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SOCIAL HEALTH PROTECTION PROJECT

SOCIAL HEALTH PROTECTION

INDEPENDENT MONITORING WITHIN THE HEALTH EQUITY FUND SYSTEM IN CAMBODIA

Since 2013, the Social Health Protection Project, funded through USAID, has supported the Health Equity Fund (HEF) system and other social health protection mechanisms, which has expanded access to healthcare for 3 million Cambodians.

EXECUTIVE SUMMARY

Cambodia's rapid development has brought myriad benefits to its population, but many poor Cambodians still need support to access health services. By providing financing for inpatient and outpatient health services for 3 million patients at 1,175 health centers and 114 hospitals in 2018, the Health Equity Fund (HEF) as implemented by the USAID Social Health Protection Project has been successful providing access to healthcare, mitigating the negative impacts of illness on millions of Cambodian poor families. The HEF has become a central component of Cambodia's public health care system.

The Social Health Protection Project works to provide services for:

3 MILLION

Patients

at

1,175

Health Centers

and

114

Hospitals

INNOVATION SUCCESSES

The independent monitoring function is an integral part of the HEF system, providing verification that health services are delivered and accurately reported by health facilities.

- Over 98,000 client interviews were conducted by monitoring teams between 2014 and 2018.
- Independent monitoring was instrumental in decreasing informal payments by hospital clients, from 5.9% in 2014 to 1.9% in 2018.
- The independent monitoring mechanism compiled and reported client complaints, 50%-60% of which were reported as resolved by the hospital management team.
- The newly semi-autonomous Royal Government of Cambodia (RGC) entity, the Payment Certification Agency (PCA), has committed to assume the independent monitoring function of the HEF nationwide.

NEXT STEPS

Moving forward, it will be critical that that the independent monitoring function receive adequate funding to provide continued oversight of the HEF system. Consideration should be given to expanding the capacity to measure additional dimensions of health service quality under the monitoring function.

THE USAID SOCIAL HEALTH PROTECTION PROJECT IN CAMBODIA

The USAID Social Health Protection Project in Cambodia (SHP), implemented by University Research Co., LLC (URC) and partners, supports the Royal Government of Cambodia (RGC) to continue progress towards Universal Health Coverage (UHC) by supporting expansion of the Health Equity Fund system (HEF) and other social health protection mechanisms throughout the country. Working closely with the Cambodian Ministry of Health (MoH), the USAID SHP Project collaborates with Australian DFAT, the World Bank, the Korean International Cooperation Agency (KOICA) and the German Federal Ministry for Economic Cooperation and Development (GIZ) to support the national HEF system.

THE SOCIAL HEALTH PROTECTION PROJECT WORKS WITH THE ROYAL GOVERNMENT OF CAMBODIA TO:

- provide technical assistance to institutionalize the HEF system into the RGC;
- provide independent fiduciary monitoring of the HEF including certification of invoices generated by facilities;
- develop and roll out the online nationwide MOH Patient Management and Registration System (PMRS);
- advocate use of HEF purchasing power to leverage quality improvements in health services; and
- setup community managed HEFs that provide locally financed complementary benefits to the poor and vulnerable.

NATIONAL CONTEXT

Cambodia's recent rapid economic growth is demonstrated by its gross domestic product (GDP) per capita having increased from US$295 in 1996 to US$1,579 in 2018. The population remains largely rural (78% in 2018), and though the proportion of Cambodians living below the poverty line has decreased, 13% of Cambodians were estimated to be living below the poverty line ($US 0.98) in 2018. It is estimated that by 2020, the total population will have grown to 16.5 million, with large numbers of elderly, children under 5 years, and women of reproductive age, leading to greater demand for health services.

Though there have been notable gains in maternal and child mortality, and control of major infectious diseases like HIV and malaria, Cambodia's health status still lags behind most nations in the region. Cambodia is undergoing an epidemiological transition, with a continued burden of communicable diseases along with an increase in the prevalence of non-communicable diseases (NCDs). NCDs now account for the largest causes of mortality in Cambodia: 52% in 2013 versus 32% in 2000.

THE HEALTH EQUITY FUND: PROVIDING ACCESS TO HEALTH SERVICES FOR THE POOR

Article 72 of the Constitution of Cambodia stipulates that "the health of the people is to be guaranteed," and that "poor citizens receive free medical consultations in public hospitals, infirmaries and maternities." Towards realization of these goals, the Ministry of Health has set forth the objective of achieving universal health coverage. In 1996, along with the institution of user fees, the Health Financing Charter called for exemptions for the poor at public health facilities, but this approach was largely ineffective in ensuring access to care for the poor. As a result, the concept of health equity funds (HEF) was developed in 2003, and since that time has

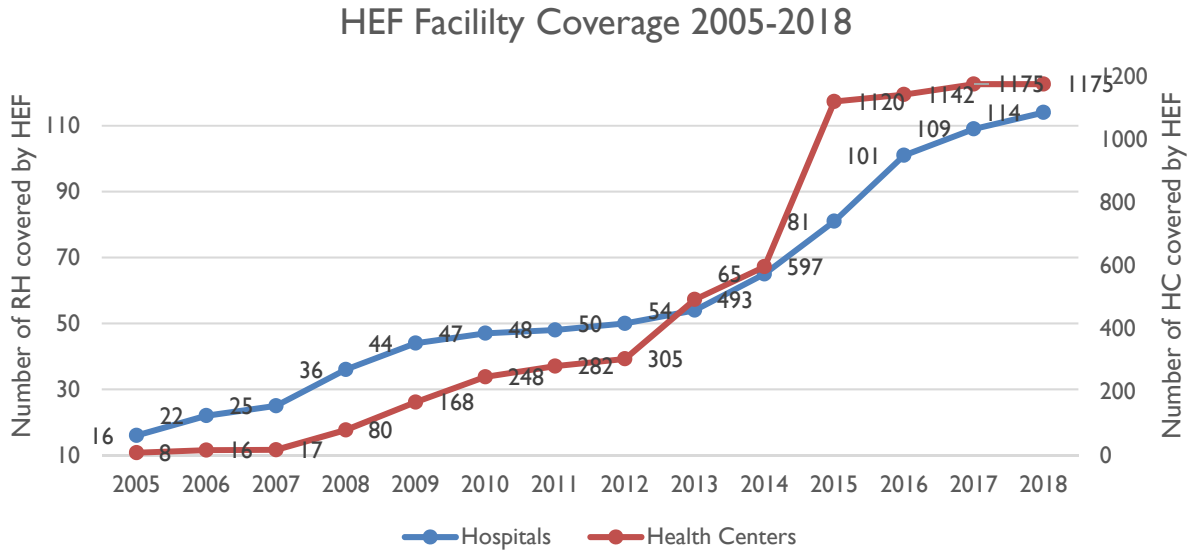

Figure 1. Facilities Utilizing HEF 2005-2018

grown to be a core component of social protection in Cambodia.

The HEF is a health insurance program with payment for the poor and vulnerable residents of Cambodia to receive essential health services at public health facilities, subsidized by the pooled funds from the RGC and Development Partners (DPs). The HEF covers both medical services and non-medical benefits to the members of identified poor households. Under the HEF, medical benefits, including diagnostic and treatment health services, are purchased from health facilities, at no cost to beneficiaries. Non-medical benefits are also provided, including: 1) transportation reimbursements for institutional deliveries at health centers for in-patient and specialized out-patient services at hospitals; 2) caretaker food allowances for inpatients; and 3) funeral allowances to the caretakers of HEF beneficiaries who die while in hospital.

By 2015, the HEF had expanded to achieve nationwide coverage of the poor, providing approximately 3 million Cambodians with health care at public health facilities. Figure 1 shows that the number of referral hospitals (RHs) and health centers (HCs) covered by HEF increased steadily, reaching 114 and 1,175, respectively, in 2018.

An external evaluation of the hospitals in the HEF in 2016 concluded that it: 1) increased access to and utilization of hospital inpatient department services by the poor; 2) increased uptake of outpatient department services at hospitals by the poor; and 3) increased utilization by the poor for hospital newborn delivery services, routine consultations, and newborn deliveries.

As with all insurance schemes, ensuring that the services purchased by the HEF are actually provided to clients is of critical importance. The potential for fraud exists in all reimbursement systems, and a governance system must be put in place to minimize the possibility of overbilling and fraud occurring. In Cambodia, URC has, under the prior USAID Better Health Services Project and current USAID Social Health Protection Project, worked actively with the MoH to establish approaches to minimize fraud within the HEF system. This has included: 1) the establishment of a web-based information system that records every patient encounter and the charges incurred during that encounter; 2) increased transparency and accountability of HEF reimbursement payments; and 3) establishment

of a monitoring system that uses a sample of patient encounters to conduct follow-up household interviews to ensure that the patients received the services for which the HEF was billed. This system has led to improved detection and response to instances of overbilling and fraud. This brief focuses on the deployment of the independent monitoring entity under the HEF system, led by the USAID Social Health Protection Project.

INNOVATION BRIEF: INDEPENDENT MONITORING UNDER THE HEF

IMPROVED EFFICIENCY

The independent monitoring function is an integral part of the HEF system overall, providing verification that services are delivered and accurately reported by health facilities. In the Cambodian HEF system, this role of independent monitoring is carried out by the Health Equity Fund Implementer, or HEFI. The USAID Social Health Protection Project served as the HEFI under an agreement with the MoH and the Health Equity and Quality Improvement Project (H-EQIP) multi-donor pooled funding mechanism through June 2018. Based on the verification of services provided to HEF beneficiaries by participating health facilities, the independent monitoring entity provides certification of the invoices submitted by health facilities to the MoH as a requirement before reimbursements are made to facilities. See Figure 2.

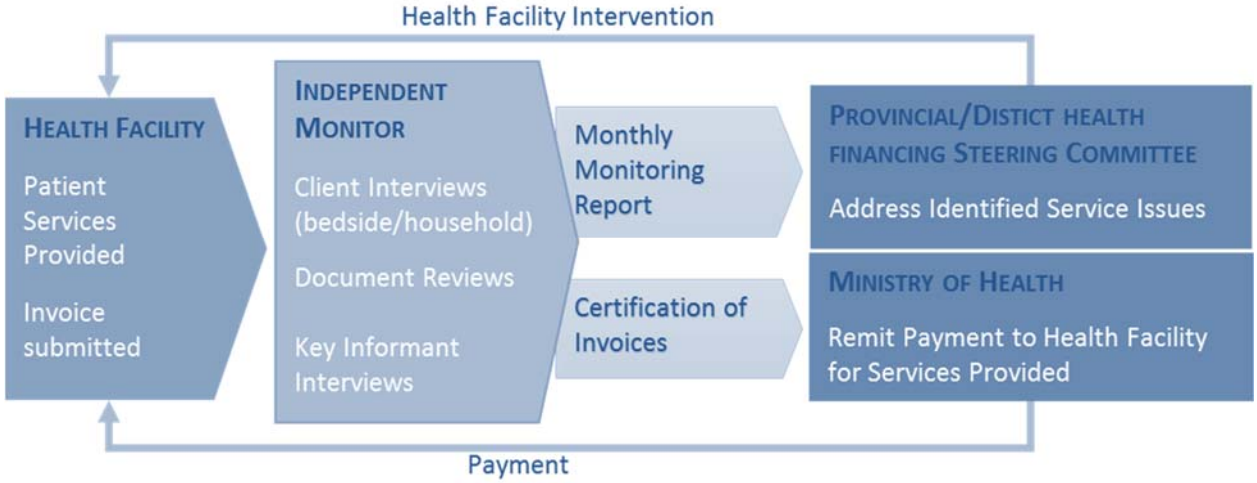

Figure 2. Schematic of Independent Monitoring in HEF

The HEFI is responsible for: 1) providing training and coaching to hospital administrative staff; 2) conducting household interviews of inpatients and outpatients and bedside interviews of patients admitted to hospitals about the services they received; 3) facility document reviews; and 4) managing the HEF complaint mechanism. These functions are described in more detail below. As the SHP project nears its close in December 2018, the project has transitioned all HEFI roles and responsibilities to a recently established RGC parastatal institution called the "Payment Certification Agency," or PCA, the project is providing technical assistance to the PCA over the last 6 months of operation.

The independent monitoring process is conducted by teams responsible for interviewing 30-40 households in each operational district on a monthly basis. Interviewed households are clustered in three-to-four randomly selected health facility catchment areas, which include a mix of randomly selected households and households that were flagged as likely to have encountered problems accessing care based on

utilization patterns. Patients are queried about their last experiences at the health facility, if they were asked to make informal payments, and whether they received the expected HEF medical and non-medical benefits. The HEF monitoring team also performs bedside interviews of patients admitted to RHs. Figure 3 shows that over 98,000 client interviews were conducted by the SHP HEF Monitoring team between 2014 and 2018, with 69% of these among hospital clients and 31% among health center clients.

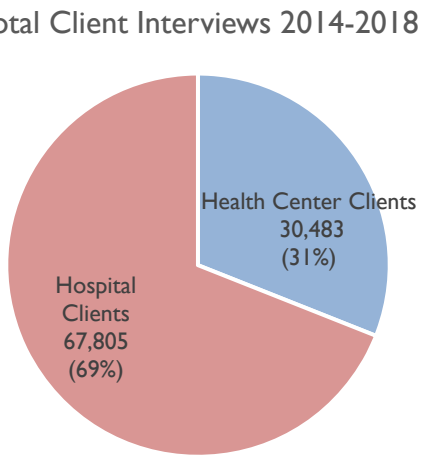

Figure 3. *Client Interviews, by Health Facility Type 2014 - 2018*

The team also reviews the documentation generated by health facilities to ensure that proper records are being kept. This includes ensuring the signatures of health facility staff and patient data were appropriately secured in the medical records. HEF monitors have reviewed approximately 20% of the total documentation generated by facilities from 2014 – 2018.

The HEF monitors triangulate data from these sources on a monthly basis to generate a detailed report of their findings from household interviews, bedside monitoring, document reviews, and key informant's interviews from facilities, which is then shared with operational district Health Financing Steering Committees (HFSCs). Overbilling and fraud has been seen in: 1) patients for whom facilities have invoiced the HEF, but whose use of services could not be verified ("ghost patients"); 2) patients who are recorded as having received services, but who never presented at the facility – usually people who were represented by another person, ("no physical presence"); and, 3) informal payments demanded by health facility staff and made by patients. Figure 4 shows that between 2014 and 2018 among hospital and health center clients, out of the total patient load, 4.4% reported informal payments, 1.1% were ghost patients, and 2% were reports of no physical presence. Informal payments are largely a hospital problem; ghost patients and no physical presence occur mainly at health centers.

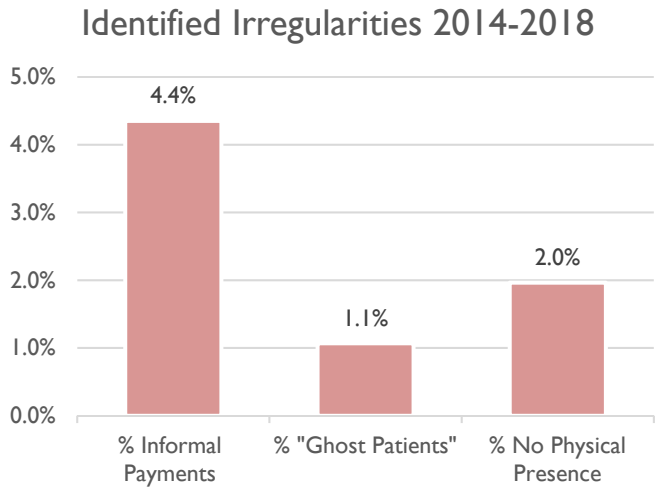

Figure 4. *Identified Irregularities 2014 - 2018*

Patients' complaints are also compiled and reported to the HFSCs. The largest category of complaints related to inappropriate attitudes of health service providers. See box 1. An average of 50%-60% of complaints were reported as resolved by the hospital management team.

Box 1 *Most Common Complaints from Clients*

MOST COMMON CLIENT COMPLAINTS:

- Inappropriate attitude of health service providers
- Ask for additional service payment
- Unhygienic toilets
- Request to buy medicines and other materials
- Long waiting times
- The quality of services is limited
- Did not get food allowance
- Did not get transportation reimbursement
- Fear of negligence

IMPACT OF INDEPENDENT MONITORING

The most compelling evidence of the impact of the independent monitoring mechanism is the decrease in identified irregularities. As described in Figure 5, nationwide, informal payments by hospital clients decreased from 5.9% in 2014 to 1.9% in 2018, coinciding with implementation of independent monitoring.

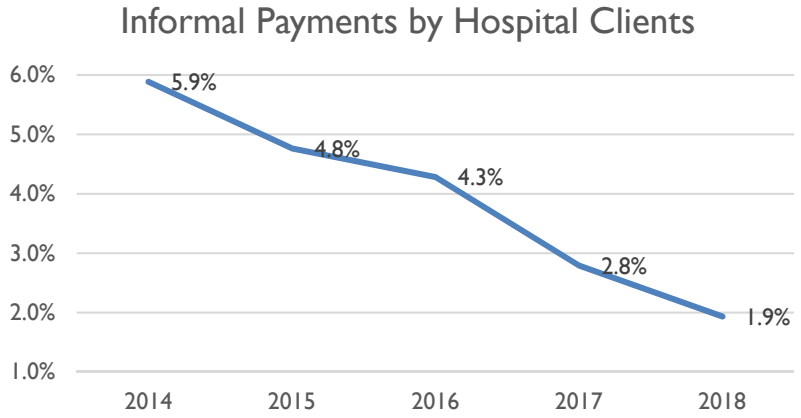

Figure 5. Proportion of Hospital Clients Reporting Informal Payments 2014-2018

CHALLENGES

While the implementation of independent monitoring has been successful, that success required overcoming some significant challenges. Chief among the challenges was resistance from providers and health facility leaders to believe that irregularities such as informal payments, ghost patients, and no physical presence existed in their facilities. There were often beliefs expressed that the data were flawed or that clients were being untruthful. To address this, in a number of locales, the provincial and/or district health financing steering committees made home visits to independently verify findings. Over time, however, as trust was established with the monitors, this incredulity diminished, and confidence of the findings of the monitors grew.

LESSONS LEARNED

The health financing steering committees have been vital to the success of the independent monitoring mechanism. These committees are led by the local governors, and as such, have authority to arbitrate and direct corrective action. The acceptance of the monitors' activities and endorsement of the monitors' findings by the health financing steering committees has meant that real changes in the behaviors of health facility personnel can be realized.

The second major lesson learned is that the demonstrated effectiveness of the HEF system through independent monitoring can serve as a catalyst for a nationwide scale up. The success of the independent monitoring mechanism was recognized by a wide group of stakeholders, most notably the government authorities. This allowed the SHP Project to work effectively with the MoH and other government stakeholders to promote adoption of this approach by the national government, as described below.

ESTABLISHMENT AND SUSTAINABILITY OF THE PCA

In September 2017, the RGC took the remarkable step of establishing the Payment Certification Agency (PCA), a semi-autonomous government entity created to assume the independent monitoring function of

the HEF nationwide. This is a testament to the recognized value of this function in ensuring the effectiveness and viability of the HEF social health protection mechanism.

The SHP Project has worked collaboratively with the PCA since its establishment, providing significant technical and logistical support. This has included orientation, coaching and training of PCA staff along with the secondment of SHP Project staff to the PCA. As a result of these efforts, the PCA has taken over the entire certification process, including HEF monitoring, verification and certification of invoices, beginning with the April 2018 HEF payments.

As the PCA is rolled out, it will be important that the monitoring function receive adequate funding to provide oversight. Having enough monitors to perform client interviews and verify facility records will remain pivotal to maintaining the integrity of the data collected, confidence in the conclusions drawn from these data, and ultimately the long-term viability of the entire system.

As the PCA evolves, consideration should be given to expanding the capacity to measure additional dimensions of quality. For example, not only to determine if a clinical service was rendered to a client or not, but also to assess the appropriateness of the care provided. The clinical capacity of the monitors would need to be expanded to enable them to discern the appropriateness of care provided, and an effective systematic process would need to be developed, beyond the current construction of the independent monitoring mechanism.

FUTURE OUTLOOK

The successful implementation of the USAID SHP Project has provided the foundation for the establishment of sustainable health service purchasing arrangements upon which the RGC can build, working toward the eventual goal of UHC.

As long as the HEF relies on donor funding for support, the risk of implementation gaps and the chances of reductions in service use remain real. This underscores the importance of the RGC's full assumption of HEF responsibilities. USAID/SHP appears to have fostered this essential government ownership and responsibility. As of September 2018, the RGC is providing approximately 70% of the total funding for the HEF, with the remaining 30% coming from the DPs.

SHP's close collaboration with the RGC at all levels, as well as with other donors and development partners, can help to ensure the future of social health protection systems in Cambodia. SHP has also been successful in linking important project milestones with disbursements from H-EQIP, increasing the probability that universal access to quality health care will become reality.

By putting in place mechanisms for the HEF, and the Patient Management Registration System that supports it, SHP and the RGC have demonstrated the viability and desirability of the system in the Cambodian context. SHP will continue to provide ongoing capacity-building support to the PCA, including the independent monitoring of the HEF system, through the project's close out in December 2018. The USAID SHP Project can claim to have contributed to the building of an important pillar of the National Social Protection Framework.

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