Health seeking behaviour and impact of health financing policy on household financial protection in post conflict Cambodia: A life history approach

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Background

1.1 Country story

Cambodia experienced over two decades of conflict. Cambodia was in the front line of the Cold War, drawn into the Vietnamese war in the late 1960s, followed by civil war and genocide between 1970-1989. The people carried a heavy burden as a result: more than 3 million dead, nearly two million people displaced, and the economy, society and health system broken. The Paris Peace Accords in October 1991 gave the country the opportunity to rebuild although outbreaks of violence still continued between the government and Khmer Rouge troops and true peace was not achieved until Pol Pot died in 1998.

1.2 Cambodia Health care system and health financing policy

Before 1995, the health system was in disarray after many years of neglect. During the various stages of conflict, the population turned to self medication and indigenous practitioners for illness treatment. Costs were met through out-of-pocket payments or exchange. After 1995, health reforms focused on improving the supply of health services; official user fees were introduced in 1996. Community-Based Health Insurance (CBHI), a voluntary scheme targeted to informal sector workers was piloted in 1999. The Health Equity Fund (HEF), a social-transfer mechanism in which a third-party payer (usually government and donors) helped pay for health costs to the poor was introduced in 2000

Objectives

This study addressed two objectives:

1) To explore the behaviour pathways followed by Cambodian people in accessing healthcare from 1950s to the present and analyse the factors that influenced their decisions;
2) To identify whether pro-poor health financing policy such as UF, CBHI and HEF contributed to household financial protection for the poor and near poor following their introduction in 2000.

Methods

A life history approach was used to collect information on episodes of illnesses, deaths and births and on health spending history through in-depth interviews with 24 participants from Phnom Penh and Takeo province.

The sampled population had to reflect the mix of single or mixed scheme users of UF, HEF, CBHI and private healthcare and they were selected on the basis of an assessment that they were poor and aged 40 or older.

Findings

4.1 Access pathway in childbirth

Table 1 shows that from King Sihanouk's rule to the later 1990s, health seeking for assistance with childbirth relied heavily on 'traditional birth attendants' (TBAs). In the 2000s increasing use of public health facilities can be noted.

Location	REGIME	King Sihanouk (1950-1970)										Khmer Republic (1970-1975)				
		60	61	62	63	64	65	66	67	68	69	70	71	72	73	74
U	1															
	2											C1		C2		
	3															
	4															
	5			C1			C2					C3		C4		
	6														S/B	
	7															
	8												C1			
	9															
	10										S/B					
	11												C1			
	12															
R	13															
	14															
	15									C1	C2	C3	C4		C5	
	16															
	17															
	18	S/B			S/B			S/B				C1			C2	
	19															
	20												C1		C2	C3
	21															
	22															
	23															
	24															

Location	REGIME	Democratic Kampuchea (1975-1979)				People's Republic of Kampuchea (1979-1990)											State of Cambodia (1990-1993)			
		75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93
U	1										C1			C2						
	2						C3			C4		C5		C6		C7			C8	
	3																			
	4																C1		C2	
	5						C5			C6						C7				
	6																	C1		C2
	7												C1				C2			C3
	8						C2													
	9	C1		C2		C3			C4		C5		C6			C7		C8	C9	C10
	10	S/B						S/B		S/B										
	11	C2				C3				C4										
	12																			
R	13														C1			C2		C3
	14																		C1	
	15	C6				C7		C8			C9				C10					
	16							S/B		S/B		S/B								
	17																	C1		C2
	18	C3		C4		C5														C6
	19							C1		C2		C3		C4		C5		C6		
	20	C4				C5			C6			C7								
	21					C1			C2		C3						C4			
	22						C1		C2		C3		C4		C5		C6			
	23																			
	24	C1		C2		C3	C4			C5				C6		C7		C8	C9	

Location	REGIME	RGC (1993-1998)					RGC (1998-2003)				RGC (2003-2008)					RGC (2008-2013)				
		94	95	96	97	98	99	2000	1	2	3	4	5	6	7	8	9	10	11	12	13
U	1														GC			GC			
	2	C9		C10				C11												GC	GC
	3										C1						C2				GC
	4			C3		C4,5							C6							C7	
	5		C8												GC			GC			
	6		C3			C4			C5												GC
	7			C4					C5					GC				GC			
	8																				
	9				C11		C12		C13,14							GC				GC	
	10						C1			C2				C3							
	11											GC	GC								
	12					C1															
R	13		C4				C5		C6									C7			
	14	C2		C23		C4													C5		
	15																				
	16							C1		C2									N		
	17			C3		C4			C5				C6				C7				
	18																				
	19																			GC	
	20																				GC
	21			C5																	GC
	22														GC						
	23																				
	24	C10		C11		C12														GC	

Legend		Code	Meaning
At public facility by medical midwife	(yellow)	C	Child
At private clinic by medical midwife	(orange)	GC/N	Grand Child/Niece
At home or elsewhere by traditional birth attendant with/without spiritual knowledge	(green)	S/B	Sister/Brother
At home by medical midwife	(purple)	N	Niece
At foreign country health facility	(red)		

Table 1: Access pathway in childbirth

Findings

4.2 Access pathway in illness treatment

Up to the late 1990s, TBAs, indigenous practitioners and private village medics filled the gap in providing services to people. Even after the war ended, when the public health care system was in early stages of rebuilding, these groups continued to meet local demand. Health seeking behaviour showed increasing use of private healthcare and public/NGO facilities across all illness treatments from the late 1990s and early 2000s.

4.3 Factors that influenced health care seeking decisions

With over 2 decades of war, public health services - especially in rural areas - were rare. Due to insecurity, fear and distrust of those outside the family, the Cambodian population for most of this period relied on self-medication, traditional Khmer healers and TBAs. Besides being available in the rural areas, they were relatively inexpensive and often people could pay in-kind, e.g. rice or bananas. With the formal end of the war in 1991, the situation changed and different factors emerged to influence a change in health care seeking behaviour.

These factors include:

- Development of the health care system including public health services, those provided by NGOs and private healthcare. For some time, services were still largely available only in urban areas, while the rural more remote and less secure regions were neglected.
- Health financing schemes that either acted as barriers (user fees) or facilitators (CBHI/HEF) of access to health care.
- Socio-political factors, such as access to information, better roads and transportation, political settlement that changed community practices and perceptions about health issues and improved local security and accessibility of people to modern healthcare, and
- Individual factors such as awareness of health issues and protection and household economic conditions

4.4 Impact of health financing schemes on household financial protection

- HEF and CBHI had positive impacts on decreasing health spending for poor people even with complex delivery, hence protecting their household finances.
- For normal birth delivery, UF alone did not cause financial burdens to the near poor
- The impact of UF, HEF & CBHI in illness treatment depended on the poverty level in each household, chronicity and severity in the type of illness they had and the implementation of the schemes.

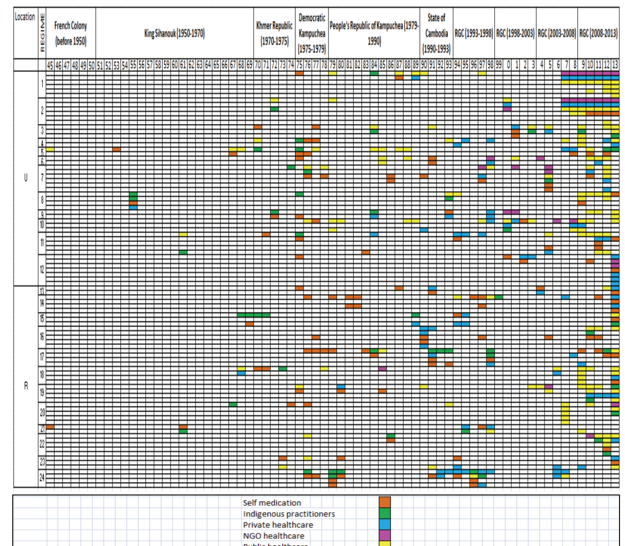

Table 2: Access pathway in illness treatment

Key Messages

- Health system development after conflicts will take time and should focus not only on developing health institutions, but also on improving socio-political and individual factors. Prioritizing tasks is important for the government and donors to work on in this process
- The government can improve the pro-poorness of the country's health financing by expanding the coverage of CHBI and HEF, increasing the scope of HEF to cover chronic illnesses and expanding the benefit package of CHBI and HEF.

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