Author's response to reviews

Title: Toward a typology of health-related informal credits: an exploration of borrowing practices for paying for health care by the poor in Cambodia

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Author's response to reviews: see over
Dear Editor,

Please find enclosed our revised manuscript with Ref. MS: 1571295338697082 and title “Toward a typology of health-related informal credits: an exploration of borrowing practices for paying for health care by the poor in Cambodia”.

We thank you for giving us the chance to revise our manuscript. We would also like to take this opportunity to express our sincere thanks to the reviewers for putting their time into reviewing our manuscript and providing insightful and useful comments to improve our paper. We think that the paper has been strengthened considerably in the process.

We added the sections on Authors’ Contributions and Competing Interests as per your request and carefully addressed the reviewers’ comments and made changes in our manuscript accordingly. All the changes are in red font. Our point-by-point responses to the comments are enclosed below; the authors’ comments are in blue font and our responses are in black.

With best regards,

Por Ir, Bart Jacobs, Bruno Meessen, Wim Van Damme
Reviewer 1: Peter Hill

Thank you for the opportunity to review this paper with its detailed insights into the borrowing practices of the Cambodian poor. The research, while exploratory, is innovative in nature and provides insights into an area that has not been explored in detail in the academic health literature. The content of the findings is rich but not always clearly presented and greater clarity in the discussions of both the context of borrowing and the forms of borrowing is essential.

I have a limited number of suggestions that may improve the accessibility of the paper, some of which are structural.

We thank the Reviewer 1 very much for his positive and constructive comments. We try to carefully address these comments as follows.

Minor Essential Revisions

1. The Conclusions section of the Abstract needs to be re-written to more accurately reflect the implications of this research.

We revised the last sentence of the Conclusion section of the Abstract which reads “We provide directions for further studies on financial protection interventions to mitigate harmful borrowing practices from informal money lenders to pay for health care in Cambodia”.

2. The results from the literature would be more appropriately located in the introductory section of the paper, before the methods. I would suggest that the sources listed precede the discussion of patterns of borrowing in the introduction, as the classification of sources is the research focus.

We moved the results from the literature review to the introductory section (BACKGROUND) as recommended. Results on the extent of borrowing for health care in Cambodia among the general population and the poor, including those eligible for health equity funds, are placed respectively in the 2nd and 3rd paragraphs of the Introduction. We added to the BACKGROUND a subsection “Credit suppliers in Cambodia” where results from the literature on credit sources are placed.

3. The terms ‘informal lenders’ and ‘microfinance agencies’ also need to be defined with their first usage, rather than subsequently. There is no indication of whether interest rates are calculated on a simple or compound interest basis – I assume that there is some variability here, but the relationship between the loan capital, interest and time need to be made clearer in the introduction and in application to specific categories.

The terms ‘informal lenders’ and ‘microfinance agencies’ are explained in the subsection “Credit suppliers in Cambodia”. A definition of ‘Informal lenders’ or ‘informal money lenders’ is given in the last paragraph of this subsection as “…professional individual money lenders, but unregulated, non-subsidized and often charge usurious interest rates, though easily accessible with little or no collateral requirements”. In this subsection, ‘microfinance agencies’ which include MFI and rural credit operators are also explained. We also briefly explain how interest
rates were reported and calculated in the second last paragraph of the METHODS section on page 10 of this revised version.

4. In the methodology, you indicate that initial contacts were identified by operators of health equity funds, with subsequent interviewees identified using a snow-ball technique. To the reader, the choice of health equity fund managers seems unusual as these presumably would be working with clients whose costs had been subsidised. It would be helpful to have some indication in your introduction as to why subsidized patients nevertheless take significant loans, and the apparent awareness of health equity fund managers of the limitations of their assistance.

We indicated why subsidized patients nevertheless take significant loans in the 3rd paragraph of the Introduction on page 4 and explained more in the METHODS section (on page 8) on why health equity fund operators were contacted to identify a first groups of patients.

5. Table 1 and its explanatory paragraph are not clear. Page 8 Para 1 needs to describe the nature and purpose of the study more fully before referring to the Table, and the final sentence needs clarification. The ratio alluded to in the table needs to be explained in the text. Essentially as I understand it, the study, repeated over two time periods, matched paying patients with patients supported by equity funds, showing that despite this subsidy, a larger proportion of fund-supported patients took loans than their paying counterparts, for sums that far exceeded the direct costs of their treatment. A smaller percentage of paying patients sought loans, and where they did the amounts were lower than their direct treatment costs. A further statement needs to be added pointing out the significance of this: do the borrowing behaviours reflect health expenditure beyond the current subsidized episodes? Why do the poor, having received assistance to cover their treatment, seek loans of this order? If Page 12 Para 2 is meant to clarify this, it needs expanding and locating earlier in the text.

As explained earlier, following the comment 2, we moved all the results from literature review, including Table 1 and its explanatory paragraph, to the Introduction in BACKGROUND section. In order to make this section clear and concise, we removed Table 1 and incorporated its related messages it into the explanatory text and adapted it accordingly.

6. Page 9 Results from in-depth interviews: again, an overview is necessary before the table is introduced. Table 2 needs some clarification – in the section where medians and means are included, brackets are not needed around the phrases: ‘in US$’; ‘in %’ - at present they are confusing. Similarly in the section Main sources of debts, there is no explanation of what the bracketed figures are – are these percentages?

We added an overview before introducing Table 2 (which becomes Table 1 in this revised version) on page 12 and made necessary corrections and clarifications in the table as suggested.

7. Page 10 Para 1 line 4: what are the implications if the deadline is not respected? Is the interest increased? How is this increase determined – simply by the additional time incurred or are there penalties implied?

We added an explanation on this in the related text (on page 13), which reads, “A clear deadline for repayment is set though not strictly respected, as failure to respect the deadline does not necessarily
result in severe sanctions but translates into harassment by the lender against the borrower to identify means to repay the debt, including sale of assets”.

8. Page 10 Para2 line 2: What does the statement about interest rate mean? That it is usually 20% regardless of duration of loan? What does the statement in line 3 then mean? What is not explicitly stated – the rate, the duration? And how is it converted into extra days – is this a extension of time to pay or an extension of the period in which interest is due or a combination of both?

We clarify this in the related text on page 13 of this revised version.

9. Page 10 Para 3 line 2: Is the loan repaid (not reimbursed) as a lump sum or as a lump sum with interest? What does an official transaction require?

We clarify this in the related text on page 13 of this revised version.

10. Page 10 Para 4 line 3: What is meant by the interest is hidden? It would appear that the interest is explicit, but calculated as an amount of grain – is this so? If not, how is it hidden? Does it depend on outcomes of the harvest?

We clarify this in the related text on page 14 of this revised version.

11. Page 14, Para 2: This study has serious implications for Health Equity funds that are not addressed clearly here: they are unable to compensate for health expenditure prior to access to the public institutions that they cover. While they can offset some of the economic impact, the potential for patients still to enter cycles of poverty is still there – as most of your interviewees indicate (Page 12 Para 2). This is likely to persist until some form of universal health insurance is available, and a statement that recognises this limitation of health equity funds should be included.

We address this issue by revising the related paragraph, which now reads as “In Cambodia, HEF have been developed to attract the poor to exempted health services and are extended nationwide as they greatly improve financial access [39]. However, the vast majority of beneficiaries of such schemes still initiate health care seeking in the private sector where they incur most expenses for treating the condition [12,13]. Accordingly, at least in Cambodia, HEF unaccompanied by additional interventions are not the panacea to overcoming borrowing from money lenders due to treatment seeking. Although HEF were not found to reduce the likelihood of incurring health-related debt, coverage by such fund did reduce the amount of health related debt by 25-28% [40]. Thus more information is required on determinants of care seeking to be able to attract them to the public sector when sick” on page 17.

12. Page 16, Para 3: Further studies will not overcome borrowing practices from informal sources: only alternative financial protection mechanisms can possibly achieve this. This needs to be integral to the conclusion of this paper and reflected in the abstract.

As indicated in our response to your comment 1, we made change to the last sentence in the Abstract as, “We provide directions for further studies on financial protection interventions to mitigate borrowing practices from informal lenders to pay for health care in Cambodia”. For the sentence that reads “Further studies to overcome borrowing practices...”, we changed it to “In order to successfully reduce borrowing practices...”.

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13. Include local names in this Table 3.

We added the local names to the respective type of loans in the table 3 (which becomes table 2 now) as suggested.

Discretionary Revisions

Page 4 Para 2: decennia is an unusual usage and decades may be a more appropriate term.

We replaced the word ‘decennia’ by ‘decades’ as suggested.
Reviewer 2: Peter Leslie Annear

General comments:
1. Household debt for health care has been identified as the leading cause of new impoverishment in Cambodia. This paper makes a useful contribution to our knowledge on the debt-for-health-care situation and suggests a process of further investigation that would strengthen the ability to design appropriate interventions.
2. While the level of debt and the impact on households have been previously investigated in Cambodia, this paper fills a gap in explaining more clearly the nature of debt by type of lender and the manner in which poorer households enter the debt cycle.
3. The description of a typology of debt-for-health-care is a useful one and provides an approach that helps policy makers to target the most immediate concerns, that is, the use of informal money lenders who charge exorbitant interest rates.
4. This paper is a useful contribution to the discussion of debt-for-health-care in low income countries, the following comments are designed simply to strengthen the presentation of the article.

We thank you very much for your positive and constructive comments and try to carefully address them as follows.

Major compulsory revisions – The following comments could remain as a commentary to accompany the publication of the article:

5. The purpose and intent of this article is not clearly stated. It appears that the aim is to develop a typology of debt. In fact, the article identifies a typology from the literature and seeks to apply this to Cambodia. The aim could be made much clearer by adding a paragraph at the end of the Introduction that clearly states the research question and purpose.

The purpose of the paper and related questions to be investigated are actually there in the last paragraph of the introduction, which were not explicit. We therefore revised the related paragraph on page 5 of this revised version which can reads “Better understanding of the process through which Cambodian households obtain cash for paying for health care and associated lending and repayment conditions will help to define appropriate policies and interventions to limit the impact of such practices. Surprisingly little has been published in the health literature on this. We contribute to this knowledge gap by exploring practices of borrowing for paying for health care by the Cambodian population, predominantly the poor, in an attempt to provide examples of available health-related informal credits and associated conditions”.

6. The article could be made stronger with some rearrangement of the argument. First, the typology of debt practices does not emerge from the research data from Cambodia but derives from a review of the international literature. For this reason, a clearer presentation of the methodology would be useful. It would be more useful to develop and present the typology as an analytical framework for the article. This framework should clearly identify the different methods and their use, beginning with a review of the international literature to establish the typology, then the use of literature and documentary evidence from Cambodia to describe the debt-for-health situation, and then the use key-informant and household interviews to provide data for applying the typology to the situation in Cambodia.
7. The Discussion section begins with a paragraph that states the apparent purpose of this article and therefore should be shifted to the Introduction. As well, the notion of “market failure” is an important underlying concept, particularly in new and emerging markets such as in Cambodia, needs to be further explained in the methods section. The concept of market failure needs to be added as part of the analytical framework presented in the paper, adding it to the concept of typology. A stronger explanation of this aspect would give the article more weight.

Indeed, the typology of informal credits emerges from the literature related to Cambodia, but not from the international literature. However, this typology does not tell anything concerning the relation of these informal credits with health and health care related payments, for which we relied on the in-depth interviews. We used the comment to add an analytical framework (including a figure and explanation about market failure) which we incorporated in the METHODS section (Analytical framework and data analysis). An elaboration on the way data were analysed is included in pages 9-10. The first paragraph of the Discussion section was consequently removed.

8. More thought needs to be given to the presentation of the final sections of the Discussion and to introducing a Conclusion to the paper. In fact, some of what is currently included under Discussion is rightly a Conclusion, particularly beginning with the second last para on p.16. More broadly, a much more structured discussion is needed, one that specifically relates the proposed typology to the results of the data collected in Cambodia.

9. The passage (p.14) that begins “In Cambodia, health equity funds ...” needs to be reconsidered and a much stronger argument presented. In Cambodia, underlying the issue of debt for health care is the broad and equally significant question of the role and impact of the health equity funds (which are approaching national population coverage of the poor). While this article is not intended to focus on the health equity funds, if the question is to be introduced it requires a much more careful explanation. This should be referred to in the Introduction and taken up as a particular question in the Discussion.

In response to comments by Reviewer 1 above (1, 2, 11 and 12), we made a significant revision of the Introduction, DISCUSSION and Conclusion sections (also in the Abstract for the latter). We believe that these revisions sufficiently address these points 8 and 9 made by Reviewer 2.

Minor essential revisions – The following comments could be removed as soon as they are addressed by the authors and need not remain with the final publication:

10. - p.4, Background section, end of second para: the claim that “We use case studies to illustrate the conditions of each type of informal credit source” is an overstatement. Clearly, the description of a single household case of each type of debt is a useful illustration, but it does not add to the research methodology and cannot be described as a “case study” in the sense that is commonly used in research methodology. Rather, these are examples.

We removed the related sentence in the Introduction and revised the sentence with ‘case studies’ on page 15 of this revised version and replaced the word “case studies” in the sentence and title of Box 1 to “examples” as suggested.

11. - p.5 Methods: a clearer distinction needs to be made between the development of the typology using the international literature and the data collection process in Cambodia. The
Cambodia data were used to populate the typology with a particular country case and to use the results to make recommendations for further action. This needs to be clearly stated in the methods section.

Please refer to our response to Reviewer 2’s comments 6 and 7 above.

12. - p.7 Results from the literature: The description of the research results on the distribution of debt-for-health in Cambodia is confusing, and no clear summary of the meaning of this data is presented. The reader is left wondering just what the situation is and how apparently contradictory data are reconciled. First, Table 1 should present a summary, designed by the authors, of the data from all literature sources aligned side-by-side for comparison, rather than simply the results of one of the surveys. Secondly, the data from the table should be described to identify similarities and differences. For example, there needs to be some explanation why one reported survey found only 11% of people reported borrowing with interest. The discussion should then comment on the significance of these data all together for the argument related to typology.

Please refer to our response to comment 2 by Reviewer 1.

13. - p.14 second para: Needs to state clearly what the data suggests about the situation in Cambodia. The claim that “the problem of borrowing with perverse interest rates should be tackled” is completely normative and needs a further justification based on health science: is this because of issues related to equity, or to development needs, or to health outcomes, or something else? Similarly, the claim that “common sense would argue” is not sufficient and instead the claim should be based on some accepted principle, such as the goal of greater equity.

14. - p.14 The sentence from “To achieve this ...” up to “… common place these days” is very confusing and has no clear meaning. This sentence needs to be broken down and a clear explanation presented, or the sentence deleted.

As indicated in our response to comment 11 by reviewer 1, this paragraph has been revised significantly. We believe that this revision sufficiently addresses these points.

15. - p.15 second para. The claims made about the role and significance of MFI institutions in rural Cambodia are not supported by the data or the argumentation presented in the paper and need to be revised. The article argues first that MFIs are generally not relevant to the poor. It then argues on p.15 that MFIs “can be effectively extended to the poor”, they insufficiently penetrate rural Cambodia and “should be investigated”. These claims are inconsistent and need much more thought.

We are afraid that you misunderstand our point in this paragraph. Our statements in the early part of the paragraph were mainly based on literature. In the last part of the paragraph, we argued that there is a need for further study on ‘how MFIs can be effectively extended to the poor’, but did not state that ‘MFIs can be effectively extended...’.

16. - p.16 second last para: the conclusion that “Such credit practices most likely put many households in a debt trap...” is weak and needs to be reconsidered. Rather, the conclusions to the article should state clearly what value the use of the typology is to the analysis of the debt situation in Cambodia.
We adapted the statement from “Such credit practices most likely put many households in a debt trap ...” to “Such credit practices most likely put many households in a vicious borrowing cycle ...” and added references to support the statement. The suggested conclusions are stated in the following paragraph of the Discussion.

17. Some simple corrections need to be made to the text:
- p.4 Socio-economic and health context ... : The word “decennia” should be “decades”. Instead of “... along Maoist ideology” it should read “... following Maoist ideology”.

We replaced the word ‘decennia’ by ‘decades’ and made necessary correction as suggested.

- p.5 second para: the first sentence should read: “To better understand existing sources if credit and their associated practices as well as their impact on livelihoods in Cambodia ...”

Change was made by adding “in Cambodia” to the related sentence as suggested.

- p.8 first para: the claim that “proportions of exempted or paying patients getting loans with interest ... were 30%, irrespective of their economic status” is not substantiated by the figures presented in Table 1 and needs to be revised and verified.

This point has been addressed by our revision of this paragraph and moved it to the Introduction to address comment 2 by Reviewer 1.

- p.10 second para: the statement: “it is not explicitly stated and instead converted in extra days to repay the loan” has no meaning that can be easily understood. Here, a full stop is needed after ... to be 20%” and then a new sentence that clearly explains the intended meaning of the phrase.

This point has also been addressed by our revision of this paragraph to address comment 8 by Reviewer 1.

- p.12 Discussion section, second line: the phrase “failure on several markets” should read “failure in different markets”.

We corrected the phrase as suggested, but this paragraph is now moved to a new subsection “Analytical framework and data analysis” on page 9.

- p.13 second para. The meaning of the following phrase is not at all clear and needs to be explained: “... but fail to assess the interest rates”.

We changed the related phrase, which now can reads “…but do not mention interest rates associated with such loans”

- p.16 final para. Claiming that “… to successfully overcome borrowing practices...” is unrealistic. The approach presented in this paper provides a useful approach to “managing” or “reducing” the debt problem but is unlikely to overcome it.
We replaced the word “overcome” by “reduce” in the related paragraph as suggested - p.16 final para. The addition here of a proposal for “additional interventions to health equity funds to make them more effective” is a positive and useful recommendation, but it is not well supported by the data or the argumentation presented in the article. For this reason, the argumentation about the role of equity funds in the management of the debt situation needs to be stronger in the Introduction and the Discussion (see comments above).

As indicated in our response to comments 2 and 11 by Reviewer 1 and comments 8 and 9 by Reviewer 2, we revised and moved the first paragraph which describes the Table 1 (of the non-revised version) to the Introduction (the first paragraph on page 4 of this revised version). Moreover, we also revised the concerned paragraph in the DISCUSSION section (second paragraph on page 17 of this revised version) and conclusion in the Abstract.