CHAPTER III

PROPOSAL

Assessing the Willingness of Rural Population to Join A Community Financing Scheme in Prasat, Krava and Treal of Baray-Santuk Operational District, Cambodia

3.1. Introduction

Economic recession has been struggled many countries recently especially developing countries. Due to economic pressure, governments are forced to reduce their budget allocated for social services including health, as a result those sectors face the problem of under financing, particularly health services which find it difficult to provide quality health care to population in absence of the required resources.

The objectives of "Health for All" by the year 2000 using the Primary Health Care approach is hampered by the inadequate government resources for health. Ron, (1993) in his paper entitled "Health Insurance in Least Developed Countries" said that:

> "Governments of developing countries are now facing two challenges: the recognition of basic health care for all citizens as a right on the one hand, and the difficulties faced by governments in developing countries to maintain resources to provide health care through general taxation on the other." (Ron, 1993, p. 1)

In order to continue provide better quality of basic health services to its population, governments of many developing countries have been committed to reshape their former health financing system which was based on general taxation, to some form of user contribution such as user fees or health insurance.

Nevertheless, nothing are perfect, different strategies have their own strengths and weaknesses and are not applicable to every situation. There is continuing debate concerning the pros and cons of user fees versus insurance among policy makers and health professionals. Some countries prefer the former while others think about the possibility of the latter.

Ron, (1993) further explored that there is growth in developing countries in developing health insurance as a stable method of financing health care and to improve the access to health care of its citizen. Other countries may prefer to use the two methods combined.

The purpose of this proposal, is to explore the possibility of introducing health insurance to complement the current users fee scheme as a stable health financing strategy for long term development of a referral health system and for the achievement of health sector reform in Cambodia.

Prasat, Krava and Treal health centers, of Baray-Santuk operational district, in Kampong Thom province (See Figure 3-1 & 3-2) will be selected as a study area for which the outcome of this study will provide policy- makers at the ministry level with the required information for decision making.

Figure 3-1. Map of Cambodia

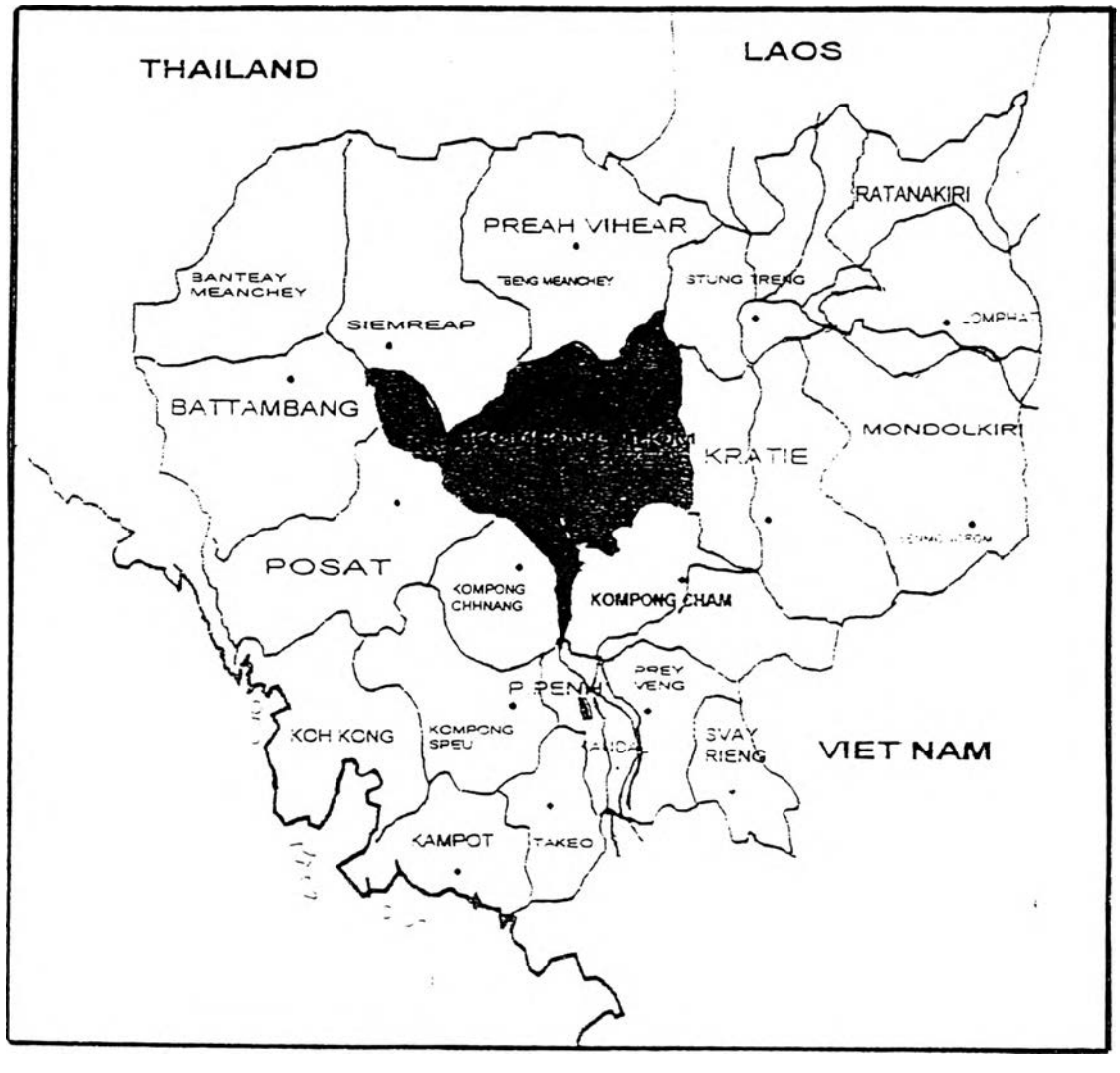
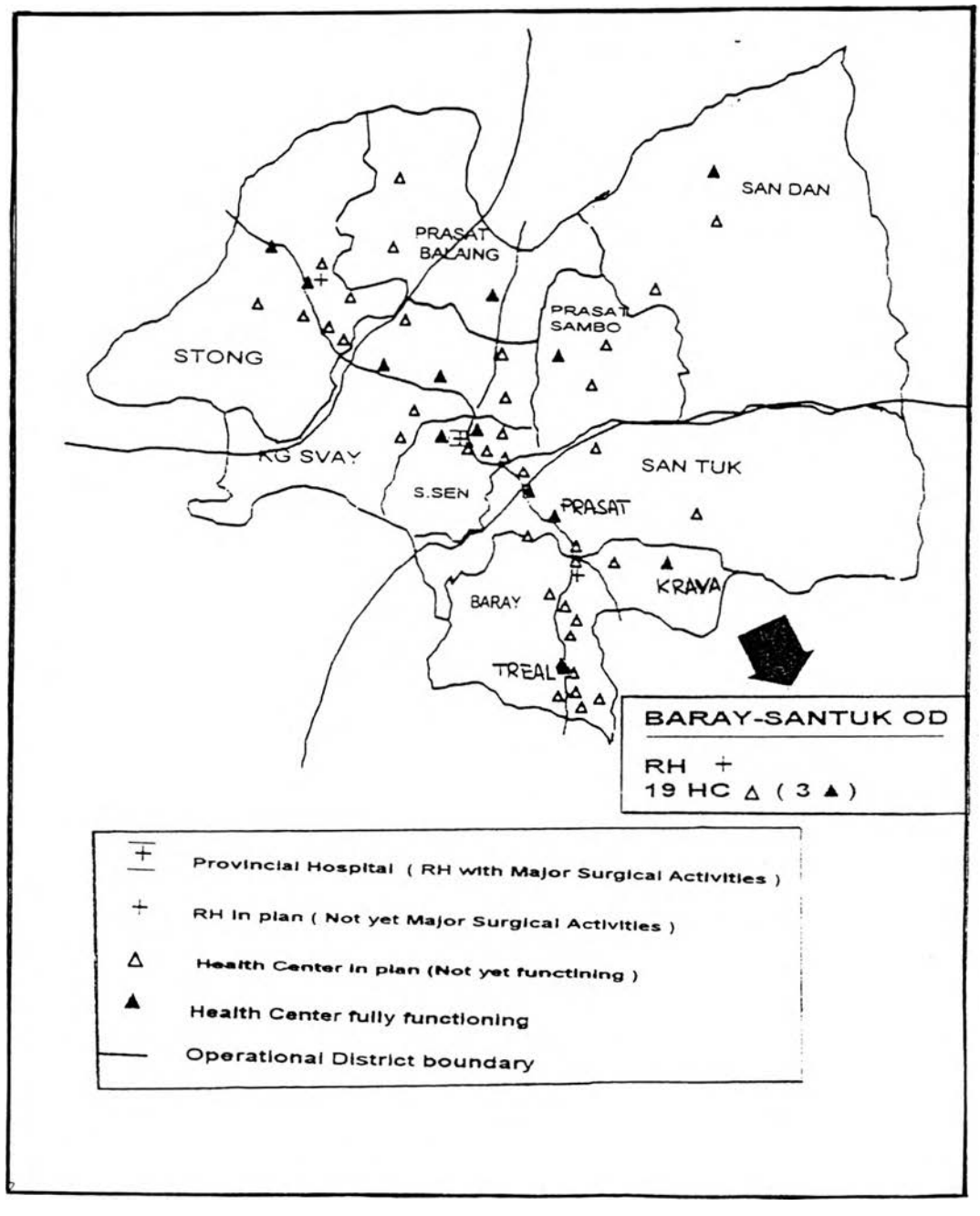


Figure 3-2. Map of Baray-Santuk Operational District



3.2. Background Information

3.2.1. The Cambodian Health Care System

The Cambodian health care system has undergone considerable transformation during the past couple of decades. Prior to 1995, the health care system was organized into 4 levels based on administrative boundaries. In this system, Cambodia had one commune dispensary in each commune, one district hospital per district, one provincial hospital in each province and several hospitals at the national level.

In practice this system seemed not to work properly, the population coverage varied greatly between commune and districts, some have either too large or too small population, therefore public resources were not equally distributed. Hospitals were not appropriately located, mostly at populous areas in towns, thus making it difficult for rural population in terms of accessibility when they needed care.

Realizing this problem and with the aim to improve the equity in access to and utilization of good quality services by the population, the Ministry of Health of the Kingdom of Cambodia initiated a countrywide national health sector reform based on population size and geographic criteria rather than administrative boundaries.

The **"Health Coverage Plan"** was adopted in May 1995. Under the reform, the Cambodia Health Care System was divided into 3 levels namely national, provincial and operational district level. National and provincial levels provide support to the operational district in terms of policy and planning, while the district level is the operational level to directly deliver health care to population.

In each operational district there is one referral hospital and a network of health centers according to the number of population covered. In principle, one health center is designed to serve a population between 8,000 to 12,000 while one operational district will serve a population between 60,000 to 200,000 (MoH, 1997).

According to Health Coverage Plan, health centers were assigned responsibility to deliver primary health care activities through a minimum package of activities (MPA) defined by the Ministry of Health. The activities including consultation for common health problems as: malaria, sexually transmitted disease (STD) and diarrhea, minor surgery, antenatal care (ANC), birth spacing, expanded program of immunization (EPI) and outreach activities.

Referral district hospitals were responsible for a complementary package of activities (CPA) including management of the referred cases, medical and surgical emergencies, complicated delivery, laboratory diagnosis, hospitalization etc. In principle the health center is not allowed to have in-patients and the referral hospital is not allowed to have out-patient consultation (MoH, 1997).

The emphasis is on the development of operational districts, particularly make use of health centers and referral district hospital to serve rural population. The aim is to have a total of 67 referral hospitals and 935 health centers network for the whole country all of these should soon be fully functioning to serve population.

Moreover, community participation has been seriously considered by the ministry of health as an essential element for the achievement of the health sector reform. Community participation not only in terms of financial contribution but also participation in decision making, management of funds and evaluation of the scheme (MoH, 1997). For this reason, the health center management committees have been established by making sure that different segments of the community will have their representative in the committee. Community participation in the organization of health services is essential to ensure that health services will offer services according to community's needs.

3.2.2. Cambodia's Health Financing System

Under the communism era, the period between 1970's and 1980's, health financing of Cambodia followed the pattern of the Former Soviet Union (FSU) countries, the state finance and provision of health services, resources for health sector mainly came from government funding. During this period the health sector became paralyzed due to the problem of under financing.

After 1993, following the peace agreement among the major conflicting parties, Cambodia gained international recognition and more resources from the international community were mobilized to support the country. Health is one of the sectors for which attention has been paid to, and the Ministry of Health is a major recipient ministry, where resources are channeled through non-governmental organization (NGOs) and international bilateral and multilateral organizations. Since then resources for the health sector have been increased by international aid.

Still the financial gap has not been filled completely, further aid is not a sustainable solution, and donors going to gradually withdraw their assistance once the country is stable. Realizing this, the Ministry of Health in 1996 initiated health financing reform to adopt the cost recovery scheme in which user fees are implemented by the government to deliver health services in order to get additional resources to finance the public health sector.

Health financing reform is being considered as an important element to support the whole organizational reform of the country. The government realized that it is impossible to sustain health services without additional resources. The national charter on health financing in which public health services are permitted to charge fees from the user was developed in 1996 in consultation with other ministries and the inter-ministerial commission.

The Cambodian government took one step forward to gradually introduce the new health care financing policy, such as a cost sharing mechanism through user fees. The public health system is now in the process of piloting user fees in a number of health facilities.

The Constitution of the Kingdom of Cambodia states that the Ministry of Health will develop health financing pilot projects, which will include financial participation by users of health services as long as the poor can be protected, meaning that health care must be available free of charge to the poor people. (MoH, 1996).

3.3. What is Community Financing?

Community Financing is the term increasingly used by many health professionals and policy analysts especially following the Bamako Initiative in Africa which has proven to be successful in implementing health financing reform. Still we can observe slight differences in the definition. Some people define the term as:

> "Community empowerment, through improving the accountability of the health services to the population and encouraging communities to take responsibility for their own health. It is this goal which distinguishes community financing schemes from national user fees systems or social insurance, as it leads to the direct involvement of community representatives in the management, and sometimes the design, of schemes." (Gilson & Mills, 1995, p.281)

In the World Health Organization document entitle "Health Insurance Scheme in Least Developed Countries" define the term as:

> "The initiative in which local financing mechanisms are created and the community, through its representatives, becomes involved in the management of its health care resources." (Ron, 1993, p.5).

Ron, (1993) further mentioned that, one element of community financing is the regular predetermined contribution or prepayment and that community financing has some areas in common with voluntary health insurance scheme.

In this proposal, the term Community Financing means: the community's contribution through a voluntarily health insurance in which the funds collected will be used for the local health care delivery point, and managed by a local community committee. Whereas the term community is defined for this proposal as a group of people living in the catchment area of a health center. According to new health coverage plan of the ministry of health of Cambodia such community has a population between 8,000 to 12,000.

3.4. Rationale of the study

3.4.1. Why health financing reform?

Cambodia has experience of historically low public spending for health. In 1995 the government budget allocated for health accounted for only 0.7 of GDP, this figure is equivalent to less than 2 US dollar per capita. This amount it is far less than 12 US dollar per capita recommended for low income countries (World Bank, 1993).

Within the current budget deficiency and increasing demand for health services as the result of re-emergence of infectious diseases. It is difficult to ensure good quality of health within the public services; therefore, patients gradually lost confidence in public services, and turned to use traditional and private sector for medical care. This stresses that additional resources should be generated through a health financing system in order to finance public services, as William, 1997 indicated that:

> "Many developing countries have traditionally provided health care services without charge, but decreasing government resources and increasing demand for health services over the past decades have created a need for new revenue sources to operate public health system" (William, 1997)

Within the limited government budget, there is little possibility that the quality of health services can be maintained to meet the patient satisfaction. Therefore there is a need to find alternatives to generate additional resources to finance public health services by means of co-payment from the service users. Since user fees have been already implemented, therefore community financing through voluntary health insurance should be introduced to complement the existing fee system.

Households in Cambodia already spend a substantial amount of their monthly expenditure on health care and this money most of the time is paid for uncertain quality of health care within the private health services. There is nothing wrong with private health care providers, except that most of the private practices in Cambodia work out of government control. Anyone who whishes to operate a private clinic can do so without much concern about the ministry of health regulation. More recently

there are some rules but since these were not strictly implemented there is still uncertain quality of health care.

Although the delivery of government health services, is officially free of charge, people may have to pay unpredictable informal charges by the health staff. The people are uncertain about how much and to whom they should pay and sometimes unluckily end up paying a huge amount of money for little service.

The above reasons suggest that instead of allowing those unofficial practices, the appropriate and clear official fee schedule should be established for the government system. The money collected could be used to upgrade and assure the quality of health services. The people would, then get value for their money, and the money could be spent efficiently. It is difficult to prove that additional resources could upgrade the quality of health services since the word quality might have a broad meaning, but the resources could at least secure the availability of drugs, thereby improving the quality to some extent.

The Socio-Economic Survey of Cambodia 1993-94 indicated that households spend about 22 US dollar a year per capita on health care which is about 7 percent of a household budget and it is already ten times higher than the government budget allocated for health.

Health Care Demand survey, (1998) also shows that households in Cambodia spend about 22.1% for health care in relation to total expenditure (HCDS, 1998) this is relatively high as compared to Thailand where the figure is only 3.3% to 3.5% (Viroj, 1995). This may be due to the fact that the data were presented at different times. It might not make such difference if data present the situation in the same year. This figure suggests the ability of Cambodian population to pay for health care.

Most of the money spend by household was for the uncertain quality of care in the private sector, leaving the government health sector with little revenue because people will come to government health facility mainly when they run out of the money. This can be supported by the figure of Health Care Demand Survey that 70% of those who are ill initially seek care within the private sector, mostly buying drugs in an unregulated drug store (HCDSC, 1997). This result is poor quality of care because, self-prescribed medication or prescription by uneducated drug sellers from drug outlets can be very harmful to their health.

Although people are poor, they are not poor all the time throughout the year. There are times when cash is available for them, especially after the harvest season. Therefore, a prepayment system that collects a premium once a year (especially after harvesting time) and for which the subscribers are entitled to free care throughout the year might be appropriate to facilitate accessibility to health services particularly for farmers.

In order to regain the public confidence in the government delivered health services so that the utilization of services is increased and public health system once again becomes popular among the population, the Ministry of Health has launched a campaign strategy by contracting services out to private organizations. The campaign is trying to improve quality of services by securing the availability of drugs therefore quality is upgrade and so on. Also during this period services are provided free to the people, it is proposed that after the campaign period when the service is in good reputation, the government will try to introduce prepayment as a financing strategy.

Cambodia is currently heavily dependent on external resources as a means to finance its health care system. In the long run, these resources will not be sustained as the donor will withdraw their support as soon as the country can support itself. Therefore, in order to provide health care to population on a sustainable basis, the government has to look for other sources of revenue to finance its health care system.

3.4.2. Why community financing?

Firstly, especially community-based prepayment is a fundamental step in developing the complicated forms of insurance such as social security scheme or Health Insurance. Particularly for the countries in which health insurance does not exist, but would like to include in their health financing strategy. Siripen, (1997) mentioned that community financing in Thailand, particularly health card program is a key strategy toward a voluntary health insurance.

Another important characteristic of community financing scheme is that, it is appropriate for a rural population (community) of which the majority are working in the self employment sector, especially farmers which have no regular income. They generally have a low income, and they might find that paying for health care cost at the time of illness (user fees) is difficult.

Compulsory health insurance, is suitable only for those who work in the formal sector or those who are employes in the industrical sector who earn regular income and have employer contribution. It is impossible and socially unacceptable to force farmers to pay for monthly or quarterly health insurace.

The benefit gained from the scheme is two dimentional. First it helps to alleviate the financial burden imposed upon patients, especially the poor who usually can not afford to pay out-of-pocket expenses at the time of illness. This will improve accessibility to health care.

Secondly it can contribute to generate additional resources available to the public health system which in general suffers from under financing. Additional resources next to user fees and government annual budgets could contribute to quality improvement by (a) securing the availability of drugs and (b) giving incentives to staff (higher wages, better housing etc.) to motivate them to do better work.

Community participation is considered to be an important element for achieving the goal of "Health for All by the year 2000", by involving the community in the management and orgainzation of health centers. It could possibly increase people confidence in health services, and therefore people will be willing to pay for health services. Especially if they understand that the money they contributed will be retained and used for the improvement of the quality of services.

Community financing as defined above, is a mechanism by which the community is enabled to control and to manage health services, through their representatives. However community financing in this proposal is not a strategy which is going to substitute others health financing strategies such as user fees or government budget, but rather to complement these to generate additional resources to finance the health sector and address the problem of low utilization of health services.

3.5. Objectives of the study

The objectives of the study are as follows:

3.5.1. General objective

To explore the possibility of introducing the community based voluntary prepayment scheme in rural villages of Krava, Treal and Prasat, of Baray-Santuk district, Cambodia

3.5.2. Specific objectives

1. To estimate the proportion of rural people who have knowledge about health insurance.
2. To identify the willingness and ability of rural population to pay prepayment premium.
3. To identity type of services preferred by people to be covered by prepayment scheme.
4. To explore the affordability on premium by the community.
5. To identify the relationship between household income and willingness to join prepayment scheme.
6. To assess the knowledge and understanding of rural population about community financing.

3.6. Research questions

1. Is there a relationship between household income and the willingness to pay for a health insurance card?
2. Will the people in rural areas agree to buy card if there is an insurance system for health care in which the premium will be collected once a year and the insured persons are entitled to access health care without payment when they need?
3. By empowering rural people to control and organize health center (through their ownership), will they use the health center?

3.7. Methodology

3.7.1. Study design

The proposed study will be a cross sectional design where descriptive statistics will be applied to describe the level of knowledge and preference of a rural population about health insurance, also information referring to which system of payment do the people prefer will be explore through household interview questionnaires.

3.7.2. Study population

The study will be conducted in three communes of Prasat, Krava and Treal, of Baray-Santuk Operational district, in Kampong Thom province. The total population living in the catchement area of the three health centers is about 36,300 people distributed in 6,832 households (Provincial Health Report, 1997), the majority of population (about 85% of total population) are farmers and their main income is from agricultural production. The target population of this study includes all households located in the health center's catchement areas. The very poor households which should be excluded from payment need to be identified with this survey and need to be confirmed by the health center management committees. The term household used in this proposal is defined as a group of people living in one house that could comprise of one single or an extended family.

The three health centers are selected for the following reasons:

- Two health centers have been recently constructed and the third has been renovated. All three are already equipped with standard equipment, and the health staffs have been recently trained to deliver the minimum package of activities, therefore the quality of basic services is improved.

- These three health centers received approval from the ministry of health for the implementation of the cost recovery scheme and are now is in the process of piloting health financing reform under which the acceptability user fees will be tested out. Shaw & Ainsworth, (1995) recommended that user fees is a stimulus to health insurance. One can not jump into health insurance scheme without imposing user fees in the government facilities, otherwise there is no meaning to introduce insurance in a situation where health services could be obtain at zero or low cost. Arhin, (1995) also support this by adding that: when health services are free, some of the financial burden is diminished and this may limit the demand for prepayment or insurance.

- The German Technical Cooperation Organization (GTZ) agreed to provide support for three years, therefore, initial budget constraints can be alleviated. According to Lambo, (1996) health insurance can not be financed by the subscribers only, to be successful it requires a tax-based subsidy from the government or donor support. Ron, (1993) support this

by adding that health insurance developed in the low-income countries as a response to the need for additional funds, is not to substitute other financing sources.

3.7.3. Sample Size and Sampling Technique

3.7.3.1.Sample Size

According to Milton, (1992), the sample size for cross sectional study using Simple Random Sampling Technique can be calculated using the following formula:

$$n = Z^2_{1-\alpha/2}\, p(1-p)/d^2$$

Where

Z: z value for normal distribution, and Z =1.96 for 95% confidence interval

d: is absolute error

p: expect proportion of interesting event in the population

Since the proportion of people who have knowledge about health insurance in Cambodia can not be obtained because the country had no experience with insurance, a second formula for determining the sample size can be used based on the fact that the fraction p(1-p) can never exceed 1/4 regardless of the value of p:

$$n = Z^2/ 4d^2$$

Where n: sample size required

Z: normal value in which Z=1.96 for 95% confidence interval

d: Absolute error and in this case d = 0.05

Therefore $n = (1.96)^2 / 4 (0.05)^2$

n = 384 will be required for the study

3.7.3.2.Sampling Technique

For the household survey, systematic random sampling (SRS) technique will be applied to select households for interview by assuming that people living in the three areas are homogenous in terms of knowledge on health insurance. The respondents will be the head of household defined as aged 20 to 45 years, husband or wife whoever is in the position to make the decision about seeking health care.

The sampling frame, which is in this case a list of all households, can be obtained from the recent national census conducted by the National Institute of Statistic (NIS), Ministry of Planning, Cambodia. All households within sampling frame will be numbered consecutively, the sampling interval is calculated by dividing the total number of households by the sample size required. The first household to be included in the study will be randomly selecting a number between 1 and the sampling interval. The next households will be selected by systematically adding to the previous sampling interval.

3.8. Data Collection Techniques

The study will use a combination of three types of data collection techniques to obtain qualitative and quantitative data. The qualitative, data will be collected using Focus Group Discussion (FGDs) and observation whereas for the quantitative data, interview questionnaire for household survey are used.

3.8.1. Focus Group Discussion

Like any other qualitative method, Focus Group Discussion can be used to formulate questions for structured interview questionnaire as well as a means to develop and refine research hypothesis (Vong-Ek, 1991). Therefore, in order to get information to assist in the construction of household interview questionnaires four Focus Groups Discussions will be conducted prior to the household interviews.

Eight participants of an age between 20 to 45 year will be invited for each focus group session. Two groups of men and two groups of women will be conducted separately in a neutral atmosphere so that the participants can freely express their opinion without fear of intimidation.

Each sessions will be guided by two persons one will act as a moderator and another is a recorder, open question will be used to guide the discussion. The information obtained will be recorded using written note taking and tape recording. The information obtained which will be later used to revise the structured questionnaire for household interviews to modify to local understanding.

A small gift will be prepared and given to participants at the end of sessions to compensate their time and effort, the gift will not be expensive but useful as a souvenir so that it will not bias participants.

3.8.2. Observation

In complement to the interview questionnaire, interviewers will also be instructed to observe the household while interviewing. The observation activities include the following items 1), General characteristic of housing such as type of roof and wall 2). Commodities that each household own such as do they have radio, TV, motorbike, car etc. so that the information can be used to evaluate the living condition of the people and compared with the response of respondents.

3.8.3. Household interview questionnaire

For the household interview, a structured closed-end questionnaire will be used. Respondents are heads of household, husband or wife who are in the position to make decision in seeking care when a household member falls sick.

Questionnaires will be tested before the real data collection. The information gathered includes (1) Monthly household income including sources of income. (2) The information regarding health care expenditure and willingness to join prepayment scheme if existing. (3) Information regarding household members who have been sick during one month prior to interview and the amount of money spent for health care. The reason for limiting to one month is to avoid a recall bias, because for more than one month past, the respondent may forget. (4) Information regarding perception on co-management and co-financing committee and community participation (5) Lastly knowledge and preference about a voluntary health insurance scheme.

The questions will be first developed in English, when tested and modified to local understanding the questionnaire will be translated into Cambodian language for data collection. Translation will be made with justification adapted to local language and culture so that the respondent can answer questions properly and to avoid leading questions due to the interviewer trying to guide the respondents.

Twelve interviewers will be recruited and training will be provided. Interview guidelines, demonstration and role-play by interviewers will be used during the training session, to ensure that interviewers can properly apply the standardized questionnaire for data collection. Knowledge and experience for field data collection is a selection criteria to select interviewers.

3.9. Data Management

3.9.1. Focus Group Discussion

Information obtained from focus group discussion through note taking and tape recorder will be category into group keep to use for the constructing and revision of questionnaire for household interview.

3.9.2. Household interview questionnaire

3.9.2.1.Data entry

The information gathered will be coded and entered into the computer using EPI INFO program version 6.04b. Data will be entered twice by two persons (double entry) which will then require cross-check later to ensure the accuracy using validating in EPI INFO Program. Data cleaning will done when there are mistakes found when comparing with the original data sheet.

3.9.3. Data analysis

Analysis of data will be done by using the statistical software: Statistical Package for Social Science (SPSS). Percentage distribution of people who have knowledge about health insurance and who want to joint the scheme etc., will be display in table or graph using descriptive statistic such as percentage, mean and standard deviation.

The correlation between variables such as household income with educational background with the ability and willingness to pay will be operated using statistical test such as chi-square or correlation. Findings and recommendations will be publicly disseminated through a workshop to variety health professionals and policy makers for decision making.

3.10. Limitations

- The questionnaire was tested in a country of which the population has experience with health insurance. Therefore questions might be difficult to understand for people who have no experience with insurance.

- This proposal is a complementary to a feasibility study on a community financing scheme in Cambodia. The proposal is addressing the willingness of the community mainly while the readiness of the health care personnel will be explored in the larger feasibility study.

- It was difficulty to obtain a proper sampling frame since the proposal was written outside the country of origin and communication was difficult. An accurate sampling frame will be collected once I return to my country.

- It was difficult to collect reliable information from Cambodia, especially lack of documentation because considerable documents has been destroyed during the political upheaval of the country. Only a few documents have been published recently after the country is stable.

3.11. Budget estimation

The budget needed for conducting the household survey and focus group discussions includes: allowances for personal, materials/equipment and transportation etc. The total budget required for the study is estimated to be 5,484 USD. It was estimated based on the actual payment rate used in Cambodia, the detail breakdown of budget is as follow:

- **Preparation phase**

  Printing of questionnaire: 600 x 20 x 0.015 = 180 USD

  Stationnary and logistic: 80 USD

  Tape recorder: 1 x 60 = 120 USD

  Tape: 20 USD

  Gift: 50 USD

  Sub total 1: 450 USD

- **Pre Data collection (training of interviewers)**

  Coffee break: 8 person x 5 day x 2 = 80 USD

  Per Diem for trainees: 8 persons x 5 days x 5 = 200 USD

  Per Diem for trainer: 2 persons x 5 days x 15 = 150 USD

  Field Pre-testing: 8 persons x 2 days x 10 = 160 USD

  Sub total 2: 590 USD

- **Field data collection (Per Diem and accommodation allowance)**

  Supervisors: 2 person x 21 days x 20 = 840 USD

  Interviewers: 8 person x 21 days x 15 = 2 520 USD

  Local Guide: 2 persons x 21 days x 2 = 84 USD

  Sub total 3: 3 444 USD

- **Data processing**

  Data Entry: 2 persons x 10 days x 10 = 200 USD

  Data analysis and report writing: 300 USD

  Sub total 4: 500 USD

Total = Sub totall + Sub total 2 + Sub total 3 + Sub total 4

= 450 + 590 + 3 444 + 500

= 4,984 USD

Miscellaneous (10%) = 500 USD

- **Total budget required**

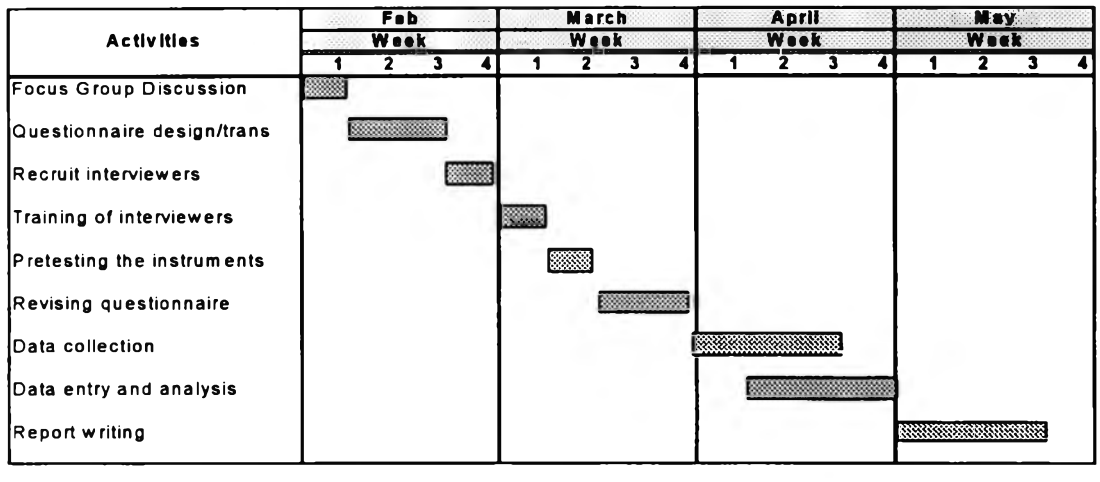
Grand Total = 4 834 + 500 USD

= 5,484 USD

3.12. Activity Plan and Time frame of the study

The study is planed to be conducted starting from February 2001 till May 2001 according to the schedule below:

Table 3-1. Gantt Chart: The Activities Plan and Time Schedule



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