FEASIBILITY STUDY

Health Insurance Scheme in Factories

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CARE International in Cambodia
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FEASIBILITY STUDY

INTRODUCTION
I............ The project

The Sexual and Reproductive Health Project at CARE International in Cambodia (RAS/98/P11) is funded from UNFPA/EC and CARE Deutschland. The project has three purposes designed to challenge barriers to health services and aid young workers to make informed choices regarding their sexual health. To make an informed choice this project believes that a young person requires knowledge, attitudes, skills and the ability to communicate his/her needs in order that a safer sexual decision can be made in any area of sexual health. Reproduction is one of the choices available. The purposes of the three-year project are:

1. To contribute towards increased knowledge and awareness of RH amongst at least 10,000 out of school youth and train 50 health providers in RH;
2. To contribute towards increasing availability and use of clinical RH services;
3. To contribute towards building national capacity among at least two Local Non Governmental Organization (LNGOs.)

2 Baseline needs assessment

After adopting a participatory approach and applying participatory learning and action tools in a sexual health needs assessment (1998/99). Financial burdens and cost of medical services were clearly one of many concerns the young target population faced.

“In brief, the needs assessment of this young group of workers aged between 15 24 years, concluded that many were making sexual health decisions from a confused base of fragmented factual knowledge undermined by rumor and compounded by poverty” (Forder 1999 p5).

The unmet needs encountered due to a lack of human biology and relationship education are being addressed through participatory sessions over a period of six weeks with groups of workers. Unmet needs due to the economic situation in Cambodia and the economic situation of the workers (their salaries) is beyond the scope of this project. It is within the scope of the project however, to examine the feasibility of introducing a prepayment scheme of health insurance.

The initial feeling among the project staff was that the young Cambodians had no experience of prepayment and that their salaries were small and interest would be minimal, such a plan was not considered possible. A consultant was hired to examine the extent of interest in such a plan within the factories.¹

¹ Safer decisions are those whereby no harm is brought to partners in sex. “Harm” is less easy to define considering the potential social and psychological damage in addition to the physical bodily harm of infections or unwanted pregnancies. Wherever RH is written reference should be made to the earlier definition of safer sexual decisions. ²Forder JA (1999) ²PLA tools in action, lessons learnt during a sexual
3. Consultancy

The terms of reference for the 20 day consultancy were as follows:

Aim: to produce a report in English and Khmer making an assessment and recommendations as to the feasibility of a health insurance scheme in the five factories of the UNFPA project.

Objectives:

1. Interviewed key personnel:
   - factory workers
   - factory managers
   - factory health staff
   - project staff
   - urban sector health project
   - Ministry of Health personnel

2. Networked with other NGOs implementing health insurance scheme (GRET)

3. Assessed the interest in such a scheme

4. Made a logistical and financial plan if the scheme is viable

   - what transparency would be required;
   - who would be responsible for the money;
   - how much money would be needed from each worker;
   - which health services/providers would be recognized by the scheme;
   - who would manage it;
   - any other issues raised during the study and in consultation with the project advisor.

5. Produced a final Khmer language report and English language report:

   - stating the feasibility of a health insurance scheme and recommendations for its implementation if appropriate (appendices with the logical and financial plan).
   - or
   - stating who was interviewed and reasons why the scheme is not feasible.

METHODOLOGY

1. Situation in Cambodia

In Cambodia there are a few organizations and departments in the MoH who are considering implementing some pre-payment /health insurance schemes. At the time of writing the report there is little actual implementation of schemes with communities other than employees of LNGOS.
GRET have introduced a system of health insurance since 1997 with families in a rural community. This system was not initially successful because the majority of members were elderly who were interested in death/funeral benefits. Problems of fraudulent claims and clarity of transactions including which illnesses were covered lead GRET to employ a medical doctor. This combined with group discussions over a long period of time, gaining agreement with members in a participatory fashion for which illnesses to cover has meant that GRET have revised their initial insurance policies. In a later revision GRET have encouraged family membership not individual alone. GRET have little funds to support the scheme, they are therefore working towards a sustainable benefit system, though this will take some years.

Urban Health Sector project is working in three squatter areas in Phnom Penh. During its participatory research many unmet needs were identified despite several NGOs operating in the areas. A clear need amongst many others was that people were dying because they could not afford the cyclo ride to a hospital (2000 riel). It was clear from the advisor that an equity fund might provide some assistance to the target population (appendix 1).

Ministry of Health - bureau of planning. This department has a plan to introduce a health insurance scheme for members of the public in the municipality of Phnom Penh and government employees. This is a tentative plan with no implementation dates at present.

Consultations were held with CARE's NGO partners, Reproductive Health Association of Cambodia and Women's Development Association in addition to project staff. These interviews were held to discuss the prospect of introducing an insurance scheme for health in some factories of the project.

2 Situation in the factories

While the above information was important, it was necessary to go directly to the factory project sites and discuss the possibility of such a proposal with the senior management and health staff personnel of the factory. There was a great variety in the replies, some factories agreed while others thought it was of little importance and talked only of business.

The workers were then approached and asked about their ideas and thoughts on a prepayment scheme for health (appendix 2). The system was explained clearly, however at this time, the advisor of the project wanted to understand if there was an interest and had not yet developed a list of conditions, which would be covered by a scheme. This would be a future step if sufficient interest, funds and time allowed.

ANALYSIS

1 Interviews

Due to the limitations in time and resources the feasibility study was kept purposefully small. 300 workers were interviewed of the 5,600 total number of employees working in the five factories. These factories have cooperated very closely with CARE's sexual and reproductive health project for one year already. Both a knowledge attitude and practice
survey and participatory research had already been conducted, CARE have also held interactive educational sessions with workers to improve their knowledge and understanding of reproductive health issues. In addition to the education sessions CARE has renovated the factory clinics and supported health staff to treat reproductive health problems.

In this study interviews were conducted:
1 in clinics with the clients;
2 with workers who had attended participatory research or attended interactive educational sessions (CARE’s project activities);
3 with workers in their free time (lunch after work).

2 Tables

Table 1 "Number of employees interviewed" showed that the number of workers interviewed responded differently by factories. However, the number of interviewees per factory reflects 5.4% of the total workforce per factory.
The researcher interviewed men and women under 25 years (in Cambodia, it is believed that people under 25 years have different ideas to older people, in addition the project tries to target the younger populations of the factories). The information learnt was that the majority of the workers are under 25 years old. Therefore interviewees who are more than 25 years old only represent one third of the total interviewed.

Table 1: Number of employees interviewed

<table>
<thead>
<tr>
<th>NAME</th>
<th>W/ per</th>
<th>Wi/ per.</th>
<th>AGE</th>
<th>%</th>
<th>REMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>m</td>
<td>total</td>
<td>Q5</td>
<td>&gt;25</td>
</tr>
<tr>
<td>factory 1</td>
<td>2300</td>
<td>87</td>
<td>37</td>
<td>124</td>
<td>91</td>
</tr>
<tr>
<td>factory 2</td>
<td>700</td>
<td>33</td>
<td>4</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>factory 3</td>
<td>400</td>
<td>15</td>
<td>6</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>factory 4</td>
<td>1500</td>
<td>54</td>
<td>27</td>
<td>81</td>
<td>62</td>
</tr>
<tr>
<td>factory 5</td>
<td>700</td>
<td>27</td>
<td>10</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5600</td>
<td>216</td>
<td>84</td>
<td>300</td>
<td>219</td>
</tr>
</tbody>
</table>

W- employees
Wi- interviewees
In the garment factories male employees represent about 10% of the workforce, however in this study 39% of the interviewees were male. In Cambodia it is widely believed that women have more health problems than men do, and would therefore be more interested if indeed any interest were to be found. Thus it was felt to be important to interview a larger proportion of males to gain a clearer picture of this assumption.

"Cambodia is ranked 73rd among 78 developing countries in terms of the UN poverty index:" It is therefore safe to say that Cambodian garment workers are amongst the lowest paid in the world, this is due to a number of factors namely: a government system that requires strengthening; a lack of implementation of laws including of human rights; under developed macro-economy and a poor education system which leaves the workers vulnerable to exploitation. Difficult working conditions and small salaries were clearly reported in the needs assessment, it was therefore anticipated that their would be a strong negative reaction to this study and the requirement to pre-pay for health services.

In picture 1 "The percentage of employees expressing interest" shows that out of 300 interviewees, four reported no interest in the health insurance scheme. Some believed that they have good health and are never sick, so why do they need to spend money. By far, and quite unexpectedly, the majority of 98.5% of interviewees expressed an interest in the scheme, they reported that they would make contributions, even though their salaries are small and budgeting for their needs is a big problem.

**Picture 1: Percentage of employees expressing interest**

In table 2 "Employees' suggestion for monthly contributions" shows that most of the workers are focussed on health problems and they give a high value to budgeting their meager income towards a prepayment plan, even though they are acutely aware that budgeting is very difficult in their situation. When asked how much they would be willing

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In table 2 "Employees' suggestion for monthly contributions" shows that most of the workers are focussed on health problems and they give a high value to budgeting their meager income towards a prepayment plan, even though they are acutely aware that budgeting is very difficult in their situation. When asked how much they would be willing
to contribute (remembering at the time there was no clear list of illnesses covered or incurred costs covered) the contributions fell roughly into three categories.

A  Under 2000 Riel
B  2000 - 5000 Riel
C  More than 5000 Riel

182 (61%) of interviewees' responses fell in level A; 97 (32%) in level B; and 17 respondents (6%) in level C.

Table 2: Employees suggestion for monthly contributions

<table>
<thead>
<tr>
<th>NAME</th>
<th>A&lt;2000</th>
<th>2000&lt;B&lt;5000</th>
<th>C&gt;5000</th>
<th>D</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>factory 1</td>
<td>84</td>
<td>36</td>
<td>3</td>
<td>1</td>
<td>124</td>
</tr>
<tr>
<td>factory 2</td>
<td>24</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>factory 3</td>
<td>13</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>factory 4</td>
<td>34</td>
<td>40</td>
<td>6</td>
<td>1</td>
<td>81</td>
</tr>
<tr>
<td>factory 5</td>
<td>27</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>37</td>
</tr>
<tr>
<td>TOTAL</td>
<td>182</td>
<td>97</td>
<td>17</td>
<td>4</td>
<td>300</td>
</tr>
</tbody>
</table>

A- Employees suggestion less than 2000 R.
B- Employees suggestion between 2000 R.-5000 R.
C- Employees suggestion more than 5000 R.
D- Employees not interested

Currency Exchange: 3700 riels = 1 $
In picture 2 "Graph demonstrating employees contributions" demonstrates the information learnt about categories of payment; the majority of interviewees responded in category A with a minority willing to pay a significant percent of a monthly salary of 5000 Riel or more.

CONCLUSION

The limited resources available for this study (one consultant working 20 days) meant that there was little time to introduce the subject of insurance and develop a participatory dialogue with the respondents. This was an important consideration remembering that the project staff felt the workforce would not understand or want a scheme such as this.

Another important point to remember when interpreting the data is that the project wanted to understand if a pre-payment scheme was possible. It had not developed a choice of policies or plans that the workers could select and know clearly which illnesses would be covered and what percent of their bill would be reimbursed. While these two important points did not deter the consultant from gathering data which expressed an interest in a pre-payment system they must be taken into account when actual implementation of such a scheme is deemed viable.

From the analysis there is a clear indication that there is an interest in a health insurance scheme which would cover reproductive health concerns. This interest was expressed from both men and women of all ages, despite their socio-economic situation. If a health
insurance scheme is to be introduced based on this feasibility study then the following recommendations are suggested.

RECOMMENDATIONS

A logistical and financial plan for implementation was initially in the terms of reference for the consultant. However, during the course of the feasibility study it became clear that this must be a consultative and participatory process with the potential members. This was beyond the scope of this consultancy and therefore in agreement with the project advisor the terms of this consultancy were revised. The need to have a consultative process is important for the success of the pre-payment system so that the members have a sense of ownership, they make the decisions of illnesses covered, contributions made and how to settle claims.

Issues that need to be covered in a consultative process:

1) Discuss with specialists in reproductive health:
   - kind of illnesses covered
   - list of common complaints
   - price lists for treatment
   - facilities that provide quality of care

2) Have a key medical person/s who act as a diagnostic and referral centre for people who cannot be treated in the factory clinics. Or for people who have left a factory.

3) List of facilities that have an agreement with the health insurance scheme to which the key figure/s can refer.

4) Consider opening the policy to non-garment workers

5) Transparency of all transactions:
   - collection of funds
   - legitimacy of claims
   - reimbursement for treatment/travel costs
   - possibility of fixed fee for a claim

6) A minimum three-year time period is required with associated relevant financial and technical support to cover application of a participatory approach for the development of protocols, procedures, transparency of funds and development of revolving funds. Additional funds to those of the members will be initially required and must be guaranteed if trust and efficiency in the scheme is to be realized.
   • Costs need to cover
     - personnel costs of implementation;
     - key persons;
     - revisions to contributions due to salary of workers increase with cost of living;
     - develop surveys and use participatory methods to adapt and change the insurance scheme's strategy;
     - gain support from government and Ministry of Health;
     - make advertising promotion campaigns by eg TV and radio;
     - increase membership to make insurance scheme sustainable and viable with revolving funds.

7) Consider some general health problems to be covered in scheme.
Equity in Health Care

Some non-governmental organizations (NGOs) such as CARE and Oxfam are beginning to develop pilot initiatives to address the issues of financial barriers to emergency care. Oxfam is in the process of undertaking a community based monitoring of community health financing in Georgia and Armenia, and the report of the monitoring will be available shortly. CARE India and CARE Peru have also initiated savings funds for access to emergency obstetric care. These experiences are currently also undocumented.

Key approaches covered in the community health financing literature include revolving drug funds (based on the Bamako Initiative), user fees and health insurance schemes. While small-scale community based savings schemes for health have often been initiated at the local level in the context of these broader community health financing approaches, these experiences remain largely undocumented. There are undoubtedly many local level experiences of savings schemes for emergency health care which have developed out of broader micro-credit programmes. However, these experiences also remain largely undocumented.

Options consultant (Kirsten Hawkins) review of the literature focussed on drawing out some of the lessons learned from community financing experiences, which raise important issues for consideration by UHP. The review synthesized key lessons and areas of concern in community health financing with a particular emphasis on issues of equity, targeting of the poorest, community ownership and sustainability.

The findings of this review suggest that there is both a strong interest in local level experiences in the use of savings schemes as social safety nets, and the need for systematic documentation of lessons learned. It is therefore strongly recommended that the UHP focus on the documentation and dissemination of lessons learned from their experiences with equity and / or emergency funds.

The review highlighted the need to ensure a particular focus is placed on mechanisms to ensure: equity, inclusion of the poorest, sustainability of funds and community ownership.

The UHP - through its Health Services for the Urban Poor (HSUP) initiative aims to improve the quality of medical care available, ensure increasing access by working with local communities and health service providers, to overcome the barriers to timely usage of quality services.

In seeking to overcome financial, social and physical barriers to access; the project will assist in the development of community groups to provide services as close to communities as possible, through a health room approach (out-reach / in-reach) approach. In order to overcome the effects of catastrophic illness and the need for emergency medical services to project aims to develop emergency finance and transport schemes.

The main aim of the emergency finance fund is to allow immediate access to cash resources, at any time of day or night, in the event of a medical or surgical emergency.

Community financing of Health Care

We define community financing as "a system comprising consumer payments (either as a user fee, some form of pre-payment mechanism, or other charge) for health services at community level, the proceeds from which are retained within the health sector and managed at the local level" (McPake et al 1993:1384).
Rationale for Community Financing of Health Care

Increased reliance on community financing of health care has been advocated on several grounds. Firstly it is often suggested that in most developing countries individual households already spend substantial amounts of money in purchasing health care from the private modern and traditional sector. Therefore encouraging the redirection of this expenditure towards services, which have a greater impact on health, would not be placing an additional financial burden on individuals.

Other suggested benefits of community financing are that it attracts additional resources for use in the health sector (e.g. cash, labor or contributions in kind), community participation in health financing will increase utilization, and gives the community the right to ensure that services are acceptable and accessible.

On the other hand critics have suggested caution in the approach to community financing on the grounds that it does too little to promote equity, resources can rarely be raised on a sustained basis, and that a high degree of external support is needed to mobilize and sustain community efforts.

Payment Systems

Community financing usually implies either the introduction of user fees or some mechanism of pre-payment (or a mixture of the two). In implementing these mechanisms decisions must be made about the point at which the payment is made, and how (and whether) charges are related to volume of services consumed and the characteristics of the consumer.

A number of different payments systems and combinations of systems exist. These include payment for each visit to a health service, payment per episode of illness, payments for consultation and medicine separately and pre-payment of a fixed amount for health coverage.

Approaches to community financing may include: payment of full or preferential rates for health care organised through community efforts; socially organised voluntary community insurance schemes; community contribution of gifts, labour or kind in support of health care.

The different systems have different implications for efficiency, equity and administration.

Ability and Willingness to Pay

The distinction between 'ability to pay' and 'willingness to pay' is central to the evaluation of user financing.

Studies, which point towards a high willingness and ability to pay, have frequently been used to support the introduction of user fees. In these studies evidence of existing payments and patterns of expenditure on health are usually cited as evidence of affordability of charges for health care.

For example, evidence that poor people already pay for health care, from private providers or traditional providers, is taken as evidence of both willingness and ability to pay.

However, a more recent body of literature has raised doubts about assumptions regarding willingness and ability to pay, and have indicated that demand for health care is, in fact, highly elastic. Recent studies have shown a price sensitivity of demand to health care among the poor, i.e. that as prices increase, utilization decreases.
Willingness to pay may be higher than actual ability to pay if the felt need is sufficiently strong, even if this entails failing to adequately meet other needs. Although an individual or a household may express a willingness to pay for a particular service, and may in fact have enough income to do so (as cash in hand), this may present an unacceptable strain when placed in the context of other equally pressing needs.

Ability to pay is difficult to measure in practice. The proportion of household budgets devoted to all necessities, in conjunction with data on the extent to which these necessities are being met, will provide a good indicator of 'ability to pay'.

The argument is often made that the ability to pay is far greater than is generally assumed, a common example is that patients visit traditional healers who charge more than health facilities. However, poor households can sometimes come up with substantial sums of money to pay for a service, but at considerable duress (Cambodian research shows, debt at high rates, children dropping out of school, selling of land, girls into CSW and the selling of babies). Ability to pay must therefore be assessed in relation to the impact of expenditure on the total household budget, taking into account all other needs.

We need to move away from a simple focus of demonstrating that community financing mechanisms make services available more cheaply than they were before the introduction of fees, as such studies leave out important questions concerning the implications for households of the introduction of charges and payment mechanisms.

And where informal fee's were levied, prior to introduction, we need to unpack the impact of formal fees not only within government facilities but also on the costs within private facilities.

We need to understand more fully the impact of health expenditures on the rest of the household budget as this may be more important than whether or not payments are actually made. For example do payments lead to increased impoverishment of already poor households? The data from Cambodia strongly supports the idea that the cost of health care is the major reason for land loss, debt and the fueling of the poverty cycle.

Our study (Baseline Demand Study in Urban Poor Areas of Phnom Penh) found that payment for health services is sometimes made only with the greatest difficulty, substituting for expenditures on food and education. Payment for health services is often made at considerable cost to the family and cannot therefore be-considered as 'willingness' to pay in the usual sense.

Few studies have addressed affordability in this way and the literature suggests that no general conclusions about affordability of community health financing can be reached. Affordability is highly context specific and must be assessed at local level.

**Equity**

One of the more serious limitations identified in community financing has been their inability to bring greater equity, often exacerbating existing inequalities within and between communities. Given the evidence regarding high price elasticities of demand of the poor, as well as the distinction between ability and willingness to pay, **safeguarding equity must be a crucial concern in user financing. A critical first test of user financing is therefore whether it improves the situation of the poor.**
The issue of `vertical equity' is central to current discussions concerning health financing and health care provisions. The concept of vertical equity is rooted in the understanding that the achievement of equity requires specific concern for the health and health care situation of the most vulnerable and marginalised in society, i.e. reaching the poorest, not only the 'majority poor'.

These groups bear the main burden of health problems in any society due to the complex web of causes underlying ill-health, which includes a variety of socio-economic and socio-political environmental factors beyond their control.

Cost-recovery schemes which prefer payment in cash are likely to be more inequitable than cost-sharing schemes, which allow payment in labor or in kind. The poor and less advantaged are less likely to have equal access to cash resources, but are comparatively more likely to able to contribute in labor. The utilization of labor, in the context of urban health service provision, has not been explored in depth, issues such as management of labor inputs and equivalent value need to be explored and debated.

It has also been suggested that pre-payment schemes may be capable of promoting the most equitable distribution of the financial burden among the population.

**Exemptions for the Poorest**

Proponents of user financing suggest that equity can be enhanced through mechanisms which accurately identify the poorest and exempt them from payment. Exemption mechanisms can be based on use of graduated fees; sliding scales by type of service; by gender of head of household; and by socio-economic characteristics.

Schemes intended to protect the poor have often used income criteria for exemption. However, economics of the incidence of poverty and level of income are notoriously difficult to measure. Hence proxy indicators such as land, house construction and visible assets are mostly used.

Exemption schemes directed towards equity face the particular difficulty of accurately assessing the ability to pay. Recent evidence suggests that schemes which target specific population groups have been less effective than is generally accepted. Targeting by gender of household has been found to be a particularly ineffective method for identifying the poor. A widely held view is that community based systems are better at identifying the poorest than higher level administrative systems.

While experiences are poorly documented, existing evidence suggests that performance of exemption schemes is generally not encouraging. Experiences from non-governmental organizations (NGOs) suggest that schemes are often implemented in an informal and ad hoc manner and local characteristics of the poor who are the intended beneficiaries are often not clearly defined. There is also wide spread evidence of people failing to make use of exemptions. In particular, schemes may be implemented in a manner that is stigmatising and dehumanising, there may be dishonour or a sense of shame involved in accepting an exemption.

**Problems highlighted in implementation of exemption schemes include:**

- technical feasibility and accuracy of exemption schemes (e.g. problems in defining and measuring poverty, household income does not reflect ability to pay of the individual within the household, income fluctuates seasonally)
- administration and monitoring of exemptions is fraught with difficulties
- insufficient information and stigma may prevent the poor actually taking up exemptions.
Deepening poverty and the reduced capacity and willingness of community members to maintain traditional safety nets and community solidarity exacerbates the impact on equity of the failure to establish effective exemption mechanisms (more likely in urban areas where solidarity is tenuous). In addition seasonal variations in the ability to pay are often compounded by seasonal differences in the need for services.

**User fees and community co-management**

It has been asserted by some that user financing of services is sufficient to generate accountability and responsibility between providers and users. However, evidence suggests that the numerous examples of health services in Africa which have introduced user fees, but have failed to introduce significant community management or improve quality have had substantial reductions in utilisation. Empirical evidence supports the view that user financing needs to be supported by community co-management.

However, initiating and sustaining community involvement in health financing has often been found to require ongoing and intensive external support. It has been suggested that to maximize the potential for community financed activities, considerable efforts are needed to support communities in organizing themselves where there is a basis for common action. In Cambodia there is an ongoing debate amongst players in the field as to whether there is sufficient "common interest in common action" to create community participation in urban poor areas.

**Equity Issues and User Fees**

The following key elements have been identified as essential to any user fee system designed to promote equity:

- A mechanism to protect the most vulnerable from full charges *Exemption mechanisms* established to protect the poorest from the burden of payment. Such mechanisms, it is assumed, will be most effective within community based activities as local decision makers are better able to identify the poorest.

- Retention of revenue at the point of collection and involvement of community representatives in decision-making about the fee system and its management.

- Use of revenue for community-perceived quality improvements with the aim that even without exemptions and risk sharing mechanisms, access and quality improvements lead to reductions in the cost of accessing effective care.

- Flexibility to adapt the pricing structure/payment mechanism on the basis of experience. *Risk sharing/pre-payment mechanisms* adapted to local situations as opposed to straight fee for service mechanisms.

- A supportive health system with potential for referral, and a supportive decision making structure including decentralization of management responsibilities.

Concerns about the existing situation of user fees and the potential impact on equity include:

- In reality the introduction of user fees has incorporated a simple "fee for service" mechanism rather than more complex, pro-equity risk sharing approaches.
- User financing without effective implementation of exemption mechanisms will in almost all cases worsen the well-being of the poor. Yet implementing effective exemptions is always very difficult.

- Uncoordinated and decentralised decision-making practices may promote regional inequities (or local level inequities) because of differences, in the resource base of different areas (and communities).

- Homogeneity and cohesiveness of communities is often overestimated heterogeneity and discord can prevent effective community participation.

- Regulations to support representativeness can be ineffective because of the dynamics of local life which make it difficult for the socially marginalised to take part.

- Communities may be unable to absorb the responsibilities thrust on them by governments (or projects).

- Effective community participation in decision making requires human and institutional capacity development and support (Including working with professionals to take on this new role).

**Measuring the Equity Impact of Community Financing**

The promotion of equity is a key indicator for the UHP therefore the UHP needs to focus on three inter-locking principles of equity:

- payment on the basis of ability to pay
- equal opportunity of use for equal need
- effective representation of all community interests in decision-making about health (and health system development).

**Identifying the poorest**

The characteristics of poverty, in the urban poor areas of Phnom Penh, were identified using PRA techniques, focus groups and a household survey. Data suggest the multifaceted nature of vulnerability within communities and the importance of health care costs as a major contributor to poverty. The personal characteristics generally used to identify the poorest are not ones which can easily be addressed or removed through slight improvements in cash availability.

**Benefits to the poorest of curative and preventive services**

While simple provision of preventive services at Health Rooms is likely to have broad benefits for the communities in which they were located, they need to ensure that the poorest also benefit. Evidence from across communities and countries indicate that the levying of fees acts as a deterrent to utilization by the poorest groups and prevents them from benefiting from improved or newly available curative services.

Experience indicates that the preferential allocation of benefits to the poorest requires that, at a minimum, the barriers to access are tackled through some combination of mechanisms to protect the poor from payment and/or a payment mechanism which lessens the burden of paying.
Community concerns that fees are unaffordable for some people reflects the common experience that the policies of exemptions were of limited effectiveness in practice. No country had developed effective, formal mechanisms to protect the poorest from bearing the burden of fees.

**HSUP & effective protection for the poor from the costs of care.**

Within the health centres and secondary level facilities there is a commonly stated concern that offering exemptions undermines revenue generation which is used to support salaries of health providers. **In effect there is a conflict between, providers salary needs and protection of the poor.** The failure to develop innovative protection strategies also appears to reflect the limited ability of providers to access government funds for the management of health services. (Calmette Hospital is able to reclaim exemptions from government funds - is this the only facility able to do so?) In addition the voice and views of the poorest are not heard or considered in price structure and price level decision-making:

**Sustainability**

Key weaknesses in the sustainability of community financing (identified from the literature) are:

- No parallel action established to ensure that access improvements were maintained after withdrawal of external support.
- Pricing practices could not generate sufficient revenue to cover adequate drug supply, let alone cross-subsidize the poorest and broader benefit strategies.
- Little attention given to how to sustain CHW motivation (and so clear signs of attrition across sites).
- Limited supervision and technical support offered.
- A broad ranging package is often too broad for the level of supervision and support available.

**Conclusions**

Three key design weaknesses, in community financing, were identified as contributing to general failure to ensure preferential protection and the benefit of the poorest:

- Not protecting the poorest from the financial burden of care.
- Not developing broad development strategies from which the poorest can directly and indirectly benefit.
- Not listening to the poorest in decision making.

These factors highlight three underlying concerns regarding community-financing schemes:

- The emphasis on financial sustainability, and salary income, undermines efforts to protect the poor.
- Emphasis on curative care (and the need for revenue in the sector) undermines a more preventive and promotive orientation.
- The weakness of relying on community structures as mechanisms for full community representation.

**Development of an Equity fund**
Most case study experiences have demonstrated the difficulty of ensuring total community participation while protecting the poorest from the burden of cash payments. Villagers in a subsistence economy may often prefer to contribute to community funds in kind rather than cash. Exemption mechanisms have been shown to be largely ineffective in practice.

Establishment of 'community solidarity funds' or "equity funds" which can support the poorest are seen to be of potential for ensuring equitable access to emergency health care. However, it has been suggested that such funds also need external support, e.g. from government and donors, although communities might contribute to a pool of funds.

Critical criteria to establish when developing such funds are:

- How eligibility is determined
- Level of funding necessary on an annual basis.
- Procedures to ensure transparency in decision making

Exemptions from payment into such funds could be assessed on a household basis. Local democratically elected committees could be involved in assessing which households within the catchment area of the fund should be exempt from payment.

The main potential equity advantage of prepayment schemes (through for example family health cards) lies in the risk sharing that they allow. Those who are more likely to be sick can be cross-subsidised by those who are less likely to be sick, and because there is a pool of contributors, payment required from each contributor may be less than the direct level of payment necessary. However, a potential danger of prepayment is that the principle may not be well understood or accepted. Those who have contributed may demand tangible benefits from the fund, whereas those who are unable to pay are those often most in need of the fund. In addition the UHP is targeting a squatter area with high health service needs and low ability to pay.

**Meeting the needs of the poorest**

The literature indicates that there are no easy options to meet the needs of the poorest. Design issues to consider in community financing are:

- maintaining some level of external support so that financing is not left entirely to communities;
- creation of local decision making structures which at least try to take account of the needs of the poorest (including community wide meetings with specific attempts to hear the needs of the poorest);
- developing benefits packages (such as income generation) to ensure the wide dispersion of benefits within the community;
- a package of training and supervision which supports local decision making and emphasises the importance of addressing the needs of the poorest
- a monitoring approach which enables changes in the situation of the poorest to be identified and fed back into health service planning and local decision making.

**The importance of process**
The desk review also indicated the importance of `process' to effective implementation of any community financing scheme, particularly those seeking to address the many existing and potential obstacles to meeting the needs of the poorest. Building understanding and community support through involving the community in planning, management and decision making is essential. Incremental approaches may be the most successful. The need for time and resources to this process cannot be underestimated.

**Key design elements prepayment/savings schemes**

- Potential beneficiaries should have a common interest, live in the same area and share similar socio-economic factors such as:
  - awareness of shared financial risks due to health hazards
  - existing community organization/structures
  - a wish expressed by the community to establish the fund.

- The initiative should be transparent to beneficiaries; benefits tangible and utilization of funds controllable; social control mechanisms must be familiar and therefore local.

- Payment plans need to be based on concepts already in the culture. The existence of a rudimentary savings or prepayment concept may facilitate generation of the scheme. The incorporation of understandable and locally common concepts are essential.

- Active community participation is decisive in establishing prepayment and savings funds. Final decision making and priority setting should be left to the community.

**Accessing emergency care**

Almost no research has attempted to track patients who receive referrals in order to investigate the relative importance of the constraints they face. Research is needed on the necessary conditions for the success of community risk-sharing interventions such as the strategy attempted in Samburu, Kenya where communities pre-paid for emergency transport.

Such analysis should address the following key questions:

- who are most likely to pay for membership into such a scheme and why?
- who refuses to join and why?
- are women-headed households more likely to join?
- how does the quality of the referral facility affect membership?
- should membership be mandatory?
- what are the costs of implementing the scheme?
- and how can the poor be included?
Tentative plan of diseases covered

Breaking syphilis
Cold
Fever
Genital Warts
Hernia
Hidden syphilis
impotence/week penis
irregular menstruation
lymphogranuloma venereum
malnutrition
Menstrual pain
Miscarriage
Penile Discharge
Post-partum illness
Premature ejaculation
Prolapsed uterus
Rice-water gonorrhea
Ringworm
Sweet urine
Syphilis
Syphilis-gonorrhea
Urinating difficulty
Uterine infection
Uterine ulcers
Vaginal bleeding
Vaginal discharge
Vaginal itchiness
Vulva/vaginal sore
Etc…………..