Institutional and operational barriers to strengthening universal coverage in Cambodia: options for policy development

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Nossal Institute for Global Health
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SUMMARY

The government of Cambodia and development partners have indicated in different ways that it is timely to move to greater integration in social health protection schemes—in particular, health equity funds (HEFs) and community-based health insurance (CBHI)—to provide health coverage of the poor and the informal sector. The possibility now exists to establish a national agency for HEF, CBHI, voucher and other schemes as a step towards universal coverage. This would constitute one of the country’s major social reforms of the past two decades.

Health equity funds cover three-quarters of the poor population nationally with subsidised free access to government health facilities. Voluntary CBHI schemes, which aim to cover informal-sector people who can afford to pay the premiums, are implemented in many health operational districts (ODs). The government, the Ministry of Health (MOH) and development partners are preparing to scale up and move these schemes, which are currently administered mainly through non-government agencies, under national institutions or administration.

In this study, we identify the key barriers to policy change and to strengthening national institutions for implementation of universal coverage, and suggest options for overcoming these barriers. The findings indicate that policy makers are generally in favour of establishing an interim social health protection agency for the informal sector, including both HEF and CBHI schemes. Representation of formal-sector workers is being arranged separately through the Ministry of Labour and Vocational Training (MOLVT) and the Ministry of Social Affairs, Veterans and Youth Rehabilitation. Preferably, the HEF-CBHI agency would be autonomous, attached to but independent of the MOH. Experiences from this arrangement would assist in the reformulation and implementation of the broader Master Plan for Social Health Protection (currently in draft form and under consideration within the government), which proposes a single national agency for all sectors and all schemes.

While there is as yet no clear, consistent strategic direction for establishing a national agency, carefully identifying the policy and institutional barriers and working out an appropriate response through close and effective collaboration between the government, MOH and development partners is essential.
INTRODUCTION

Ensuring equity and affordable access to health care for all without incurring catastrophic financial consequences—universal health care coverage—has been identified as a key health policy goal (WHO 2010). By strengthening financial protection through addressing the three main health financing functions—revenue collection, pooling of resources and purchasing of services—all countries can move towards universal coverage (Evans and Etienne 2010; WHO 2005; Mathauer and Carrin 2011; Poletti, Balabanova et al 2007).

In Cambodia, out-of-pocket spending is more than two-thirds of total health expenditure; more than one-quarter of the population live below the poverty line and are, by definition, unable to pay for health care. Removing financial barriers at the point of care and developing social health protection mechanisms constitute one of the five objectives of the MOH’s health financing framework (MOH 2008a). While HEFs now provide financial access to government health services for almost 80 per cent of the poor population (MOH 2011), and community-based health insurance (CBHI) offers coverage of the non-poor informal sector in a limited number of health ODs, social health insurance mechanisms for the formally employed sector are yet to be initiated.

Demand-Side Health Financing

Government funding for health care has increased significantly in recent years, and further improvement is possible. The greater part of government health expenditures is provided through the government budget (with donor support) for facilities, medical equipment and supplies, drug supply and staffing. Facilities have the right, however, to generate supplementary revenue through user fees, which are used for staff incentives and running costs. HEFs and a variety of demand-side subsidies now fund reimbursement of user-fee exemptions for the poor and insured patients at government facilities. While this has provided financial access to services for the poor and the near poor, reduced health costs and minimised impoverishment of households, taken together social health protection schemes have not yet had a major impact on reducing out-of-pocket spending overall (Flores, Ir et al 2011).

The government, donors and NGOs have worked together in recent years to create different OD social health protection mechanisms for the poor and the informal sector. Table 1 summarises these demand-side financing schemes, including HEFs, CBHI, user-fee exemptions, the government subsidy schemes (SUBO), vouchers and conditional cash transfers (Ros 2011). These demand-side schemes are considered intermediate social protection measures for the poor and the informal sector and as preparation for a longer term move to a unified national program under the Draft Master Plan for Social Health Protection now under consideration by the government (Kingdom of Cambodia 2009).

Health Equity Funds, Subsidy Schemes and Community-Based Health Insurance

Health equity funds are a demand-side, social health protection (SHP) mechanism designed to provide access to government health services for the poor and to protect them from catastrophic health expenditure (MOH 2008a; MOH 2011). The poor are pre-identified (prior to service) or post-identified (at the point of service) according to objective criteria. The HEF operators fully reimburse contracted public health facilities for exemptions from user fees for services provided to eligible poor patients. The fund also reimburses patient and carer food and transportation costs, limited funeral expenses and other basic items (MOH 2011).

Beginning in 2000, Cambodia was the first country to introduce this form of HEF, as a third-party payer for services at public health facilities. Until now, each HEF has been managed at OD level by a local agent (commonly a local NGO, known as the HEF operator) and supervised at the national level by an international NGO (known as the HEF implementer). HEFs are funded mainly by donor and government counterpart funds through the national MOH-donor Health Sector Support Program (HSSP). Through the MOH, the government also solely funds its own subsidy schemes for the poor (SUBO) at selected facilities. Donors include the World Bank, USAID, AusAID, UNFPA, UNICEF and BTC, most of the funding passing through a pooling arrangement under the HSSP.

Currently, HEFs operate in 44 ODs in 23 provinces and Phnom Penh municipality (including 42 referral hospitals and 323 health centres), covering approximately 78 per
### TABLE 1. OVERVIEW OF HEALTH FINANCING SCHEMES IN CAMBODIA

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Implementer/ Operator</th>
<th>Target group</th>
<th>Benefit/Service</th>
<th>Coverage/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax funding via government budget</td>
<td>MEF/MOH/provincial health department/OD/referral hospital/health centre</td>
<td>All population sectors</td>
<td>Recurrent funding, drug and material supplies</td>
<td>Nationwide public health facilities</td>
</tr>
<tr>
<td>User fee* exemptions</td>
<td>MOH/health facilities</td>
<td>Poor patients</td>
<td>User fees</td>
<td>Nationwide</td>
</tr>
<tr>
<td>Global health initiatives and national programs</td>
<td>National programs</td>
<td>Patients with TB, malaria, AIDS and children for vaccination</td>
<td>Free of charge</td>
<td>Nationwide</td>
</tr>
<tr>
<td>HEFs</td>
<td>NGOs for HEFs</td>
<td>The eligible poor (those under the national poverty line)</td>
<td>User fees, food, transport, limited funeral expenses and other basic items</td>
<td>In 46 referral hospitals and 318 health centres, covering approx. 78% of the target group</td>
</tr>
<tr>
<td>Government subsidy schemes</td>
<td>MOH/provincial health department/OD</td>
<td>The eligible poor (those under the national poverty line)</td>
<td>User fees</td>
<td>In 6 national hospitals and 10 referral hospitals and 89 health centres</td>
</tr>
<tr>
<td>CBHI</td>
<td>Mainly NGOs</td>
<td>Mainly informal sector living above poverty line</td>
<td>User fees</td>
<td>In 16 hospitals and 164 health centres, covering &lt; 1% of the population</td>
</tr>
<tr>
<td>Vouchers</td>
<td>MOH/NGOs</td>
<td>Poor pregnant women</td>
<td>User fees and transport for 3 ANCs, delivery and PNC at health centres</td>
<td>In 5 ODs</td>
</tr>
<tr>
<td>Occupational risk</td>
<td>MOLVT/National Social Security Fund (NSSF)</td>
<td>Formal sector workers</td>
<td>User fees (medical care), transportation, temporary/permanent disability benefits, funeral expenses and survivor benefit</td>
<td>In 3 national hospitals and 12 referral hospitals in 7 provinces, covering approx. 40% of formal sector workers</td>
</tr>
<tr>
<td>Maternity benefits</td>
<td>MOLVT/NSSF Ministry of Social Affairs, Veterans and Youth Rehabilitation/NCSSF**</td>
<td>Pregnant women formal sector workers and civil servants (spouses)</td>
<td>3 month maternity leave with 50% salary for workers. For civil servants, 3 month maternity leave with full salary and cash incentive of USD150 per newborn</td>
<td>Nationwide</td>
</tr>
<tr>
<td>Social health insurance</td>
<td>NSSF NCSSF</td>
<td>Formal sector workers and civil servants</td>
<td>Still to be defined</td>
<td>Being developed</td>
</tr>
<tr>
<td>Special Operating Agency facilities</td>
<td>MOH/donors/Health Sector Support Program</td>
<td>All population in the coverage area</td>
<td>Decentralised and performance-based incentives for providers</td>
<td>In 30 operational health districts</td>
</tr>
</tbody>
</table>

* User fees do not provide for full cost recovery but are set according to affordability by the majority of people, in principle with the involvement and support of the community and local authorities before approval by the MOH.

** National Civil Servant Social Security Fund.

Source: Ros 2011.
cent of the population living below the poverty line (MOH 2011). A review of the literature on HEFs in Cambodia 2001-10 found that HEFs are an effective means of providing financial access to public health facilities for the poor and an effective form of financial protection for health (i.e. social health protection) (Annear 2010). The MOH’s Health Strategic Plan 2008-15 aims to promote and finance the expansion of HEFs to achieve national coverage (MOH 2008b).12

The government subsidy scheme, SUBO, is described as one type of HEF. The MOH provides direct funding for OD- and hospital-based subsidies as a line in the annual budget. Currently, the schemes directly reimburse health facilities for user fees exempted for the poor at six national hospitals, 10 referral hospitals and 89 health centres in 12 ODs (Social Health Protection 2011; Men, Ir et al 2011). There is no third-party operator for these schemes, and the concerned health facilities are responsible for the schemes’ operation. The SUBO does not cover food, transportation or other social support.

Community-based health insurance schemes were initiated in a few districts in 1998. There are now 18 CBHI schemes in 17 ODs in 10 provinces, with a total membership of 170,490; these schemes are available in the catchment areas of 164 health centres, 13 primary referral hospitals and nine secondary referral hospitals (MOH 2011; Ros 2011; Annear 2008; Annear, Bigdeli et al 2008). All CBHI schemes cover both hospital and health centre services and associated treatment costs. Operated entirely by international and local NGOs and subsidised with donor funding under MOH guidelines, the CBHI schemes provide coverage mainly for the non-poor in the informal sector. They do not target the poor. The CBHI schemes contract only with public health facilities to provide services to their members.

The Policy Challenge

The operation of these schemes by government, donors and various international and local NGOs has resulted in a fragmented system with high overhead costs (MOH 2008c; Jacobs, Price and Sam 2007; Crossland and Conway 2002), high monitoring and evaluation costs and complex reporting requirements. Fragmentation has complicated the stewardship functions of the MOH, stretches the capacity of the MOH to coordinate and support the different arrangements and undermines the financial sustainability of the schemes (Jacobs, Price and Sam 2007; Jacobs and Price 2006).

More importantly, the rapid expansion of HEFs both provides the opportunity to move to national coverage of the poor and presents challenges concerning institutional capacities for national administration. While the MOH provides national guidelines for HEF, SUBO and CBHI implementation and is responsible for funding passed through the HSSP, consultation and approval between the MOH, development partners and scheme implementers commonly precede their implementation. The different implementation arrangements have weakened planning, monitoring and management information systems.

The imminent expansion of HEFs to national coverage raises the unique opportunity to address fragmentation in demand-side schemes, expand population coverage and achieve greater administrative efficiencies through the establishment of a national HEF-CBHI agency, either through the MOH or as an autonomous government agency. This recommendation has been noted already in several documents (Men, Ir et al 2011; Annear 2008; Annear, Bigdeli et al 2008; MOH and World Bank 2011; Martinez, Simmonds et al 2011). A national HEF-CBHI agency would take over responsibility for regulation and national administration of these schemes.

Paralleling these institutional challenges, a national agency would also be responsible for managing the three key health-financing functions and accelerating progress towards universal coverage:

- **Revenue collection and resource mobilisation:** Harmonise and align donor and government funding for sustainable financing of HEFs and CBHI.
- **Fund pooling:** Pooling of funds from different sources (government and donor) to scale up HEFs and increase coverage of the poor and vulnerable populations; manage linkages between HEF and CBHI schemes in a way that avoids unwanted cross-subsidies that favour the better off (Annear, Bigdeli and Jacobs 2011).
- **Purchasing of services:** Using pooled funds and the purchasing power of a uniform national agency as leverage to provide improved quality of health service.

These are challenging tasks, and planners face numerous constraints. By identifying the main policy
and operational barriers to a national agency, and developing policy options that help to overcome these barriers, the MOH and partners can form a common strategy and discover a way forward. In this process, it is necessary to examine critically the views and values of government policy makers, development partners and scheme implementers, who may have different interests and may respond differently to new opportunities and to change (Antunes and Saksena 2009; Brenzel and Naimoli 2009).

METHODS

The findings of this report are based on a review of policy documents and on qualitative data collected through key informant interviews. The principal official documents reviewed included the MOH’s Health Strategic Plan 2008-15, the draft Master Plan for Social Health Protection and the Strategic Framework for Health Financing 2008-15. Supplementary publications and documents were also assessed, including the Overall Assessment for Mid Term Review of Health Strategic Plan 2008-15, the Evaluation of Subsidy Schemes Under Prakas 809, the MOH’s Annual Health Financing Report 2010 and the MOH’s Guideline for Implementation of Health Equity Funds and Government Subsidy Schemes. Different NGOs and donor-partner documents were reviewed, including the draft MOH-World Bank Synthesis Assessment of Supply- and Demand-side Issues for the Mid-term Review of the Health Strategic Plan 2008-15.

The key documents were sourced from the MOH, development partners and NGOs. The policy documents were reviewed against a prepared list of topics to determine the level and nature of support for establishing a national agency, to understand the most common constraints and to identify possible options for policy development. Gaps in understanding or information were noted for further analysis.

Key informant interviews were carried out to collect the perspectives of health financing policy makers and program implementers. Purposive sampling was used to select informants from:

- national policy makers at various ministries (including the MOH, the Ministry of Economics and Finance, the Council for Agriculture and Rural Development and the Council for Administrative Reform)
- development partners
- scheme implementers and operators.

The research team interviewed 18 key informants, comprising 10 national policy makers, four representatives of development partner organisations and four program managers. Informants were guaranteed anonymity to encourage an open expression of their views.

Interviews were carried out in September 2011 using a semi-structured questionnaire to collect information on the policy and operational barriers to establishing a national agency and to investigate the policy options. The instrument was designed to collect data on both the institutional barriers related to administration and management, including agency location, staffing, capacity strengthening and financial management, and health financing challenges related to the three principal health financing functions.

Data were analysed using the OASIS conceptual framework proposed by Mathauer and Carrin (2011) (see Figure 1), which identifies stewardship functions related to resource collection, fund pooling and service provision at two levels: (1) institutional design and organisational practice and (2) nine key health financing performance indicators. This provides a strong analytical framework for policy making within the context of moving towards universal coverage.

FINDINGS

Documentary Analysis

The recent World Bank Synthesis Assessment echoes an increasingly common view among domestic and international policy makers in Cambodia that ‘it is now of the highest priority to begin establishing a national institution to implement HEFs and CBHI, and to hand over capacity and systems from the national HEF implementers to this system.’ The key documents carry a common message, building from the commitment to universal coverage in the broad Health Strategic Plan and working consistently through appropriate stages in establishing achievable and appropriate social health protection mechanisms. The main documents reflect the institutional and financial challenges involved:

- The Health Strategic Plan: proposes a ‘mixed model’ of health financing that combines public
FIGURE 1. SUMMARY OF THE PROPOSED ANALYTICAL FRAMEWORK

Stewardship

Resource Collection and related tasks
- Institutional design
- Organisational practice

Pooling and related tasks
- Institutional design
- Organisational practice

Purchasing/provision and related tasks
- Institutional design
- Organisational practice

Sufficiency and sustainable resource generation

Financial accessibility

Optimal use of resources

Universal coverage

Improved and equitable health outcomes


*BP = Benefit package
and private revenue collection and service delivery with fee-based pre-payment and social-transfer mechanisms, including HEF, CBHI and social health insurance schemes; the ultimate objective is to bring all pre-payment schemes under a common institutional umbrella that combines the different elements of the current health financing system into a single strategy and moves towards universal coverage.

- **The Strategic Framework for Health Financing:** within the ‘mixed model’, focuses on strengthening government funding (Strategic Objective 1) and on reinforcing interim measures to protect households (Strategic Objective 3); as immediate measures, recommends the strengthening of the different existing SHP mechanisms, in particular the scaling up of HEFs along with the expansion of CBHI as an intermediate measure leading to implementation of compulsory health insurance; proposes to prepare existing schemes for an eventual move to universal coverage.

- **The Draft Master Plan on Social Health Protection:** proposes steps including consolidation of existing demand-side financing schemes for the poor and the informal sector before a long-term strategy to consolidate all existing schemes (particularly HEFs and CBHI and the proposed formal-sector social health insurance scheme) under a single national administration; and proposes the establishment of a national, inter-ministerial Social Health Protection Committee under the direction of the central government to formulate strategy, develop policy and coordinate the implementation of the social health protection system.

- **The Overall Assessment for Mid-Term Review of Health Strategic Plan:** significantly, recommends scaling up HEFs to cover the poor population in all ODs nationally, increasing government funding to HEFs and developing an institutional arrangement to transfer national HEF management and funding functions to a government-led institution; proposes expanding coverage of the proposed compulsory private-sector employee health insurance scheme under the National Social Security Fund and implementation of the proposed compulsory health insurance scheme under the National Civil Servants Social Security Fund (NCSSF); recommends defining the scope of work of a joint MOH and health partners technical group for health financing matters.

- **The Evaluation of Subsidy Schemes Under Prakas 809:** having found a number of gaps and challenges in the design and implementation of the government’s subsidy scheme, recommends continuing the scheme only with improved design consistent with HEFs, or using the SUBO budget line to pay user fee exemptions through the HEFs, or replacing the SUBO with HEFs supported by government funding; eventual integration with HEFs was the preferred option; a government third-party agency will be required in this case because the government does not favour an NGO third-party arrangement.

- **The Synthesis Assessment of Supply- and Demand-side Initiatives:** the MOH-World Bank document sees the highest priority as beginning now to establish a public institution to implement HEFs and CBHI and to hand over capacity and systems from current NGO implementers to this institution; among detailed recommendations, proposes the establishment of a National Social Security Fund for Subsidy Schemes (NSSF-S) comprising HEFs and CBHI for the poor and the informal sector, together with developing regional structures in line with decentralisation; also sees as a high priority establishing a national SHP umbrella structure in line with the Master Plan.

The documentary analyses found that a significant institutional shortfall undermines the effectiveness of the different SHP schemes. The expansion of SHP coverage of the poor and the informal sector through demand-side schemes is widely regarded as the next step along the path towards universal coverage. The documents are, however, prescriptive and not analytical, and propose policies and initiatives that reflect a wider discussion among the main stakeholders. A deeper understanding of the concrete measures needed for further reform, and the means for identifying the pathways available for these measures, can be achieved only by a critical investigation of the views and values of the main health financing stakeholders. These include both the key institutional and organisational design issues and the health financing issues identified by Mathauer and Carrin (2011). While the main documents refer to such questions, they do not investigate them critically or define solutions. The investigation of key stakeholder and policy maker attitudes provides evidence for further policy making.
Key Informant Analysis

While the key reports propose initiatives for moving to national responsibility for implementation, institutional strengthening and combination of demand-side schemes, progress in this direction has been constrained by a lack of clarity and agreement on the precise measures required to move ahead. The Master Plan is yet to be officially adopted, arrangements for transferring HEF implementation to the government have not been agreed on, and institutional and organisational capacity to govern and implement the demand-side arrangements has not yet been developed.

Key informants provided a deeper understanding and additional information both on the institutional and policy barriers that constrain implementation of the recommendations of the key reports and on the health financing practices that are necessary for achieving effectiveness and equity in universal access to health services.

INSTITUTIONAL AND POLICY BARRIERS

Key informants responded to questions on institutional design related to the draft Master Plan, the proposed location of a national agency, the institutional and organisational structure, its mandate and its responsibilities, institutional and human resources capacity development, management information systems and procedures for financial management and accountability.

Draft Master Plan on Social Health Protection:
Many informants saw the Master Plan (which is yet to be adopted by the government) only as a long-term plan and understood it would take a long time to bring the formal and informal sector schemes under a single institutional arrangement. Some thought the Master Plan may appear too ambitious and this could explain the delay in adopting the draft.

The main aim of the Master Plan is not to centralise management power to any single institution, but [to propose] a multi-sectoral approach within a common strategic framework (Key informant #4).

I don’t support the idea of the Master Plan. HEF is a subsidy program, and CBHI is based on an insurance mechanism; the context is different. There would be conflicts of interest among the ministries. Complete integration is not possible and not realistic (Key informant #7).

Establishing a national HEF-CBHI agency: Key informants favoured the establishment of a national HEF-CBHI agency as an intermediate arrangement, rather than waiting for the implementation of the draft Master Plan. The informants emphasised the political will and leadership and commitment needed to establish such an agency. While there is agreement on such a course within government, the mechanisms to achieve it are yet to be found.

Implementation of the Master Plan is not easy and may not be feasible in the short run. We must go step by step, and we know in other countries this process takes a very long time. It is better to be more realistic for any future plan, and it should be based on a feasibility study and experience from pilot projects and proper studies (Key informant #18).

We don’t need to wait for a long-term arrangement for all insurance schemes at this stage; we should go ahead for the [poor and the] informal sector (Key informant #11).

For any new initiative or proposal, the most realistic thing for me is a gradual expansion plan, starting in a few places as a pilot and drawing the lessons and then gradually expanding it. If we can do that, the request for government funding will be easier (Key informant #6).

One informant explained that HEFs, which can be established relatively quickly in new ODs through the current NGO programs, can be expanded into new geographic areas without waiting for new institutional arrangements or establishment of a national agency. This would create little additional burden following transfer to government-led administration. In the meantime, the processes needed for reform and institutional change towards an autonomous national structure could take place. Some key informants, though, thought it may be dangerous to move too quickly to set up a national HEF-CBHI agency because
it may lead to competition and diverse actions among different health financing stakeholders.

I am not sure whether we need an autonomous HEF agency. From a SHP perspective, there is no need for MOH to create an autonomous agency (Key informant #8).

Location of the national agency: Most informants stressed the need for an autonomous agency, rather than one placed within the MOH internal structures. There was, however, considerable confusion about its location, whether within the MOH or alongside it. Some informants recommended the Council of the Minsters (the executive body of the government) as a location for the agency.

The MOH will face a conflict of interest, because it is responsible for delivering quality health services, and so it cannot also be the same institution that is responsible for paying for these health services. The payment for health services must be with an independent institution outside of the MOH, but this problem is not yet solved (Key informant #15).

The MOH, especially the DPHI [Department of Public Health Information], is doing its job relatively well regarding these tasks compared to other ministries. The implementation and the scaling up of HEFs seem to go well and they are better performing and less fragmented than CBHI. Let the MOH and the DPHI continue to do their job, while giving more technical and financial support to and more collaboration with them (Key informant #2).

The MOH does not have sufficient capacity to implement and monitor the activities of a national HEF-CBHI agency. The MOH will need enough human capacity and other resources. The agency at the beginning could be located at the MOH and later could be converted to an independent agency attached to the MOH (Key informant #16).

Organisational structure, including reporting: According to most informants, a sub-decree (legal authorisation), terms of reference and organogram will be needed for the proposed national HEF-CBHI agency, which should be governed by an independent board. A sub-decree could establish the national agency as a Public Administrative Enterprise. The board could include higher level policy makers from the Council of Ministers, MOH, Ministry of Economy and Finance, the Ministry of Labour and Vocational Training's NSSF, the Ministry of Social Welfare, Veterans and Youth Affairs’ NCSSF, HEF implementers, CBHI implementers and community representatives. Reporting could be directly to the Office of the Prime Minster, regardless of the location of the agency.

Capacity development: Stronger administrative, management and technical capacities are needed for operational tasks, monitoring and evaluation, contracting arrangements and management, procurement and managing NGOs, community-based organisations and private organisations. The agency requires qualified professionals, including health economists, financing specialists, coordinators, technical professionals, public health doctors, accountants, IT professionals and evaluation specialists.

The lack of funding and capacity in implementation of the HEFs and CBHI within the government structure are the two main challenges for the government to take over this role completely (Key informant #10).

Initially, the required staff and infrastructure could be seconded, under contract, from the existing NGO administrators. The proposed board could identify staff requirements and initiate staff recruitment. Interdepartmental transfers could be used to bring experienced professionals from other areas of government administration, though this would require a high level of cooperation and trust and initiatives at the political level. Some informants proposed recruitment from the private sector, but cautioned against recruitment of employees from the existing HEF and CBHI schemes to avoid conflict of interest.

Management information system: Most informants recognised the need for a common, central membership and reporting database for all HEF and CBHI schemes,
but also expressed concern that the required capacity may not exist.

We do not have a common national monitoring and evaluation framework for SHP schemes, including key indicators for different levels of activities. So far, very few institutions or line ministries have a clear monitoring and evaluation system for their schemes, and data on only a few indicators have been collected. This results from a lack of a central data management system (Key informant #1).

However, key informants believed that developing a common database between schemes would be challenging and require standardised reporting formats. Currently, each scheme has its own database, though a single IT system could handle different data sets.

Contracting out the IT requirements at the beginning could be an option. IT professionals of the national agency will get the opportunity to work with the experienced professionals of the contracted agency (Key informant #12).

**Funding management**: The Royal Government of Cambodia and donors each provide funds to the HEFs through the Second Health Sector Support Project. The contributions of the government and donors are 20 per cent and 80 per cent [of project funding] respectively ... The government contribution depends on the financial arrangements of the donors. There should be a sub-decree for the informal sector so that government funds can be channelled through an account like the National Social Security Funds of the Ministry of Labour and the Ministry of Social Welfare. This type of account should be opened in the MOH (Key informant #3).

Agency funds need to be managed at both national and local levels. A Ministry of Economy and Finance (MEF) sub-decree will be required to decentralise provincial and district fund management, administered possibly through the structures of the MEF. Arrangements would be needed to overcome complications related to the third-party purchasing role of the national agency, the involvement of the MEF and the control of provider pre-payment mechanisms. Transfers between the accounts of the agency and health providers and payment of patient benefits could be managed centrally and routed to the decentralised units. But administrative delays in the release of funds under decentralisation could be a concern. One informant suggested the preparation of financial management guidelines and building the capacity of the management team would be the keys to success, though current government administrative practices may not be sufficient.

The current state budget disbursement for health is not good enough. We learn about some negative feedbacks from our tracking survey. I think that introducing banking transfer can improve disbursement quality. But there will be a lot of reaction from those who benefit from the existing system. Moreover, this may need strong leadership from the MOH to initiate such change and to propose a comprehensive and convincing plan for that. As a leader, we should say everything is possible (nothing is impossible, depending on the context and time) (Key informant #13).

**Third-party status**: The status of the proposed agency as a third-party purchaser of health services from government facilities is still not clearly defined, nor is there yet agreement on this in principle. The role of the MOH in service delivery and its possible management of the national agency are as yet unresolved. It is not clear whether the proposed agency would act as both an implementer and an operator of HEF and CBHI schemes. And no decision has yet been made on the potential for using CBOs (rather than local NGOs) as district operators. However, many key informants, especially among current HEF/CBHI implementers, strongly support a third-party role through the agency.

The national agency must consider third-party arrangements in implementation. These would facilitate smooth implementation and monitoring (Key informant #17).

**HEALTH FINANCING POLICY BARRIERS**

Reflecting the nine indicators presented in the Mathauer and Carrin (2011) framework, key informants provided a range of views on health financing issues associated with the work of the proposed national agency.
Level of funding: All informants recognised the need for additional funding for the establishment and functioning of the national agency and the expansion of HEF and CBHI schemes, and the proposed national agency was seen as an opportunity for further aligning government and donor funding. Informants indicated that there is general agreement between the government and development partners, but also saw the need to regulate the common funding arrangements in a way that satisfies the funding agencies. The expected expansion of HEFs and CBHI under a common funding arrangement would require increased government budget allocation for health along with the additional contribution from households (specifically for CBHI).

Most of the donors are willing to provide funds to a common pot. Additional funding will be necessary for the expansion of the HEF and CBHI schemes (Key informant #5).

Sometimes donors are not on the same ground, and disagreements are found among them. All of them may not agree on common funding arrangements. Therefore, donors have to be motivated by the plan, estimated budget and arrangements. They have to be assured that proper use of funds will be monitored effectively (Key informant #14).

Level of population coverage: One of the key objectives of the proposed national HEF-CBHI agency is to expand social health protection coverage to the informal sector through expansion of HEFs and CBHI. Accurately targeting the poor and enrolling the non-poor in a voluntary insurance scheme both present challenges.

Identification of the poor to receive free services and subsidy remains always problematic and challenging. (Key informant #4).

Currently, CBHI schemes have high costs to reach the middle 50 per cent of the population [the non-poor informal sector] for enrolment in the schemes. [These] ... costs can be reduced through joint identification and management systems [between HEF and CBHI] (Key informant #7).

Key informants reported that both pre- and post-identification procedures for the poor have problems. While the national pre-identification program conducted from 2008 through a community survey by the Ministry of Planning helps to identify the poor, gaps were found in the pre-identification procedure due to internal displacement and migration of families, reflecting the need to survey households repeatedly. In some cases, implementing NGOs have their own pre-identification processes, which can be costly. Informants also reported that relying only on post-identification at health facilities did not promote utilisation by the poor (who may be unaware of the possible benefits).

Level of equity in financing and degree of financial protection: Decisions about two critical questions are vital for ensuring equity in financing and to provide financial protection: (1) the content and structure of the benefit package and (2) the nature of beneficiary contributions. The way in which these questions are resolved will have serious implications for the management of membership under the national agency.

The poor and unemployed need access to expensive health services, especially inpatient services, and at the same time basic primary health care services should be free for them (Key informant #14).

Often, the informal-sector population are unable to pay the premium for the CBHI scheme due to their irregular income. They easily drop out from the scheme [when income is short] (Key informant #6).

Key informants had no clear idea how these two design issues could be resolved under a common institutional arrangement to ensure equity and financial protection. There was a common lack of clarity among informants, too, when the question of possible cross-subsidisation between HEF and CBHI schemes arose. Understanding the need to subsidise CBHI membership, some informants thought that cross-subsidies from the HEF schemes could be a good idea, but were not sure how that would work or exactly what benefit it would bring to
the CBHI schemes. Others referred to the recent study that identified evidence of negative cross-subsidisation from poorer (HEF) beneficiaries to less poor (CBHI) beneficiaries (Annear, Bigdeli and Jacobs 2011).

**Level of pooling:** HEFs and CBHI schemes have diverse financing mechanisms—one a direct subsidy and the other an insurance mechanism—and CBHI generally has a limited pre-payment mechanism. Informants understood that the opportunity for pooling risk between these two different schemes was limited. One informant commented that the ‘pooling of funds would be difficult; no fund to pool’ (Key informant #1) and another that ‘pooling of funds ideally will not be possible; may not be easy’ (Key informant #5). Many informants therefore favoured separate funds for HEFs and CBHI. Consequently, it appears that the proposed national agency would not play a role in equalising risk between these schemes.

**Level of administrative efficiency:** The anticipated integration of administrative, management and information systems within the proposed national agency is expected to reduce costs and provide efficiencies. Even so:

> [Achieving] administrative efficiency will depend on the [precise] role of the autonomous agency. The current administration of HEF and CBHI schemes through international and national NGOs is expensive, and transaction costs are high due to the different arrangements. We must minimise these costs (Key informant #16).

The agency initially may have to face complex coordination, administrative and management arrangements. Only strong leadership and capacity can make the agency administratively efficient (Key informant #10).

The national agency may reduce costs by standardising contracts with implementers and with health providers and by applying uniform provider payment mechanisms with a carefully negotiated rate across both HEF and CBHI schemes. Different types of provider payment (mixed payment, capitation payment, flat rate) were recommended by informants. The agency could use its power as a single national purchaser to negotiate appropriate rates with the providers. Efficiencies would also be possible, according to informants, as the national agency developed standard operational guidelines, improved management tools, implemented effective monitoring and resolved outstanding design issues.

**Equity, efficiency and cost-effectiveness of the benefit package:** Key informants regarded the design of a standard benefit package, consistent between population groups and demand-side schemes, as desirable, though a complex issue. Ultimately, the availability of funding and the need for longer term cost control will determine the nature of the benefit package. A key consideration is that HEFs cover food, transport and other ancillary costs. Another concern, according to informants, is to tailor appropriate benefit packages for health centres, referral hospitals and provincial hospitals.

Current benefit packages can be reviewed and based on a minimum package that can be introduced at the beginning. The second option could be a comprehensive benefit package, according to the availability of funding and services at the different levels (Key informant #15).

The low average quality of service is a critical issue. Informants were hopeful that the purchasing and contracting powers of a national agency could leverage better quality of care. There may be a case for accreditation procedures for contracted providers and for penalties for failure to meet contract conditions. Additional funding will be needed to monitor the quality of care, which could be carried out centrally to reduce the likelihood of misreporting. The correct incentives will also be important.

Facilities can have income generation activities, and this income can be used for improving the quality of care. Providers should have [a source of] income and [the right] incentives. Operators can also play a big role as they supervise certain aspects of the quality of care. Sometimes operators don’t show interest to ensure quality of care as they don’t like conflict with hospital management (Key informant #18).
DISCUSSION

There is now a unique opportunity in Cambodia to establish the institution for a national social health protection mechanism for the poor and near-poor by placing HEF and CBHI administration under a new national agency. This rare opportunity arises from the consistent work that began in 1998 and especially after 2000 and is made possible, in fact necessary, by the unparalleled success in extending coverage of HEFs across most ODs in the country. The government has declared its support for scaling up HEFs to national coverage, and the Prime Minister in mid-2011 publicly endorsed the proposal. Donors and NGOs—including those principally responsible for creating structures for the national administration of the existing HEF system—also understand the need to transfer the NGO-established SHP mechanisms to government administration.

The study found clear and broad agreement in favour of establishing a national agency for the informal sector. The views of key informants were consistent with the proposal by the World Bank Synthesis Assessment to establish a National Social Security Fund for Subsidy Schemes. There is, however, as yet no clear strategic direction for establishing the national agency. The task is complex, and further work needs to be done to prepare an agreed plan. There is agreement that establishing a national agency is possible and practical, and that it is proposed as an intermediate arrangement until conditions allow a further move towards fulfilling the objectives of the Master Plan for Social Health Protection, including the creation of a national SHP agency. An intermediate NSSF-S, together with the NSSF and NCSSF in the formal sector, would provide the building blocks for a later single structure.

Both the proposal for a national HEF-CBHI agency and the wider objectives of the Master Plan are based on principles of universal health coverage, the leadership and ownership of the MOH and the government in the health sector and equity and efficiency in the delivery of health services to the whole population. Moving further along this path implies the need to establish, within or alongside ministry structures, the institutional and health financing capacities to manage and regulate a national SHP structure. The process, therefore, of moving to a national HEF-CBHI agency is itself an opportunity to extend significantly the public sector reform already under way within government services.

The MOH has a strong record in health planning, developing strategies and creating guidelines. These skills are invaluable for the new stage. Creating a national agency is, however, an unprecedented initiative, involving challenges for which the MOH has no previous experience. Creating a national HEF-CBHI agency will require new, purposeful and well-resourced planning and design that will add to MOH capacity for leadership in this area. The process of creating a legal structure, building an office, recruiting or contracting staff, negotiating with existing HEF-CBHI implementers and operators, reinforcing government budgeting processes and confronting the challenges that arise will itself reinforce government capacity to lead such an agency.

The will to move ahead is apparent among all stakeholders. It is less clear, however, exactly how the process will unfold. To move ahead, certain barriers need to be identified and navigated:

- Inter-ministerial discussions leading up to the approval of the Master Plan for Social Health Protection are taking place, and in the Council of Ministers, and the draft plan is currently under review; the proposal for a national HEF-CBHI agency is consistent with the Master Plan and can proceed immediately through the MOH in collaboration with the broader process.
- Respecting the existing decision-making structures within the MOH and the government can slow the process, but is essential if the preferred outcomes are to be realised; leadership by those best placed to meet the challenges is possible with appropriate support; ultimately, a social reform of this significance can be achieved only with political support from the highest levels.
- The decentralised nature of the proposed autonomous national agency places new demands on the MOH and its staff to meet the challenges related to both implementation and stewardship; this is a new role of which there is little previous experience and will require well-balanced and well-timed support from government and from partner agencies.
- The technical apparatus and infrastructure needed to house a national agency do not currently exist;
Institutional and operational barriers to strengthening universal coverage in Cambodia: options for policy development

**Plan 2008-15** provides a starting point; by using the findings of the Overall Assessment and the Synthesis Assessment, together with this study, the main elements and key questions that remain to be resolved can be identified and a process put in place to address those issues.

- No decision has yet been made about the legal structures required to support a national agency, either as a department of the MOH or as an autonomous institution; ministerial or government sub-decrees will be needed to authorise the creation of a new structure.
- While agreement exists on the proposal to create a national agency, there is no agreed plan; producing a plan for the concept, design and working procedures of a national agency is a necessary prerequisite to moving ahead; agreement on providing the time and resources for such a task is needed between the government and development partners.
- Perhaps the most critical policy decision is agreement on the status of a national agency as a third-party purchaser of health services; the MOH faces a conflict of interest in the provision of services and the management of demand-side payment for those services (one that does not exist for current supply-side budget line funding of facilities); confidence needs to be established that the purchasing role of a national agency is independent from the service provision responsibilities of the MOH.

There are a range of options for dealing with these policy challenges, and all will require planning and negotiation. While the general direction is clear, the details are yet to be worked out, and the critical task is to find an immediate way forward. To make further progress, agreement on a single approach (even one that is varied and complex) is required. Working out what that agreed approach might be is the next task, one that will lay the basis for establishing mutual commitment and the motivation to succeed. Options for further consideration include:

- Building on what exists is the most productive approach; rather than waiting for adoption of the Master Plan, it is possible to strengthen existing programs and implement intermediate arrangements that are consistent with the longer term goal of universal coverage.
- The mid-term review of the Health Strategic Plan 2008-15 provides a starting point; by using the findings of the Overall Assessment and the Synthesis Assessment, together with this study, the main elements and key questions that remain to be resolved can be identified and a process put in place to address those issues.
- Currently, the national administration of HEFs is centred mostly on an international NGO, the University Research Company (URC); one possibility is to find an appropriate way to transfer the management of that apparatus to the MOH (or possibly to an autonomous body), with URC continuing to provide technical advice; a patient and constructive process of negotiation between the DPHI and URC would facilitate this process.
- It is not necessary to wait for the creation of a national agency to scale up HEFs to national coverage, and such an expansion would create relatively little additional burden on future requirements under the MOH; it is likely the administrative resources needed for national expansion are already available within URC’s current national program for HEFs; careful consideration of URC capacities and MOH capabilities is needed.
- Recent studies have highlighted the constraints on CBHI expansion as a pre-payment mechanism for the informal sector, including the cost of premiums to families, the lack of complete trust in the insurance system and concerns about the quality of service delivery at government facilities; moving immediately to reform the CBHI system in a way that overcomes these constraints (perhaps with responsibilities transferred to some degree to the government system, and appropriate subsidies on the demand side) is possible and necessary; careful negotiation with current CBHI providers could begin.
- The most direct route to establishing an independent agency using the existing legal and administrative structures of the government is to establish a Public Administrative Enterprise attached to the MOH; this would be a consistent part of the government’s public administration reform and would run in parallel with the existing NSSF and NCSSF agencies.
- Under current conditions, moving to a national agency will require clear support from both government and donors and a program of additional support to the MOH; MOH capacity for policy, management and administration (including
The next steps will benefit from strong leadership through the DPHI at the MOH that produces a single common and agreed approach. Appropriate technical support from development partners can facilitate such an outcome. One possibility suggested by some key informants was to use the process of a formal feasibility study to develop a response to the most important concrete questions related to implementing a national HEF-CBHI program through an autonomous government agency. This could be a first step in a more detailed design process to determine the mission of the proposed agency, its organisational structure, function and so on. Such a process could define the content and practice of a national agency and provide the basis for project support that will make its establishment possible.

CONCLUSION

The extensive coverage of the poor population achieved by Cambodia’s HEFs, together with recent increases in government funding for health care (a product of impressive economic growth) and commitment from development partners provide the foundation for a major social reform in the health sector. The conditions are right, the time is right and there is a consensus on establishing a national agency for HEF and CBHI (including also voucher and other demand-side financing schemes).

The challenge facing health planners now is to determine the process by which this reform can be implemented. No one group, acting alone, can create such an agency; rather, a common agreed plan is needed. A national agency for demand-side financing in the informal sector (principally HEFs and CBHI) is not only called for, but its establishment will also provide the means for addressing the institutional requirements for universal coverage and will provide an impetus for strengthening the key health financing functions related to equity and efficiency.

Our analysis confirms that the OASIS framework offered by Mathauer and Carrin (2011) is a useful tool for carrying out the policy work related to the creation of such a national agency in or through the MOH. While the key policy issues still need to be resolved in Cambodia, the framework underlines the need to balance institutional with health financing requirements and directs attention to the major policy questions that must be answered.

The creation of an autonomous agency of this type—which will depend also on strong regional links, the participation and support of local government and new forms of public administration—will fit well with the government’s decentralisation and deconcentration. Developing a common framework for administration, financial management and monitoring through the agency will help to create the basic administrative structures for universal coverage.

As well, moving to a national agency involves policy design that will harmonise the practices, tools and guidelines of the various HEF and CBHI schemes and bring greater uniformity to a range of health financing indicators. These include arrangements for financing and fund management at the different levels, resolving the nature of coordination between HEF and CBHI schemes, avoiding overlap with other financing mechanisms (like voucher schemes), defining an affordable and sustainable benefit package with minimal or co-payments, finding an appropriate provider payment mechanism and potentially improving the quality of service.

The need now, through a process of collaboration and consensus, is to establish the feasibility of creating a national agency and to begin the necessary design.
REFERENCES


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