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### ***The political economy of inclusive healthcare in Cambodia***

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## **Abstract**

Over the past 15 years, Cambodia has made significant strides in expanding effective access to free healthcare for poor people, thanks largely to 'Health Equity Funds' (HEFs), a multi-stakeholder health-financing mechanism. HEF operators have helped expand access, incentivise health staff, and lobby on behalf of poor patients. However, despite their successes, they have been unable convincingly to address some of the deeper-seated problems of the Cambodian health system, such as under-resourced facilities, underpaid, poorly qualified staff, and a burgeoning private sector. This paper explains this state of affairs as a product of Cambodia's 'political settlement', in which relatively successful multi-stakeholder initiatives exist as 'islands of effectiveness' in a sea of rent-seeking and patronage. While such islands may currently be the best solution available for poor people, the deeper problems are unlikely to be solved without a shift in the political settlement itself.

**Keywords:** politics, political economy, political settlements, inclusive development, Cambodia, healthcare, Health Equity Funds

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## **Introduction**

Over the past 15 years, Cambodia has demonstrated an increased commitment to making health services inclusive by supporting the expansion of a variety of schemes that provide fee exemptions for poor people, notable among which are 'Health Equity Funds' (HEFs). HEFs are multi-stakeholder initiatives in which NGOs reimburse public health facilities for treating poor patients, using a combination of state and donor money. They also contribute to improving the quality of care by providing cash incentives for staff and facilities, lobbying on behalf of poor patients, and monitoring health facility performance. Despite their manifest successes, HEFs have been unable thoroughly to address some of the deeper-seated problems of the Cambodian health system, including poorly paid and inadequately trained staff, under-resourced facilities, and a burgeoning private sector poaching public patients and staff.

In the current paper, which should be read as a contribution to the literature on the political economy of developing country healthcare, we explain this state of affairs using a 'political settlements' framework developed at the Effective States and Inclusive Development Research Centre at the University of Manchester (Hickey 2011; Levy and Walton 2013). We begin by sketching the history of healthcare in Cambodia, relating this firstly to the national political settlement, and secondly to the political settlement in the health sector itself. We then discuss the rise of Health Equity Funds, their strengths and weaknesses, and, in a final section, identify reasons for differential local HEF performance.

The study draws on official documents and data, six focus groups (FG1-6), 16 interviews with expatriate health experts, Ministry of Health officials, and NGO staff at national level (N1-16), and 46 semi-structured interviews with health managers, frontline staff, local government authorities, and NGO staff and volunteers at local level (L1-46).

## **Inclusive healthcare in Cambodia**

When describing the history of inclusive healthcare in Cambodia, we are really describing three things. One is the formal access that poor people have to healthcare; another is their effective access; and another is the quality of the healthcare they receive. Chronologically, we can identify three periods: 1979-1990, when healthcare was formally free, but extremely rudimentary; 1990-2003, when healthcare was both expanding and formally free (for poor people), but effective access was low; and 2003 to the present, when healthcare has continued to expand, remained formally free (for poor people), but during which both effective access and, to a lesser extent, quality, have also improved.

### **1979-1990**

Between 1970 and 1979, Cambodia was devastated by civil war and the Khmer Rouge communist dictatorship. At the end of the period, health facilities were ruined,

empty buildings, and the entire health workforce numbered fewer than 100 (Keovathanak and Annear 2011; Slocomb 2010). After 1979, the country was occupied by the Vietnamese, and the health service rebuilt using Soviet bloc aid, as well as assistance from UNICEF and NGOs such as World Vision. Health services remained rudimentary, however, reaching only around half the population (Grundy et al. 2009; Keovathanak and Annear 2011; Slocomb 2010).

### **1990-2003**

Following the 1991 Paris Peace Accords, Cambodia received increased assistance from international health organisations and NGOs. These were coordinated via a peak body, MEDiCAM, which liaised closely with the Ministry of Health and provincial departments (Slocomb 2010). A number of major reforms were put in place with the aim of expanding and deepening health services (Annear 1998; Barber et al. 2004; Grundy et al. 2009). For example, the 1996 Health Coverage Plan (HCP) was created to re-construct the health infrastructure, with a clear definition of services, roles and responsibilities at each level. It gave birth to a system of Provincial Health Departments and Operational Districts (ODs), each having responsibility for a referral hospital and a network of health centres (Barber, 2004, 16).

Despite the steady increase in health infrastructure, effective access for poor people remained a problem. Central disbursements to local health organs were both low and unpredictable, meaning that health staff had little incentive to work. One informant spoke of gleaming new buildings with no staff in them (N3). Where staff did work, under-the-table payments were rife. This acted as a deterrent to patients, especially those who were poor. Consequently, in 1996, the National Health Financing Charter (HFC) was adopted, paving the way for the introduction of user fees (Hardeman et al. 2004; Ministry of Health 1996, 2003, 2006, 2008). By providing health staff with an incentive to work, user fees actually led to an increase in health service utilisation. By exempting poor people from paying fees, however, the system created disincentives for health staff to treat them, meaning that the level of actual exemptions, and effective access for the poor, was low (Jones et al. 2012; National Institute of Public Health 2012).

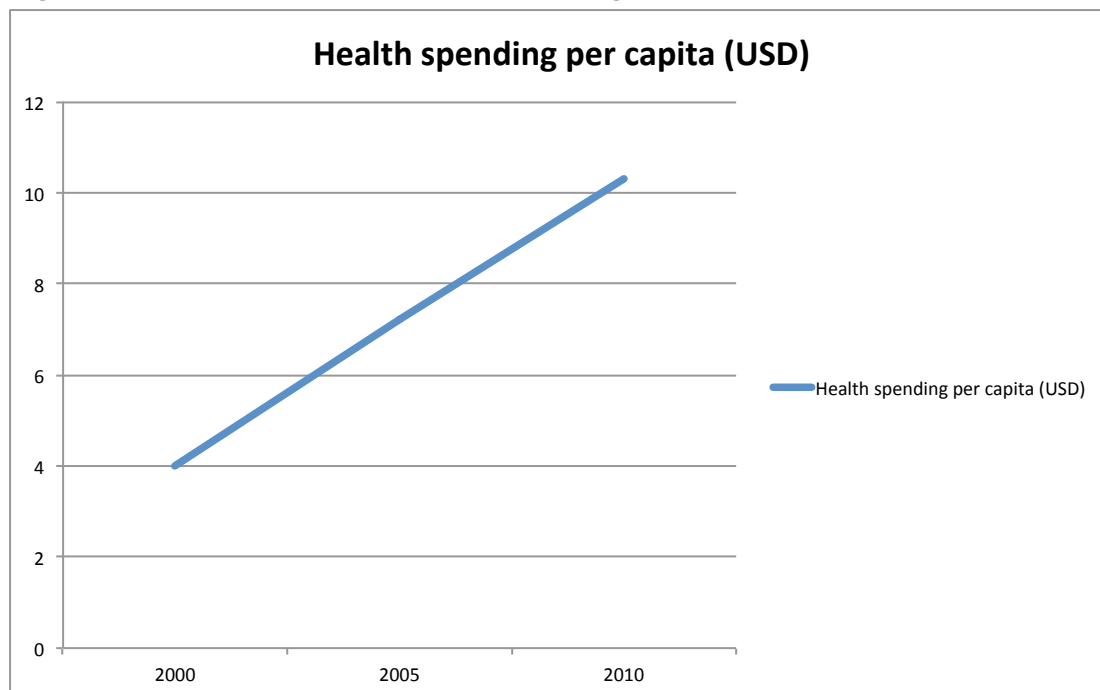
### **2003-present**

The 2000s have seen a continued expansion in public health spending (see Figure 1). General government expenditure on health increased from US\$4 per capita in 2000 to US\$ 7.2 in 2005 and US\$ 10.3 in 2010.<sup>1</sup> Put differently, it rose from 8.7 percent of government expenditure (1.3 percent of GDP) in 2000, to 11.7 percent (1.5 percent of GDP) in 2005, and 11.5 percent (1.3 percent of GDP) in 2010.

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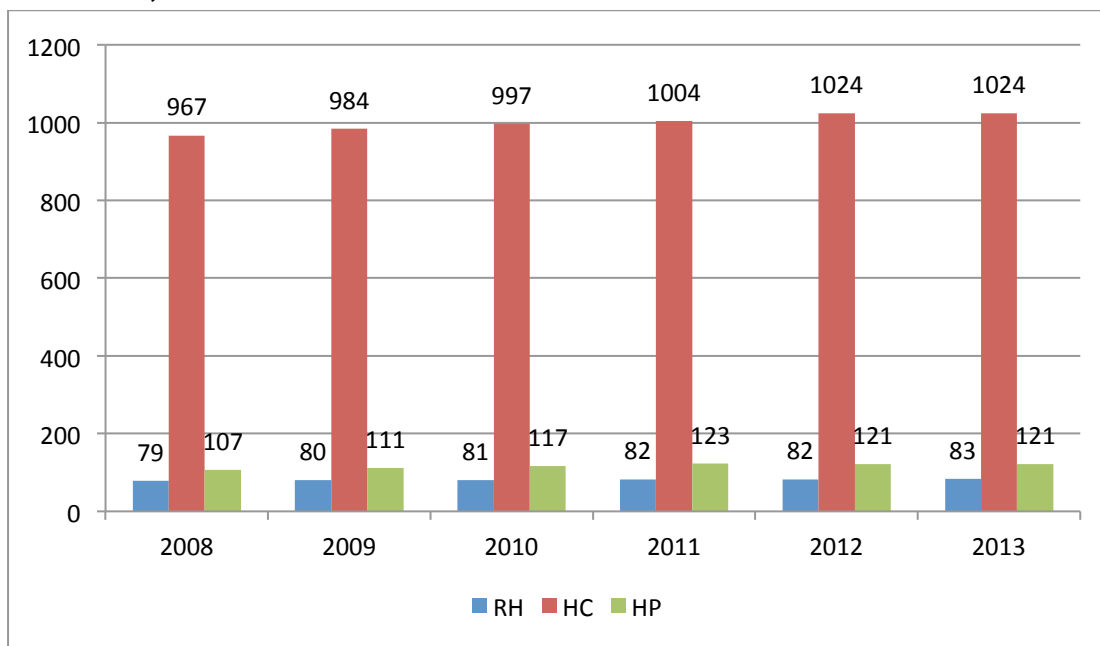
<sup>1</sup> WHO website: <http://apps.who.int/gho/data/node.country.country-KHM>. Accessed 18 November 2013.

**Figure 1. Cambodian public health spending per capita, 2000-2010**



Part of this money has fed into a gradual expansion of health infrastructure: the number of hospitals rose from 79 in 2008 to 83 in 2013; health centres increased from 967 to 1024; and health posts rose from 107 to 121. The total number of health workers increased from 18,096 in 2008 to 19,721 in 2012.

**Figure 2. Number of referral hospitals, health facilities and health posts in Cambodia, 2008-2013**



This expansion has been accompanied by a number of schemes aimed at increasing access. The most important, as we shall see below, have been Health Equity Funds,

in which a third-party NGO reimburses health facilities for exempting poor patients (Annear and Ahmed 2012; Net and Chantrea 2012). Another initiative has been in Community Based Health Insurance, first piloted in 1998 by a French NGO and later expanded (Annear and Ahmed 2012; Net and Chantrea 2012). More recently, the Ministry of Health (MoH) piloted 'a voucher scheme'<sup>2</sup> to pay user fees and transport costs for poor or vulnerable women of reproductive age (Ibrahim et al. 2012).

There has also been considerable innovation and experimentation in health programming, with the ultimate aim of improving staff performance and the quality of care. Indeed, informants told us that Cambodia was 'famous' for its piloting approach (N10, N4). Between 1999 and 2002, five ODs experimented with contracting out *their entire public health service* to NGOs. Between 2004 and 2008, a further 15 ODs experimented with contracting an NGO in, to manage the public health service. At the same time, an 'internal contracting'<sup>3</sup> model was piloted and funded by the Belgian Technical Cooperation (BTC) in five additional ODs. Subsequently, in an attempt to streamline and regain national ownership over what were considered to be successful experiments, the internal contracting pilot was institutionalised within ODs granted Special Operating Agency (SOA) status. Beginning in the 16 former contracting ODs (Keovathanak and Annear 2011), the MOH adopted the role of principal, signing contracts with SOAs, the agents. As part of the contract, SOA managers were given more autonomy to ban private practice, hire and reshuffle staff, and adopt a raft of performance-based staff incentives typical of new public management approaches (Keovathanak and Annear 2011).

These developments have coincided with considerable improvements in health outcomes (Figure 3). Life expectancy at birth has increased from 57.5 years in 2000 to 62.6 years in 2010. Mortality rates, especially infant and under-five mortality, as well as the maternal mortality ratio, have dramatically declined (see Figure 2). In consequence, MDGs 4 and 5 have already been met. As for MDG 6, malaria and HIV/AIDS seem well under control, with the record on tuberculosis, though still giving some cause for concern, improving (United Nations Development Programme 2014).

To explain this as an unequivocal triumph for the public health system would be premature, however. It is difficult to say to what extent the progress is attributable to more and better quality healthcare, or to rising economic growth, road-and-vehicle access, income, education and access to private medicine. Moreover, although poor people's access to public health services has certainly improved, health progress has not been equally shared, either geographically or by socio-economic group (Annear

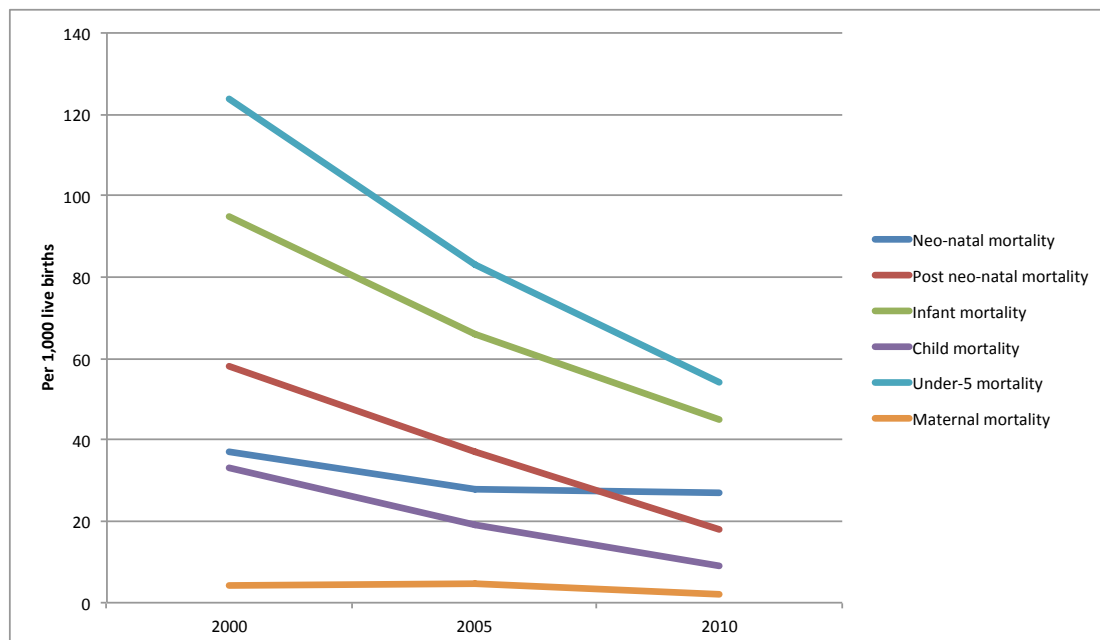
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<sup>2</sup> Vouchers are offered for family planning counselling and services, prenatal care (up to four visits), delivery services, and post-natal care (up to six weeks postpartum), and abortion services. In addition, a transportation stipend based on kilometres travelled is provided in cash to women at facilities (Brody et al. 2013, 3)

<sup>3</sup> The internal contracting model, which is different from two types of contracting models, was managed by government OD managers with support from Provincial Health Department, BTC technical advisors (Keovathanak and Annear 2011, 50).

et al. 2008; Asante et al. 2011; Jones et al. 2012; Lane 2007; National Institute of Public Health 2012).

**Figure 3. Child, infant and neonatal mortality rates and maternal mortality ratio, Cambodia, 2000-2010**



In fact, Cambodia still faces serious health challenges. One of the most pressing remains low overall utilisation of the public health sector (Annear and Ahmed 2012; Grundy et al. 2009; National Institute of Public Health 2012). Although representative statistics are hard to come by, it seems certain that large numbers bypass the public sector (National Institute of Statistics 2011; World Bank 2013a). This is of particular concern, since private sector regulation is weak, and the quality of many private providers concomitantly low. One client survey, conducted in Phnom Penh, found that ‘57% of consultations with private providers were potentially hazardous and only 32% met broad MoH guidelines’ (Vickery et al. 2001). In a more recent study, the World Bank found problems of misdiagnosis throughout the sector, with private providers faring worse (World Bank 2014).<sup>4</sup>

### Health and the political settlement

In recent years, the study of institutions and the political settlements that lie behind them has emerged as a promising field for development research. A ‘political settlement’ has been variously described as: an ‘expression of a common understanding, usually forged between elites, about how power is organized and exercised’ (DFID 2010, 22); ‘an interdependent combination of a structure of power and institutions at the level of a society that is mutually “compatible” and also “sustainable” in terms of economic and political viability’ (Khan 2010, 20); or ‘the

<sup>4</sup> The study found that 55 percent, 60 percent, 77 percent, and 93 percent of cases were misdiagnosed in public facilities, private facilities, small private consultation rooms, and the informal sector, respectively.

balance or distribution of power between contending social groups and classes, on which any state is based' (Di John and Putzel 2009, 4).

This paper is one of the first attempts to expand political settlements analysis beyond its normal preoccupation with stability and growth, and towards the issue of social provisioning (ESID 2012; Hickey 2011; Parks and Cole 2010; Sen 2012). It is also one of the first attempts to extend political settlements analysis from the national to the sectoral level. In doing this we draw on a framework developed for ESID by Brian Levy and Michael Walton. This divides political settlements into four basic types, according to whether they have dominant rulers or competitive polities, predatory or developmental outlooks, and personalistic or rule-governed administrations. From this framework, Levy and Walton derive a number of hypotheses about service delivery. For example, they predict that dominant developmental states with hierarchical governance will produce effective outcomes, with multi-stakeholder governance possibly adding some value in respect of solving principal-agent problems.<sup>5</sup> They also predict that multi-stakeholder governance can result in good performance under 'competitive clientelist' settlements, provided the external stakeholders are, among other things, well connected politically. By contrast, they predict that hierarchical governance under dominant-predatory regimes will be ineffective, with multi-stakeholder governance unlikely to act well as a countervailing power (Levy and Walton 2013).

In the next section, we describe the evolution of the national political settlement in Cambodia.<sup>6</sup> We categorise it as a hybrid formation characterised by a dominant party subject to strong competitive pressures, for which both predatory and developmental goals are important. In the subsequent section, we describe the political settlement in the health sector as similarly hybrid. We then argue that by melding the aforementioned Levy and Walton hypotheses, we can explain both the successes and limitations of Health Equity Funds.

### **The political settlement: national level**

In 1979 the Khmer Rouge was overthrown by the Kampuchean People's Revolutionary Party (KPRP), and it is from this date that we can trace the origins of Cambodia's current political settlement (Chandler 1991). The KPRP was a coalition of former Indo-Chinese Communist Party ideologues, and Khmer Rouge defectors from the Eastern region, backed by Vietnamese troops. Lacking resources and legitimacy, it gradually built a state by incorporating local power brokers into a national architecture. Its Foreign Minister was Hun Sen, a young Khmer Rouge

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<sup>5</sup> Levy and Walton (2013) define 'multistakeholder governance' as a situation in which, 'there is a politically salient coalition of external stakeholders that is working in concert with an organization's management (whether through the proactivity of the organization's leaders or social pressures on the leadership) with a mutual interest in pursuing the organizations goals'.

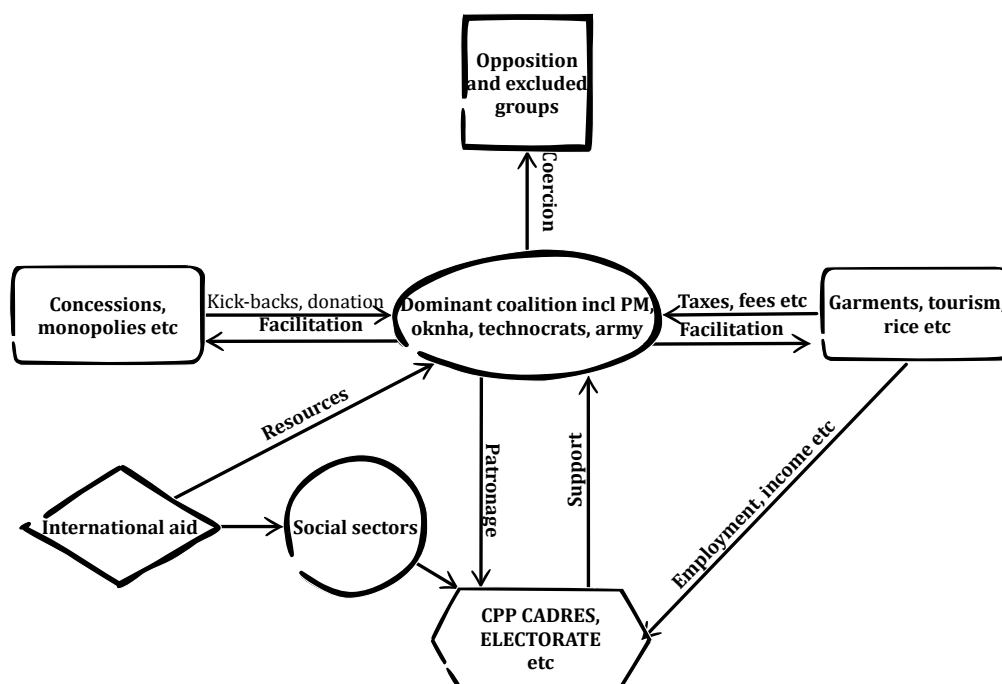
<sup>6</sup> To build a picture of the political settlement we began by conducting four focus groups to map the national political settlement, followed by a single focus group to map the sectoral political settlement.

commander, who by simultaneously learning the art of patronage politics, surrounding himself with able technocrats, and cultivating good relations with private businessmen and the Vietnamese, had by 1985 risen to the position of Prime Minister. As he did, so the KPRP/CPP's ideology shifted from socialism to pragmatism. Military spending remained high because of the threat of the Khmer Rouge (still active in some parts of the country), and market reforms were adopted because they were considered crucial to economic growth and regime survival (Gottesman 2004; Hughes and Conway 2003; Slocomb 2010).

The KPRP renamed itself the Cambodian People's Party (CPP) prior to a transition to democracy in 1993. It lost the election to royalist party FUNCINPEC, but bullied its way into a power-sharing deal. The next four years saw an arrangement in which Hun Sen and FUNCINPEC's Prince Norodom Ranariddh acted as co-prime ministers, with much of the business of government dominated by clientelistic competition for forestry rents. Nevertheless, it was also a period in which development partners were given remarkably free rein to strengthen or create institutions such as the Ministry of Finance, the Council for the Development of Cambodia, and to drive policy in the social sectors, including, as we saw in the previous section, health. In 1997, tensions between the two coalition partners spilled over into armed confrontation in the streets of Phnom Penh, forcing Norodom into exile. Hun Sen and the CPP consolidated their power in elections a year later, and although it still governed in coalition with FUNCINPEC – which held the health portfolio until 2008 – it was indisputably the senior partner (Kelsall and Seiha 2014 forthcoming; Le Billon 2000; Roberts 2001).

The political settlement in Cambodia has changed little since that time. As sketched in Figure 4, it has been characterised by an inner circle of rent-seeking businessmen (*oknha*), politicians, army generals and high-ranking technocrats, presided over by Hun Sen, and interlinked by a dense network of affinal ties. Rent-seekers have been gifted contracts and concessions, and in return have made kickbacks or donations to the ruling party. The Prime Minister has taken great care to avert internal challenges by balancing party factions: the top leadership shows remarkable continuity, and although rent-earning opportunities are by no means equal, they are shared around. In the meantime, technocrats have been given just enough latitude to nurture relatively competitive industries, such as garments and tourism, which generate economic growth, mass employment, poverty reduction and foreign exchange. The inner circle has been supported by an outer circle of development partners, the monarchy, clergy, business associations, and pro-regime trades unions, and linked to subaltern groups via both programmatic policies and patronage ties, with the emphasis on the latter. Until recently, the social sectors were relatively marginal to this settlement, with health typically footing the table of spending ministries (N8). In the vacuum, development partners have been afforded exceptional influence (N8) (Hughes and Un 2011; Jones et al. 2012; Kelsall and Seiha 2014).

Figure 4. The CPP's growth and legitimization strategy



As the regime has matured, the focus of its leaders has shifted from mere physical survival, to self-enrichment, to catching up economically and socially with larger, richer ASEAN neighbours (nationalism is an important motivating factor here). The regime also has to win elections, by foul means or fair, receiving strong challenges in 2003 and 2013.<sup>7</sup> Connected to this, observers have noted a shift in governance tactics from coercion, which dominated early elections, to mass patronage. The Prime Minister has increasingly styled himself in the mode of generous benefactor, *a la* Prince Sihanouk,<sup>8</sup> and there has been a growth in parallel party-state structures to pool rents, dispense patronage and/or realise policy goals. The rise of the Cambodian Red Cross, which pursues a number of high-profile campaigns in health and disaster-relief, is a good example. It is chaired by the First Lady, a trained midwife, and patronised by some of Cambodia's biggest businessmen (Craig and Pak 2011; Hughes and Un 2011; Jones et al. 2012; Kelsall and Seiha 2014 forthcoming).<sup>9</sup> Another good example are Party Working Groups, which co-opt powerful officials and businessmen to make off-budget infrastructure investments in communes across the country (Pak 2011).

Although patronage politics dominates the political settlement, programmatic policies, including in social provisioning, have also received increased support. Over the past five years, health's share of the government budget has crept up, as has the government's own contribution to it. The state now funds around 60 percent of the

<sup>7</sup> The Opposition's seven-point policy-plan included a promise that: 'Poor people would receive free healthcare'.

<sup>8</sup> Cambodia's former King, who abdicated the throne to lead his country to Independence.

<sup>9</sup> In at least two of the health districts we worked in, national politicians had made high-profile donations to the health service.

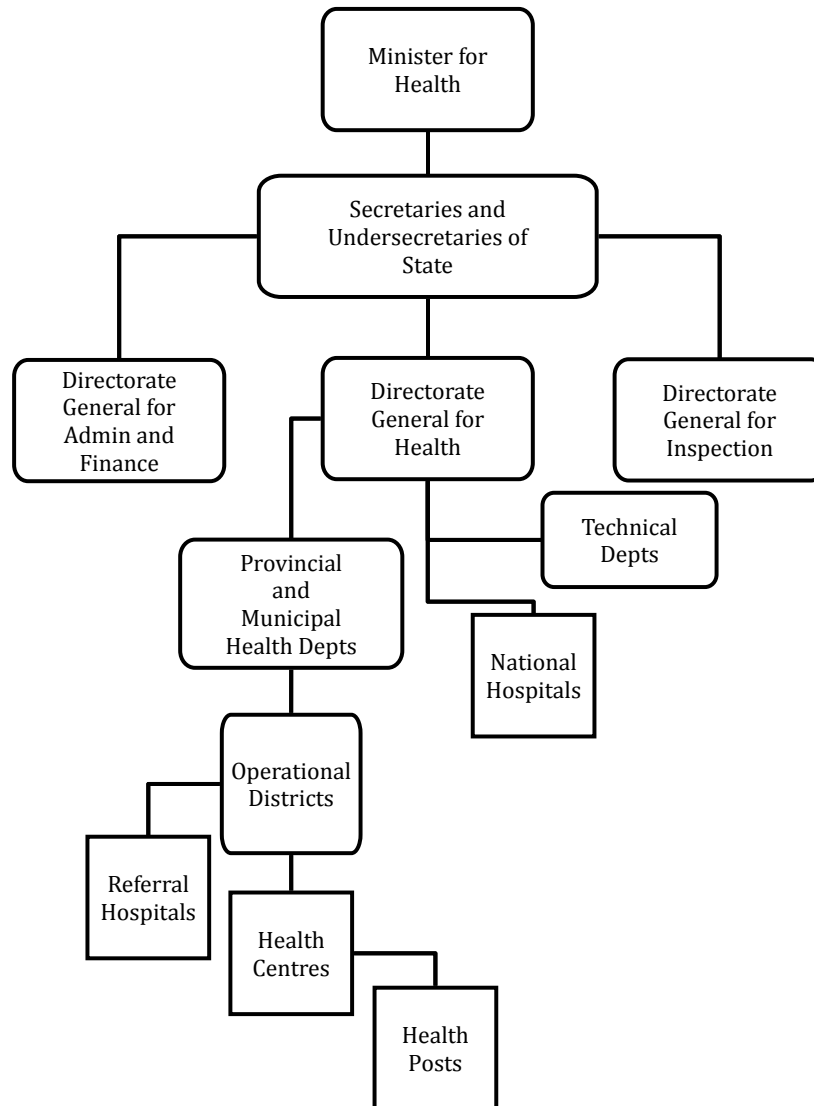
health budget from its own funds, up from around 30 percent in 2005. The Prime Minister has signalled his support for a number of health campaigns designed by development partners and MOH technocrats, including reducing maternal mortality, child malnutrition, and increasing poor people's access to health services (Jones et al. 2012). As the regime has become more financially self-confident, and increased its share of the health budget, so its employees have demonstrated an increased desire to take national ownership of health policy (N15). Whether or not this will result in more effective and more inclusive social provisioning, however, depends partly on the nature of the political settlement in the health sector itself.

### **The political settlement: sectoral level**

Today, the Cambodian health service is formally structured as follows: the Minister for Health presides over eight Secretaries of State and 12 Under-Secretaries of State (these are known as 'policy-level' cadres), and three Directors General ('technical' cadres). Under all three Directorates are various technical departments, and under the Directorate General are the operational health facilities (Asante et al. 2011).

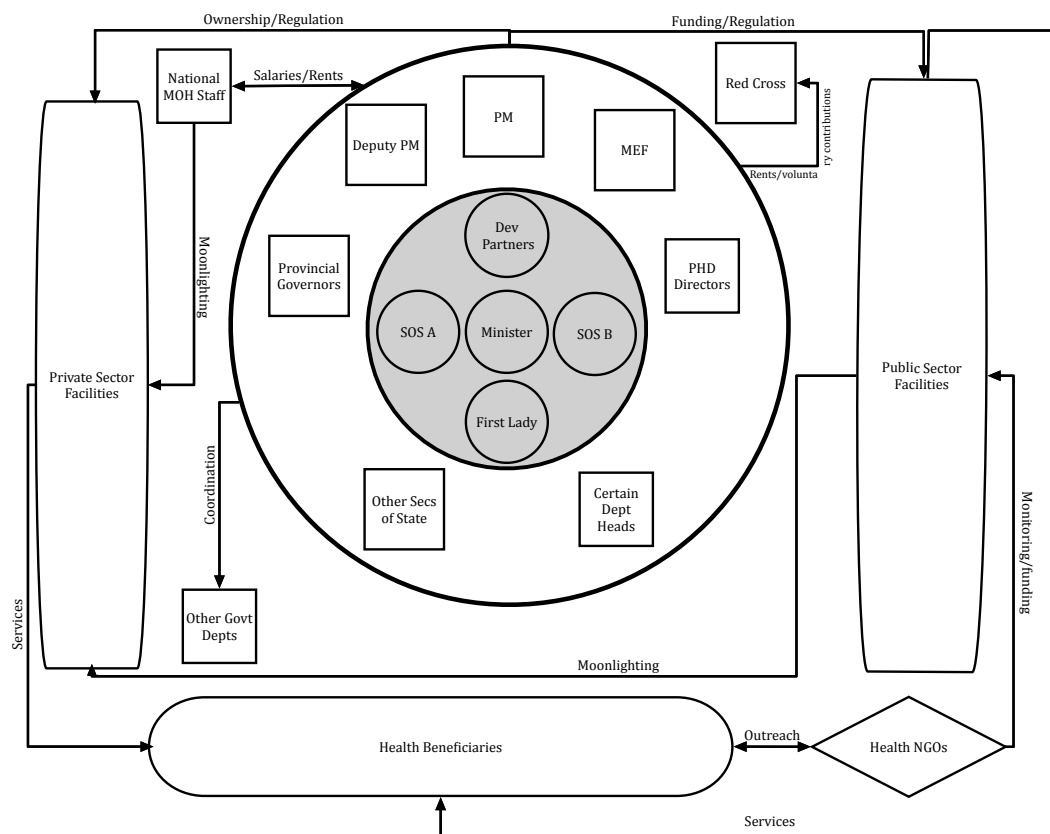
Figure 5 gives the appearance of a Weberian-style bureaucracy, but this does not capture the realities of power and decision-making on the ground. Although examinations for lower-level cadres have recently been introduced, and there are, as we shall see, some long-standing islands or channels of rule-governed effectiveness, appointments and promotions are generally made on grounds of nepotism, financial contributions (the buying of offices), and only thirdly on competence. The result is a Ministry in which many staff are under-qualified for the posts they hold, while other more qualified people are held back or encouraged to leave. Firing MOH staff is extremely difficult, since it requires an application to the Council of Ministers: as in other areas of the Cambodian civil service, non-performing staff are hardly ever sacked, merely, if anything, transferred (N2, N4, N12, N14).

**Figure 5. Cambodian Ministry of Health, formal structure (simplified)**



Power relations are better represented in Figure 6 below. In the inner circle of power is the Minister (a trained doctor and former Secretary of State in Health), and networks around two current Secretaries of State (SOS A and B), discussed further below. Development partners are also very influential, as is the First Lady, who despite not holding an official government position, plays a key role as ‘national champion’ of maternal and child health issues (United Nations in Cambodia 2014). In the outer circle of power are other influential actors, but with a less of a role in day-to-day decision-making. These include the Prime Minister, who takes an overall interest in health outcomes; the Ministry of Economy and Finance, which funds the majority

**Figure 6. The sectoral political settlement in health**



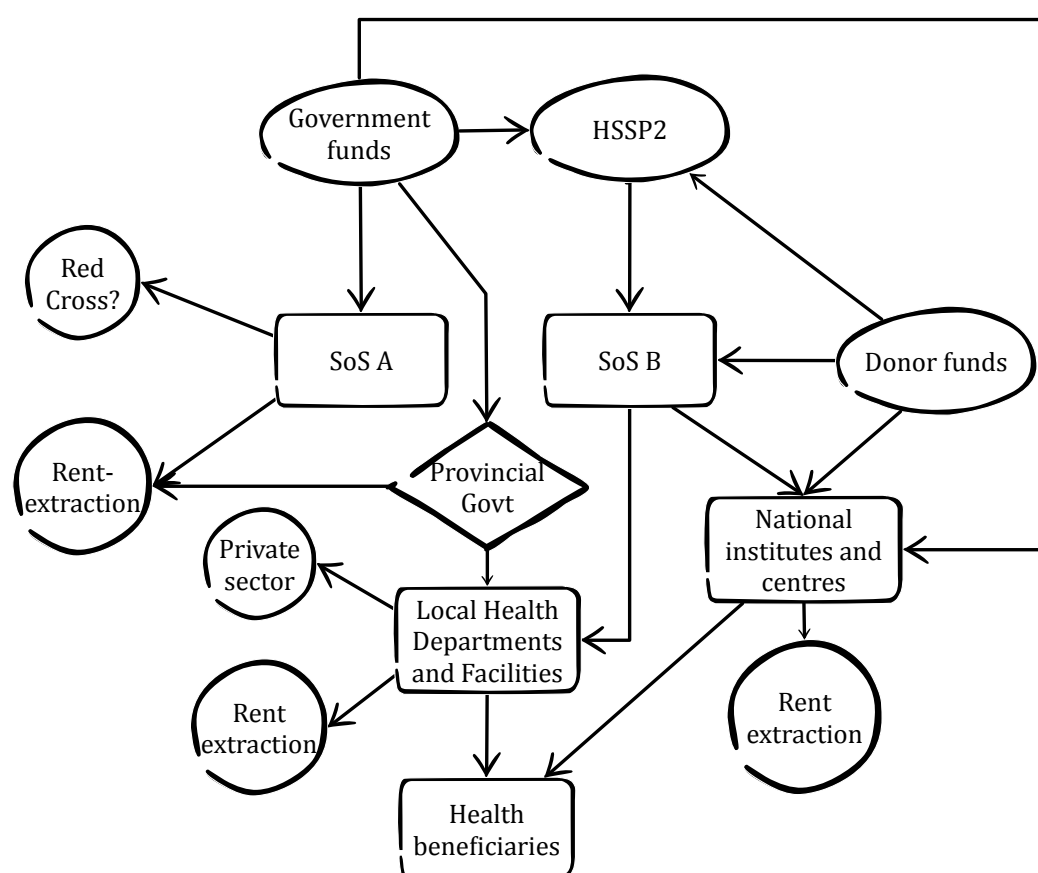
of the health budget, and effectively sets limits on staff salaries; Provincial Governors, who deliver budget to Provincial Health Directors; a certain Deputy Prime Minister, who owns a private teaching hospital with which national policy must align; plus a small number of other Secretaries of State and Health Ministry Departmental Heads.

Together, the inner and outer circle of elite actors comprises the dominant coalition in health. The dominant coalition pays the salaries of and extracts rents from more junior MOH staff, channels rents and ‘voluntary’ contributions to the CPP and Red Cross, funds and regulates public facilities, to some extent regulates private facilities (as well as having ownership stakes in them), and coordinates with other government departments. Private and public sector facilities deliver services to patients, and are to some extent monitored by health NGOs, who also conduct outreach with health beneficiaries, as we will shall below. Most public sector health staff also spend a considerable amount of time moonlighting in the private sector.

It is easier to understand this if we think of the political settlement as an elite bargain, in which both appropriating rents and delivering health outcomes are important. At the lower grades, salaries are insufficient to cover basic living expenses, driving

actors to look for income earning opportunities on the side;<sup>10</sup> while at higher grades, most office-holders, having made sizeable financial contributions to acquire their offices, are under pressure to recoup their investments. Even in one of the more effective ministerial departments, we were told that of around 15 staff, only four or five actually worked; the remainder simply showed their face, donated a portion of their salary to their head of department, and then pursued private activities (N12, N14). As for health outcomes, both development partners and the top leadership have demonstrated an interest in improving them, and have succeeded in forming alliances with like-minded actors internal to the Ministry, who strive to achieve their goals in the face of larger system dysfunctionalities. In practice, the balance between rent-seeking and health-seeking outcomes plays out through access to and control of two main resource flows controlled by two different Secretaries of State (Figure 7).

**Figure 7. Resource flows in the Cambodian Ministry of Health**



Secretary of State A is a pharmacist by training and an in-law of the Minister. Acting in concert with the Director General for Administration and Finance, these two men control the lion's share of government funds that flow into the Ministry at national level, and in particular the procurement budget. This budget is highly opaque and

<sup>10</sup> A recent study of health professionals' remuneration made similar findings (see Various authors 2013).

presumed highly fungible (World Bank 2011), with much said to leak out via various forms of rent extraction, and some rumoured to find its way into the Red Cross. Although we could not verify this, it would be consistent with a tendency, seen in other areas, to use a combination of state and non-state resources to create parallel structures closely linked to the Prime Minister and his family. Developmental partners have complained vigorously about the procurement budget, but with little success (FG5, N8, N10, N14).

Donors put the majority of their funds, meanwhile, into the Health Sector Support Programme (which also receives contributions from the Ministry of Economy and Finance (MEF)). Now in its second iteration (HSSP2), most of this money goes to 'Service Delivery Grants' for SOAs and financial support to HEF benefit packages (see below).<sup>11</sup> This is administered through a Multi-Donor Trust Fund by a World Bank-funded Secretariat in the Ministry of Health, under the operational control of

Secretary of State B. A technically skilled, results-oriented leader, B was one of the first doctors trained in Cambodia after the fall of the Khmer Rouge. He amassed considerable authority under the previous, FUNCINPEC, Minister, and is trusted by the current Minister, with whom he also shares a professional history, to manage donor funds and relations.

Thirty percent of government funds also bypass the central level and flow into Provincial Treasuries, from where they are supposed to go to Provincial Health Departments, Operational Districts and, ultimately, health facilities; but there is considerable leakage at each stage. Informants also spoke of other, smaller centres of patronage within the Ministry, all keen to grab a pot of resources. In 2013, for example, a scandal broke surrounding the use of monies from the Global Fund for Health to pay inflated prices for mosquito nets to two companies from Singapore (Hruby 2013). There was also alleged to be considerable network construction by individual Secretaries of State around the time of the election, each trying unsuccessfully to become the new Minister (FG5, N8, N12, N14).<sup>12</sup>

The basic contours of this bargain place some fundamental constraints on the ability of the state to supply inclusive healthcare. While relatively successful innovations in health equity flow, as we shall see below, from the network of Secretary of State B, these constitute but a channel of technocratic effectiveness in a sea of personalised governance and institutionalised rent-seeking. Those rent-seeking pressures lead to the purchase of inappropriate or overpriced drugs and equipment, plus the emergence of an almost entirely unregulated and burgeoning private sector, owned and staffed by public sector workers. Indeed, the very presence of a large and opaque procurement budget makes it impossible to develop medium-term expenditure and budget frameworks, making rational budgeting and planning a non-

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<sup>11</sup> Previously, a large proportion of HSSP funds went to health infrastructure projects (N1).

<sup>12</sup> Note that one of our informants (N10) was sceptical of this account, but we believe it to be sufficiently corroborated.

starter. Lack of funds for training and low salaries mean that the competence and motivation of frontline staff are frequently low, with predictable consequences for the quality of care. This has hardly been alleviated by the emergence of private teaching hospitals producing inferior products (FG5, N8, N12, N14).

All of this can be explained by the fact that the political settlement's dominant tendency continues to be one of rent seeking and patronage. Powerful elites are allowed either to pillage the state budget or to leverage state authority to earn rents outside, provided they pour money into CPP patronage vehicles, such as the Red Cross and Party Working Groups (PWGs). PWGs provide infrastructural investments such as roads, schools and, to a lesser extent, health facilities, highly visible to and approved of by local electorates (Pak 2011). Providing for recurrent system costs or improving the quality of social provisioning, despite progress in recent years, remains, however, a subordinate affair, left in the hands of development partners and a small group within the MOH, with some support from the Prime Minister and MEF (N3, N8, N15).<sup>13</sup>

### **Inclusive healthcare and Health Equity Funds**

We now move to Health Equity Funds (HEFs). HEFs are a purchasing mechanism that provides free healthcare to the poor, based on the principle of 'purchaser-provider' split. They are by far the most significant inclusive healthcare innovation in Cambodia, Cambodian health actors are proud of them, and they have even attracted global interest (FG5, N1, N3). As of 2013, they covered more than two-and-a-half million people in 51 out of the nation's 81 operational districts, supporting more than a million health centre consultations and deliveries, and more than 300,000 hospital visits.<sup>14</sup>

### **Background**

HEFs trace their origin to 2000, when the Urban Health Project, sponsored by WHO, Options UK and DFID, began to reimburse clinics for treating poor people in two Phnom Penh squatter settlements.<sup>15</sup> Around the same time, *Médecins Sans Frontières* and UNICEF began a similar scheme in Siem Reap and Banteay Meanchey in the county's north-west (Annear et al. 2008; Hardeman et al. 2004; Por et al. 2010). As we saw in an earlier section, the schemes responded to a situation in which the introduction of user fees had boosted staff motivation and increased health service utilisation, but failed to address the needs of poor people (N3) (Barber et al. 2004). The Urban Health Project and *Médecins Sans Frontières* responded by

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<sup>13</sup> And while development partners are generally a force in favour of delivering inclusive, quality healthcare, their role in the political settlement is not beyond reproach. They often suffer from fragmentation, have cumbersome procedures, high costs, objectives not necessarily aligned with local realities, rivalries, unpredictability, lack of mutual accountability, and do not always deliver on their promises. Understandably, some of the more committed Cambodian health actors are desirous of reduced donor involvement and increased national control

<sup>14</sup> HEF Annual Data 2013

<sup>15</sup> A similar scheme run by MSF Holland in Tmar Puk Referral Hospital, may have come even earlier (N4).

devising a system for identifying poor people, then paying their fees through a third-party NGO (Jacobs et al. 2007).

The scheme proved popular and grew, with NGOs such as Health Net International, *Enfants et Développement*, UNICEF, the Swiss Red Cross and the Belgian Technical Cooperation<sup>16</sup> introducing them to a variety of districts (Annear et al. 2008; Por et al. 2010). Initially they were implemented with considerable flexibility and experimentation, attended by new innovations, such as systems for pre-identifying poor people, support for transport and care-givers, and community involvement in fund-raising; but all retained the principle of a third-party NGO fund manager that would reimburse user fees and also conduct community support activities (Annear et al. 2008; Jacobs and Price 2008).

Key decision-makers in the development community and the Ministry of Health were involved in the pilots from an early stage (N3) (Por et al. 2010). Thanks to the sharing of evidence and information, by 2003 HEFs had been included as part of the Government's Poverty Reduction Strategy and Health Strategic Plan (Por et al. 2010). In 2006, NGOs, international agencies and the Ministry of Health shared experiences at a National HEF Forum, followed in the same year by a drive to scale up and standardise HEFs in the National Equity Fund Monitoring and Implementation Framework (DFID 2014). In 2007, interest in HEFs skyrocketed as Health Equity Fund Operator (HEFO) funding began to be routed through the Ministry of Health. The same year, an interministerial Prakas decreed that the state health budget be used to support reimbursement of poor people's user fees (Annear et al. 2008; WHO 2013). In 2010 the Prime Minister expressed his support for such schemes in an off-referred to speech at the University of Health Sciences (FG5, N1, N3, N7, N10).<sup>17</sup> With high-level political backing, government and development partners have vigorously expanded the schemes, aiming for nationwide coverage by the end of 2015. As of 2013, development partners funded 60 percent of the costs of the scheme, and government 40 percent (N4).

### **How HEFs work**

There are currently three HEF models operating in Cambodia, but by far the most widespread is the standard model, whose key financial and accountability relationships are illustrated in Figures 8 and 9 below.<sup>18</sup> Standard HEFs function as follows. Every three years, the Ministry of Planning pre-identifies poor households through its ID Poor scheme, and provides them with an Equity card. This entitles them to free care at health centres and hospitals in districts where a HEF is running.

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<sup>16</sup> BTC is a bilateral donor, not an NGO.

<sup>17</sup> There is some debate over whether the PM referred specifically to HEFs or whether he made a vaguer statement about free healthcare for the poor. There is also some debate over why the PM chose to emphasise free healthcare at this point in time, with some suggesting that he was influenced by former Thai PM, Thaksin Shinawatra, his one-time 'financial advisor'. Others have suggested that the PM was personally moved by a story he read in the newspaper. Whatever the case, HEF champions picked up the sentiment and ran with it.

<sup>18</sup> The others are a government subsidy scheme (SUBO), and a scheme that integrates a voluntary health insurance model for the non-poor with the standard model.

Every month, individual health facilities calculate the number of poor people treated, and submit a claim to their local HEFO, an NGO or CBO with a Ministry of Health contract to run the HEF in that district. The HEFO, using HSSP2 funds, then reimburses the health facilities based on a standardised 'case rate'.<sup>19</sup> The facilities devote 60 percent of the funds to staff salary supplements, 39 percent to running costs, and remit 1 percent to the Provincial Treasury.

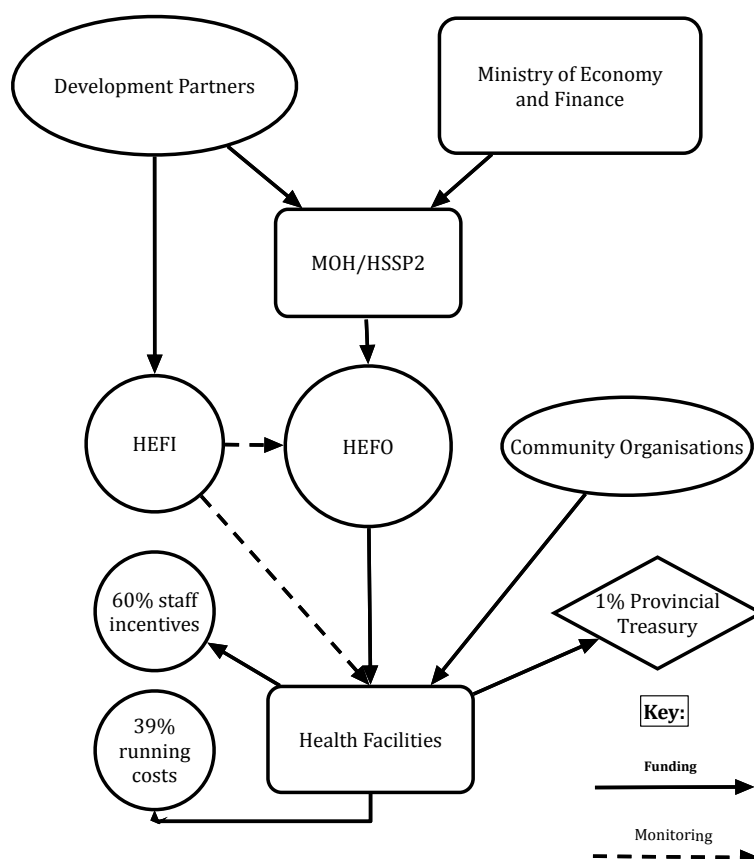
In addition to performing these basic functions, the HEFO provides a number of supplementary services. It registers HEF patients at the hospital and into the MOH Patient Management and Registration System database; helps identify poor people at health facilities who for one reason or another lack an ID Poor card (see below); reimburses transport costs for poor patients; provides food and care allowances; visits in-patients every day; advocates for poor patients who experience problems with their healthcare providers; and conducts community outreach and fundraising (USAID/URC N.d.).

Health facilities and HEFOs are monitored by University Research Co. (URC) LLC, an international NGO known as the Health Equity Fund Implementer (HEFI), funded by USAID. Every month in each OD, URC monitors conduct document reviews in every hospital, three to five health centres, and interview 40 to 80 households. In cases where mistakes are made or ghost patients found, deductions are made from the HEFO invoice. Once it has verified that the HEFO is doing its job, URC certifies the monthly HEFO invoice and forwards it to HSSP2. It also provides technical assistance to HEF partners (USAID/URC N.d.), and in some districts, monitors the quality of care.

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<sup>19</sup> In some ODs a proportion of the exemptions are paid by (mostly religious) community organisations.

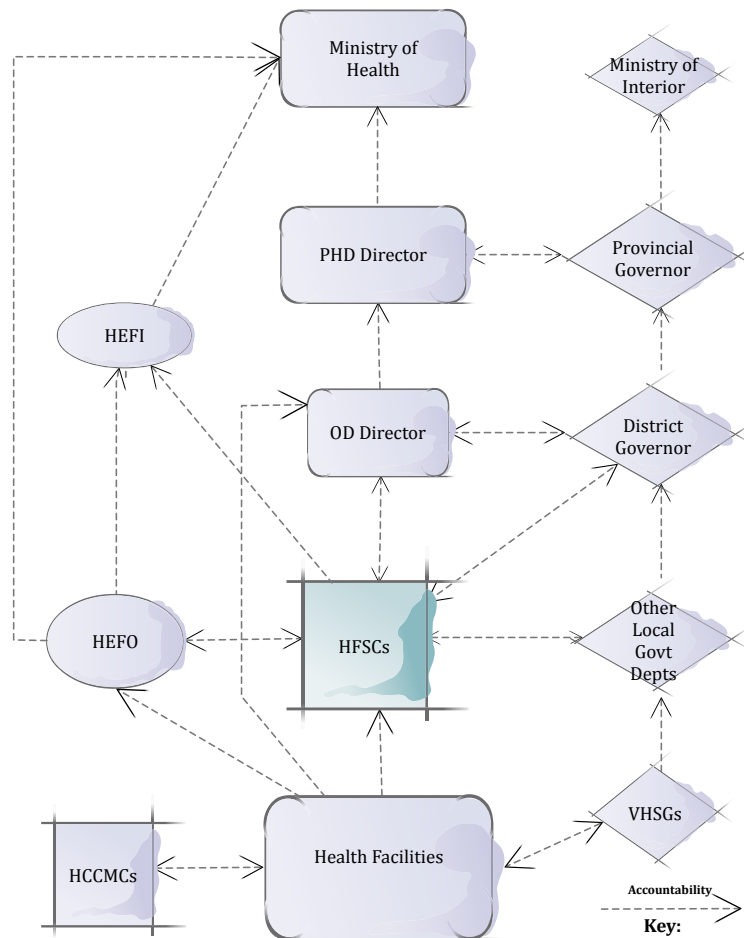
**Figure 8. HEF financial relationships**



At local level, HEFs are overseen by Health Financing Steering Committees. HFSCs are a multi-stakeholder forum bringing together health officials, the HEFO, and other government authorities. They assess the performance of the HEF, identify problems, and recommend solutions, based on monitoring data generated by the HFSC monitoring sub-committee, which every month randomly samples patients and interviews them about their experiences at the health centre, including such questions as whether they were greeted correctly, had to pay under-the-table fees, were satisfied with their treatment, and so on. HEFI technical officers also sit on the HFSC, where they discuss the HEFI's monthly monitoring reports.

The HFSC also connects with MOH internal accountability systems. Under these, health facilities report to the Operational District Director, who reports to the Provincial Health Director, who reports to the Minister for Health. There is also a system of community participation in the management of health facilities, comprising multi-stakeholder Health Centre Co-Management Committees (HCCMCs) and Village Health Support Groups (VHSGs).

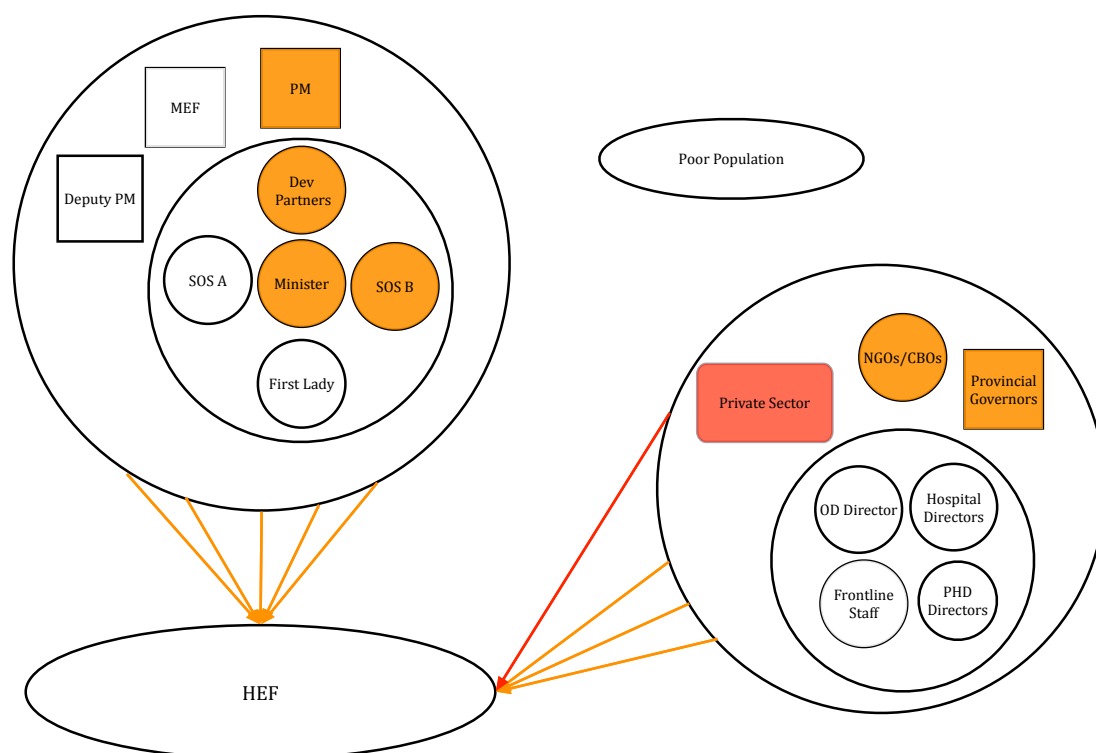
**Figure 9. HEF governance arrangements**



The interest-mapping below (Figure 10) illustrates how HEFs work in political-economic terms. Actors with an interest in HEFs are coloured in orange; those whose interests are negatively affected are in red; while those interests likely to be neutral or ambivalent are left white.

In the top left corner is the national dominant coalition in health, and here we see that the Prime Minister, the Minister, development partners, and the network of SOS B, who are all motivated at least to some extent by issues of performance legitimacy and health goals, have an interest in supporting HEFs. As discussed below, some SOS B actors may also receive financial benefits through their relationships with HEFOs, though this is difficult to verify (FG5, N1). The other actors in the dominant coalition may be ambivalent or neutral, but they are not seriously threatened by HEFs. In the bottom right of the picture is the dominant coalition at local level.

**Figure 10. HEF interest mapping**



Generally speaking, provincial governors have an interest in performance legitimacy, while health NGOs/CBOs benefit financially from HEFs, so can be expected to support them. By contrast, the private sector loses patients because of HEFs, so is coloured red. The stance of PHD directors, OD directors, hospital directors and frontline staff, meanwhile, is likely to be ambivalent. On the one hand, they are motivated to some extent by public health goals and under some pressure from the national dominant coalition to perform. On the other hand, many own or work in private facilities, so experience a conflict of interest here. Finally, the poor population is represented in the diagram as white. Although it has an objective interest in HEFs, it will not necessarily realise this subjectively unless it is sensitised to the role of HEFs and the benefits of public health care generally. That said, there appears to be a sufficient balance of actors in favour of HEFs to suggest that they will be reasonably well supported politically wherever they are; they are likely to work best, however, where conflicts of interest among key local-level actors, together with the disconnectedness of the poor population, can be mitigated.

### Successes and limitations

Studies have shown that where HEFs operate they are a significant force for inclusion, with poor people accessing public health services at a level higher than their weight in the population (as opposed to around half that level in ODs without HEFs) (Annear et al. 2008). Further, they reduce household health-related debt and out-of-pocket expenditures, provide a significant source of additional revenue to health facilities, reduce under-the-table payments, and help correct the under-

utilisation of public health facilities generally (Flores et al. 2013; WHO 2013, 22-25).<sup>20</sup> HEF advocates also claim that HEFs act as a powerful incentive to improving performance, helping ensure that facilities are always open with staff on hand, educating citizens about their rights to health, and introducing internal and external monitoring systems that help improve the quality of care (N1). They have even been described as, 'the force driving the entire public sector' (N3).

However, HEFs are not a panacea. Forty to 50 percent of poor people never use the HEF (N4), with many poor patients preferring not to seek treatment or to seek it in the private sector (World Bank 2013a). Some of this may be down to 'cultural' preferences for superfluous injections, or reluctance to travel the distance required to public health facilities (Hardeman et al. 2004; Jacobs et al. 2007). More worryingly, it may be a result of the inability of HEFOs to raise awareness about the HEFs or to help raise public facilities to attractive standards (Hardeman et al. 2004). As we have seen, the nature of the political settlement, both in health and nationally, puts limits on the level and consistency of the care the health service provides, which health NGOs cannot by themselves address (N3, N7).

Further, there is some evidence of unevenness among HEFOs in terms of cost efficiency, ability to solve problems, and local community involvement and outreach. HEFOs are contracted by the Ministry of Health, in an ostensibly competitive process with stringent safeguards. However, more than one informant suggested that some are entwined in cosy, nepotistic relations with Ministry officials and consequently feel under little pressure to perform, doing the absolute minimum as per their terms of reference (N1, N3).<sup>21</sup> Ironically, the stringent safeguards applied by the Bank create a set of requirements for funding applications that militate in favour of large NGOs staffed by professional classes (N3, N7). Other factors, which we explore below, may also contribute.<sup>22</sup>

Other poor people are excluded involuntarily. For example, one informant opined that the Ministry of Planning's ID Poor scheme captures only around 70 percent of the poor.<sup>23</sup> There is anecdotal evidence that provincial governors are under pressure to reduce the number of cards they distribute in line with falling national poverty figures, and also rumours that commune and village chiefs discriminate against poor

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<sup>20</sup> In 2012, total HEF expenditure was USD 9,457,954, 85 percent of which was spent on direct benefits to patients, (fees, transportation, food), and the rest on management and operational costs (Na 2013). See also Annear and Bigdeli (2009), 560-64; Jordanwood, Van Pelt and Grundmann (2009); and Flores et al. (2013), 1180-93.

<sup>21</sup> Part of this problem has been addressed via a move to output-based contracting, which now covers about 50 percent of HEFOs (N1).

<sup>22</sup> Other criticisms include the focus of HEFs on curative care, the implicit bias shown to hospitals over health centres, the upward pressure on health costs caused by HEFs' standard benefit package and transport costs (N3), ultimately borne by the nearly and non-poor.

<sup>23</sup> Interview, with expatriate health expert. Please note that this is a correction to an earlier version of this paper that incorrectly claimed that 'studies show that the Ministry of Planning's ID Poor scheme captures only around 70 per cent of the poor'. The correction was made in March 2016 and applies to all previously published versions of this paper.

households that support the opposition.<sup>24</sup> Other anecdotal evidence has village chiefs selling ID Poor cards.<sup>25</sup> Although HEFOs identify many poor people through post-identification (a kind of safety net for the safety net), this situation is not ideal.

Finally, the scheme does not cover the large percentage of Cambodian households that sit just above the poverty line, who can still be flung into poverty by catastrophic health episodes (N3, N10) (World Bank 2013b). Another problem is that as the percentage of poor people in Cambodia decreases, so the unit costs of HEFs rise. Some, though by no means all, health actors in Cambodia see a closer integration of Health Equity Funds with community-based health insurance schemes as the solution (N3, N4) (Annear 2012).

### **The future of HEFs**

At time of writing, the future of Health Equity Funds stands at a crossroads, with a new Health Financing Policy under construction. The government, increasingly financially confident as we have seen, recognises Health Equity Funds as the largest and most important social welfare item in its budget, and an integral part of its National Social Protection Strategy for the Poor and Vulnerable 2011-2015. Unsurprisingly, it is uneasy about the pivotal role of international and national NGOs in the scheme, and is consequently looking at ways of bringing Health Equity Funds in-house. USAID has also signalled that it will phase out support for URC over the next five years. Other development partners, meanwhile, are worried that, if brought in-house, HEFs will be less well monitored and subject to the same predatory pressures as other MOH funds. The existing experience with government subsidy schemes, known as SUBOs, is not encouraging in this regard (Flores et al. 2013)(L16).

HEFs are also seen as a part of a long-term series of stepping-stones to universal health coverage (UHC), now on the political agenda in Cambodia (N8, N10) (Annear and Ahmed 2012). Whether this will take place through gradually expanding HEF benefits to other population categories, or by integrating HEFs with other forms of health insurance, remains to be seen.<sup>26</sup> A heated debate among health sector actors, all of whom have different ideas about and interests in the future of HEFs, is currently underway.

### **HEF frontline performance**

Our study also looked for political economy answers to the question of why some HEFs perform better, locally, than others. Initial consultations suggested that the character of the HEFO, and in particular whether or not it was a top-down NGO or a

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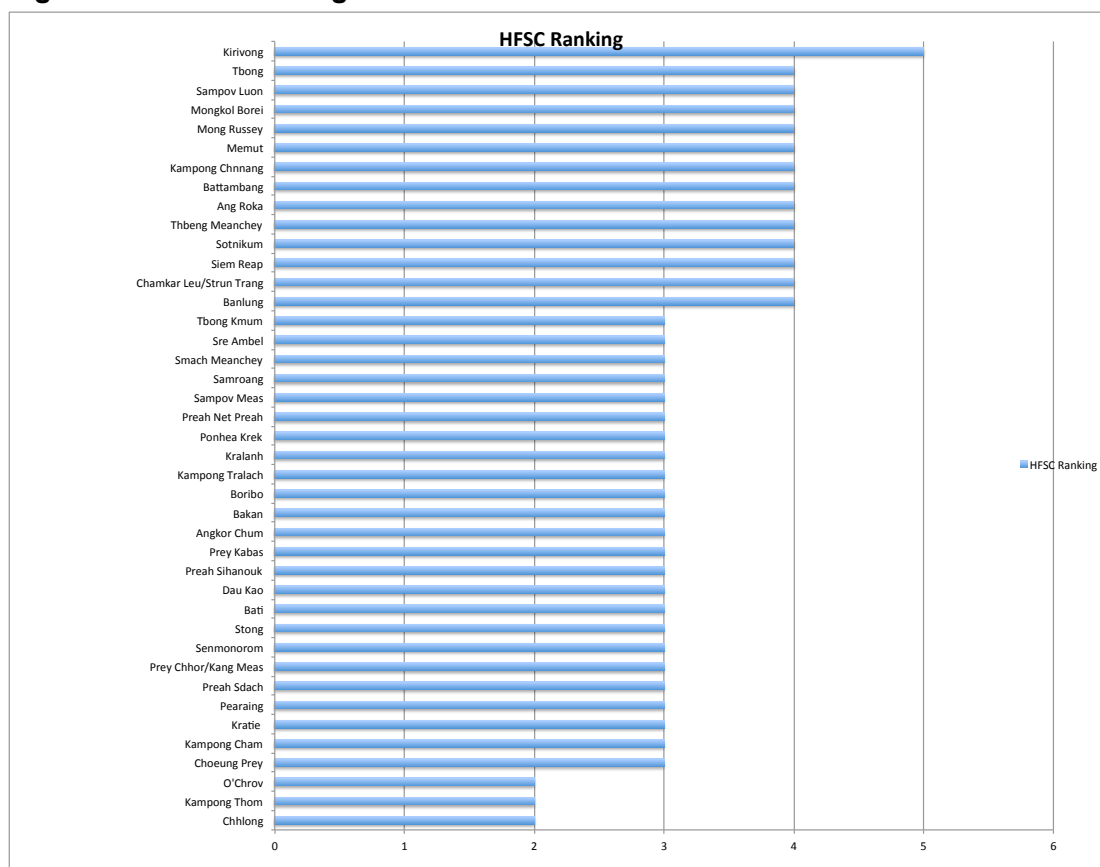
<sup>24</sup> Some of our local-level interviews supported these allegations (LI4, L11, L26).

<sup>25</sup> In interview, Ministry of Planning officials rejected these allegations, and explained to us how systemic safeguards prevent this (N11). Other informants told us that national-level MOP staff were often ignorant of what happens to their schemes on the ground.

<sup>26</sup> There appear to be two main reasons for earlier resistance to UHC. One is the MEF's concerns about the fiscal implications, and the other is the belief that frontline MOH staff will not work unless incentivised via user fees.

bottom-up CBO might be significant here (N1, N3). They also suggested that a study of Health Financing Steering Committees, the key stakeholder forum overseeing HEFs at local level, would be a good window on the governance processes behind differential local performance (N1). We proceeded to conduct a focus group with technical officers at URC to explore this idea, producing an ‘effectiveness’ ranking of 41 of the 45 HFSCs with which URC works (see Figure 11).<sup>27</sup> At the top end of the scale was Kirivong, run by Buddhism for Health (previously described as a bottom-up NGO or CBO), and joint-bottom were Chhlong and Kampong Thom, both run by Action for Health (a ‘top-down, NGO’) (N3).

**Figure 11. HFSC ranking exercise results**



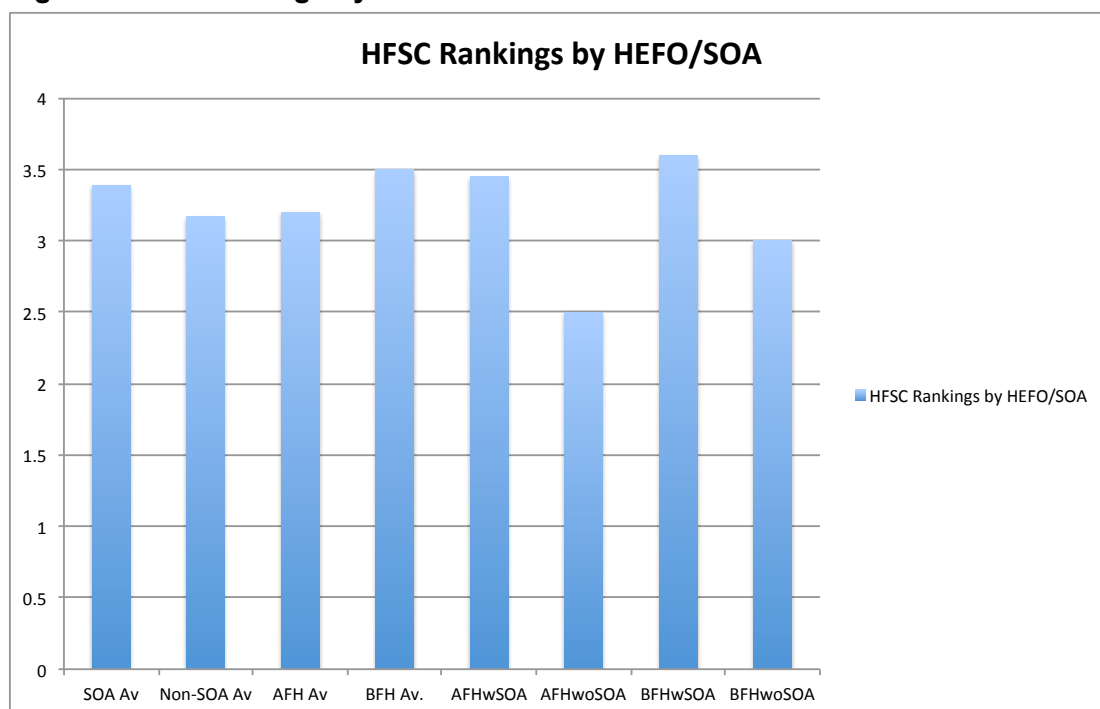
Following an ‘extreme case logic’, we made exploratory field visits to Kirivong and Chhlong to elicit qualitative insights into this finding. We discovered that, although the nature of the HEFO might be explanatorily significant, another important factor appeared to be whether the OD was an SOA. SOAs, as mentioned earlier, introduce a chain of performance-linked contractual relationships between national, provincial, district and facility health managers, all geared to meeting health targets.<sup>28</sup>

<sup>27</sup> ‘Effectiveness’ was defined as ‘the extent to which key stakeholders were engaged with the HFSC and successful in solving HEF-related problems’.

<sup>28</sup> NB: Annear et al. (2008), 189-226.

We developed a working hypothesis that a bottom-up NGO combined with an SOA would produce the best HFSC performance, and that a top-down NGO without an SOA would produce the worst results, with other combinations producing intermediate results. That hypothesis was borne out by an additional analysis of the HFSC ranking exercise (Figure 12).

**Fig. 12. HFSC rankings by HEFO/SOA**



To trace the causal processes at work, we devised a qualitative comparative study with four cases (Figure 13), covering all possible permutations of our bivariate hypothesis. For each District we studied HFSC meeting minutes for 2012 and 2013, and HEF annual data for 2013. We also conducted semi-structured interviews with local government authorities, some of whom sat on the HFSC, health service managers and frontline staff, and NGO staff and volunteers.

The following sections provide some background on the Districts, data on HFSC effectiveness, and an explanatory discussion. We argue, in a modification of our working hypothesis, that HFSC effectiveness is primarily determined by whether or not the District is an SOA and by the leadership qualities of key stakeholders. The nature of the HEFO may affect other aspects of overall HEF performance, but in the Districts we covered, it did not have a big impact on Steering Committee effectiveness.

**Fig 13. Comparative case matrix with two variables**

	BFH	AFH
SOA	Kirivong	Pearaing
Not SOA	Preah Sihanouk	Chhlong

### **Background to the districts**

Kirivong, Pearaing, Chhlong and Preah Sihanouk ODs are all based in Southern Cambodia. Their populations' main occupations are farming and fishing, with tourism also important in Sihanouk. Socio-economic data for ODs is not obtainable, but Sihanouk is thought to be wealthier than the other Districts; it is also more urban.<sup>29</sup> Ethnically, all the Districts are predominantly Khmer and Buddhist by religion, although each also has Muslim minorities. Table 1 below provides data on numbers of registered poor people, plus HEF coverage for 2013.

**Table 1: Poor populations and HEF coverage by OD**

OD	Total no. of poor people	Total HCs	HEF-covered HCs
Kirivong	59,967	21	21
Pearaing	45,966	14	6
Chhlong	43,672	8	5
P Sihanouk	46,812	13	13

Kirivong and Pearaing were among the first Districts to experiment with contracting and both are SOAs. Neither Chhlong nor Preah Sihanouk shared this experience.

In Kirivong and Sihanoukville, the HEFO is Buddhism for Health, while in Chhlong and Pearaing, it is Action for Health. Buddhism for Health grew out of an experiment

<sup>29</sup> Economic differences between the Districts makes it more difficult to isolate governance impacts on HEF performance. However, Preah Sihanouk is the only BFH District that is not an SOA, making its selection inevitable. Although we could not control for economic differences in the study design, we have been alive to them in interpreting the data.

in the early 2000s to base community participation structures on local pagoda and mosque committees. Later a Health Equity Fund was created at the pagodas, and then the operation was scaled up as Buddhism for Health (Jacobs and Price 2003). Action for Health, by contrast, was created by Healthnet International, and is run by a former National Institute of Public Health employee, with close links to officials in the Ministry of Health (N1).

In each OD the formal governance structure approximates Figure 9, with the HFSC acting as a multi-stakeholder forum to monitor HEF performance and solve problems. The main difference is that in Kirivong, the HFSC is convened at District level, while in Chhlong, Pearaing and Preah Sihanouk, it is convened at Provincial level. Accordingly, in Kirivong it is chaired by the Deputy District Governor, and in the other three ODs, by the Deputy Provincial Governor.<sup>30</sup>

### **Performance**

All of our informants regarded HEFs as important to their District, not only in terms of making health services accessible to the poor, but also in supporting the public health service generally. All informants also praised the HEFOs in general terms. However, beyond this general affirmation, we did find some differences in the degree to which Health Financing Steering Committees were active and able to address problems.

In Kirivong, the HFSC was said by informants to be very active and highly effective, with all key stakeholders engaged. It had helped solve problems of unofficial payments to health staff, improved hygiene in some health centres, and staff attitudes had generally improved. Nevertheless, these problems continued to crop up in isolated cases from time to time, and there had also been some cases of health staff treating ID Poor cardholders less favourably. Toilet facilities at the District Hospital were a persistent problem, but health authorities claimed they lacked the resources to fix this. Most importantly, however, there were said to be no general problems of staff respecting working hours, which differentiated Kirivong from elsewhere (L1, L3, L4, L5, L6, L8, L44).

In Pearaing, the HFSC was also said to be active and effective, with key stakeholders, especially local government authorities, engaged. Occasional problems of late reimbursement of user fees, traditional gratuities, and staff politeness occurred and were apparently dealt with. There were some lingering problems of poor patients not having ID Poor cards. On the crucial question of staff attendance, the situation was not bad, but not as good as in Kirivong (N9, L15, L17, L18).

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<sup>30</sup> In Kirivong and Pearaing we found that the CPP has also established its own, party-based social protection funds patronised by powerful party figures. These did not directly impact the HEF, but would justify a study in their own right.

In Preah Sihanouk, the HFSC was somewhat less effective, due to a comparative lack of engagement by health authorities. In addition to the familiar problems of staff attitude, there had been a period during which hospital staff had been selling blood. Recently, a new PHD Director had been installed, who was said to be more engaged with the HFSC, and some of the aforementioned problems had been solved (L36). However, a persistent problem was staff attendance, with staff typically working at public facilities in the morning, leaving only standby staff on duty in the afternoon (N9, L27, L28).

In Chhlong, the HFSC was least effective of all, with the PHD Director and the Hospital Director said to be disengaged, and unwilling to take HFSC sub-committee and URC monitoring reports seriously. Poor staff attitude was said to be a persistent problem, and, most importantly, health staff did not respect working hours (N9, L11, 12, 13, 38, 39).

## **Discussion**

All the Steering Committees we studied encountered minor problems in the day-to-day operations of their HEFs, and most of these problems were solved by the HFSCs. However, there was a significant difference between Kirivong and Pearaing, where the health authorities were said to be active and engaged, and Sihanouk and Chhlong, where the authorities were less so. This was manifested most clearly in problems of staff attendance in public facilities. This is a crucial issue, since if public facilities are not well staffed, poor people are less likely to use the HEF, and more likely to seek treatment in the private sector, with all the problems of quality and indebtedness that entails.

Attendance was related to the willingness and ability of health managers to insist that staff respect working hours. In Kirivong, the OD Director was said to be very strict on this matter. In Pearaing, the authorities told us that they tried to get staff to respect working hours, but that they had to show some flexibility, otherwise there would be a revolt. When facilities were quiet, which was increasingly rare, managers turned a blind eye to staff slipping out. In Sihanouk and Chhlong it was more or less a norm that staff worked only in the mornings.

What explains this? The clearest message from our interviews was that the nature of the OD – SOA or non-SOA – was the crucial factor. SOAs empower OD Directors in three ways. First, they provide increased resources in the form of equipment, technical assistance and salary supplements. Second, they strengthen definitions of roles and responsibilities and monitoring arrangements. And third, they link resources to performance targets. In terms of our interest mapping diagram (Figure 10), SOAs appear to be a force pushing local actors from ambivalent (white) to positive (orange). Because OD Directors and Hospital Directors have an added incentive to meet targets, they are more likely to value a steady flow of HEF-assisted patients, and more likely to intervene actively to solve problems related to the HEF. Because frontline health staff receive performance-linked salary supplements, they

are more likely to be responsive to managerial discipline. Health staff in Kirivong, for example, told us that they remained at their posts in the afternoon because they had targets to meet and because they were afraid of the OD Director, whereas informants in Sihanouk and Chhlong told us that they could not survive if they worked eight hours a day in their public jobs, and even that health managers were scared of disciplining their staff (L6, L9, L28, L35, L40, L39). This is not to say that SOAs are cost-effective, since they come with significant transaction costs and their net benefits are as yet unproven (Keovathanak and Annear 2011). However, they do appear to have positive spillover effects on HEFs.<sup>31</sup>

But even between SOAs, we found a difference in the seriousness with which working hours were enforced. We attribute this primarily to differences in individual leadership. Informants described the Kirivong Director as a strict, rigid, highly driven individual from a successful family in the area, anxious to prove that he could run the public health service as well or better than his predecessors. He was even said to be willing to discipline individuals with powerful connections, a common factor attenuating formal health service hierarchies elsewhere (L3, 4, 5, 6). Indeed, we found plenty of other anecdotal evidence of the importance of leadership. For example, there are two SOAs in Prey Veng, Pearaing and Preah Sdach, with the former said to perform better than the latter on account of leadership (L17). In Kratie, Chhlong performed poorly but Kratie itself, despite not being an SOA, was said to perform quite well (L4, L5, L6). Even in Chhlong, the previous PHD Director was said to be stricter, and thus more effective than the present one, who was described as ‘a nice guy’, and ‘a bit soft’ (L11). The OD Director in Chhlong, meanwhile, had had a stroke recently, and his performance had understandably dropped; he was also hamstrung by the fact that the Hospital Director and PHD Director were in-laws (L17, L40).

What about the nature of the HEFO? It will be recalled from our interest mapping diagram that the poor population was coloured white, and we speculated that political support for HEFs would be stronger if it could be pushed into orange. Buddhism for Health was described to us as a community-based organisation, since it had grown out of equity funds established in local pagodas. To this day, it convenes mixed stakeholder pagoda-based management committees that raise money for health centres through donation boxes and flower ceremonies. Some of the members of this committee, including monks, also sit on health centre co-management committees. Additionally, it has a network of community volunteers who double as representatives on health centres’ village health support groups. In this way, BFH is integrated with community structures, which are in turn integrated with health authority structures (L45, L46). We were also told that BFH is piloting the use of community scorecards.

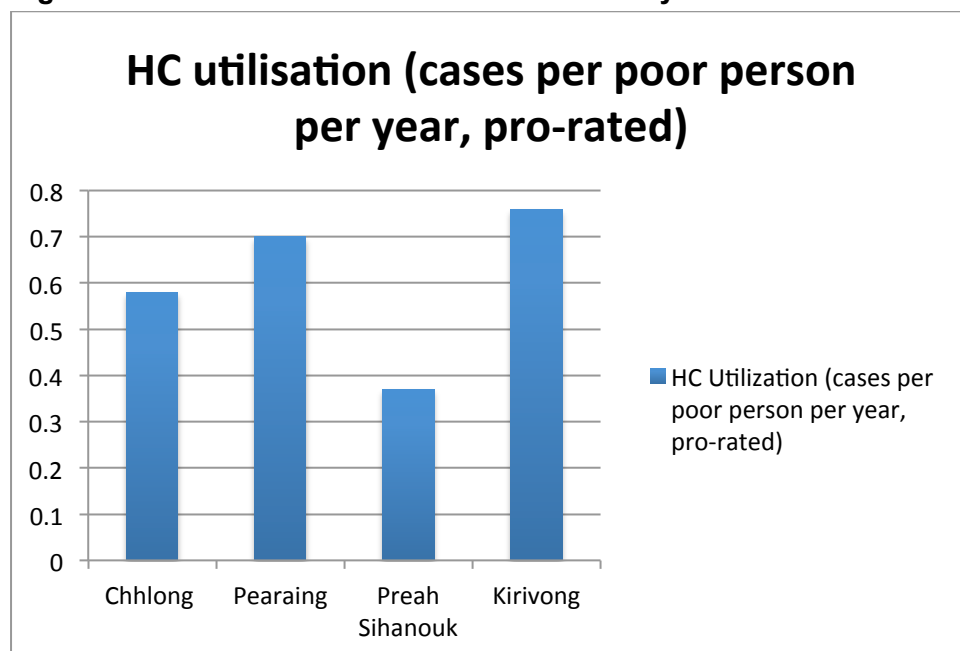
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<sup>31</sup> Although it should be noted that health managers in Preah Sihanouk told us that, even with SOA supplements, they would not be able to compete with the private sector, which is exceptionally strong there.

Action for Health, by contrast, was described to us as a top-down NGO. Nevertheless, it also maintained a network of volunteers. These were used to collect data about the functioning of the HEF, to publicise the HEF and explain the ID Poor scheme. Although volunteers appeared to meet fairly regularly, they were not well integrated with health authority structures.<sup>32</sup> Further, AFH staff admitted that a significant number of these volunteers, especially those living in more remote villages, were not contactable, so did not attend meetings or monitor the performance of the HEF in their village (L13, L17, L23).

In general, HCCMCs and VHSGs seemed to meet more regularly in BFH Districts than AFH ones, though detailed figures were unobtainable. In Kirivong, the local commune council funded per diems for committee members, and informants said that BFH had brought the health service and local authorities closer together. In other ODs, volunteer remuneration was a problem. As for how the committees functioned, health staff tended to say first that they were a means of disseminating information to the community, and only secondly that they were a means of receiving feedback. The order was sometimes reversed when we spoke to volunteers, but not always. In SOAs, health staff seemed to be using the HCCMCs and VHSGs as vehicles to help them achieve their targets (L6, L9, L25, L30, L30.1, L36, L40, L43). Although this is a positive development, it should be noted that it is a kind of top-down community mobilisation rather than bottom-up participation. Given Cambodia's historical and cultural background, this perhaps is unsurprising.

**Figure 14. Health centre utilisation in four study Districts**

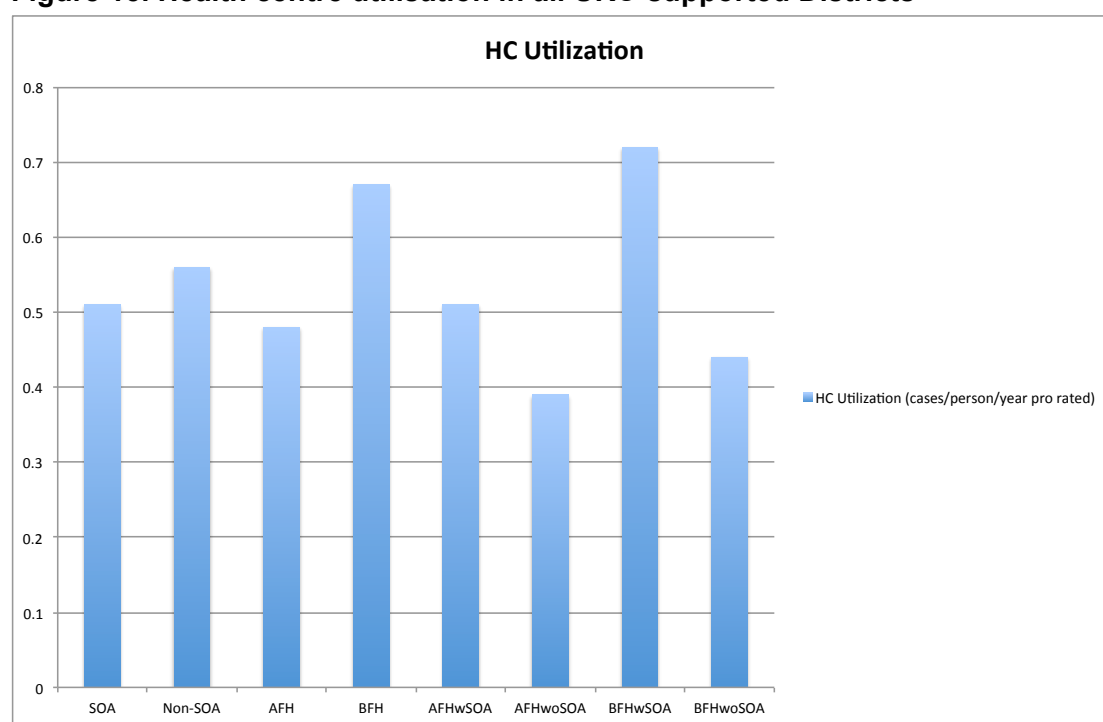


<sup>32</sup> Apparently, AFH head office had advised them not to target established VHSG reps, but to choose poor people instead. As it was, around 20 percent of the VHSG reps in Pearaing were poor and were consequently co-opted by AFH.

It seems probable, nevertheless, that BFH's higher level of community engagement has some positive effect on HEF performance generally. This is supported by health centre utilisation figures for 2013 (Figure 14),<sup>33</sup> which are highest in Kirivong, where BFH has been established longest.<sup>34</sup> And HC utilisation is generally higher in BFH Districts than AFH ones (Figure 15).

The generally better health centre utilisation found in BFH districts is not, however, replicated in terms of increased in-patient discharges at District referral hospitals, where AFH runs BFH much closer (Figure 16). It is possible that AFH concentrates more of its energy at hospital level, and gets better results there, though this is only speculation.

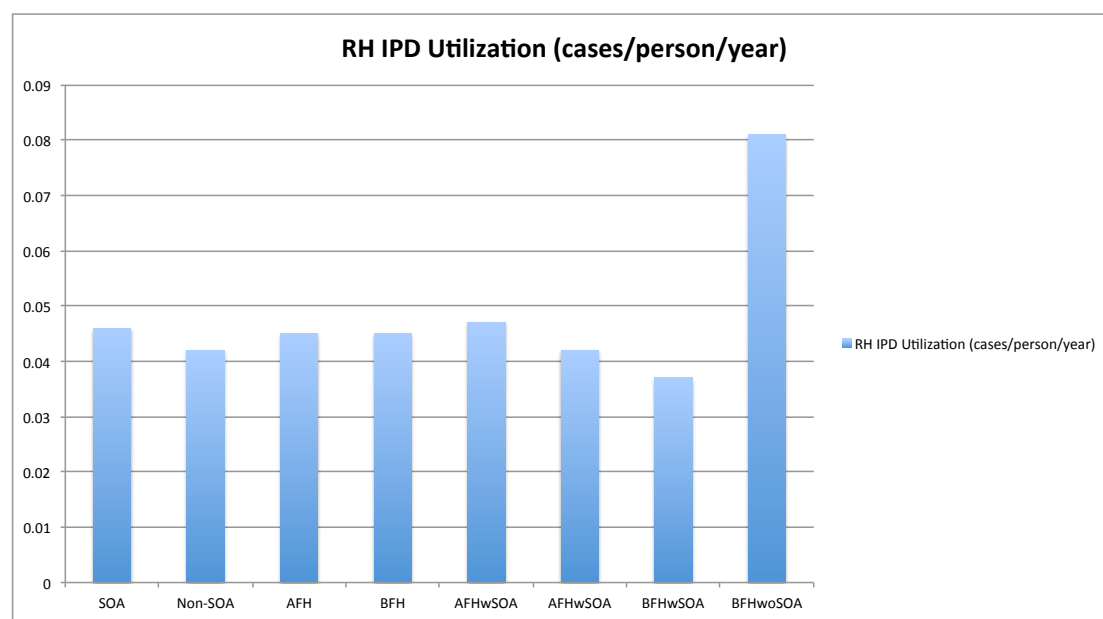
**Figure 15. Health centre utilisation in all URC-supported Districts**



<sup>33</sup> Obviously a longer time series would be better, but we do not have this. It should also be borne in mind that utilisation statistics may double-count individuals who use their equity card more than once.

<sup>34</sup> The very low HC utilisation in Sihanouk, and correspondingly high hospital usage, is probably affected by the more urban character of Sihanouk.

**Figure 16. In-patient discharges at referral hospitals in URC-supported Districts**



Our crucial finding, however, was that BFH's community focus, no matter how much it was appreciated by local informants, was insufficient to empower citizens to demand that health staff stay at their posts during working hours, or to ensure that health authorities engaged actively with the HFSC, in Preah Sihanouk. It is debatable, then, whether BFH's community work has unequivocally pushed the poor population into the orange zone, where they actively, politically, support the HEF.

To sum up, our findings show that HFSCs were appreciated and working reasonably well in all our Districts. They were working better in SOAs with strong leadership, and best in the SOA with the strongest leadership and a more community-focused NGO. While tracing the link between SOA, strong leadership, and better performance was relatively straightforward, that between community engagement and HFSC performance was less clear. Further, a comparison of Pearaing with Preah Sihanouk showed better staff attendance in the former than in the latter. Both of these findings lead us to believe that the nature of the HEFO (top-down or bottom-up), is a less important factor in HFSC effectiveness than individual leadership, and SOA-status.

## Conclusions

The preceding sections have provided an account of the political economy of inclusive healthcare in Cambodia. We have argued that HEFs have been a relatively successful mechanism for expanding access to free healthcare to the poor. At the same time, their effectiveness in ensuring *quality* care, notwithstanding some success in this area, is constrained by prevailing levels of low pay, low resourcing, inadequate training, and burgeoning, unregulated private practice.

We have also argued that both the successes and limitation of HEFs can be explained by underlying characteristics of Cambodia's political settlement. On the one hand, the settlement, including the role of donors and nationalism therein, creates some pressures for performance legitimacy and some space for multi-stakeholder-supported islands of effectiveness. On the other, the dominant logic of patronage politics serves to hollow out the state, constraining the creation of a more genuinely effective, results-oriented health service.

According to the ESID framework, given Cambodia's hybrid political settlement, some reasonably effective multi-stakeholder initiatives in service provision, as we see in the case of HEFs, are to be expected (Levy and Walton 2013). Indeed, they are probably the most that Cambodia and states with similar political settlements can hope for. This is because deeper-seated problems in service provision are unlikely to be resolved until the settlement's dominant tendency shifts from winning votes through predation-fuelled patronage, to programmatic public goods supply; and this shift is unlikely to take place until the dominant coalition senses that the existing way of governing cannot be sustained.

Interestingly, there are some signs in Cambodia that such a perception is growing. In the 2013 general election, for example, the ruling party received a rude shock when large sections of an increasingly youthful electorate rejected its patronage appeals, and turned instead to the Opposition. Whether or not this will provide the incentive the leadership needs to try to change the nature of the political settlement, and whether it will result in support for even more inclusive and effective forms of health-care, remains to be seen. Policy-makers need to monitor the situation closely, since it will be important not to overhaul too radically a reasonably effective health-financing model, before the underlying political conditions for a better replacement have emerged.

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