USAID FROM THE AMERICAN PEOPLE SOCIAL HEALTH PROTECTION PROJECT

URC

Transitioning the Cambodian health system to self-reliance: URC's contribution 2002-2019

FROM A HEALTH FINANCING PILOT TO A NATIONAL SOCIAL HEALTH PROTECTION SYSTEM:

COMPLETING THE TRANSITION

The cost of health care is often a significant deterrent for people seeking care, particularly for the poor. Health financing interventions can create more access to preventive care, increase financial stability for those most at risk of a catastrophic health event, and decrease the prevalence of serious illness. During the past three decades, URC has assisted the Royal Government of Cambodia (RGC) to incrementally develop a pro-poor health insurance scheme that meets local needs and is integrated with government structures for long-term sustainability.

University Research Co. LLC (URC) supported the Royal Government of Cambodia (RGC) to strengthen the health system through four USAID projects:

- Health Systems Strengthening in Cambodia (HSSC), 2002-2008
- Better Health Services Project (BHS), 2009-2013
- Quality Health Services Project (QHS), 2014-2019
- Social Health Protection Project (SHP), 2014-2019

Through these projects, USAID sought to support the RGC improve the quality of primary care and hospital services, increase demand for health services and reduce financial barriers to access, and build provincial and operational district (OD) capacity to manage services and social protection programs.

CONTEXT

In 1996, Cambodia introduced user fees at public health facilities to increase revenues and motivate underpaid staff. Although the poor were theoretically exempt from the new fees, applying the exemptions was challenging. In response, several non-profit organizations piloted models to resolve the challenge.

In 2003, URC selected the health equity fund (HEF) model for expansion under the USAID HSSC Project. HEFs are a pro-poor health financing scheme that targets identified poor households in a given area and provides financial and social support so that these households can better access government health services. The HEF were found to successfully reduce catastrophic spending, increase utilization of health services by the poor, and provide a reliable source of financing to health facilities. URC's scale-up of HEFs was also supported by the World Bank-managed multi-donor Health Sector Support Program (HSSP). By November 2008, URC was the largest HEF implemented in Cambodia, supporting HEFs in 26 operational districts covering roughly 28% of the country's poor.

Under the follow-on USAID BHS Project, URC continued to assist the RGC to establish the national HEF system. URC helped develop a standardized model for HEFs, including a staffing structure, benefit package, treatment, transport and food payments, pre-identification and post-identification procedures for poor clients, a data management system and a financial reporting process. Quality improvement was linked to health facility HEF eligibility.

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. The SHP Project was charged with achieving universal health coverage for the poor, using reimbursements to leverage improvements in quality of services, increasing capacity of RGC institutions to administer SHP schemes, and increasing SHP coverage of people living with HIV and most-at-risk populations.

KEY INTERVENTIONS

REMOVING THE MIDDLE MAN

As the momentum built toward national management of the HEF system, URC worked with the Ministry of Health (MOH) and the World Bank-managed Health Equity and Quality Improvement Project (H-EQIP) to streamline the HEF system. Payments were originally channeled through community-based organizations who served as HEF operators (HEFO). In 2016, the role of HEFOs was discontinued and invoices are now generated directly by individual health facilities and submitted electronically through the MOH's patient management and registration system (PMRS).

Health equity fund basics

A poor person is eligible for HEF-subsidized care if he/she has an "Equity Card" issued through the national Identification of the Poor Households (ID-Poor) Program run by the MOH's Department of Planning. Public hospitals and health centers are reimbursed by the HEF for a standard set of services and benefits that they provide to HEF card holders. These include health service fees, transportation costs, food allowances, and funeral support for those who die under hospital care. Facilities are paid monthly based on the services provided; card holders are paid transportation and food benefits directly and immediately.

ESTABLISHING A NATIONAL AGENCY FOR INDEPENDENT MONITORING

A second key role in the early HEF system supported by URC was played by third-party monitors. HEF implementers (HEFI), typically community-based organizations, tracked indicators using a random selection of reported cases from household or bedside health facility interviews to ensure that the services recorded and invoiced were actually provided. URC provided the HEFI with training and supervision. Under SHP, URC also developed an online submission of monthly facility invoices to the HEF system for services and benefits provided to the poor, significantly reducing turnaround time. *(see Technical Brief: Independent Monitoring within the Health Equity Fund System in Cambodia).*

Already under BHS, URC began discussing the need for a national health financing agency to take over the independent monitoring function of the HEF nationwide. Under SHP, this became reality, as the RGC established the semi-autonomous Payment Certification Agency (PCA) in September 2017 by Royal Sub-Decree with support from URC and H-EQIP. To launch the PCA, URC provided significant technical and logistical support, including coaching and training of PCA staff along with the secondment of SHP 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.

LEVERAGING HEALTH FINANCING FOR IMPROVED QUALITY OF CARE

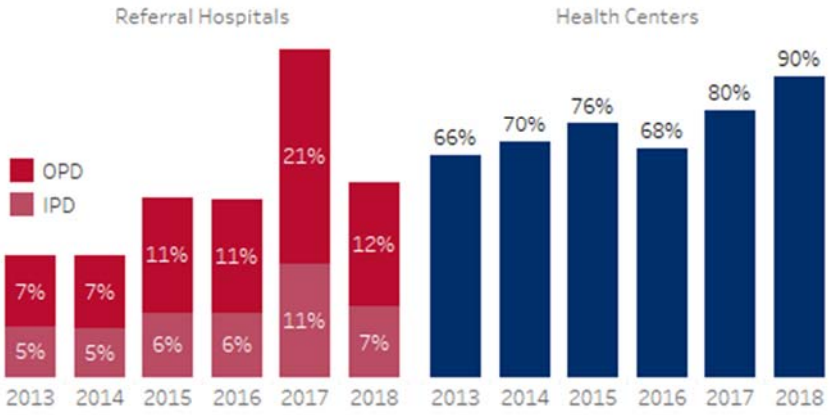
URC worked with the MOH's Quality Assurance Office to establish regular quality assessments under both the HSSC (Level 1 assessments focused on availability of resources) and BHS (Level 2 assessments focused on service delivery processes) projects. To provide facilities and operational districts a strong incentive for improving and maintaining quality, URC linked health facility performance on these assessments with eligibility for HEF support. Under SHP, URC worked with the MOH Department of Planning and Information to identify increasingly specific HEF benefit packages. These packages build off of existing MOH protocols and guidelines for care and define a minimum level of care necessary for the service to be reimbursed by the HEF. This encourages better charting beyond the minimum by including the results from charting in a quality-adjusted payment scheme, further strengthening the focus on quality. *(see brief: Building the foundation for quality services).*

SHP by the Numbers

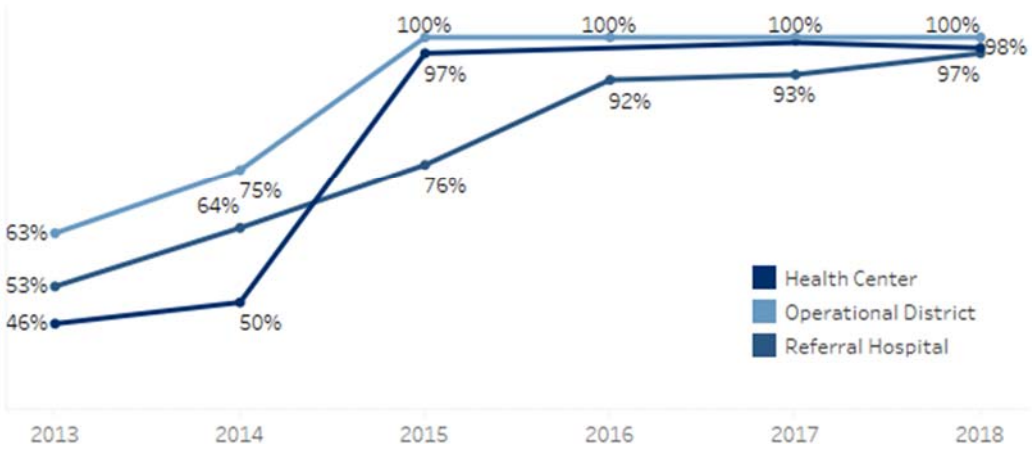
SHP has facilitated access to free care for millions of patients over the course of the project

3 Million Patients *at* **1,175** Health Centers *and* **114** Hospitals

Utilization Rates of HEF-Supported Services by the Identified Poor



More facilities have signed HEF contracts to provide services to the identified poor under SHP



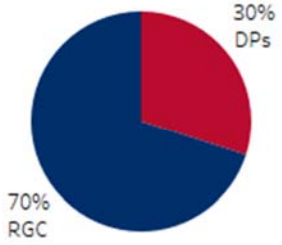
All **114** Hospitals *and* **100%** *of* Operational Districts *use the* **PMRS** *to manage HEF patients*

Additionally, **88** Hospitals *And* **176** Health Centers *use the* **Full PMRS** *to manage HEF and Non-HEF patients*

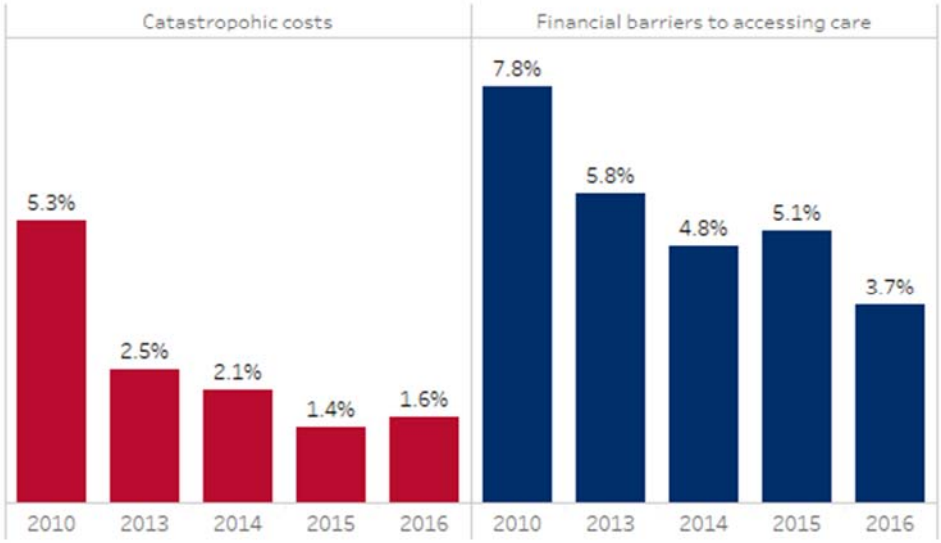
98,000 Client Interviews

Helped decrease informal payments by hospital clients from **5.9%** in 2014 *to* **1.9%** in 2018

The RGC now provides most of the total funding for the HEF



Cost barriers have decreased significantly under SHP



GOING BEYOND HEFS: THE PATIENT MANAGEMENT AND REGISTRATION SYSTEM

Under HSSC, URC developed the "HEF Operational Database" as a patient level-database at individual referral hospitals. The HEF system quickly outstripped the capabilities of a distributed database. Under BHS, URC worked with the Department of Planning and Health Information to develop the PMRS, which was rolled out in 2010 as a web-based database. The PMRS manages patient data by using nationally unique patient identification numbers to record personal information, service use, and payments. It includes the poverty targeting data generated by the ID-Poor Program, the online financial invoice submission by facilities for HEF reimbursements, and the independent monitoring of HEF payments, linking various parts of the system together seamlessly.

Although initially developed for use only by the HEF, hospitals soon realized the utility of the PMRS for registering non-poor patients ("full PMRS") and were willing to invest the 50% cost-share to support system installation. By June 2018, 75% of public hospitals and 15% of health centers were using the full PMRS. *(see Technical Brief: Patient Management and Registration System of the Cambodian Health Equity Fund System).*

EXPANDING BENEFITS AND TARGETING

While the ID-Poor process collects data that informs the identification of community members who qualify for HEF support, vulnerable population segments such as the elderly and disabled can be accidentally overlooked. Under BHS, URC tested urban and rural models of community-based health insurance. Under SHP, URC worked with partners to scale up the model of community-managed health equity funds (CMHEF). A CMHEF is a self-funded and sustained social action committee at the health center level that extends the HEF system by defining, targeting, and funding a set of additional complementary benefits to meet the health care needs of the poor and vulnerable. *(see Technical Brief: Social Health Protection – Community-managed Health Equity Funds).*

Community members learning about CMHEF

CONCLUSIONS

After three decades of working with the RGC and its partners to develop, update, and refine the HEF system, it is nearing the point of full transition to Cambodian ownership. As of September 2018, the RGC is providing approximately 70% of the total funding for the HEF. Reliance on outside funding poses a risk, as seen by the decline in utilization rates during a gap in funding between the end of HSSP 2 and the start of H-EQIP. Despite the delay in facility reimbursements, however, no single hospital or health center suspended their treatment for the poor, demonstrating a high level of trust in the HEF system. Furthermore, the establishment of the PCA as a public administration establishment, demonstrates the commitment of the RGC to improved access to and quality of health care services, and signals a continued commitment to reducing the financial burden of health care to poor Cambodians.

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