CHAPTER II

Essay

Issue: Low Utilization of Health Center Services by the Poor Needy Population

2.1. Introduction

Many developing countries' health financing system are historically based on general taxation, the state or government is responsible to financially pay for government delivered health services where in most of the countries, health care is available free of charge for all citizen in government run health services (Ron, 1995; William, 1997).

Following the world economic crisis of the late 1970 and 1980's, government of many countries had to change the way of financing health care. Many developing countries have been unable to finance the increasing cost of health care. In response, some governments began to develop health financing reform aiming at improving the efficiency and quality of services (Collins, Quick, Musan, Kraushaar, & Hussein, 1996).

As a result health sector suffers from the problem of under-financing of health services and the quality of services in general have deteriorated. Particularly for Cambodia, lack of medical supply especially drug combined with low paid staff salaries, resulting in irregular working and informal charge for the officially free services has brought these health services in bad reputation. People begin to lose confidence in public health services and turn to use other services when they are in need. All in all, the utilization of government health services is drastically decreased. In turn the population health status is generally bad.

There have been many attempts to bring in more resources for improving the quality of government health services by introducing a cost recovery scheme through some form of cost sharing or risk sharing mechanism. Since the 1980s, policy makers and government officials in developing countries have relied on increasing cost recovery in health sector as a means to supplement the insufficient government budget allocated for health and to improve quality of health services (Willis & Lieighton, 1995).

The purpose of this essay is mainly to look at the problem of low utilization of health services which sporadically occurs in developing countries because of poor quality of health services or that may arise after the implementation of cost recovery scheme. This essay also tries to identify the contributing factors to the problem and to propose a possible strategy to address the problem and improve the situation.

2.2. Why target the poor?

Investment in poverty reduction has become a major challenge among varieties of institutions including banks, the donor community and government agencies. Overcoming poverty is a goal for economic development. However the issue is not easy to address. Reducing poverty requires involvement of many sectors such as health, education, agriculture and others which one can do separately or in coordination.

Impact of health to reduce poverty is enormous. Health can directly or indirectly have an impact on poverty reduction; some are short term and others have a long-term impact. The direct impact is through increasing income. World Bank, (1993) said that by improving access to health services by the poor will probably increase their income by reducing illness, thus enhancing their ability to work.

The indirect impact that one should not overlook is the effect of health on education that will subsequently provide people with good employment and, therefore, better pay. The World Development Report: "Investing in Health" emphasized that investment in schooling particularly for girls will result in better health of the whole family because knowledgeable women are more likely to able to prepare nutritious foods for the family.

Investment to reduce poverty can contribute to improve health. WHO, (1999) in trying to identify sources to make mortality decline confirmed that income improvement could lead to reduced mortality. Increase in income, indeed, has correlated with mortality decline, especially the relationship between infant mortality rate (IMR) and Gross Domestic Product (GDP).

Therefore, it is necessary that the poor need to be taken care of by the government to ensure that they have no constraint to access health care. World Bank, (1993) further stressed that when introducing user fees, it is important to make sure that it will not impose a financial barrier to the poor; in other words, the poor should not be excluded from services.

However, people may have different perspectives about "the poor". The way poverty is defined could vary from country to country although there was an endeavor to standardize it for international comparison purpose. The Royal Government of Cambodia has not set an official poverty line yet. The term "poor" used in this essay is based on the document entitled " A Poverty Profile of Cambodia" in which the poverty line is defined for the Cambodian context as those who earn 1,578 Riels per person per day for person living in Phnom Penh, 1,264 Riels for people living in others urban and 1,117 Riels for people living in rural areas (Prescott & Pradhan, 1997).

Although the aim of health financing reform is to mobilize resources for the health sector, the mechanism to protect the poor to assure that they have access to health care needs to be established. Otherwise the scheme will diminish equity and the reform objectives will not be met.

2.2.1. Health as a basic human right

There is increased recognition that a human rights approach can contribute to the enhancement and protection of people's health, discrimination and failure to protect human right directly affect the health status of the population (Leary, 1997).

Human rights became a concern related to health issues and health has been considered as a basic human right. In the document outlining the Global Strategy of Health for All by the year 2000 states: "Health is a fundamental human right and a worldwide social goal...people have the right and the duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1981).

This means that all people regardless of economical background, social status, race or religion should have equal right in access to health care. Therefore the health care system should be organized in such a way that the poor are not discriminated and have access to health care when they need without barrier.

2.2.2. Health investment and poverty reduction

In the World Development Report: "Investing in health" the World Bank, (1993) said that, the goal of poverty reduction, although different is as equally important as the goal of health investment. The investment in health, especially providing basic health services such as family planning, nutrition and primary health care to the poor, could contribute to reduce poverty.

The income of the poor depends on physical labor. Once they suffer from ill health, they face daily production loss and this subsequently results in a income decline. When a family member gets ill, the rest of the family need to work harder to support the sick, or may even reduce consumption because of reserving food for the ill. Increased workload might make other members vulnerable for sickness and the whole family will suffer.

It is disease that makes people poor because of production loss and the cost of treatment. On the other hand, it is poverty that makes people ill more often. Therefore, it is important that health status of the people especially the poor should be promoted so that it could contribute to poverty reduction by the enhancement of working capability.

World Bank, (1993) challenges the position that the provision of cost effective health service or any investment to improve health status of the poor is an effective and socially acceptable approach to poverty reduction. Improving the access to health services of the poor is important both for increasing income of the poor, because illness reduces people's ability to work, or for raising living standards even when poverty remains.

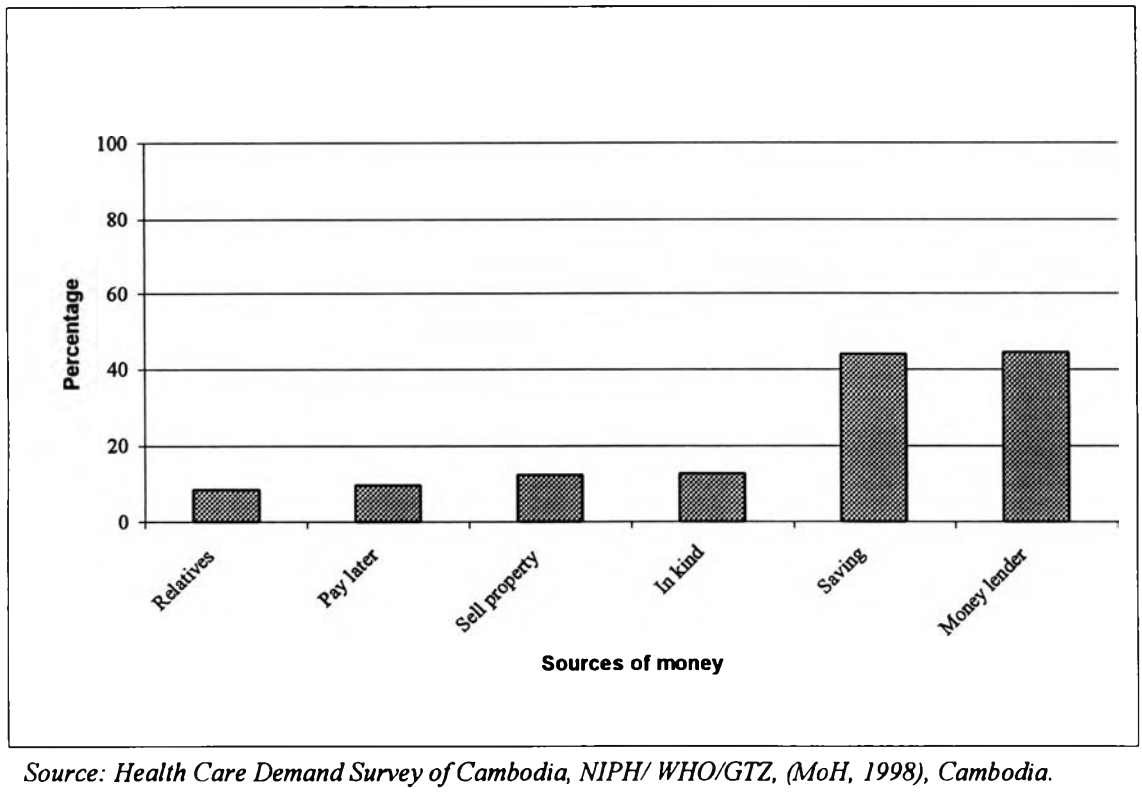
Poverty is one of the factors hampering the endeavor to promote population health. WHO, (1996) identified obstacles to achieving better health, and accused that because the poverty is on the increase about one-fifth of the world population lives in extreme poverty, the unfavorable living condition which exposes to disease, make it difficult to control diseases especially infectious diseases.

2.2.3. Poor and their health status

Poor are more prone to get disease than their affluent group especially the income related sickness such as malnutrition and infectious disease such as tuberculosis, etc. Likewise, they need health services more often. In a situation where the poor have been neglected, in order to get such services they must to some extent pay for, they need to borrow from money lenders and pay back later at a high interest rate.

The Cambodian Health Care Demand survey, (1998) shows that the sources of money spend for health care, about 44.6% come from money lenders while the other source is through selling their property (see figure 2-1). Thus they end up paying back the money during their lifetime from generation to generation and getting into debt forever and there is no way out of this circle. That could be one reason why the poor become poorer, the rich become richer. Improving income of the poor can indirectly prevent them from getting diseases and will further foster development.

Figure 2-1. Percentage of respondents given when household heads named one or more sources of funds used if a family member became very sick



Source: Health Care Demand Survey of Cambodia, NIPH/ WHO/GTZ, (MoH, 1998), Cambodia.

2.2.4. Resources distribution inequity

Historically, many countries had experienced intentionally or unintentionally misallocated public resources and the poor are being seen as the socially disadvantaged group who gain very little benefit out of public expenditure. Typically the health system of the past is a clear example of how money was spend and clearly shows evidence about public money spent on mostly tertiary care which was to entertain the better-off group living in cities.

World Bank, (1993) said that public money was being used to fund the expensive curative health services to serve the urban residents, leaving the majority of poor people in rural areas lacking access to health care.

Although the effort is to assist the poor and public expenditure aims to alleviate poverty by targeting the poor, the non-poor are more privileged in getting benefit, and in contrast the real poor are a social disadvantaged group. The two critical questions for reviewing the public expenditure on health are: (1) how to reallocate public spending to improve health outcome, and (2) how to ensure that the poor will gain benefit.

An example of inequity in the distribution of resources among the poor and rich could be observed everywhere. In Indonesia in 1990, only 12% of households, who would be expected to need more health services, because of the poverty role in illness. The wealthiest 20% consumed 29% of the government subsidy in the health sector, (World Bank, 1993) despite having better health status and more private resources.

2.2.5. Constraint in accessing health services

According Braveman, (1995), there may be concern that health sector reform could be leading to wider gaps in utilization of quality health services between very poor people and others, or that basic living conditions are deteriorating for poor relative to general economic changes with likely adverse health effects.

The health financing reform strategy to introduce cost recovery schemes, particularly user fees, may restrict access to health services especially for the poor. Although there is a policy to protect the poor to ensure that they have access to health services without payment by developing exemption criteria, the system works very little in the real world.

Thomas, Killingsworth & Acharya, (1998) said that even if the poor could be accurately identified, the application of exemption is difficult because of the absence of an efficient administrative system. Thomas et al., (1998), further emphasis that even if an administrative system does exist, still local political factors could distort the application and the non-poor often take advantage because of their political power. Therefore the real poor, which comprise the majority of the population, often have constraints in accessing health services especially financial constraint and might identify themselves as poor and denied to seek care when sick.

2.3. Problem statement

Cambodia's health infrastructure has been totally destroyed by the destructive policy of the Khmer Rouge[1] in the 1970's, followed by almost 20 years of civil war and international isolation. As a result, the health system and infrastructure at all levels were dismantled.

Many commune clinics and hospitals exist in principle, but in reality are non-existent or virtually not functioning. Most of the district hospitals function as large commune dispensaries offering out patient consultation, maternal and child health, vaccination and limited inpatient care for tuberculosis patients. Lack of equipment, materials, unmotivated staff because of very low salary and most of the time not present, are being viewed as problems that the government can not deny.

Sometimes there is no building at all or there is a facility which is in very bad condition. The results of the Asian Development Bank (ADB), Health Facility Survey, in 1995 show that out of 100 commune clinics surveyed, only 55% currently have buildings, of which only 60% are in use for health services; therefore under utilization of health facilities and services are clearly no doubt. Where services are available, the quality is poor and utilization of health services is low.

Realizing this problem, in 1995 the Ministry of Health of the Kingdom of Cambodia has undertaken a major health sector reform (HSR) with the expectation that this new system will be able to provide health care, especially addressing basic health needs of rural population. Within the reform, a lot of resources have been spend for capital investment such as reconstruction and renovation of health facilities and providing them with standard equipment to improve the quality of services to meet the patients' satisfaction.

Still the situation did not much improve, people still prefer other services rather than government facilities and only come at the later stage of disease, when other alternatives do not work. This statement can be supported by the findings of national health survey (NHS) of Cambodia showing that the percentage of people who are slightly ill seeking care with trained health workers at either public or private outlet is only 10.3% and 29.5% respectively. About 57.7% of them prefer to buy drugs or decide not to seek any treatment at all (see table 2-1).

---

[1] The genocidal regime that reign Cambodia from 1975 to 1979, during that period the country's

The figure of people using trained health workers as a means to restore their health is increased to 35% and 47.6% for public and private services respectively when disease become serious (see table 2-1). It is not appropriate that people seek care at hospitals at the later stage of sickness since the disease might have develop into a critical condition which difficult to treat and therefore may result in high mortality rate.

Table 2-1. Percentage distribution of household member who were sick by type of treatment according to severity of illness

Background Characteristic	No treatment	Trad. Healer	Buy Drug	Trained health worker		Total percentage	Total Number
				Public	Private		
Severity of illness							
Slight	**24.4**	2.7	**33.1**	**10.3**	**29.5**	100.0	1169
Moderate	11.1	4.9	**22.8**	20.5	40.6	100.0	2495
Serious	6.4	4.0	7.0	**35.0**	**47.6**	100.0	667
Total	14.0	4.2	23.2	**20.0**	**38.7**	100.0	4330

Source: adapted from national health survey, NIPH/GTZ/ADB, (MoH, 1999), Cambodia.

Although they come to seek care at the hospital, the majority of them preferred private hospital rather than a government hospital. The national health survey (NHS) of Cambodia further found that, overall, the government health sector is currently utilized in only one-fifth (20%) of all illness and injuries. In contrast, the private health services are being used by more than one third (38.7%) for all types of illness.

---

resource's were destroyed including human and infrastructure

The figure is increased up to one-third (35%) and nearly half (47.6%) for public and private health services respectively when the illness is considered to be more serious (see table 2-1).

When people fall sick, they will find other alternatives suitable to their means in order to restore their health; some prefer a traditional healer whereas others buy drugs from street drug sellers. For particular groups where money is not being seen as a constraint they may go to a hospital in the city or go to a private hospital which are considered to be the places where appropriate treatment can be found.

Yet, the utilization of health services in Cambodia as a means to restore the population's health status after suffering from illness is still very low. The percentage of people reporting illness and seeking care at any level of public health facilities is only 31.7% (CSES, 1995), this means that the remaining 70% of sick persons are seeking health care from unidentified sources or that they do not have access to health care at all when sick.

This result is comparatively similar to the findings of the health care demand survey (NIPH/GTZ, 1998) in which about 78% of household prefer home treatment as the first action taken when family members is sick (see table 2-2).

Table 2-2. Reported first intended and the actual action taken by household when family member sick

Health Providers	Intended first action if household member had fever		Actual first action for household members who were recently ill
	If a child had a fever	If an adult had a fever	
Buy drug	38%	35%	57%
Hospital (district or province)	16%	17%	14%
Commune Clinic	16%	13%	7%
Private provider	15%	14%	
Private provider/ home	14%	20%	8%
Traditional healer	1%	1%	4%
Percentage of treatment at home	**53%**	**56%**	**78%**

Source: Health Care Demand Survey of Cambodia, NIPH/ WHO/GTZ, (MoH, 1998), Cambodia.

Table 2-2 shows that a high percentage of households prefer home treatment[2], the actual action taken is 78% even higher than the intended action. It could be noted here that among those sources of treatment, buying medicines without prescription at unregulated pharmacies account up to 57% which might result in having serious consequences on health. Using medicine from an unregulated pharmacy without prescription can be harmful to health especially for young children.

[2] Note: Treatment at home included: buy medicine, call private provider at home, and traditional healer.

The reason why people prefer to buy drugs when they are sick might be because it is the cheaper as shown in table 2-3. People have to pay only 12,100 Riels[3] or about 5 US dollars if they buy drugs which is more than three time cheaper compared to public hospital which will cost them up to 45,800 Riels or about 18 US dollars.

Table 2-3: Health care cost regarding difference type of assistance

Type of assistance	% First action	Estimated average cost
Buy medicine	57.3%	12 100 Riels ($ 4.65)
Public hospital	13.8%	45 800 Riels ($ 17.60)
Private practitioner	8.4%	42 300 Riels ($ 16.27)
Commune clinic	7.1%	13 800 Riels ($ 5.31)
Do nothing	6.9%	
Kru Khmer (Traditional Healer)	4.5%	21 400 Riels ($ 8.23)
Home remedy	2.1%	10 400 Riels ($ 4.00)
Total	100.0%	19 000 Riels ($ 7.30)

Source: Health Care Demand Survey of Cambodia, NIPH/GTZ/WHO, (MOH, 1998), Cambodia.

Of the patients seeking care at public facility, most of them did so at the provincial hospital or hospital in a big city, leaving a small percentage of them using a health center. That is not surprising since almost all of the facilities at the peripheral level have not yet been fully functioning.

[3] Riel is the Cambodian currency and the exchange rate at the time of survey was 1 US$= 2600 Riel

Further, the national health survey, (NHS, 1999) shows that about 14% of all illness did not receive any treatment at all when sick (see table 2-4). The discrepancy in terms of seeking health care could be clearly seen from the table that high percentage of poor people (21%) are more likely to go without treatment compared to 8% in the better off group.

It should be noted here that, the percentage of poor people seek treatment with trained health worker is only about 43.9% while the figure for the better off account up to 75.2% (Table 2-4). One reason could be argued here is that, it might be due to financial constraints, since the poor have less ability to pay health care cost as they have limited money; therefore they do not seek health care.

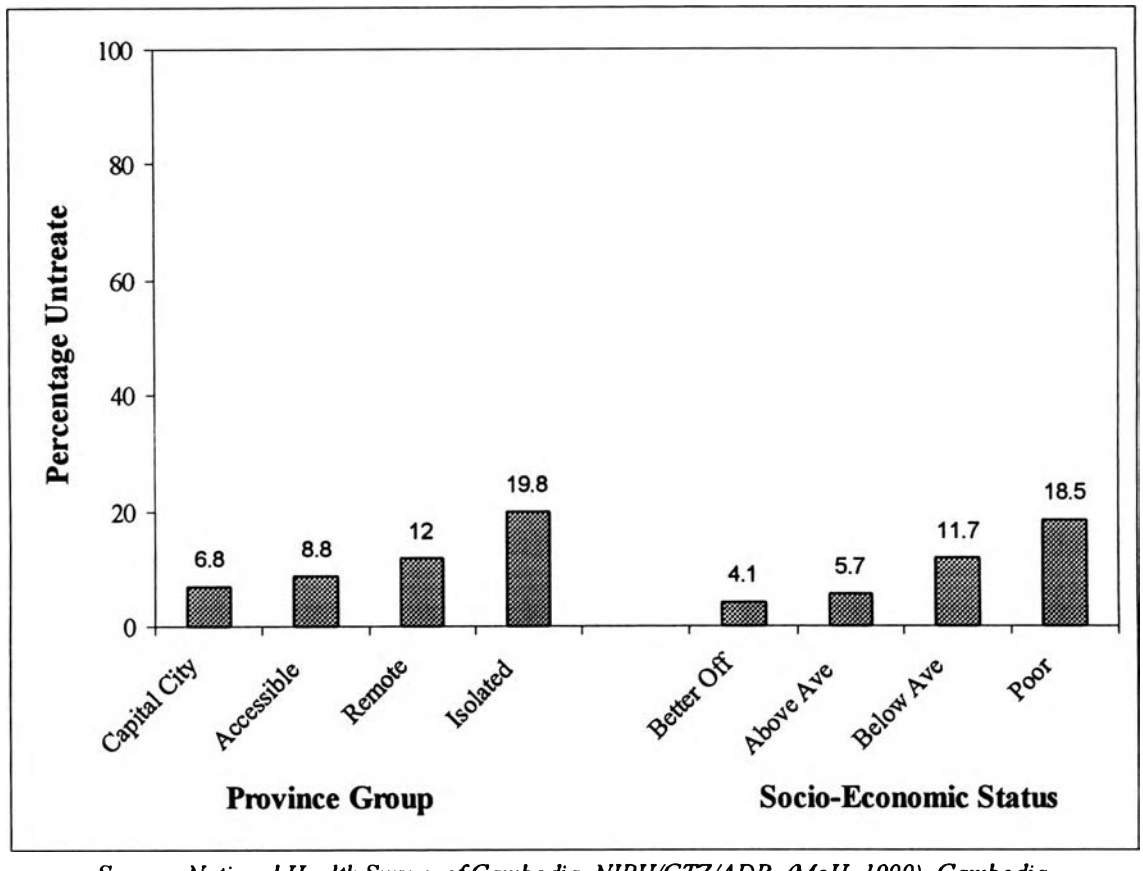
Table 2-4. Percentage Distribution of Household Members who were Sick By Types of Treatment According to Socio-economic and Demographic Characteristic

Background Characteristic	No treatment	Home remedy	Trained HW	Buy drug	Total percentage	Total Number
Province Group						
Isolated	21.0	6.7	59.8	12.5	100.0	348
Remote	15.7	3.8	50.9	29.7	100.0	481
Accessible	13.3	4.1	58.5	24.1	100.0	3254
Capital City	9.3	2.6	74.5	13.6	100.0	247
Socioeconomic Status						
Poor	**21.8**	7.4	**43.9**	27.0	100.0	811
Below average	16.2	4.2	53.3	26.3	100.0	1568
Above average	9.4	3.6	65.4	21.5	100.0	1211
Better off	**8.0**	1.8	**75.2**	15.0	100.0	740
Total	**14.0**	4.2	58.7	23.2	100.0	4330

Source: adapted from National Health Survey of Cambodia, NIPH/GTZ/ABD, (MoH, 1999), Cambodia.

The people who have no treatment become even worse when disease became more serious. Figure 2-2 shows that for people who live in isolated rural provinces, the percentage of no treatment is about 19.8%, almost three times as high in comparison with people living in the capital city which account only 6.8%. When discussing socioeconomic status, the figure for the poorest segment of population is 18.5%, that is more than four times more likely to go without any treatment compared to better off group which figure is only 4.1%.

Figure 2-2. Percentage of Moderate/Serious Illnesses or Injuries Which Received no Treatment, by Socio-Economic Status and Province Group



Source: National Health Survey of Cambodia, NIPH/GTZ/ADB, (MoH, 1999), Cambodia.

2.4. Main Causes of the problem

According to Bitran (1988), factors influencing the utilization of health services are namely quality of services, travel distance to the facility, consumer decision, environmental variables and more importantly the price especially for countries which have recently introduced user fees in public facility which previously provide health care free of charge.

In the case of Cambodia, although formerly health care was officially available free of charge at any public health service, the chronic and widespread informal charge, which is illegally applied in most of the facilities brings a bad reputation to the government run health facilities. The staff receive very low salary of (about ten to twenty US dollars a month), and in order to supplement their living costs they have little choice about doing this, even though they realize that it is illegal.

Although there is no systematically collected evidence about the corruption practices in the public health system, information obtained from informal talks with patients proved that, the amount of money paid by patients varies for the same disease treated depending on the bargaining process and on the ability of patients to pay.

Sometimes for those who can afford, the charge can be unpredictably higher than if they go to a private clinic. This could be the reason why, when people need health care, they might decide to go to private sector instead of going to the government health services. People are not certain about how much they will be asked to pay for some kinds of services before they go to hospital, therefore they may decide not to go because they are scared that they have not enough money for services.

Nearly half of the Cambodian population are very poor. Poverty assessment in Cambodia shows that about 43% of population are living below the poverty line (Prescott & Pradhan, 1997). So far there is not yet any clear mechanism established to protect the poor, so that they can have access to health care when they need care, regardless of their ability to pay. As a result, they might find it impossible to pay and

decide not to seek care at the government services. All these factors will result in, patients deciding not to seek care by government delivered health services and contribute to the low utilization of public health services.

Quality of care is another issue affected by inappropriate infrastructure and equipment, by inadequate drug supply or drugs taken out of the facilities to sell in the private market, and by unmotivated staff because of low incentives. Therefore, they are not working regularly and sometime impolite to the patients. All of these contribute to the poor quality of health services in Cambodia.

According to the Health Care Demand Survey of Cambodia (1998), when questioned about quality of health service, about 53.4% of respondents mentioned that commune infirmaries did not have enough drugs and another 20% stated that they have to wait long time to get services. Although they seek care at the hospital or commune clinic, they will finally be requested to buy drugs outside the hospital. This may be one reason why a high percentage of population go to buy drugs at drug stores first when they get sick and come to hospital as a last alternative. This may contribute to the high mortality rate in the country because disease is more severe and difficult to treat at the later stage.

There is no study available on the impact of a user fees policy on the utilization of health service by the patients in Cambodia because this policy was only introduced in 1995 and is still in the process of piloting in a number of public health facilities. But experience from other countries with similar economic background,

especially low- income countries in the Sub-Saharan Africa in which user charges were started several years ago, suggest that it can impose a financial barrier to the user especially the poor. Therefore, utilization of health services decrease because the poor might be denied access due to economical factors.

Chisadza, Maponga & Nazerali, (1995) admitted that there is evidence from both developed and developing countries that the introduction of fees in public hospitals has resulted in a significant reduction in the utilization of health services and has deterred those who in greatest need health care but unable to pay.

2.5. Conceptual Framework: Factors Influencing the Utilization of Health Services

Figure 2-3, describes the factors leading to low utilization of health services. There are mainly three factors contributing to the low utilization of public health services namely (1) quality of health services, (2) accessibility and (3) lack of participation from the community.

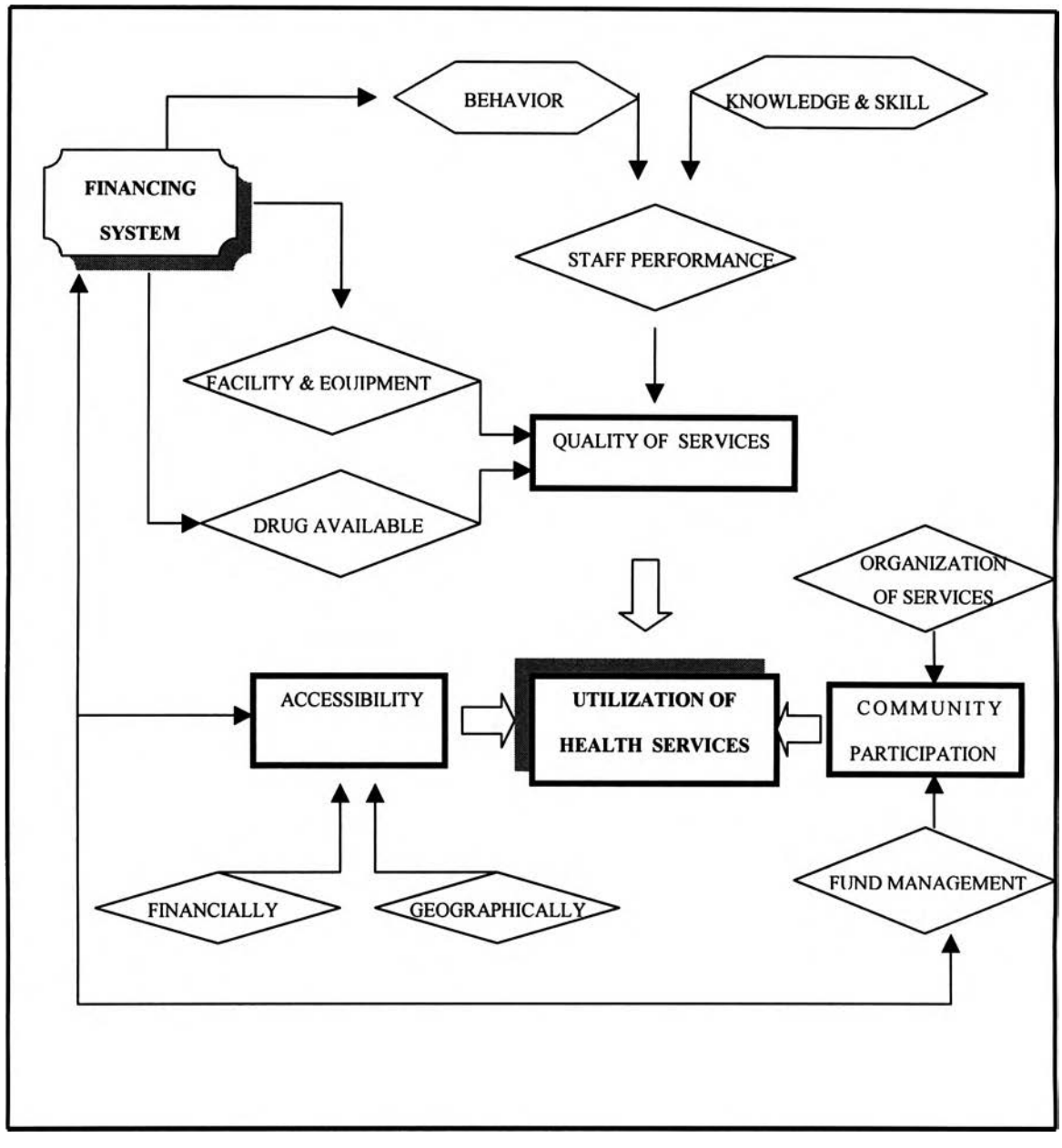
The first question people have in mind and often ask themselves before taking the decision about where to seek care is whether the quality of services is good they will visit the place that they perceive as having good quality of care. This problem usually happen that many patient bypass the lower health system especially health center and prefer the higher level such as a provincial hospital because of they perceive that it offers better quality. Although the word quality may have a broad

meaning, it is used in general to refer to health services that have good facility, where the health staff are friendly and perform their duty well and more importantly where drugs are available.

Accessibility is another factor that could influence the utilization of health services. Health service is accessible to the users in term of geographical location if it is located in the community near to the population and located on the main road so that it facilitates travelling. Others aspects affecting accessibility are delivering of essential services at a low or affordable cost for users.

Community participation is also an important factor which contributes to the utilization of health services. There is increasing recognition that people will be willing to financially contribute and make use of health services if they can be involved in the management of health services and the services are organized according to their needs.

Figure 2-3. Factors Contributing to Utilization of Public Health Services



2.6. Consequences of the Problems

2.6.1. High Mortality Rate

The health status of the Cambodian population is among the lowest compared to other countries in the region. The problem is mainly the result of the political turmoil and two decades of civil war in the country but might also in part be due to the poor quality of health services, in other words people are not using health services.

Reliable information about morbidity and mortality is difficult to obtain. The result of recent National Health Survey of Cambodia (NIPH/GTZ/ADB, 1999) shows that the Infant Mortality Rate is 89 per 1,000 live births and the Under Five Mortality Rate is about 115 per 1,000 live births. These figures are relatively high and far above the goal of Health for All by the year 2000 by WHO which aims to reduce IMR and Under five mortality rate to less than 50 and 70 per 1,000 live birth respectively. Life Expectancy at birth for Cambodia in 1995 is about 53 years, almost ten years lower than Health for All which aims to increase to more than 70 years (WHO, 1996).

Maternal Mortality Ratio is estimated to be 473 per 100,000 live births (NMCHC, 1995) as a result of pregnancy related complications, indicating the poor quality of health services. People not using health services and use it only as the final alternative when the other means of health care can not help. Seeking care at health services at the later stage of disease could also be one reason of a high mortality rate in the country.

2.6.2. Rise in Morbidity

Rise of disease morbidity, especially from preventable infectious diseases such as tuberculosis and malaria, is probably the result of people not using health services. When people get a disease, and do not seek treatment, the impact is that not only will he/she not get cured but they can transmit the disease to others and the society as a whole will suffer.

Malaria and tuberculosis are the major cause of morbidity and mortality for the adult Cambodian population particularly in the reproductive age group, this might be one reason hampering economic development of the country. The malaria incidence is 7.05 per 1,000 population whereas the prevalence of tuberculosis is estimated to be 4.5 per thousand populations.

2.6.3. High Birth Rate

A high birth rate is another consequence of people not using health center services as family planning. Cambodia has an annual population growth rate of 2.4% which is relatively high if compared with its neighbor Thailand which has only 1.5% annual population growth rate (WHO, 1999).

It is important to reduce the birth rate because that will promote the health status of mother and children. Having frequent pregnancies, might result in nutritional deficiency of women due to insufficient food intake, which might then have serious consequences on the baby such as low birth weight, mental retardation and so on. A high birth rate could also be one of the reasons of a high infant mortality rate and maternal mortality.

2.6.4. Investment Loss

With an endeavor to provide health care with good quality equally to population, Cambodia has been committed to restructure its health system according to number of population covered and geographical accessibility, thus it was anticipating that this will increase the utilization. The Health Coverage Plan of Cambodia aims to have a total of 67 referral hospitals with a network of 935 health centers throughout the country. The majority of them will be newly constructed and will be provided with better equipment using public resources.

This is a large capital investment next to the budget for running cost and staff salary that the government need to spend for all facilities. Therefore the government should making use of this effort by encouraging people to use health services, therefore better value for money will be obtained. Otherwise there is no need to spend scare resources for nice facilities because no patients come and use services.

2.7. Possible strategies to improve the situation

Experience from elsewhere suggests that, to improve the problem situation, in other words increase the utilization of public health services, quality of services must be improved first in order to regain the confidence of people in health services. Once the quality of services is being perceived as good by the people, they will come and use the services they need then and, therefore, utilization will increase. But it is not easy to improve the quality of services within the present condition of insufficient resources unless additional resources can be made available.

To generate additional resources for the health sector, the government has little choice but to charging the service user. For this reason, governments in many countries, especially developing countries, have adopted and implemented a new health financing strategy in which user fees or health insurance are among the popular schemes. Careful consideration should be made prior to the implementation of cost recovery, especially the mechanism to protect the poor.

One should remember that the design of new health financing system should take the poor into consideration, the poor must be protected so that they have access to health services without barriers when they need. Otherwise they will decide not to seek care and utilization of services will not improve. Weaver, (1995) said that, user fees could discourage people from seeking care, higher price affect utilization in three ways: (1), patients will avoid seeking care at public hospitals; (2), patients will delay

seeking care and make fewer visits; and (3), patients will seek care from other alternatives including private facilities.

2.7.1. User Fees

In 1987, the World Bank recommended increased cost recovery as part of an agenda for financing publicly provided health services in developing countries (World Bank, 1987). Introducing user fees was seen as a way to improve the efficiency and equity of the health system. Quality of health services has, in general, deteriorated due to limited capacity of the government to finance and deliver health services to all citizens.

The reason why user fees needed to be introduced in the government operated health facility, which used to provide health care free of charge to the population, is simple. There is a rising health care cost due to technological development and high-income group tends to consume more sophisticated services at an expensive price. Therefore, it is reasonable to charge those who are more able to pay and use the revenue collected to subsidize the poor who can not afford to pay (Shaw, 1996).

Studies show that private, out of pocket, payment represents a high percentage among the health care finance sources in many countries. Strategies to mobilize these private resources need to be established because it is a means for increasing revenue to finance the current ill public health sector.

2.7.1.1. Advantage of user fees

The two benefits that promote the implementation of user fees in the health system are efficiency and equity impact (Shaw, 1996). User fees can promote efficiency by strengthening and making use of the referral system and curb the unnecessary use of health services. If health care is available free of charge or at no different price between different levels of the health system, it is normal that people tend to use secondary or tertiary health services that are sometimes not necessary.

It is expensive to provide simple care at the above two mentioned levels. Health care can be obtained with a very high cost efficiency at the lower level such as health posts or health centers and refer to higher level only those complicated cases which can not be handled by health centers. Price differences for different levels of care could warn patients and, therefore, encourage the use of the lower system and foster efficiency (Shaw, 1996).

Charging the wealthier group who are more able to pay for health service they use through user fees can improve equity by increasing revenue to subsidize those who are least able to afford, thus as a means to help the poor. Although the better off might deny payment and may prefer to use private health services, still increased public resources will be available to finance government health facility, to assist the poor and of course quality will be improve if there is additional resource (Shaw, 1996).

2.7.1.2. Disadvantage of user fees

Experience suggest that some proportion of the population find it impossible to pay for user fees even though the prices are low, and might be denied access when they need care. Therefore exemptions have to be made to assist them in access to health care. Fees should be set at an affordable price and not increased often so that the middle group could afford to pay. Otherwise it will hamper accessibility and result in low utilization.

According to Ron, (1993) user fees can sometimes reduce accessibility to health services by imposing financial barriers especially the poor to seeking health care at the time of need, and therefore lower the utilization of health services. An attempt to recover cost by charging patients for services has not always been adequate successful.

Although it is beneficial to implement user charge so that more resources become available to finance the health system, the decision needs to be made with careful consideration to ensure that negative consequences could be minimized.

2.7.2. Health Insurance

Health insurance is one of the health financing systems aimed at protecting individuals against catastrophic illness. Without access to such a system people might be unable to obtain treatment or must incur debt to pay for treatment. People might

find it difficult to pay health care cost at the time of sickness, especially farmers who face seasonal fluctuation of income, and can not allocate fund to spend for care due to low income, as Normand, (1999) said that:

> "Most people in most countries can afford to pay for the health care they consume over a lifetime, but will not have set aside the funds unless they know they will be needed at a particular time. There is also a problem that people are able to finance care at times when they do not need it and cannot when they do".

Insurance offers a way out of this dilemma by providing people the opportunity to pay a premium in advance, and in return entitles them to receive free or at reduced cost of health care when they are ill. For some groups of the population, especially the farmer, cash income is not available for sometime, therefore the registration period should be adjusted to a particular season like after harvesting time.

Another benefit of health insurance is, like user fees, insurance can also assist in generating additional resources to the health sector. The funds can be used for other purposes such as preventive and primary services that benefit the poor (Griffin & Shaw, 1996).

Therefore insurance is beneficial in terms of contributing to generate additional resources to finance the health sector on the one hand and on the other to assist the population in terms of access to health care at the time of need. Arhin, (1995), argued by saying that the rationale for encouraging insurance financing is that it will raise additional revenue to fund the cost of health care provision and will

diminish financial barriers to obtaining health care at the time of illness, therefore increase accessibility.

The Word Bank, (1993) also mentioned that the investments to improve the health status of the poor and the provision of insurance against catastrophic health care costs are important elements for poverty reduction strategy.

However, health insurance is not problem-free, it can also create many potential drawbacks that could weaken the system. The insurance planner should realize this. Adverse selection and moral hazard are both major potential causes of market failure and have received considerable attention (Griffin & Shaw, 1996).

Adverse selection refers to the possibility to enroll sick persons in the scheme while the healthier do not join, especially for voluntary health insurance. This is the main cause that health insurance may failure. However, this problem can still justified especially if the scheme is designed appropriately, prior to implementation, by putting the condition that if a member of the family does join the scheme, the rest of the household must join as well, in other words take the entire family as a unit of coverage.

Lambo, (1995) said that by making the entire household the unit of coverage, means that households pay the premium irrespective of their size can minimize the adverse selection, since the entire family member tend to spread the risk well, compared to single individuals.

Another consequence is moral hazard which means that once people are insured they may take advantage of their membership to use health services more frequently than if they are not a member. This problem could be adjusted by making co-payment or a deductible system at the time of use. Also it can be minimized by encouraging those who have not used the card to renew their membership card without payment (Griffin & Shaw, 1995).

2.7.3. Community Financing

Community financing, is a kind of health financing strategy in which a community makes financial contribution and through its representative could fully or partially control the pool of resources collected. This pool consist of prepayment and used to fund all or part of the health care cost of community members. This definition implies that the communities participate in the design and the implementation of a scheme (Arhin, 1995).

Three terms have been used interchangeably namely community financing, community health fund and community insurance by different authors and health professionals of different countries (Shirima, 1996; Arhin, 1995; WHO, 1993). These three words might have a slight difference in meaning, but the principle is to show the involvement of the community in the management and organization of health services.

It is important to involve the community in the design of the scheme for successful implementation. Arhin, (1995) further said that community participation in the design of the scheme is the main mechanism for achieving financial compatibility and helps to ensure that the benefit packages offered by the scheme are socially and culturally acceptable to the community.

The scheme is appropriate for a rural population who work in the informal self-employment sector, engage in small scale farming or agricultural production, where cash income is relatively low and has seasonal variation. Arhin, (1995) estimated that the period in which households suffer from cash insufficiency are often as much as 50% of the year.

Since they have no income on a regular basis, they might find it difficult either to pay for health care at the point of use or impossible to pay a monthly or quarterly health insurance premium (Lambo, 1996).

Rooted from the Bamako initiative type of community financing in Africa, many schemes were originally based on fee-for-service, only a few schemes involve prepayment. Later schemes evolved to include prepayment as the rural health insurance for rural community. Ron, (1993) said that "Community financing scheme have several areas in common with the development of health insurance at national level or for specific population groups in a compulsory or voluntary framework."(p. 5)

The development of community financing prepayment schemes could be established in a situation where user fees are already in place so that those who not insured should pay out of pocket money to get health services, the premium for community financing schemes should be low as compare to user fees.

Cambodia's health care infrastructure suffered heavily from dismantling, use for others purposes, and in some areas simply not existing. Availability of adequate and appropriate health facilities is a pre-requisite when considering community financing. These capital investments for construction, renovation and equipment need to be realized before implementing community financing. Community financing will only generate moderate additional resources to meet running costs.

2.8. Conclusion

As explored above, government delivered health services of many countries, particularly of developing countries is losing their popularity and the utilization of health services is in general low. The factors that are believed to be the reason for low utilization include: Poor quality of services due to lack of budget especially for running cost; majority of people is very poor and could not or denied access to care.

Realizing this problem, governments are trying hard to improve the situation so that the population health status could be improved. Health sector reform as well as health financing reform strategy has been adopted and implemented by governments in many countries around the globe. The overall goal of reform is to generate additional resources available to health sector on the one hand and to improve access to health care by the poor on the other.

From the review of different types of health care financing strategies above, each have specific advantage, disadvantages and consequences for the health system, no one system is perfect. Therefore the policy to implement either user fees or insurance need to be considered thoroughly and implemented gradually.

Although user fees might deter people in terms of access to health services, insurance might also create drawback that could weaken the system or might even promote the rise of health care spending, especially if moral hazard and adverse selection have not been minimized or removed.

Experience suggests that a health financing strategy should be implemented in combination so that it could complement other schemes to mobilize additional resources for the health sector. Prepayment or insurance alone can not stand on its own to generate enough additional fund. A combination of schemes, providing consumers of health services with alternative choices among difference forms of payment is necessary.

Ron, (1993) in his document entitled "Health Insurance in Least Developed Countries" stated that: If health insurance to be developed in the low income countries, it is likely to begin as a response to the need for additional fund and not to immediately substitute for other financing sources.

The health care system is suffering from chronic shortage of resources. Especially lack of budget for running cost, bring the quality of government health services down. The way out of this problem is to generate additional resources to finance the health sector, and use these resources for quality improvements including the availability of drugs and improvement of staff performance.

Community financing as explored above is one method combining a health financing strategy with community participation and is considered to be an effective way in generating additional resources to finance health services. By involving the community in organizing and managing health services, especially in setting affordable and acceptable prices for the community would probably increase participation and subsequently promote utilization of health services.

Therefore it is beneficial to develop a community financing strategy to assist in generating additional resources to finance the health sector and at the same time develop community participation mechanism. This strategy will be proposed for the proposal in the next chapter of this thesis.

References

Arhin, D., (1995). Rural health insurance: A viable alternative to user-fees? London School of Hygiene and Tropical Medicine, Publication No. 19, ISSN: 0962-6115.

Bitran, R., (1988). Health care demand studies in developing countries: A critical review and agenda for research. Unpublished paper, Resource for Child Health (REACH) Project, USAID Contract No. DPE-5927-C-00-5068-00.

Braveman P., (1995). Monitoring equity in health: A policy-oriented approach in low- and middle-income countries. Geneva: WHO.

Chisadza, E., Maponga, C. & Nazerali, H., (1995). User fees and drug pricing policies: A study at Harare central hospital. Health Policy and Planning, 10(3). London: Oxford University Press. pp. 319-326.

Collins, D., Quick, J., Musan, S., Kraushaar, D., & Hussein, I., (1996). The fall and rise of cost sharing in Kenya. Health Policy and Planning 11(1). London: Oxford University Press. pp. 52-63.

Griffin, C. & Shaw, R., (1996). Health insurance in Sub-Saharan Africa: Aim, findings, policy implications. In Financing health services through user fees and insurance. Shaw, R & Ainsworth, M (Ed.). Washington, D.C.: World Bank.

Lambo, E., (1996). Aims and performance of prepayment schemes. In Sustainable health care financing in Southern Africa. The Economic Development Institute (EDI), the World Bank. http://www.worldbank.org/healthreform/

Leary, V., (1997). Human rights and the renewal agenda. In Ethics, equity an health for all. Bankowski, Z., Bryant, J. & Gallagher, J (Ed.). Geneva: Council for International Organizations of Medical Sciences (CIOMS).

Ministry of Health/WHO, Cambodia, (1999). Priority indicators for monitoring and evaluation of health sector reform. Unpublished paper, MoH/WHO Phnom Penh: Cambodia.

Normand, C., (1999). Using social health insurance to meet policy goals. In Social Science & Medicine Journal. 48(7). Elsevier Science, Pergamon, England. pp. 865-869.

Prescott, N. & Pradhan, M., (1997). A poverty profile of Cambodia. World Bank discussion paper No. 373. Washington, D.C.: The World Bank.

Ron, A., (1993). Health insurance scheme in least developed countries: Review of the potential. Geneva: WHO.

Royal Government of Cambodia, (1995). Report on the socio-economic survey of Cambodia. National Institute of Statistic, Ministry of Planning, Kingdom of Cambodia.

Royal Government of Cambodia, (1995). Preliminary finding of health facilities and services survey. Asian Development Bank/Ministry of Health, Kingdom of Cambodia

Royal Government of Cambodia, (1995). Indirect estimated of mortality. Phnom Penh: Ministry of Health, National Center for Maternal and Child Health, Kingdom of Cambodia.

Royal Government of Cambodia, (1998). National Health Survey. Phnom Penh: Ministry of Health, National Institute of Public Health, ADB/GTZ.

Royal Government of Cambodia, (1995). Health coverage plan. Phnom Penh: Ministry of Health, Kingdom of Cambodia.

Royal Government of Cambodia, (1998). The demand for health care in Cambodia: Concept for future research. Phnom Penh: National Institute of Public Health, WHO/GTZ.

Shaw, R., (1996). User fees in Sub-Saharan Africa: Aims, findings, policy implications. In Financing health services through user fees and insurance. Paul Shaw, R & Ainsworth, M (Ed.). Washington, D.C.: The World Bank.

Shirima, R., (1996). The community health fund in Tanzania. In Sustainable health care financing in Southern Africa. The Economic Development Institute (EDI), the World Bank. http://www.worldbank.org/healthreform/

Thomas, S., Killingsworth, J. & Acharya, S., (1998). User fees, self-selection and the poor in Bangladesh. Health Policy and Planning: 13(1). Oxford, UK: Oxford University Press. pp. 50-58.

Weaver, M., (1995). User fees and patients behavior: Evidence from Niamey national hospital. Health Policy and Planning: 10(4). London: Oxford University Press. p. 350.

William, N., (1997). Cost should not exclude the poor from health care. World Health 50(5), p. 12.

Willis, C. & Lieighton, C., (1995). Protecting the poor under cost recovery: The role of mean testing. Health Policy and Planning, 10(3). London: Oxford University Press. pp. 241-256.

World Health Organization, (1981). Global strategy for "Health for All" by the year 2000. Geneva: WHO.

World Health Organization, (1993). Evaluation of recent changes in the financing of health services. WHO Technical report series No. 829. Geneva: WHO.

World Health Organization, (1996). The world health report: Fighting disease, fostering development. Geneva: WHO.

World Health Organization, (1999). The world health report: Making a difference. Geneva: WHO.

World Bank, (1987). Financing Health Services in Developing Countries: An Agenda For Reform. Washington, D.C.: The World Bank.

World Bank, (1993). Poverty reduction handbook. Washington, D.C.: The World Bank.

World Bank, (1993). World Development Report 1993: Investing in Health. New York: Oxford University Press.