

3. Lessons Learned

3.1 External to MOH - The Linkage with Larger Government Reforms

a) National Public Administrative Reforms

Health Finance Schemes have become an entry point for various mechanisms relating to management and quality improvement at public sector service institutions. Certain issues that have been addressed either effectively or otherwise include:

1. Internal management rules and regulations for staff discipline, attendance, courtesy and ethical standards;
2. The effect of salary supplements on staff motivation and productivity informing the level of salaries required for health workers;
3. The volume and skill mix of workforce needed as a critical mass to adequately provide services at different rates of utilisation and service activity.

A major lesson relates to the high volume of staff at service facilities. In some provinces, Health Centres employ 6-8 persons and the average contact rate has been 1.2 patient visits per staff member per day (Pickering 1999). Provincial Hospitals have over 120 personnel on their payroll, and District Referral Hospitals around 40 personnel with the actual number of in-patients at even lower numbers. Distributing rewards among a large number of personnel have not been successful in raising staff morale especially when revenues are low. Without effective downsizing of staff, the current model of health finance schemes may not survive.

b) Relevance to Budgetary and Fiscal Reforms

The experience with establishing and managing Health Finance Schemes have yielded the following benefits that connect with other kinds of financial reforms:

1. By providing opportunities to improve financial management skills;
2. Enabled managers and service providers to be aware of costs and expenditures and make efforts towards improving efficiency;
3. Provided the basis to explore the viability of an alternative and supplemental system of financing health services and the critical linkage to other types of budgetary support mechanisms;
4. Created the setting for better understanding of contractual obligations and partner negotiations;
5. Given an opportunity for some managers to develop good business management skills and entrepreneurial talent for fund-raising including establishing linkages with the community.

The government recurrent health budget situation is improving dramatically after the record lows of 1998. A big increase in expenditure is anticipated following a substantial increase in the recurrent health budget from \$22.5m in 1999 to \$31.8m for the year 2000, representing 9.2% of the government budget. (MOH, 2000) (See following table.) The capacity of provincial and district managers to manage funds and appropriately allocate resources is critical towards enabling expenditures that justify the increase in national health budget. The experience with managing user fee revenues and expenditures has laid the groundwork for some of the more complex responsibilities associated with budget management.

Table 3: Ministry of Health Budget and Expenditure from 1995-99 (in US Dollars)

Year	Recurrent Budget (Millions)	Recurrent Expenditure (Millions)	% Budget Actually Implemented	Budget as % of Govt Recurrent Budget	Spend per Capita	Spend as % GDP
1994	\$15.0m	\$11.7m	68%	5.8%	\$1.2	0.49%
1995	\$14.9m	\$10.7m	72%	5.0%	\$1.0	0.36%
1996	\$23.0m	\$16.2m	71%	7.7%	\$1.5	0.52%
1997	\$20.7m	\$15.4m	70%	7.4%	\$1.4	0.51%
1998	\$16.6m	\$11.7m	73%	6.7%	\$1.0	0.39%
1999	\$22.5m	\$19.9m	88%	7.3%	\$1.7	0.63%
2000	\$31.8m	NA	NA	9.2%	NA	NA

3.2 Within Public Health Service Infrastructure

a) The Ability to Raise Revenues and Enable Cost Recovery

The success and failure of health finance schemes are graded according to different case scenarios. In general, the schemes in referral hospitals have been more visible which may be related to a higher level of demand for curative services in comparison with low coverage rates of preventive care available at health centres. Thus, certain provincial and national hospitals such as Takeo Provincial Hospital, the National MCH Centre, Calmette Hospital, the Takeo Eye Hospital would fit the "best" case scenario where utilisation and client intake is high (80 – 120 per cent bed occupancy rate), and cost recovery² is high (38 – 40 per cent). Others such as the Kampong Chhnang Provincial Hospital and Svay Rieng Provincial Hospital can be considered "average" case scenarios. The bed occupancy at these facilities has improved after health finance schemes have been set up but is still hovering around 40-60 per cent, and cost recovery is around 10 – 15 per cent of recurrent costs. Health Finance Schemes at certain hospitals such as Preah Kossamak and Preah Norodom Sihanouk have not had major success. The bed occupancy at these facilities is around 30 per cent or lower with minimal revenue generation.

An issue connected to revenues is the level of exemptions given to patients. Some of the "best case" facilities actually record very low levels of exemptions in terms of number of patient visits as well as earnings forgone. (Takeo Provincial Hospital loses around 1-2% of their revenues through exemptions.) It seems that the clientele at these hospitals may not necessarily be the poorest of the poor. However, the management had tried to concentrate on keeping fees fair by reducing the average price to at least half since official charges were introduced. The average case facilities report exemptions by visits to be around 15 per cent and incur income loss around 20-25 per cent out of expected monthly charges.

b) Relating Revenues to Management Practices and Service Quality

A cursory overview of performance at the different facilities gave the impression that the best case facilities did invest a certain amount of effort into improvement of service quality either through on-the-job skills training by international organisations or at training institutions within the country. Most of these facilities had strong managers who also possessed personnel management capability, fund-raising abilities and entrepreneurial skills in seeking out contracts for service delivery, training, etc.

An important element concerns staff motivation among these different facilities. The service providers and managers at the "best case" examples receive a high level of incentives. The

² Cost Recovery Ratio: Total User Fee Revenues / Total Recurrent Costs

supplemental salaries of doctors participating in provincial hospital schemes range between US\$ 150 – 200, nurses are paid around US\$ 80 and the cleaners receive around US\$ 50. The clinical staff at average case facilities receive less, i.e. around US\$ 50 for doctors, US\$ 20-30 for nurses and about US\$ 10 for cleaners.

The distribution of incentives at some of the facilities in the top category is linked to performance. In Takeo Provincial Hospital, salary supplements are awarded to individual staff members on the basis of productivity, attendance and clinical audit. In general, the “best case” schemes have established a management framework that links rewards with performance and enabling strategies for quality improvement.

Another unique feature of high performing facilities is to establish standards and norms supported by internal management regulations. Staff members enter into a contract to benefit from the proceeds of the Health Finance Scheme based on their job descriptions updated to reflect the tasks assigned. There are a few examples of punitive measures against staff members who charged unofficial fees to patients by transferring them out of the facility.

One major observation at facilities with health finance schemes is the indirect gains in organisational development and internal regulatory systems. The benefits that emerged have been team building where the different committees meet to monitor activity rates, revenues, exemptions granted and go through problem solving exercises to develop strategies that generate high returns. Staff members plan together for efficiency, by monitoring expenditures and initiate self-regulatory procedures to maintain standards for the facility as a whole. *Overall, health finance schemes have given the opportunity to bring in positive outcomes in management development at service facilities that may outweigh their gains in generating funds.*

Prominent schemes such as in Takeo Provincial Hospital have also been a learning ground for field visits, clinical training, reference documents for other hospitals. Other lessons to be shared include the improvement in data recording for health information systems, data for improvement of health budget distribution and in developing strategies for improving hospital efficiency.

3.3 The Effect on Health Service Use and Equity

Official user fees were established at public sector health facilities amidst a context of high disease burden among a population struggling against the impoverishing effects of high health expenditures. The critical issue is whether formal fees have either reduced or have added to the existing levels of expenditures. At present, 36 per cent of the nation's population lives in poverty (Cambodian Human Development Report 1999). It would be important to promote

health service use, i.e. both preventive as well as curative care, as cost-effective measures to reduce disease burden and alleviating poverty. Thus, the critics of user fees have argued that it may not be the correct strategy to combat the prevailing problems. An evidence base is required to discern whether the intended aim of reducing unofficial payments by enabling a controlled environment that induces accountability and protects the poor through exemptions has been achieved. Different kinds of methodologies can be used to examine this; either through "mystery clients" or by tracer studies that follow up patients (especially the poor) at home to inquire whether unofficial fees were charged.

Unfortunately, there is very little documentation or evaluation of the effect of official fees on access and equity. There is no objective and reliable information on who benefits from exemptions and whether they are truly poor. There is also a dearth of evidence on the socio-economic profile of customers who obtain services at these facilities, and what their reactions to service quality and staff behaviour have been. One main concern is to examine clients' perspectives towards whether there was any change in amounts paid for care before versus after official fees were introduced.

Generally, a sliding fee scale is exercised at most facilities, and some provide self-selection of certain non-priority services such as better rooms or mattresses for paying patients, etc. Often, private sector providers are preferred because of their ability to accommodate customers' ability to pay, i.e. by giving credit, or allowing payments in installments, and even payment in kind and labour. Unfortunately, the public system is not always that flexible and relies only on cash payments. Although some provisions for installments do exist in some facilities, not many schemes are that flexible to motivate poor customers to avail of their services nor are they marketed sufficiently to inform them of the opportunities to be exempted. Other reasons why private providers are preferred include the hours of service availability, willingness to cater to clients' demands for drugs and injections, and courteous behaviour (NIPH/GTZ/WHO, 1998; Collins, 2000).

3.4 The Question of External Assistance

A perpetual question relates to whether facilities that are setting up health financing schemes should receive funding from donors and international organisations. Or rather, the other question is whether health finance schemes can be set without initial "priming" funds and assistance for quality improvements. A number of successful schemes are known to have received financial – in some cases – also technical support from various agencies based on long-standing relationships such as the case of Swiss Red Cross and Takeo Hospital, Japanese Red Cross and Chamcarmon Health Centre, JICA and the National MCH Centre. The assistance has enabled

them to improve the quality of service delivery and physical condition of the facilities, and provide guaranteed financial resources for running costs and incentives to staff members. The support was an important element in the success stories but raises questions concerning overall sustainability of operations, particularly for salaries, at the same level of quality when the donors phase out their support.

An important feature is the on-site management advice from hospital management advisers and other type of technical assistance provided by agencies involved in health sector reform. These advisers have been essential in enabling government health staff to develop the schemes and their management systems. On rare occasions, they also assist in helping the management to maintain transparency and accountability within the facilities. These kinds of inputs have been given to many of the top and medium range health finance schemes.

Likewise, on-site advice and training was also provided through teams of clinicians and nursing staff stationed for a number of years at these facilities with support from the same agencies. The experts extended on-the-job training and assistance towards improving service quality and physical conditions.

3.5 Overall Merits and Demerits

In broad terms, the merits of establishing user fees have been an opportunity to raise some income for a small portion of the recurrent costs, enable staff motivation and commitment, and facilitate organisation development through team building and improvement of management skills.

User fee schemes have also enabled health facility management to build linkages with the community. Community representatives have played an important role in some health financing schemes, especially at health centre level where their input is the most visible. In some health centres, charging and fee levels have been discussed with co-management committees and Feedback Committees. Where those committees exist, discussion on financial matters in monthly meetings helps to improve transparency in the management of generated income. Committee members also promote and explain the health financing scheme objectives and practices to the population. At hospital level, such as with Svay Rieng Provincial Hospital, there is growing awareness for community-based structures such as Feedback Committees and Village Development Committees to participate in the implementation of exemption schemes. The feasibility of exemptions to be decided at village level where the status of the person could be directly observed is being explored. The idea is taking shape slowly and cautiously because it is quite complicated to implement and calls for good understanding of all partners. Community

participation also provides opportunities for increasing health service quality as it provides a channel for obtaining information from customers. Feedback Committees have also helped in conducting health promotion activities in the community.

A word of caution needs to be inserted in discussing demerits. Facilities with user fees may have encountered lower utilisation rates, and there is no evidence as to whether they have or have not created higher expenditures for consumers. However, it should be reminded that user fees might not have been the causal element but rather the lack of organisational readiness and management skills to implement and regulate the systems effectively. It would be important to examine what would be required to enable public health staff operating within the current organisational climate to implement user fee schemes successfully according to guidelines and principles established. Another concern is the potential conflict of interest of staff at public health facilities operating private practices who are reluctant to fulfil required number of work hours and keep price levels low to attract customers. Their commitment to service delivery at the public facility and team goals within the institutional setting is critical to the success of health finance schemes. Management supervision to render a clear separation of roles and responsibilities is necessary to enable this.

The support of the Ministry of Health, the civil authorities and the Provincial Health Department played a critical role in the success of the schemes. The assistance of these partners affected many inputs such as sufficient supply of drugs, medical supplies and equipment, adequate access to budgetary support and technical advice on management and clinical tasks. As the public health system become more decentralised, there is a growing role for the provincial health department in monitoring, supervision and support for facilities with health finance schemes.

The different schemes implemented within the past two years have yielded many lessons. Across the board, the rubric of best practices include on-site management and technical advice, adequate incentives to staff, external financial support, concrete strategies for improvement of service quality including clinical skills, and last but not the least, internal management regulations that enable performance at optimal levels.

Other issues that have emerged in the process of learning from existing models include the following:

1. That user fees cannot exist as the sole means to finance a health service delivery system as even the most successful schemes are not fully self-sustainable;
2. Cost recovery will be limited when public health goals are to be achieved;
3. An efficient service delivery system will reduce the need for higher fees and enable lower prices without compromising quality;

4. Price levels, and a host of other factors such as poor service quality, lack of courtesy in staff behaviour, clients' perceptions of quality and the inadequacy of medicines can affect access, especially of the poor, to priority health services.

The Ministry of Health is at the crossroads of reform where clear and reliable evidence is needed to develop financing policies that promote access and equity and enable poverty alleviation. The next logical and essential step is to conduct in-depth analysis of how user fees have affected access, equity and health service delivery.

4. Conclusions, Recommendations and Plans for Further Analysis

The present paper takes stock of the situation at hand regarding the current model of user fees in the public sector. The Ministry of Health and its development partners stress the importance of an in-depth evaluation in a sound and comprehensive manner.

The various components to be evaluated are listed as follows:

1. Financial performance concerning the uptake of services, revenues, expenditures, exemptions and the distribution of incentives to the staff;
2. The effect on access and equity in health service use, with special attention given towards the impact on the poor. The evaluation should gather the opinions of customers and their perceptions of service quality in conjunction to prices encountered;
3. The different modes of exemption systems, the socio-economic profile of those who have been exempted from payment and how the systems have affected health service use among the poor,
4. The effect on management and quality improvement at health facilities and whether there have been any changes in managerial practices and organisational behaviour at health centres and referral hospitals;
5. Documentation and presentation of views and perspectives of decision makers and resource persons involved in the design, supervision and policy formulation of health financing policies to discern their sense of direction regarding the current model of user fees.

A series of monitoring, evaluation and operations research activities are envisaged for the purpose of developing a best practice package. The current plans include institutionalisation of a reporting system that requires facilities with user fee schemes to provide information on utilisation, exemptions, revenues, expenditures and the distribution of salary supplements on a quarterly basis. At later stages, the monitoring system will provide the means to construct an

evidence-base for policy, and training in effective management of health finance schemes at both central and peripheral levels.

Also in the pipeline is a qualitative study that aims to get in-depth information on providers' practices and customer opinions and preferences from areas where user fees are being piloted. The documentation of policy makers' perspectives would be an important item to balance the information gained from field observations, discussions and interviews with providers, managers, customers and non-users of public health services. In this context, the design of future policies will be shaped according to the perspectives of all these different stakeholders.

A host of questions have emerged for further analysis in determining the way forward with health finance schemes:

Figure IV: Key Questions to Consider in Reviewing Current Government Policy on User Fees

1. *Have official fees for services been effective in reducing household health expenditures?*
2. *Have health finance schemes been able to induce transparency and accountability in health facilities?*
3. *Have exemption systems been effective in protecting the poor from high medical expenditures?*
4. *What actions are necessary to promote access and increase utilisation of services at public sector health facilities?*
5. *Would cross-subsidies be possible within the range of services included in the Minimum and Complementary Package of Activities at government facilities?*
6. *Have health finance schemes been able to increase cost efficiency especially when delivering priority services currently provided free such as immunisations and treatment for tuberculosis?*
7. *Should there be changes in policy to enable staff to benefit a larger share of the revenues as salary incentives given the limited progress in National Public Administrative Reform?*
8. *Would that policy change be possible if there is a tangible increase in resources available for running costs?*
9. *Is it possible to implement user fees successfully without external donor support or is the promised increase in the national health budget adequate to close the resource gap?*
10. *Would alternative / complementary measures such as equity funds and external financing of exemptions adequately protect the poor from impoverishing effects of health expenditures?*

Several other initiatives are also being designed to assist and complement the current system of user fees in the public sector. Through the existing Health Sector Reform Project, the Ministry of Health is exploring alternative financing strategies and management arrangements that would function as a booster to the Health Coverage Plan. The basic concept is to provide a resource envelope at the Operational District level enabling adequate budgetary support and improved

incentives for the staff. The design tables contractual arrangements for the District teams to deliver tangible performance outputs. Such experiences would provide valuable lessons to the larger government agenda such as the National Public Administrative Reform and Fiscal and Budgetary Reforms.

Additionally, the project is also exploring ways to manage the competition faced through the growth of the private sector. The vision is to outline strategic options that enable an effective mix of public-private mix of service delivery based on defined roles, regulatory mechanisms and arrangements for contracting and out-sourcing. Opportunities such as sub-contracting certain services from health facilities such as for laundry, catering, maintenance can be explored.

Overall, the question remains how user fees would feature in a scenario of higher and more adequate national health budget that provides sufficient resources for recurrent and capital costs of service delivery. This is also intertwined with civil service reforms that enable higher salaries and more effective regulatory systems. Thus, the purpose, value and shape of health finance schemes would have to be figured out within the context of these other critical agendas.

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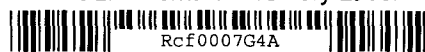
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UNICEF Alternate Inventory Label



Rcf0007G4A

Item # CF-RAI-USAA-DB01-2003-967867