14].
Another voucher scheme is the 'Purchase Maternal and Newborn Health Services' programme implemented by the Reproductive Health Association of Cambodia (since 2008, supported by USAID). This programme targets all pregnant women – poor and non-poor – in 18 health districts in five provinces. Although no in-depth impact assessment of this scheme has been conducted so far, analysis of the available data suggests that the scheme is contributing to an increased number of deliveries in public health facilities.
Since early 2011, a voucher scheme for reproductive and maternal health services (funded by the German Development Bank KfW) has been launched in nine

Table 2: Comparison of key characteristics of HEFs and vouchers

Key characteristics	HEFs	Vouchers
Type of scheme	demand-side social health protection mechanism	demand-side social health protection mechanism
Sources of funding	public (government and/or donor) subsidies	public (government and/or donor) subsidies with possibly a small contribution by client
Implementation/ operation	mostly by a third party, usually NGO, but sometimes done by a government body	often by a third party, usually NGO, but several large voucher schemes are operated by a government body
Target population	the poor (those under the national poverty line)	the poor and vulnerable groups
Health service providers	exclusively public health facilities	public health facilities, but also private (for-profit and non-profit) providers
Level of health service providers	originally only hospitals, recently some HEFs have been experimenting with inclusion of primary health care centres	all levels of health service providers, from primary health care centres, district hospitals to referral hospitals
Health services covered	all kinds of services available at the contracted facilities	mostly specific services (those of high priority, and easy to be defined)
Physical entitlement	HEF card (or poor card) for pre-identified poor households	Voucher (certificate or other token), with an indication of covered services and other benefits (often with monetary value, including a small conditional cash transfer)
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health districts in the provinces of Kampong Thom, Prey Veng and Kampot. Overall responsibility for the financial cooperation-component lies with the Ministry of Health as project executing agency.[d] The scheme forms part of a joint Cambodian-German 'Social Health Protection Programme', and covers safe motherhood, family planning and comprehensive abortion services.[e] In addition, it also reimburses transportation and other costs associated with a visit to the health centre and a hospital stay (if not covered by an existing HEF). Safe motherhood and family planning services are limited to eligible poor pregnant women, whereas comprehensive abortion care is provided to all women in need. The services are provided by selected public health facilities (mainly health centres), and some (not-for-profit) private health providers – such as Marie Stopes International for family planning and comprehensive abortion care services. Though it is too early to assess outcomes, preliminary data show a high number of women seeking safe abortion care – a figure far larger than expected, indicating the need for such services in rural areas.

Conclusions and discussion

In Cambodia, despite considerable progress in the health sector, access to effective and affordable health care remains a problem, especially for the poor and vulnerable. More than two thirds of health care expenditure is paid for directly out-of-pocket, mainly to private health providers. Several social health protection mechanisms have been developed to address this problem. HEFs have proven effectiveness in improving access to public hospital services for the poor, and have demonstrated potential for protecting the poor from iatrogenic impoverishment. However, there is no evidence of the cost-effectiveness of HEFs at health centre level. Moreover, HEFs cover only 70% of the public referral hospitals and 20% of the public health

centres. Further implementation and expansion of HEFs face a number of challenges, including the lack of reliable and sustained funding.

Health vouchers are considered a potentially effective means to address demand-side barriers to access to, and use of, priority health goods or health services for particular population groups, usually the poor and socially disadvantaged. There is a body of evidence of the impact of health vouchers on access to and utilisation of reproductive health services and insecticide-treated bed-nets[10-13]. Since 2007 health vouchers have been implemented in Cambodia. Most of these programmes are an extension of HEFs, specifically targeting poor pregnant women for delivery and associated services at public health facilities, including support for transport and referral services in case of complications.

Although not specifically mentioned in the social health protection policies in Cambodia, health vouchers are a social health protection mechanism sharing many key characteristics of HEFs. Available evidence suggests that if well-designed and implemented, health vouchers have some advantages over other mechanisms. Their strength lies in the ability to target the neediest and actively inform and invite them to use the health services, thereby increasing the demand for these services. There are other advantages, such as their potential to increase quality and their relative ease of administration, once the voucher scheme is established. However, like other output-based financing mechanisms, health vouchers require close monitoring to prevent over-reporting, abuse or fraud.

Taking into account the current gaps in health financing of priority services which are not covered by HEF or other SHP mechanisms, there is a strong case for scaling up health vouchers. Applying vouchers would complement the existing mechanisms in providing social health protection to the poor and vulnerable. Health vouchers are particularly suitable for specific health services of high priority such as reproductive and maternal health services, preventive and curative services for major communicable diseases (e.g. HIV/AIDS, tuberculosis and malaria), and chronic non-communicable diseases (hypertension, diabetes and associated disorders, and cataract-related blindness). Although health vouchers also need to be subsidised by government and donor funding, expanding health vouchers for clearly defined priority health services may minimise funding constraints, as this is potentially less expensive than expanding HEFs for all available health goods or health services.

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a | http://www.globalpropertyguide.com/Asia/Cambodia/gdp-per-capita; accessed on August 17th, 2011
b | 2007 Cambodian Socio-Economic Survey
c | The maternal mortality ratio from CDHS 2010 is not available yet. Therefore, the figure of National Census 2008 (462) is used.
d | MOH and KfW subcontracted the management of the voucher scheme to EPOS Health Management, a German consulting firm as the lead agency, together with other partners Oxford Policy Management, PriceWaterhouseCoopers and Action for Health. EPOS, Oxford Policy Management and Action for Health have a delegate in the voucher management agency, that manages the voucher scheme locally.
e | Services covered: (1) Safe Motherhood (three antenatal care, labour and delivery, one postnatal care to six weeks, and referral services, including C-section if not covered by HEF), (2) family planning (advice and counselling on available methods, IUD and implant insertion and removal, female

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