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Equity in Access to Healthcare and Poverty in Cambodia

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Abstract:
The relationship between equity in access to healthcare and poverty is of major concern. The Health Equity Funds mechanism is used by countries to ensure access to healthcare for the poor, with the overarching intention of ensuring equity in access to healthcare among the rich and the poor. Perhaps the best country on earth committed to its use is Cambodia. Despite several studies conducted on equity in healthcare and poverty in the country, there is a dearth of research on the relationship between the two concepts as well as policies to overcome challenges in the health system, in order to achieve the all-important equity. Based on empirical research, this paper explores the relationship between equity in access to healthcare and poverty in Cambodia and critically analyses the policy measures required to overcome challenges in the health system, to ensure equity in access to healthcare in the country.

Keywords*: Access, equity, healthcare, poverty, Cambodia, poor*

1. Introduction

The relationship between equity in access to healthcare and poverty is of significant concern to all those interested in the plight of people bedevilled by poverty. Given variations in conditions in countries, working towards helping the poor benefit from healthcare is considered a benign effort towards the achievement of equity in access to healthcare. Lack of equity in access to healthcare implies that the poor are always worse off as the rich are always better off in terms of accessing healthcare, inasmuch as financial status directly affects equity in access to healthcare. It is in light of this that in the 2005 World Health Organisation Assembly, it was resolved that countries commit to the provision of Universal Health Coverage (UHC) to all its citizens – rich and poor alike (WHO, 2005), showing the organisation's commitment to equity in access to healthcare. This coincides with the fact that global policy agendas, including the Sustainable Development Goals (SDGs), are trumpeting the need to help provide access to healthcare for the poor as a prerequisite for equity in healthcare (Marmot & Bell, 2018).

The Health Equity Funds (HEFs) mechanism has been adopted by countries to help provide access to healthcare for the poor, with the overarching objective of ensuring equity in access to healthcare for both the rich and the poor. Perhaps the best country on earth committed to its use is Cambodia. The mechanism was implemented in the early 2000s as a measure to save the poor from the payment of user fees while also safeguarding the payment of the fees to healthcare centres (Jacobs et al., 2018). Thus, it was the need for financing Out-of-Pocket (OOP) payments for healthcare and transport fares for the poor that led to the implementation of the HEF in a few public health facilities in the beginning (Jacobs & Price, 2004; Jacobs & Price, 2008; Jacobs et al., 2018), extending to all public facilities by the year 2015, with its administration being transferred from a local NGO to an autonomous Ministry of Health entity (Jacobs et al., 2018; Nagpal et al., 2019). This illuminates a policy commitment by the Royal Government of Cambodia to save the poor from OOP payments, a testament to its conscious effort to increase the poor's access to healthcare.

Indeed, several studies have been conducted on equity in healthcare and poverty in Cambodia (Annear et al., 2013; Annear et al., 2019; Flores et al., 2013; Hardeman et al., 2004; Ir et al., 2019; Nagpal et al., 2019; Jacobs & Price 2004; Jacobs & Price 2008; Jacobs et al. 2018). However, they fail to critically analyse the relationship between the two concepts and how they relate to other issues, implying myriad lacunas in the equity in healthcare and poverty literature pertaining to the country. This is consistent with the several research lacunas in issues regarding equity in healthcare and poverty in developing countries (Meesen et al., 2011). Evidence points to the fact that poverty constitutes a major barrier to accessing healthcare and represents one of the key issues to address before progress can be made in achieving equity in healthcare in Cambodia (Ir et al., 2019; Masiye et al., 2016; Meesen et al., 2011).

Addressing such issues means identifying and overcoming the challenges that prevent the poor from receiving the full benefits of healthcare interventions (Braveman & Gruskin, 2003). This implies conducting empirical research which focuses on exploring the relationship between the two concepts, examining the related salient concepts, and discussing measures to overcome challenges that impede equity in access to healthcare. That is the aim of this paper. Focusing on Cambodia, it explores the relationship between the two concepts while examining the related pertinent concepts and analyses measures required to overcome challenges that prevent the achievement of equity in access to healthcare in the country. Hence, it will contribute to the equity in healthcare and poverty literature by helping to fill the myriad lacunas.

This paper proceeds as follows. This part will be proceeded by the conceptual framework before the methodology. The next part will analyse the issues connected to equity in healthcare and poverty, such as catastrophic health expenditure and chronic poverty, entitlements and freedoms, the HEF as a panacea, and traditional medicine. The direction the policymakers in the country need to take to overcome the challenges that militate against the achievement of equity in healthcare will be explored in the next part before the conclusion of the paper. This paper has the potential to bridge the equity gap in healthcare among the rich and the poor in Cambodia. While this paper can contribute to the country's achievement of UHC, it can prove useful in informing future policies of other countries with similar conditions. Moreover, it can provide the empirical basis for such research to be replicated in other regions of the world.

2. Conceptual Framework

One fundamental reason for the shortcomings of healthcare equity and poverty research is that the relationship between them had long been isolated from broader trends in the literature. In the literature, health outcomes of the poor were hitherto neglected, given that improvement in health outcomes was not the priority of key international organisations such as the WHO and the World Bank (Gwatkin, 2000; World Bank, 1997; World Bank, 2000). Consequently, measures to address the plight of the poor to improve their access to healthcare were also non-existent.

However, in recent times, there has been a growing interest in improving the healthcare of the poor among international organisations, reflecting growing trends in the literature (Sen, 1999; Wagstaff, 2000). In line with this, poverty reduction has been viewed as an overriding mission, emphasising the extent to which health must be regarded as a key concern of poverty (World Bank, 2000). There have been calls for a systematic focus on how poverty can negatively affect healthcare while taking into account the key factors associated with the relationship between equity in healthcare and poverty (Braveman & Gruskin, 2003). Numerous policies and programmes targeted at reducing poverty and improving access to healthcare for the poor have been implemented (Feinstein & Picciotto, 2000) as a germane strategy of ensuring equity in healthcare among the rich and the poor.

A significant concept for providing a lurid analysis of the relationship between healthcare equity and poverty is the HEF mechanism. It helps improve access to healthcare for the poor and seeks to close the equity gap between the rich and the poor, thereby ensuring equity in healthcare (Annear et al., 2019; Hardeman et al., 2004; Jithitikulchai et al., 2021). This provides an understanding of the presence of an income barrier related to healthcare consumption and how it is removed. If there is a financial barrier that prevents one from seeking healthcare, once a financial mechanism such as the HEF is instituted, the barrier is removed. Therefore, asserting that the HEF effectively improves financial access to healthcare for the poor (Hardeman et al., 2004) is logically correct. Despite this usefulness, it does not feature prominently in contemporary research on the relationship between equity in access to healthcare and poverty.

Additionally, the issue of OOP payment is worth discussing. It, unfortunately, puts untold stress on the poor as they are forced to spend the little they have on healthcare. It reduces their disposable income and limits their use of healthcare, sustaining or widening the equity gap between them and the rich (Ntembe et al., 2021). Nevertheless, it is argued that little is known about the concept's applicability in reality (Rezayatmand et al., 2012). However, the recent upsurge in social theory of its negative impact on the poor makes this assertion contentious.

It is important to analyse several significant concepts in the provision of a lucid understanding of the relationship between equity in healthcare and poverty. Drawing on empirical evidence, the analysis will focus on the relationship between equity in access to healthcare and poverty in Cambodia, thereby exploring other significant concepts. Thus, it helps to embed the analysis of the relationship between equity in access to healthcare and poverty in a broader understanding of various perspectives in social theory.

3. Methodology

Data collection was based on qualitative methodology: primary data collected from in-depth semi-structured interviews. This is because, as Rubin and Rubin argue, the qualitative in-depth interview approach is appropriate for understanding the experiences of interviewees and is applicable when it is imperative for interviewees to explain their answers further and provide examples to buttress their points (2005). The respondents were made to share their experiences and buttress their responses with examples, where necessary. The people interviewed were those who were knowledgeable in and conversant with issues of equity in healthcare and poverty in the country. The data were supported by useful information from myriad articles and reports written about equity in healthcare and poverty.

The interviews were conducted between February and March 2018 in Singapore. They were carried out by the face-to-face approach, and via written correspondence, with follow-up or repeat interviews, where appropriate. Based on the recommendation that in qualitative research, data can be collected from three to twelve respondents (Onwuegbuzie & Collins, 2007), five interviews involving Cambodians were conducted in Singapore by the face-to-face approach. With the help of those respondents, three more people working in Cambodia were contacted. Their responses were sent to the researcher via written correspondence. The respondents were informed about the purpose of the exercise.

Therefore, this paper employs the snowball sampling technique. This technique involves the researcher making contact with a small group relevant to the research topic and using the members of the group to establish contact with other potential respondents (Bryman, 2004). It is arguably the mostly-employed technique, which serves as a fall-back alternative when other means of obtaining information are not possible (Noy, 2008). Therefore, it is employed in this paper because it was not possible for the researcher to go to Cambodia to collect data. This means the snowball technique makes the impossible possible in research.

In order to analyse the responses persuasively, the thematic analysis technique, which involves gathering pieces of information, interpreting and sorting them into themes (Vaismoradi et al., 2013), was adopted. Braun and Clarke contend that the thematic method of analysis is an effective tool for the production of intensive and rich data (2006). The technique has helped align the responses to the themes in the research, effectively providing an intensive and rich understanding of issues in equity in healthcare and poverty.

4. Pertinent Issues

4.1. Catastrophic Health Expenditure and Chronic Poverty

The analysis of chronic poverty lacks broadness as it fails to capture the experiences of the chronically poor and how the concept relates to other ones. As Hulme and McKay note, existing work on chronic poverty is conceptualised as very narrow, studied exclusively in relation to income or consumption poverty, and uses household panel survey data, creating significant limitations in the literature (2015). Therefore, to be able to explore the concept of chronic poverty and contribute significantly to the literature in providing a broad understanding of the concept in various places and across different times, scholars and analysts must analyse it in tandem with other concepts.

According to the World Health Organisation, Catastrophic Health Expenditure (CHE) refers to OOP payments for medical expenses that constitute 40% or more of household expenditure (Wagstaff & Doorslaer, 2003; Xu et al., 2003; Zhu & Xia, 2018). Therefore, CHE is precipitated by excessive financial burden because of OOP payments on healthcare, which can push households into poverty (Fan et al., 2021) and even worsen the plight of the poor by plunging them into chronic poverty. The chronically poor are the "people who remain poor for much of their life course, and who may 'pass on' their poverty to subsequent generations" (Hulme & Shepherd, 2003: 405). Thus, for these scholars, chronic poverty refers to the poor languishing in poverty for much of their lives so that future generations may also get infested with the canker of poverty. Sight should not be lost of the fact that such an extended period of poverty can linger throughout the lives of the poor and some might have inherited it.

A significant finding from the responses is that CHE contributes to chronic poverty in the country. Two main factors were identified: borrowing and the sale of assets. Some people resort to borrowing and selling their lands, shops, and motorbikes to raise funds for healthcare, plunging them into chronic poverty. It should be noted that people do not sell their assets to settle money borrowed. Rather, they borrow and sell their assets to get funds to access healthcare, with the amount involved constituting more than 40% of their household expenditure. By borrowing, they are confronted with the herculean task of raising money to settle their debts amid huge interests of 10% to 20% per month. By selling their assets, some of which serve as their sources of livelihood, they are left with no source of income, rendering them poor for much of their life course, and may, unfortunately, pass their poverty to their children and other generations.

Therefore, distress financing – borrowing and paying with interests – is a key feature of the Cambodian health system. It is more common among the poor and less common among the rich. It is unsurprising, as such a finding is consistent with findings from Nepal and Myanmar (Mohanty et al., 2017), India (Mohanty & Kastor, 2017), Indonesia (Sparrow et al., 2014), Vietnam and other countries (Nguyen et al., 2012). Given that poorer individuals and households are bereft of collateral, they tend to be confronted with loans with high interest rates due to the perceived risks in offering them loans.

Furthermore, the preceding analysis points to the extent to which asset poverty dovetails in chronic poverty. Asset poverty refers to poverty precipitated by the loss of assets. Assets have the potential to provide households with economic stability, passing it on to future generations (Sherraden, 1991). Making it more explicit, Sherraden and Yodama argue that assets have a positive effect on expectations and confidence about the future while also helping in influencing people to make specific plans about work and income flow (1996). Inasmuch as assets help individuals and households in securing income, their loss can equally wreak economic havoc on them, plunging them into chronic poverty (Carter & Barrett, 2006; Hulme & McKay, 2015). Thus, the loss of land, motorbikes, and shops, through selling to raise funds to access healthcare, not only disrupts the economic expectations and confidence of individuals and households about the future in Cambodia but also deprives them of the means of securing income, plunging them into an economic quagmire, causing chronic poverty. This positive correlation between asset poverty and chronic poverty implies that the maintenance of assets can help offer a positive effect on expectations and confidence about the future and help people make plans about work and how to secure income, thereby preventing chronic poverty.

This is a novel research as it provides a detailed explication of the linkage between asset poverty and chronic poverty. Therefore, while contributing to eliminating the limitations of the over-production of longitudinal data research as well as the narrow analysis of chronic poverty in the literature (Hulme & McKay, 2015), this research contributes to providing an alternative approach to the analysis of chronic poverty, deepening our understanding of the dynamic nature of the concept.

Another finding worthy of illumination is that CHE-induced chronic poverty is not peculiar to the rural areas, it is prevalent in the urban areas as well. This is inconsistent with a finding of a study conducted in the country, which alludes to the fact that CHE is a major cause of chronic poverty among only the rural poor (Kassie, 2000). Moreover, it conflicts with some studies conducted in other countries (Wagstaff, 2002). Rural communities are confronted with structural disadvantages that tend to prevent individuals and households from experiencing improvements in their living conditions. Conversely, conditions in urban centres are somewhat idyllic and provide opportunities for people to improve their conditions. As such, many argue that chronic poverty is more pervasive in rural areas than urban areas (Kabeer, 2004; Kassie, 2000). However, in this study, it is found that individuals and households in both rural and urban areas are plagued

with CHE and its consequent chronic poverty. The prevalence of the chronically poor in both the rural and urban areas in the country has been pointed out in other studies (Ir et al., 2019; Kaba et al., 2018).

The work of Kabeer on livelihoods in Bangladesh helps in analysing how people are trapped in chronic poverty (2004). She uses 'ladders' to explain the mechanisms that aid people to escape poverty and 'snakes' as the mechanisms that push people into poverty, serving as 'traps.' Given that analysis of chronic poverty helps in revealing the extent to which structural causes are intractable (Mitlin, 2003), Kabeer's analysis of the traps that keep poor individuals and households poor over much of their lives reflects structural forms of disadvantages that distort the distribution of resources (Kabeer, 2004). In the context of Cambodia, the 'snakes' that serve as 'traps' are borrowing and the sale of lands, shops, and motorbikes. Borrowing and selling assets must be regarded as the structural causes that trap people in the quagmire of chronic poverty. Possessing lands, shops, motorbikes, and abstinence from borrowing can be regarded as 'ladders' that help people escape poverty. While research on equity in healthcare and poverty has not provided a lurid analytical linkage between CHE and chronic poverty, this study has moved the discussion from mere correlates of CHE to explicating how it dovetails in chronic poverty, providing a lurid analytical linkage between the concepts.

4.2. Entitlements and Freedoms

A common thread in the responses was the poor's deprivation of the right to healthcare. Sen explicates poverty as a condition resulting from the 'absence of entitlements' reformulated as a broader package of rights to health, and terms extreme poverty *unfreedom*, arguing that it is a state in which a person lacks the right to healthcare (1999: 53). Additionally, Khosla contends that the constraints that serve as impediments to expanding freedoms, termed as *unfreedoms,* are the barriers that militate against accessing healthcare (2002). These scholars draw our attention to the fact that freedoms and *unfreedoms* determine people's rights to access healthcare. Therefore, with the implementation of the HEF, the *unfreedom* of poverty in Cambodia is turned into freedom, inasmuch as it offers people the right to access healthcare.

From the right-based standpoint, Braveman and Gruskin assert that rights are crucial to equity in healthcare and poverty, inasmuch as they dictate the tapping of equal opportunity for healthcare for poor people and other marginalised groups (2003). The poor possess the right to access healthcare just like the rich. Offering people the freedom to access healthcare can go a long way to ensure equity in healthcare. The evaluation of the degree of freedom people possess cannot be done without perceiving their rights (Khosla, 2002). Furthermore, the success of a country regarding the provision of healthcare for its citizens is to be evaluated by the freedoms members of the country possess in accessing healthcare (Sen, 1999). It is important to assess the need to remove the *unfreedoms* that make people go through distress in accessing healthcare (Khosla, 2002) in order for them to enjoy their freedom. Possessing the freedom to access healthcare reflects entitlement to healthcare.

Implicit in Sen's analysis are 'direct linkage' and 'close linkage' of poverty with healthcare, with the former being poverty which robs people of the freedom to access healthcare, and the latter being the lack of freedom to access healthcare caused by the unavailability of health facilities or programmes (Sen, 1999: 4). Thus, the direct linkage concerns *unfreedom* of poverty that prevents people from accessing healthcare. On the other hand, the close linkage has to do with poor societal arrangements, which rob societies of the facilities or programmes that will help people access healthcare. Per this study, the direct linkage is what obtains in the Cambodian system, where poverty denies people the freedom to access healthcare.

Sen's work unfortunately assumes that rights and entitlements are latent across societies and notions about rights have a universal legitimacy (Green & Hulme, 2004). Such viewpoints are problematic. This is because, as Gore argues, they do not specify the 'institutional mechanisms' through which effective right regimes could be established (1993: 453). Moreover, Braveman and Gruskin note that providing a universal frame of reference on the ticket of rights may serve as a recipe for dispute (2003). These contentions point to the fact that rights should not be regarded as universal phenomena. As Park and Kim note, rights are not inherently universal, as they differ from society to society, as, for instance, 'Asian values' place a premium on economic rights over civil rights (1998). However, given that this study examines the direct linkage between poverty and access to healthcare from a right-based standpoint, in the context of Cambodia, it has contributed to enriching the literature.

4.3. HEF: A Panacea?

It was revealed by the respondents that the HEF has benefited some poor individuals and households by providing them with financial coverage and eliminating OOP payments. It has also increased access to healthcare in public health facilities for the poor. The HEF eliminates the stumbling block of poverty that prevents the poor from accessing healthcare. Thus, it can be said that the strategy adopted by the government of Cambodia and its agencies and NGOs to eliminate the poor's inability to access healthcare to achieve equity in healthcare in the country has been somewhat successful. This is consistent with some studies in the country (Annear et al., 2019; Ensor et al., 2017; Flores et al., 2013; Hardeman et al., 2004).

What the above means is that the HEF is an empowerment mechanism. At the centre of the concern with equity in healthcare is the empowerment of people (Marmot, 2007; Sen, 1999). While empowerment entails achieving a fairer distribution of power to secure healthcare, the differential status of people in almost every society is inequity in access to healthcare, which reflects 'disempowerment' among the disadvantaged in accessing healthcare (Marmot, 2007: 1155). This refers to a lack of power on the part of the poor to secure healthcare. Inasmuch as the mechanism helps increase healthcare access for the poor and eliminates such inequity (Bigdeli & Annear, 2009; Marmot, 2007), it can safely be said

that the mechanism empowers the poor to access healthcare. Therefore, the solution to their inability to pay for and access healthcare, like the rich, is the power offered them by the mechanism. It makes the poor better off in terms of the ability to access healthcare in Cambodia.

However, not everybody has benefited from the mechanism. In some rural areas, some of the poor still pay for health services in public facilities, despite being HEF-entitled individuals and households. What is more shocking is that some of the HEF-entitled (poor) people choose to seek healthcare at private health facilities where they still make huge OOP payments. That the poor choose the private facilities over the public ones, where they can utilise the HEF to seek healthcare, implies there is something the private facilities offer them that the public ones do not. Private facilities provide better services in terms of quality than public facilities. Thus, the move to save the poor from the OOP payments (that sometimes prevent some of them from seeking healthcare) has not materialised in that regard. Similar studies of the poor not benefiting from the HEF have been replicated in the country by some scholars (Annear, 2008; Jacobs et al., 2018; Kolesar et al., 2019; Nabyonga et al., 2011).

While the above illustrates that the HEF has mixed effects in terms of helping the poor to access healthcare, it needs to be pointed out that studies on the HEF in Cambodia have predominantly been conducted quantitatively and have covered its composition and operations, with a few covering its impact (Annear, 2010; Flores et al., 2013; Hardeman et al., 2004; Ir et al., 2019; Jacobs et al., 2018; Jacobs et al., 2020; Kaba et al., 2018; Korachais et al., 2019; Nagpal et al., 2019; Noirhomme et al., 2007). Such limitations will not auger well for the equity in healthcare and poverty literature, as they are liable to thwart persuasive arguments and analyses. Therefore, the arguments that equity in healthcare deliberations that target how best all people, including the poor, should have access to healthcare, have been rather narrow (Jensen et al., 2021) and fall short of being given priority (Braveman & Gruskin, 2003), are logically correct. These limitations haunt the health systems development agenda and mar the analysis of equity in healthcare and poverty by refusing to incorporate other significant concepts (Braveman & Gruskin, 2003; Jensen et al., 2021). What this means is that there is an incontrovertible need for more qualitative studies that would assess the impact of the mechanism, as a move to provide a broader analysis and deeper understanding of issues in equity in healthcare and poverty.

4.4. Traditional Medicine: The 'Kru' Practice

Another issue that featured prominently in the responses was traditional medicine. Notions of what constitutes traditional medicine are different from one society to the other, given that changes and innovation occur in it in some countries at the expense of others. Nevertheless, there are significant parallels in how the concept is examined as it captures the realities of the people involved in its application. It is often sensitive to the socio-cultural and livelihood realities of its users (e.g. Izugbara et al. 2005). This means the concept conforms to the social values and economic status of people.

Traditional Cambodian healers, called *Kru Khmer,* may read the palm of the sick person, draw up astrological charts or enter a trance to conduct diagnosis, exorcise evil spirits believed to be inflicting victims (making them sick), and may heal the sick through supernatural means or magic (Bith-Melander & Efird, 2008). The practice thrives on superstition and belief on the part of both the practitioner and the victim in serving as a pathway for accessing healthcare.

Before the Khmer Rouge regime in the 1970s, the majority of people in the rural areas made use of the practice in treating diseases and exorcising evil spirits (Ka et al., 2015; Theth, 2005). It is noteworthy that poverty is more prevalent in rural areas than urban areas (e.g., Green and Hulme 2004). Therefore, it is understandable that people in the rural areas, given that they were plagued with the shackles of poverty more than people in the urban areas, adhered to the practice. If one is not financially sound to seek modern medical services, it is reasonable to resort to traditional medicine, which is affordable. This implies that poverty which prevents people from seeking modern medical services pushes people to the *kru* traditional practice. Thus, poverty plays a crucial role in adherence to traditional medicine. The role poverty plays in influencing adherence to traditional medicine has been confirmed by several scholars (Bishop & Lewith, 2010; Joseph et al., 2016; Mekuria et al., 2017).

However, the practice is now ubiquitous in Cambodia. The presentation of the practice as a ritual in the rural areas at the expense of the urban areas is at odds with what obtains in the country in recent times, as poverty is widespread in all parts of the country. This underscores the fact that poverty across different geographical locations can yield similar effects in healthcare over time. This is the reason Oduro and Aryee argue that studies of poverty across different geographical locations reflect similar clusters of associated phenomena, including the lack of, or poor, access to healthcare (2003). Moreover, Bauman contends that how poverty is experienced changes through society and history, as do the relations that tolerate its effects, although the variation can be eliminated over time (1998). While this paper illuminates that traditional medicine has a tentative function of contributing to equity in healthcare, it proves that structurally disadvantaged people have access to an institutional resource they can obtain help and support from when the need for healthcare arises.

The above proves that the practice offers the poor the latitude to access healthcare. Without it, they will not have access to healthcare. According to Chung et al., it is the healthcare system that constitutes a safety net of 'caring' when poor people find themselves in devastating situations, with no hope of obtaining healthcare from modern medicine (2020: 5). Thus, when the poor find themselves in dire need of healthcare and cannot afford the modern means of healthcare, the traditional medicine saves them. In this context, the practice can be said to be the last resort of the poor.

Nevertheless, caution should be exercised here. Not everybody indulges in the practice because of poverty. In other words, some non-poor people indulge in it. Although several people indulge in it because of the lack of financial resources to afford modern medical care, some people indulge in it only because of the belief they have in it. This is

consistent with the contention of Izugbara et al. that some people practise traditional medicine based on cultural beliefs (2005). Belief as a cause of people's involvement in the practice in the country has been identified in other studies (Ka et al., 2015; Theth, 2005). This points to the need to refrain from making hasty conclusions in the analysis of poverty as a causal mechanism of the practice.

5. Policy Direction

Healthcare systems are replete with challenges that make the elimination of health disparities and the achievement of equity in healthcare daunting (Williams et al., 2016). Hence, it is not surprising that the Cambodian healthcare system is full of challenges. This is echoed in the contention that despite the significant improvements in the healthcare system of the country in the past two decades, challenges still remain in achieving equity in access to healthcare (Jithitikulchai et al., 2021). Given that the findings in this study corroborate the existence of such challenges, it is important that the policymakers in the country turn their attention to such challenges and implement policies to overcome them.

As noted above, CHE causes chronic poverty in the country. Since borrowing and the sale of assets by people to raise funds to seek healthcare disrupt their sources of livelihood and cause chronic poverty, it is incumbent upon policymakers to strive to protect the poor in order to eliminate such tendencies. Apart from the policymakers reducing interest rates on loans to a (bare) minimum so that those who borrow to seek healthcare can easily pay back such loans, a useful and effective way is to ban the sale of assets to seek healthcare. However, the two measures can only be effective in the country if the policymakers institute effective monitoring mechanisms. That is, the measures will be less effective unless they are backed by the institutionalisation of effective monitoring mechanisms.

Moreover, it has been proved that the HEF has not yielded its intended benefit of completely eliminating the OOP payments. According to Culyer and Wagstaff, healthcare should be distributed in such a way that it will be as close as feasible to an equal distribution of health (1993). This means it pays for equity in healthcare to be distributed among all people, especially the poor, regardless of one's geographical location. The policymakers must make sure the HEF is distributed among all the poor people in the country – rural and urban inhabitants. Thus, to get greater benefits from the HEF, there is the need for, as Ravalion notes, a combination of universal eligibility and a considered degree of targeting (2016). This can immensely reduce or totally eliminate OOP payments and help to ensure equity.

The issue of some HEF-entitled poor seeking healthcare at private health facilities must also be tackled. Inasmuch as poor quality of service at public health facilities serves as the main reason some HEF-entitled poor choose to seek healthcare at private facilities, incurring huge OOP costs, the policymakers need to increase the quality of service in the public facilities. The quality of service can be increased through, for example, investment in training medical staff while also working on the supply-side – equipping public health centres in Cambodia with state-of-the-art facilities. Since perceived quality of care in public health facilities among patients increases healthcare utilisation in such facilities (Kruk et al., 2018), increasing the quality of healthcare can go a long way to increase the utilisation of such facilities in the country. With this measure, the HEF-entitled poor that patronise the private health centres can be influenced to stop and turn to the public ones, where they can use the HEF to access healthcare, saving them from OOP payments.

There is also the need for targeting a reduction in poverty and chronic poverty. It is unfortunate that policy documents and discussions have focused on only increasing financing in Cambodia (Flores et al., 2013; Hardeman et al., 2004; Jithitikulchai et al., 2021; Noirhomme et al., 2007), ignoring how the canker of poverty can be reduced. That is not to say that working around the clock to increase healthcare financing to ensure equity is a bad idea. But that approach should commensurate with the implementation of measures to reduce poverty and chronic poverty. This requires putting the requisite structures in place to help people escape poverty and chronic poverty and also prevent people from slipping into them. The policymakers can help make credit facilities available to the people, giving people tax rebates to encourage self-employment (for example, business ventures) and creating more employment avenues. These can help offer the poor the financial strength required to pay for healthcare.

That takes the discussion to the unequivocal need to remove *unfreedoms* and expand freedoms. Some of the most important policy issues in the promotion of healthcare equity are deeply dependent on removing *unfreedoms* so that people can access healthcare (Sen, 1999; Sen, 2002). Healthcare is not fungible, so making arrangements to offer freedom to the poor to access it is surely a way of ensuring equity in healthcare. This can be done by removing *unfreedom* and expanding the freedoms people possess (Khosla, 2002; Sen, 1999). Removing *unfreedoms* and expanding people's freedom to satisfy their capabilities of achieving healthcare are in consonance with policy goals. Achieving this entails not only simply increasing the incomes of people but also improving their conditions, leading to the expansion of basic capabilities (Khosla, 2002). Thus, the policymakers should strive to remove the *unfreedoms* that can prevent some of the poor from accessing healthcare, for example, the OOP payments by HEF-entitled individuals and households. The health centres must be admonished to stop them from making OOP payments. Moreover, freedoms can be expanded through increasing the incomes of people, a situation which can expand their basic capabilities.

Lastly, policymakers should direct their attention to spurring up support and taste for traditional medicine. Over the years, like other countries, the policymakers in the country have concentrated on and pinned all their hopes on modern medicine. However, conditions and occurrences in the country have led to the emergence of the *kru* traditional practice, with the covert objective of providing alternative healthcare for people, especially the poor. It behoves the policymakers to streamline and strengthen policy designs that focus on how best the two would help provide healthcare services. Because of the co-existence of the two systems, there should be a collaboration between them to avoid unhealthy competition and poor coordination. Such a synergy can inure to the benefit of all the people, especially the poor, and help ensure equity in access to healthcare. Additionally, the traditional medical practitioners can be offered medical training to

help acquaint them with the basics of modern medicine. This can help them render quality healthcare services. The policy can also target influencing the media to help in promoting awareness of the reforms in the traditional medicine. This awareness can help increase the utilisation of such services and motivate the practitioners to render quality healthcare, thereby helping to ensure equity in access to healthcare.

6. Conclusion

The relationship between equity in access to healthcare and poverty has become an attractive currency in Cambodia in recent times, as myriad research works have been conducted on it. However, no critical analysis of the issues has been provided. This study has provided a critical analysis of the relationship between equity in access to healthcare and poverty. By so doing, it explored the connectivity between CHE and chronic poverty, entitlements and freedoms, the HEF as a panacea and the *kru* traditional practice. The study explored the direction the policymakers should take to address challenges in the health system of the country in order to help increase the poor's access to healthcare to achieve equity in access to healthcare, a situation useful for achieving UHC. Therefore, this study can prove enormously useful to students, scholars, analysts and policymakers, in terms of devising measures to overcome challenges in the health systems of countries as a means of helping to ensure equity in access to healthcare among the populace.

This study was conducted using a small number of people. However, it has provided a thorough and detailed analysis of the relationship between equity in access to healthcare and poverty, exploring several related issues. Future studies involving several respondents can be conducted to provide further analysis of the issues. For example, future studies can extensively explore the link between poverty and access to healthcare in the country from a right-based perspective.

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