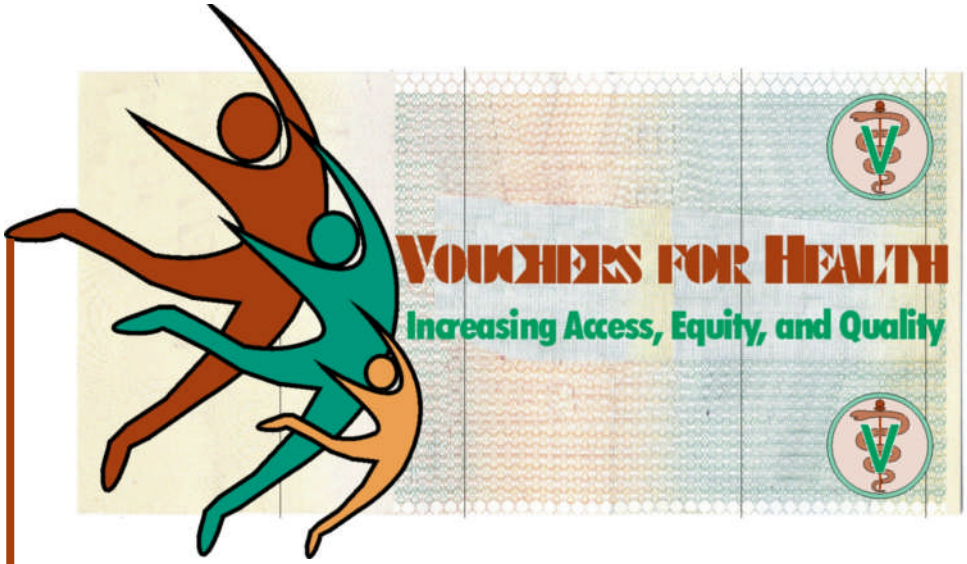

April 12 - 13, 2007 I Best Western Resort Country Club I Gurgaon, India

Equity Fund Program-Kirivong Operational Health District,Cambodia

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Background on user fees

- In Cambodia, introduction of transparent user fees for health services since 1997 is generally associated with an increase in utilisation, especially at hospitals.
- Reasons are a reduction in under-the-table payments and better staff attitude, especially interpersonal skills and quality of care.
- Income of staff is linked to revenue from user fees whereby exemptions are rarely granted.

Background on user fees (contd.)

- Only 1-6% of patients are exempted. Most are family members of staff and civil servants
- Observed increase in utilisation happens because of higher utilisation by the non-poor while the poor are deterred.
- To safeguard positive effects of user fees while ensuring access to public health services for the poor, health equity funds were developed.

Health equity funds (HEF)

- By use of a health equity fund, a third party pays providers the equivalent of user fees for services provided to the poor.

- To date 26 health equity funds are operational at Cambodia. Their services are mainly limited to enabling access to hospital services.

Health equity funds at Kirivong Operational District

- Operational Health Districts are the lowest organizational level in the public health system.
- Kirivong Operational District consists of 4 administrative districts that have together 31 communes with 290 villages with a population of about 220,000.
- Health care services are provided from 20 health centres and an 80-bed referral hospital.

HEF at Kirivong Operational District (contd.)

- HEF is managed through pagodas and mosques - there are 91 pagodas and 5 mosques.
- Monks are not allowed to manage money; this function is carried out by pagoda committee, made up of volunteers (PAV)
- Since April 2003 PAV collect money from the population and manage it for the pagoda, where it is used for the HEF.
- 2 PAVs per pagoda are selected to be on the Health Centre Management Committees (HCMC).

HEF at Kirivong Operational District (contd.)

- One pagoda committee per health centre is in charge of accounting while others focus on collecting money
- Pagoda managed equity funds are retained at health centres for increasing and maintaining the degree of community participation.
- The remainder of this presentation is concerned only with the HEF services at the health centres and targeting the poor.

The vouchers

- To overcome financial constraints with administrative procedures related to the HEF at health centres a voucher system was introduced
- When an equity fund beneficiary (EFB) approaches a facility for services (curative, delivery, contraceptive) the provider completes a voucher in duplicate: one is retained and one given to the EFB

The vouchers (contd.)

- The EFB gives the voucher to the PAV in the area in who gives it in turn to the pagoda representative at the HCMC.
- At monthly meeting the vouchers from both parties - PAV and health providers - are compared and when they match payment takes place
- Payment to providers is made based on standard user fee schedule

The vouchers (contd.)

- Constitutes an easy system that minimizes potential fraud
- Uses existing community structures
- Low administrative costs

Targeting approach

Criteria to guide identification of poor were formulated by the member of advisory board to Kirivong Operational District: the District Chief Monks and Deputy Governors in-Charge for Health

Targeting approach: Criteria for eligibility to benefit from the equity funds

Comply with all three major criteria:

- Poor composition of house (roof and wall from thatch/palm/bark/aluminium sheets)
- Owning less than 0.5ha of land
- Daily household income of US$1 or less

and

Targeting approach: Criteria for eligibility (contd.)

Comply with at least one additional criterion:

- No “luxury goods” assets (such as TV, motorcycle)
- No farm animals
- Having at least seven economically-inactive household members

Targeting approach (contd.)

- Village health support group apply targeting criteria and identify EFB
- Village lists are forwarded to respective pagoda chief monk who - together with the elders present - endorse the households on the list
- Community-based targeting approach coordinated and supervised by HCMC member from village
- So far 3 rounds of community-based targeting have been completed

Targeting results

Variable	EFB n = 299 (%)	NB n = 201 (%)
Casual worker	102 (34)	4 (2)
Literate	39 (13)	63 (32)
Finished floor	0	42 (21)
Iron roof	41 (14)	162 (81)
Has TV	9 (3)	87 (43)
Has motorbike	2 (1)	71 (35)
Landless	91 (30)	10 (5)

Results of health equity fund on care seeking
(Data from health information system)

Variable	EFB	NB
Annual OPD per capita	0.65	0.47
Annual IPD per 1,000 population	32.5	18.4
Assisted deliveries per 1,000 person per year	4.4	9.8

Results of health equity fund on care seeking

(Data from 199 matched EFB and NB who were hospitalised)

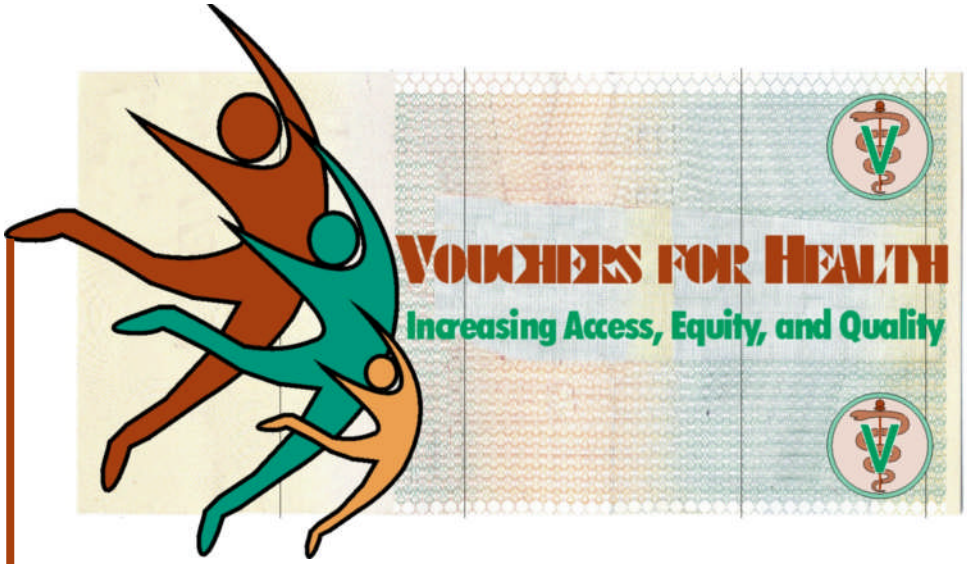
Variable	EFB (%)	NB (%)
1st place consultation		
Private practitioner	131 (6)	149 (75)
Health centre	53 (27)	24 (12)
Hospital	11 (6)	24 (12)
2nd place consultation		
Private practitioner	8 (4)	7 (4)
Health centre	36 (18)	14 (7)
Hospital	143 (72)	168 (84)
Total health centres	89 (45)	38 (19)

Lesson learned

- Community based identification of poor is feasible
  - High quality targeting with low cost (uses volunteers)
- HEF greatly increase access to in-patient curative services
- Difference in assisted deliveries requires exploration

Challenges

- Replication elsewhere, with other faith based organisations
- Getting regular proportion of income by pagodas
- Adding additional required interventions by other sectors



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Thank you

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