K I N G D O M O F C A M B O D I A

Nation - Religion - King

Ministry of Health

Health Economics Task Force

THE NATIONAL CHARTER ON HEALTH FINANCING IN THE KINGDOM OF CAMBODIA

Comments and interpretations

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With the collaboration of the

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CONTENTS

INTRODUCTION.

The Ministry of health of the Kingdom of Cambodia is making significant steps towards laying the foundation for sustainable long term organisational and financing reforms. In terms of organisational reforms these to date are as follows;

*** Completion of the public sector *coverage Plan* which has brought agreement on the rationalisation of services.**
*** A new nationwide health information service.**
*** Completion of an essential drugs list and legislation for inspectorate functions.**
*** Infrastructure development.**

The *Health Financing Charter* is the document which outlines the financing reforms which will form a support to the above organisational reforms. It is an umbrella document which allows for the development
and approval initially of pilot financing schemes and sets out a framework by which they can be systematically tested and evaluated.

The Charter itself has two parts. Part 1 gives a policy framework which sets the Charter within the context of the reforms in general and Part 2 gives technical notes which aim to set a framework within which the schemes should be designed. Thus the Charter aims to outline a number of pre-requisites which have to be fulfilled in order for such schemes to succeed. These are based on empirical experiences from within Cambodia and from other countries and on technical considerations. It then outlines some guiding principles in more specific areas namely the role of the community, the mode of payment and use of any
fees collected, and the possibilities for contractual arrangements. Finally the Charter notes the responsibilities for follow-up and evaluation of financing schemes and the procedure for revision and amendment.

The Charter itself however consists of a series of articles and these need to be made more accessible to both the policy maker and the implementation in order to enable them to better comprehend the contents. This will thus help with both the formulation of proposals for schemes and in the implementation of these schemes. The notes therefore give an explanation to each of the Charters articles and where appropriate a short introduction to the issues discussed in each Chapter. These notes explain why the article was necessary, what the articles means technically and what it means in practice.

The format for these notes are the same as that of the Charter i.e. notes are given chapter by chapter.

OVERALL OBJECTIVE

*The overall objective of The Ministry of Health of the Kingdom of Cambodia is to **extend quality** basic health services throughout the country. Increasing financial resources to the sector and obtaining better value for money is a key strategy as a means to achieving this objective.*

Here lie the guiding principles of the Charter. In fact, almost each of the articles refers to the extension of health coverage or to service quality improvement, at least indirectly. To achieve this, adding money alone would not be sufficient. In addition, substantial efforts have to be made so as all resources available -or made available- are used in such a way as to produce maximum benefit: this is what is called "value for money".

In other words, health financing reforms should be organised to support a system in order to:

- **Mobilise additional resources;**
- **Use resources efficiently; and**
- **Support the health system reform.**

To such respect, the best system to be developed in the Cambodian context is not known; this is why it is needed to experiment different options that are recognised to have a potential. However, simple logics and evidence from abroad demonstrate that some basic rules and conditions should not be bypassed when organising health financing systems.

The various options tested in the field will be closely monitored and evaluated by both the Ministry of Health and local health authorities, which will allow comparison and the consequent selection of the most appropriate of these options as the one(s) to be extented countrywide.

CHARTER OBJECTIVES

*1. Develop a policy **framework** in which a variety of health financing schemes can be developed, systematically **tested** and evaluated, in conformity with, and as a **support** to the organisational reform of the Cambodian health system.*

*2. Ensure minimum **standards and pre-requisites** to be addressed when implementing health financing schemes.*

*3. Develop a system for first approving and then **monitoring and evaluating** health financing schemes.*

PART 1

POLICY FRAMEWORK

The policy framework describes the overall context within which health financing reforms are going to occur. This refers to institutional, organisational and financial matters.

1: *According to the **Constitution** of the Kingdom of Cambodia, and **letter No. 1291** 22 August 1995 of the Council of Ministers, the Ministry of Health of the Kingdom of Cambodia will develop health financing pilot projects, which will include financial participation by users of health services.*

According to Article 72 of the Constitution of the Kingdom of Cambodia, health care must be available free of charge to poor people.

The letter from the Council of Ministers gives authorisation to the Ministry of Health to set financial participation from the users of public health facilities. This authorisation is dependant upon three conditions:

- **Transparency of the list of fees;**
- **Adequate and transparent management;**
- **Sanctions against corruption.**

An Interministerial Commission has been created by the Council of Minister, which is in charge of health financing reform follow-up.

2: *The Ministry of Health of the Kingdom of Cambodia will **test** health financing options **in both the public and private sectors**, so as to develop and systematically co-ordinate the constituent components of the national health system.*

The Ministry of Health wishes to follow a step by step approach starting by an experimental process through which different options will be tried within the Cambodian context. This will allow the most appropriate option(s) to be further extented countrywide in the medium and long terms.

It is not the role of the Government to produce all kind of health care needed by people. Because resources are limited, and because the private sector may prove more efficient than the public sector at producing certain services, the private health sector is to be considered as a partner for the improvement of the health status of the population.

In Cambodia, the problem is that the private sector works out of any control from the Government. Legislation alone would not be able to solve this problem. In fact, experience shows that financing mechanisms can be organised in such a way as to provide financial incentives on private providers that may be much more powerfull than legislative rules in making private providers acting in conformity with public health constraints.

3: *The development of the private sector cannot be separated from the public health system but includes the* ***integration of aspects of private sector mechanisms*** *into the current functioning of public health services.*

As part of the public-private mix within an integrated vision of the national health system, is is planned to introduce management systems in the public sector that usually do not exist but in the private sector. This may range from performance related payments to staff and incentives for good management to contractual arrangements between health authorities and public health provider units. This is to be worked within a facilitated management and authority environment, which is expected to assist in accelerating the reform process.

Through such contracts, health centers and district hospitals will commit to meet certain pre-defined objectives, while health authorities will commit to allocate subsidies and other kind of support. Those concepts are explained in more detail in Chapter 4 of the Charter.

4: *The Ministry of Health is alone competent to* ***authorise*** *financing pilots in the public sector, that will conform with* ***National Health Policy*** *in general, take account of* ***equity****, the* ***protection of vulnerable groups*** *and in particular* ***community participation*** **.**

The Ministry of Health must have full control of what happens in the public sector, of which it is responsible and regarding which it is accountable to people through the Government. Therefore pilots may not start without prior approval from the ministry (see Charter Chapter 1).

Basic principles that must be respected in order such approval can be delivered by the ministry are threefold:

- **They must not conflict with the National Health Policy, in particular they should fit with the District health system strategy;**
- **Poor people must be protected, according to the Constitution of the Kingdom of Cambodia, as well as particular population groups such as women and children;**

- **Communities must be involved, not only financially but also in decision-making, management, monitoring and evaluation.**

5: *With regard to the financing of such schemes, the Ministry of Health of the Kingdom of Cambodia will ensure that:*

5.1. *Health financing schemes in the public sector are* ***guaranteed adequate funding*** *from the national health budget and are not a substitute for national budget.*

5.2. *Provincial and national health authorities are commited to match the financial contributions of populations, which implies that the budgetary allocation to health centres and hospitals involved in health financing schemes will be* ***at least maintained*** *at levels defined at the beginning of the programme.*

5.3. *Funds collected by health financing schemes are* ***retained and managed by the facility(ies)*** *that collect them in collaboration with the Management Committee(s) or its(their) equivalent. The Interministerial Committee on health financing will determine the* ***minimum*** *percentage required to control revenues raised by such schemes.*

Here lies one of the most sensitive components of the implementation context of health financing reforms. This refers to very basic economic theory and aims to promote and preserve a meaningful relationship between population payments and quality of health services received.

If public funding decreases while population financial contribution is set in motion, the overall amount of money available will not increase. As a result the quality of services will not improve and people will refuse to pay and turn back to private providers. Confidence of people will be lost and health financing reforms will fail.

On the contrary, if population payments come in addition to existing resources, the overall resources availble will increase resulting in improved quality of services delivered (provided financing schemes are efficiently managed). Ideally, government funding should even increase as population financing occurs, which would boost service quality and make payments more acceptable to people (point 5.2). This is what is called a financial partnership.

In addition, one must notice that the financial partnership will not exist if a share of monies raised is taken back by the national treasury. ***For example, if the contribution which is necessary***

for an episode of disease to be correctly treated is 2000 Riels without government deduction, and if the government deducts 10%, the bill will have to go up to 2222 Riels if the same level of service quality is to be achieved. As a result, some more people will prove enable to afford the bill. If the bill remains at 2000 Riels, 1800 Riels only will be available after government tax is paid, which will lessen the impact of individuals' payment on the quality of services and consequently make the system less acceptable to people.

Discussions have been going on within the Interministerial Commission on health financing about what the percentage of financing schemes' revenue that should be deducted by the Ministry of Economy and Finance. No consensus has been reached yet, but the National Conference has recommended that the percentage should be the minimum required by the Ministry of Economy and Finance to control the revenues of the scheme. The decision is up to the Interministerial Commission, and it seems that this percentage could be as low as 1%, which would have only marginal impact on the chance of success of the reform as almost all monies raised through health financing schemes will be retained in collector facilities, which would secure both their impact on service quality and a better involvement/motivation of staff.

PART 2

GUIDELINES FOR HEALTH FINANCING

The following consist of basic technical guidelines which aim to set a framework for action in the field. As this framework is very broad in order to allow various health financing models to be tested, these guidelines are to be considered only as a basis to be further developed in more exhaustive technical guides to health financing reform implementation.

The guidelines consist of six chapters:

- **Chapter 1 states the pre-requisites for the installation of health financing schemes;**
- **Chapter 2 concerns community participation and management of monies raised by health financing schemes;**
- **Chapter 3 sets the main principles for the choice of a method for payment, fee calculation and the use of money raised;**
- **Chapter 4 introduces contractual arrangements and describes the possible relationships between the public and the private sectors;**
- **Chapter 5 expresses the main facts in the matter of follow-up and evaluation of health financing schemes;**
- **Finally, Chapter 6 describes responsibilities for the application and the revision of the Charter.**

Overall the Charter takes experience from other countries into consideration, as well as constraints specific to the Cambodian context. It is expected that the Charter will help avoid major mistakes that could make heath financing reforms fail.

CHAPTER 1
PRE-REQUISITES FOR THE INSTALLATION OF HEALTH FINANCING SCHEMES

The main concern of this chapter is that health financing reforms need a strong basis to start and cannot be set in motion overnight. Four concerns are expressed in Chapter 1 regarding the conditions that must be met before a health financing project may start, i.e.:

- **The financing project must rely on a clear development plan of the facilities involved in the scheme, that demonstrates the usefulness of the proposed project and its capacity to function correctly;**
- **A management system must be organised (Article 4);**
- **The community must be involved (articles 4 and 5); and**
- **An effort must be made to identify the poor in order to be able to exempt them from payment (Article 6).**

■ APPROVAL CONDITIONS AND PROCESS

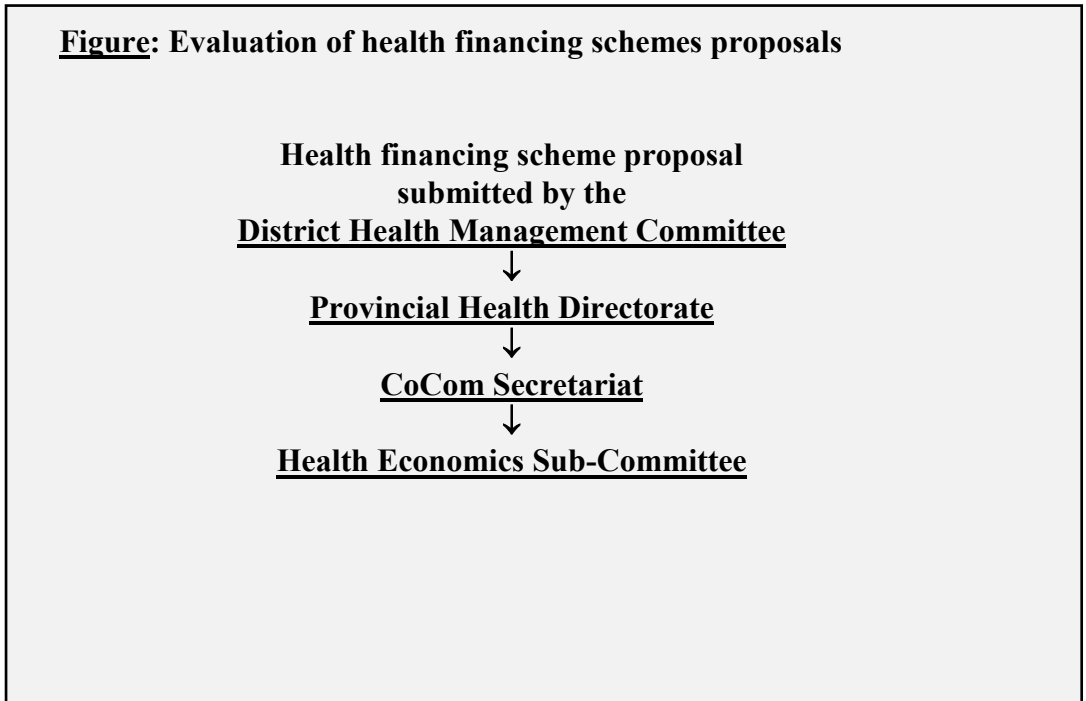
The above are the main constraints that are imposed by the Charter. A financing project will be automatically rejected by the Ministry if any of the above conditions is not met.

The above does not mean that the conditions listed in Chapter 1 are the only conditions for a financing proposal to be approved by the ministry. In fact, all articles of the Charter have to be taken into account while building a health financing scheme proposal, as stated in Article 2:

Article 2:
In order to obtain approval from the Ministry of Health, such a proposal must be prepared by the ***management committee*** *or any other body as locally appropriate. This proposal consists of a document that takes* ***all charter articles*** *into consideration and is submitted to the Health Economics Sub-committee of Co-ordination Committee (COCOM) of the Ministry of Health for approval.*

The Management Committee is responsible to build health financing proposal(s) and to sumit to the Ministry of Health through the Provincial Health Directorate, as shown on the figure beyond. Nonetheless, this responsibility may locally fall to another body. For example, in areas under contracting-in arrangements (see Chapter 4), the contractor NGO in charge of health services management will be in charge.

Figure: Evaluation of health financing schemes proposals



Technical Commission
Evaluates the proposal, gives advice and provide technical support as required

↓

CoCom

↓

Director General

↓

MINISTER OF HEALTH
Formal approval

A fundamental concern is that any health financing project involving the public sector may not start without prior approval from the ministry, as said in article 1:

> **Article 1**:
>
> *No health financing project may be **introduced** in the public sector without **prior approval** of the Ministry of Health.*

This may raise problems in the case of financing schemes that have been in existence before the Charter is issued. Article 1 clearly states that Ministry of Health approval is required for a financing project to be introduced. Here "introduction" refers to both:

- **The introduction of new schemes in areas where no formal scheme is in existence; and**
- **The introduction of major changes within existing formal schemes, such as the change in payment modes and/or fee increase.**

"Formal" scheme has to be understood as practices where fees are set in advance and managed according to defined rules, as opposed to informal practices which occur on a case per case basis at the initiative of individual health staff and on an exclusive profit-for-pocket basis.

Through the above, the Ministry of Health looks forward not to impede NGO supported existing practices, from which there is a lot to be learnt.

It has to be noticed here that no approval is required from financing schemes to start in the private sector, but these experiences may request technical advice from the Ministry of Health.

■ **TECHNICAL PRE-REQUISITES**

The health financing reform is closely linked with the reorganisation of district health services (Health Coverage Plan, Minimum & Complementary packages of services, etc). In fact, there

are not two reforms, but <u>one integrated reform with several components</u>. Both of these components are supportive to each other in doing the best to improve the performance of the public health system in terms of both quality of and access to care.

Articles 3 to 6 aim to enforce this relationship. First of all, a health financing scheme must be considered as a tool for health services development. In other words, the objective is not only money, but <u>money for something</u>, as expressed in paragraph 3.1 below:

Article 3:

Health development plan.

3.1. *A health development plan must be prepared that ensures the* ***quality*** *of health care and that fulfils the requirements as defined by the* ***minimum and complimentary package of activities*** *(according to the health coverage plan).*

3.2. *Such a plan must ensure that there is an adequate number of* ***competent staff*** *to manage such a scheme as well as provide health services.* ***Adequate buildings, supply of drugs and medical equipment*** *must also be provided.*

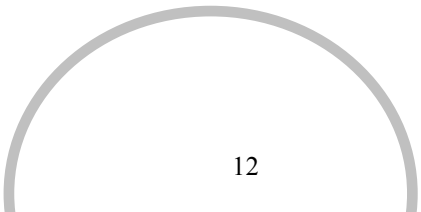
3.3. *This development plan has to be costed and show clearly what the different* ***expected expenditures*** *are and corresponding* ***financing requirements****.*

3.4. *The development plan must demonstrate the capacity of the health financing scheme to* ***function*** *as well as proposed* ***methods for payment and levels of tarification.***

Health financing reforms are expected to make possible the delivery of the Minimum and Complementary packages of services (MPA & CPA), which encapsulates health activities that meet basic health needs and mostly pertain to the range of recognised cost-effective services.

From the organisational point of view, achieving the above implies that <u>specific physical and human resources are available</u>, as well as <u>management capacities</u>, as stated in paragraph 3.2. For example one cannot expect to provide adequate health services if no -or not enough- drugs are available, nor if the health center building has no delivery room. Equally, if health staff do not own a certain amount of knowledge about medicine and management issues, they will not be able to offer proper services on a sustainable basis, i.e. people will not be cured and will turn to the private sector, drug orders will not be made on time, etc...

The above has <u>financial implications</u>: all inputs have a cost, whatever they are. If financing requirements are not well estimated, the system may fail. For example, it will appear impossible to provide communities with service quality improvements they have been promissed under the accepted pattern of user charge. This is why the development plan of the health facilities which fall under a health financing scheme has to be <u>costed</u>, as statd in paragraph 3.3. This implies four main steps:



- **Step 1: Registration of <u>all inputs</u> necessary for health services (output) to be effectively provided;**
- **Step 2: <u>Calculation of the costs</u> of the inputs indentified at step 1;**
- **Step 3: <u>Identification of financial resources</u> to cover costs calculated at step 2, including contribution from the population;**
- **Step 4: <u>Adjustment</u>, i.e. make the expected financial resources to cover the costs as exactly as possible and revise the quantity and quality of inputs and/or outputs accordingly.**

The next point (paragraph 3.4) is absolutely critical for a development plan in the context of health financing reforms to be meaningful; this concerns the capability of the health financing scheme to function on a sustainable basis. This refers to conditions and modes under which user charges are set in motion in order to supplement financing from other sources in meeting the overall cost of health facilities involved in the health financing scheme. The following main issues should be taken into consideration:

- **Expected activity of the health facilities;**
- **Number of people to be exempted from payment;**
- **Costs to be recovered (drugs and other running expenses; performance related payments);**
- **Choice of a mode for payment: alternatives available are payment per visit, payment per episode of disease, differentiated fee per kind of service, pre-payment with possible insurance component regarding referral needs.**

Particular attention will be paid to the level of fees when evaluating health financing scheme proposals. Fees will have to be set at a reasonable level and to be maintained in good balance with the quality of services delivered.

Article 4:

All health financing schemes must ensure a ***management system*** *that guarantees* ***transparency****, systematic* ***monitoring*** *and* ***accountability****, and involves representatives of the* ***community****, in conformity with principles stated in Chapter 2 of the present Charter.*

"Management system" has to be understood as a set of tools of which the combined effect is to help manage health financing schemes effectively. This includes rules and protocols that concern not only financing issues, but the daily life of health facilities as a whole. As a complete management system cannot be expected to be set up overnight, article 4 enforces only basic pre-requisites for the installation of health financing schemes, i.e.:

- **Existence of Management Committees in health facilities concerned by the scheme, with representation of the community, in conformity with the "Guide to operational district development";**
- **Transparent accounting mechanisms set in motion, such as registration of revenues and expenditures (see Article 10 of Chapter 2);**
- **Supervision visits and technical support planned;**
- **Staff functions and responsibilities clearly and nominatively defined.**

Article 5:

Health financing schemes in the public sector can only be developed ***after prior consultation with community representatives****.*

A major component of the Cambodian health financing reform's "philosophy" lies here. This refers to health services' responsiveness to people health needs. Health professionals tend to believe that what they consider as good quality services will be automatically consumed by people, but this may not be true. In fact, a difference may exist between what medical doctors consider as a good service, and what people consider as a good service. ***For example, the location of the health center, business hours, waiting time, privacy, staff attitudes and method for payment pertain to the range of quality components to which people may be sensitive despite not pertaining to most usual medical concerns.***

Consequently, there is a risk people are not really satisfied with the service they are offered. In such a case payment will not be acceptable to them. The involvement of the community prior health financing schemes are set in motion gives a chance to take communities' preferences into consideration and to avoid this problem.

Chapter 2 explains potential mechanisms for community involvement in more detail.

Article 6:

A methodology to identify those members of the community to be ***exempted*** *from payment needs to be put in place. This may be done by undertaking a census and estimating household expenditure or through other locally determined criteria.*

Exemption from payment is a major consideration in organising a health financing scheme, because it may importantly affect the financial balance of that scheme. Generaly speaking, exemption may concern two groups of population, i.e.:

- **The poor; and**
- **People who pertain to designated groups. Considerations specific to Cambodia should be reviewed here, such as the exemption in case of mine or other war-related injuries.**

Both the former and the latter must be the object of a careful review when planning a health financing scheme, because they may seriously impact on the financial equilibrium of the scheme.

The exemption of non-poor groups of population from payment may locally prove of particular importance. For example, the exemption of State employees at a health facility located near a State- owned factory may deprive the scheme from much of its revenue, which may result in bankruptcy unless payments from other groups of population are set at such a level as they allow the medical consumptions of the State employees to be subsidised.
In such a case, the system would more than probably be unacceptable to people who could not afford high costs and/or refuse to pay unless everyone is requested to pay. More generally, the exemption of the formal sector's workers introduces inequity: those who benefit from a regular income (i.e. the better off) do not pay while the others do. In the above example, the problem could be solved by the means of a system through which the State factory would reimburse the health facility for medical services received by its employees. But such a system may prove not well adapted to the current stage of the Cambodian development process, due to the complexity and the administrative costs it would introduce. In addition, the real world is often much more complicated than the situation described in the example.

Article 6 overall aims to ensure the poor to be protected by the Cambodian health financing reform. This point, which is absolutely critical to health financing reform implementation, has been the stumbling block of most health financing schemes in the developing world. Most often, the identification of the poor has been done on a case by case basis, essentially under the responsibility of health staff who determine who is poor and who is not according to cloths or other external characteristics. More sophisticated identification methods exists that could be tried in Cambodia, such as systematic visits to households of the health center catchment area in order to measure their expenditures (as a proxy of their income).

The above method would also give to health staff a chance to better know the population they are responsible for from several perspectives (i.e. what are the geographic specificities of the catchment area, where are people suffering from chronical diseases located, etc.; who is poor). This may also prove useful from a marketing point of view, as it would allow health staff to explain about and promote the services they offer and to gain trust from people.

Other methods exist in order to identify those who cannot pay for health services,such as focus group discussions with selected members of the community. These kind of approach are encouraged by the Ministry of Health.

Articles 5 and 6 could be misappropriate in certain cases and need to be amended, as foreseen by Article 7. It may be locally wished to test health financing models that concern only certain services or certain groups of population. For example, certain donors may advise Family Planning services delivered by public facilities to be paid for, as evidence from abroad demonstrates that people are willing to pay for them.

Article 7:

*Under **exceptional circumstances** articles 5 and 6 may be **amended** in order to test specific models that target certain population groups or specific services.*

However, it must be noticed that partial service delivery approach will be authorised exceptionaly as far as the public sector is concerned. In fact, the integrated package of services approach, which conforms to the District Health System approach, will be priviledged by the Ministry of Health for the two following reasons:

- **The provision of an integrated package of services guarantees a wider morbidity burden to be addressed; and**
- **It is also more appropriate from the economic point of view, as the development of the full package of services will maximise the activity of health facilities and consequently give more chance for substantial amounts of money to be collected and then a larger share of the overall costs to be recovered, among which performance related payments. In fact, the partial development of services would not provide sufficient revenue for the <u>whole</u> health facility team -as stated in Article 13- to be able to receive meaningful performance related payments.**

Nonetheless, using the development of a limited package of services as a support for further development of the whole package may be considered as a nuance to the above. This may be done, *for example*, through the initial development of such services as Family Planning, which has proved highly attractive to people in a number of countries (Nepal, Bangladesh, Pakistan, Somalia and Kenya). We could then imagine that Family Planning -or/and other service(s)- is used as an attractor. Then, once the confidence of women is obtained regarding Family Planning, there may remain little to be done in order other services be demanded as well. If such strategies are foreseen, they should be clearly stated as a suport to the health financing scheme proposal.

CHAPTER 2
COMMUNITY PARTICIPATION / MANAGEMENT OF FUNDS.

This is the chapter of the charter that describes the place of community participation in the financing initiatives. It is composed of three articles; article 8 describes the basis for this participation and the role of the management committees, article 9 describes how the community can get involved in decisions on how vulnerable people can be protected by exemptions and article 10 explains the accounting system and the role of the community therein.

The place for community participation.

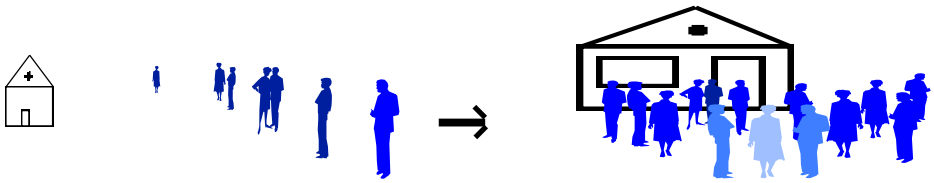
Article 8 *:*

Health financing schemes in the public sector have to be based on the ***participation of the community****, that is to say not only their financial participation but equally their participation in the process of decision making, management of money raised and evaluation of schemes. This depends on community consultation meetings and the promotion, where appropriate, of management committees or other bodies set up in order to develop community involvement.*

This article describes the place of community participation within the overall aim of an improved health service. These notes discuss what community participation actually is and why it is necessary. They then look at what form this participation could take, how it could occur and what the management committees role could be.

Why community participation ?

The overall aim of the Health services is to increase the access to and utilization of the health services, in other words move from the situation shown in A below to that in B. In A, few people are attending the health facility as is the case in many places today. In B, the health center is well used. This is what we are aiming for.



A **B**

The community can contribute to this process by becoming more involved for the following reasons;

*** People will begin to use the health facilities only when they feel the service is giving them what they want. Like service, if people are paying for something they should expect to receive a certain standard of good or service. If this is not forthcoming they then will most likely go elsewhere where they feel they will get better value for their money and not to the government health center.**

*** Community representatives can get involved in the health service and in decisions about what that service is. To ensure that quality improvements are what people actually want, people need to be actively involved in discussions of what makes up such a "quality" service. If they are not involved in this way they will remain at A and people will still go elsewhere, for example to the market for their health care.**

■ What is community participation ?

The policy framework of the charter states that the initiatives will include the 'financial participation' of the users of health services, in other words they may be directly paying for the

service they receive. However, the word participation means much more and this is developed in article 8;

"Communities should be involved equally in the process of decision making, management of moneys raised and evaluation of schemes"

Article 8.

Thus the charter states the community should get involved in decision making (for example on the level of fee, on who will not pay, and on what the money from fees will be used for.), in the management of money raised (including how it is accounted for) and in the evaluation of the financing schemes.

Examples of what the community may get involved in.

What level of fees will be asked for ?

The community representatives know the community well; what people will be willing to pay for a good quality service and what people are able to pay without impoverishing themselves. Although guidelines will be set by the Ministry of Health so fee levels also meet the immediate needs for supplying the service, the community must play an active role in discussions on the final level set.

How to protect the poor or access to certain services ?

Community representatives are appropriate people to input into discussions on which groups of people or which households should be excluded from payment and on how such an assessment will be made and implemented. Country studies have shown that often exemption mechanisms are not effective so it is likely that during the pilot phase different methods of identifying the poor will be 'piloted- tried out' in Cambodia.

How the money from fees will be used ?

Community representatives should be involved in discussions on what constitutes quality improvements and on the use of money collected from user fees. Some of the money will inevitably be needed for salary supplements but the community representatives may, for example want to negotiate the hours health staff are available for consultation.

How the money is managed and accounted for ?

As the money collected at the health facility is given by the community members, their representatives have the right to see how this money is managed. Thus they must have access to any accounts, be able to check these and have a complains mechanism for any irregularities.

Acting on communities complaints.

Community representatives must ensure action is taken on any complaints from the people within the community to the health facility staff or local authorities. There must be a channel between the different levels of community representatives to support this process. For example the community

representatives at the health facility level should be able to differ to district level if they have concerns with the health center services which they have not been able to address locally.

Evaluation.

As active participants in the health services, community representatives should be involved in any evaluation of those health services. For example, if the health facilities are still not busy the community representatives will be able to help assess why and changes made to serve the people better. If people feel involved in decisions about the service provided they will be happier with the service and hence they are more likely to use it and not turn to alternatives.

■ **The role of the management committee**

These issues are decried in articles 8.1 and 8.2 of the charter.

The role of ***Management Committees;***

8.1. *Management committees are a mechanism by which representatives of the community, local leaders and the Ministry of Health meet on a regular basis to monitor, manage and make decisions on the operation of services, including financing issues and the use of funds raised from all sources.*

8.2. *The Ministry of Health will provide guidelines on model management committees , that may differ from province to province and the level at which they are developed.*

The community representatives and the health center staff need to meet as equals. They can discuss together how to improve the health problems in the community and how to improve the services. Together they will make up the management committee.

Components.

*** The meeting must be somewhere which is mutually agreed to and within easy access to all. It could be in the health facility but it may be more appropriately held in a community building such as a Pagoda or a community center.**

*** Membership of the committee should be decided on locally but community representatives should be prominent. The committee should have a chairman (probably a community member), a secretary, set an agenda and keep minutes.**

*** At these meetings the committee will discuss matters pertinent to the provision of a health**

service within the locality. The following for example may be discussed;

- Health problems in the community and how health workers and community members can work together to improve health.

- Health education and how to get messages out to the community.

- Utilization of the health facility and how the community representatives can encourage people to come to the facility.

- Fees and what level of fees should be asked.

- Accounts and how to ensure they are open to the community for checking.

- Monitoring and evaluating, how this will be done and how they will act on the results.

■ **In summary.**

Article 8 describes how any financing schemes in the public sector should have community participation as a component. The following is specifically noted;

1. That communities should be involved in the decision making process.

This means that community representatives should be involved in the decision on, for example what the level of fee should be, who should be exempted and how to assess this etc.

2. That communities should be involved in the management of money raised.

This means that community representatives should form part of the decision process about how the fees will be distributed and how they will be used. For example they will discuss how much will be used for salary supplements for staff and how much for other running costs.

3. That communities should be involved in the evaluation of schemes.

This means that community representatives will form part of the team that will design, take part in and take action on any evaluation that takes place.

The Management committees role is explained in articles 8.1 and 8.2.

They may be a group of people composed of some health facility staff, and some local leaders with other members as decided on by the community. Election on to this committee may be by secret ballot.

The actual composition and function of these committees however will be outlined by guidelines which will be decided on as a result of discussions held both nationally and locally.

Exemptions.

Article 9.

*A system of **exemption** from payment has to be put in place for those too poor to pay. The system of exemption aims to guarantee access to care for all groups in the community, and / or access to designated services, as determined by the Ministry of Health.*

Thus article 9 looks at the role of the community in exemption mechanism i.e. how can they help decide which people should be exempted from payment in order to protect vulnerable groups ?

Background.

According to the Asian Development Bank socio-economic survey households spend a lot of money on health care (up to $42 per person per year in Phnom Penh). Thus many people it seems are willing to pay for health care. However poor people may not afford even modest levels of fees without being forced into greater poverty or falling into a viscous cycle of debt. Thus there needs to be a mechanism to protect such vulnerable groups and exempt them from paying. Likewise exemptions may apply to some services that the government wants to encourage people to use. Such services may include EPI, Ante natal care, TB treatment. In all these services uptake is not only of benefit beyond the immediate consultation. For example if someone is immunized against a disease this leads to less incidence of the disease in the population as a whole. The exact exemption mechanism will also be determined by Ministry of Health priorities.

At present it is the health workers usually who decide whether a person should pay or not. However we cannot be sure if those people exempted really reflects the poverty levels in that province. Thus it seems dangerous to make an assessment from physical appearance alone. Experience in other countries has shown that it is very difficult to come up with a ideal system for deciding who should be exempted.

The role of community representatives in exemption mechanisms.

Who should pay ? **Who should not pay ?**

In Summary.

The people who really know who will have difficulties paying is the community themselves. There may be mechanisms that exist already to identify and help such people. The community must play a strong role in such decisions. This is the basis for article 9.

The accounting system.

Article 10:

*An **accounting system** must be put in place.*

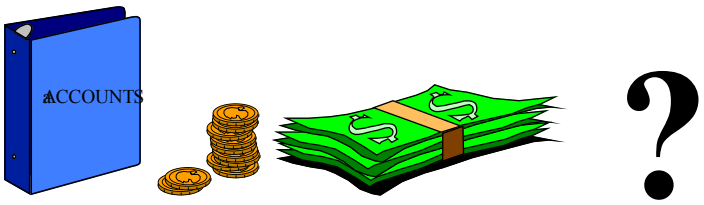
***10.1.** The accountants must maintain all receipts and expenses for facilities involved in health financing schemes, as well as any arrangements between different sources of financing, in accordance with the article 4 of the charter.*

***10.2**. The accounts must be **accessible** on request to the population representatives in the catchment area as well as to representatives of other areas. Accounts will also be provided in a systematic manner to the Ministry of Health officials at National, Provincial, and District levels.*

***10.3.** In addition to accessibility as defined in paragraph 10.2, the accounts have to be **regularly discussed** with the community; this will be achieved within the framework of community participation mechanisms under article 8.*

***10.4.** The accounts systems will be controlled by **inspectors / auditors** from the Ministry of Health / Finance.*

What is an accounting system ?



In any accounting system there has to be a note made of both income and expenditure and receipts must be available to check against these. These accounts must be easily accessible for both the community representatives and the government auditors to review and act on.

■ **What is the communities role in the accounts system ?**

10.2 stresses that the accounts must be available to the community representatives on request. It notes that this should be the representatives in the catchment area but also should be extended to laymen outside this area. This is for a number of reasons; so those persons supporting the community outside the immediate area can gain access and also so that experiences can be shared with neighboring areas.

10.3 states that in addition the accounts must be regularly discussed with the community. This may be by advertising them to the community as a whole, but also the accounts should be used as a tool to monitor progress as a part of the communities role in this as stated in article 8.

■ **What is the role of the Ministries of Finance and Health?**

The Ministry of Health must review and monitor the accounts from every health facility in a systematic manner. They must regularly compile reports on the situation at each level.
As 10.4 states such a process will be further assessed through audit of accounts; a detailed procedure of checking for any irregularities.

■ **In Summary.**

This article is concerned with the accounting system and steps that needs to be taken in order to regulate the financing system. Standard accounting systems will be developed and disseminated to guide this process.

CHAPTER 3
DETERMINING THE CHOICE OF A METHOD FOR PAYMENT, FEE CALCULATION AND THE USE OF MONEY RAISED

Two basic questions must be explored when designing a health financing scheme, i.e. How much money is needed? and How to get the money?

Before setting a health financing scheme in motion, it has to be remembered that the objective is not only to raise additional money, but also to contribute to the improvement of health services' performance and to the consequent improvement of the health status of the population.

The above implies that both:

- **An adequate amount of money comes in; and**
- **Health financing schemes are properly designed.**

It is the objective of Chapter 3 to guide and enforce the above.

■ ENSURE THAT SUFFICIENT AMOUNTS OF MONEY COME IN AND THAT MONEY LEADS TO SERVICE QUALITY IMPROVEMENT

A very basic condition for significant amounts of money to come in is that communities' financial effort toward the improvement of services quality within the public sector are matched by other sources of finance, i.e. Government and donors.

In many countries, health financing reforms have been set in motion in order to compensate for an almost total lack of government funding of non salary running costs. In Cambodia, where major financial support is secured from donors and where the national health budget is expected to increase further, this should be avoided.

If Government funding for the health sector continues to increase, it will be possible to organise a financing partnership, as stated in Article 11(see next page).

Article 11:

*Health financing schemes should take place within the framework of a **financing partnership** between the different actors in the health system (State, donors, community).*

***11.1.** The scheme should be designed to take into account the results from the **costing exercise** in the development plan (Article 3.3), the **communities demands** (Article 12), and the objectives of the scheme.*

***11.2.** Paragraph 11.1 in this article can be amended by the Ministry of Health of the Kingdom of Cambodia to satisfy constraints linked to **contractual arrangement** outlined in Chapter 4 of the Charter.*

Through such a partnership, the Government, donors and the communities will act together toward health services improvement. This means that, for example, if a patient pays Riels 2,000 for an episode of disease at the health center, he will benefit not only from a Riel 2,000 quality improvement equivalent, under the form of drugs or better staff attitudes, but also from the availability of good quality buildings, equipment, etc... Together, the financing partners will achieve more than one of them acting separately.

It results from the above that the larger Government and donors' financial effort will be, the more acceptable payment will be to people. But the latter is true only if two conditions are met, as mentioned in paragraph 11.1, i.e.:

- **If the financing scheme is designed in such a way as to achieve defined quality improvements; and**
- **If quality improvements that are set as objectives respond to people's needs and preferences.**

The first condition refers to Article 3 (Chapter 1) about the health development plan. The development plan states what kind of services will be provided to people, what their quality will be and what their cost will be. The health financing scheme will then have to study how the cost will be shared between the national budget, the donors and the health services' users. This is foreseen in further details in Article 12.

Services responsiveness to people's needs and preferences may prove a complex matter. It is commonly assumed that once reasonable medical standard is achieved, i.e. enough drugs, adequate basic equipment, clean buildings, people are willing to demand the service rather than turn back to substitutes. This is only partly true, because people's choice may be determined by non-medical factors. *For example, anthropologists have discovered that Cambodian people may be reluctant going to a health facility that is close to a police station. As well, evidence from abroad*

exists that in some places people are happy with waiting quite a long time at the health center before being examined, because this enables them to discuss with others in the waiting room (socialisation). **In practice, the best way to know about these kinds of things is to ask people about what they think. This is why the Cambodian health financing reform lies on population involvement in decision-making as one of its major stategies, as refected in paragraph 11.1.**

Where not appropriate, e.g. in certain kinds of contractual arrangements with the private sector (Chapter 4), Article 11 may be amended by the Ministry of Health, as pointed out in paragraph 11.2.

Article 12 makes the link between population payment and quality improvement more explicit. In the Cambodian public health sector, salary is recognised as a major priority if one wants to have health staff at work in health facilities and to have better attitudes. The latter are obvious components of health services quality, but users may prove more sensitive to other components which they consider more concrete (drugs for example). As a result, it may prove totally unacceptable to people to see all their payments used for performance related payments to staff (see Article 13 on this matter). Another concern is the long term sustainability of public health services: drugs currently benefit from large external aid inputs, but they will have to be paid nationaly in the future, which may be unaffordable to the national budget.

The above suggests that population payments should not be used only to cover performance related payments, as mentioned in 12.1 beyond.

Article 12:

Use of money raised.

12.1. *The use made of fees recovered should be determined in consultation with the* ***community*** *and take into account* ***users' health needs****, and the* ***cost of drugs****, medical supplies and* ***performance related payments*** *provided to staff, according to principles defined by the Ministry of Health, in consultation with local authorities.*

12.2*. Once the health financing scheme approved and set in motion, any other kind of payment by the population within the facilities concerned by the scheme must stop.*

As one of the objectives of health financing schemes is to enable health workers to earn their living when working in public health facilities, one should expect unformal payments to stop within health facilities once health financing schemes are in motion. There are several very good reasons for that, which relate to moral considerations and are probably well known by everyone; this is not the purpose of this document to hold such a debate. Let us concentrate on economics.

If both formal and unformal payments coexist, then patients will have to pay twice in order to receive health care. In Cambodia, there are examples of health facilities that have installed formal population contribution practices, but in which under-table payments still exist. This is unacceptable to people not only because they may have to pay quite large amounts, but also because they do not know in advance how much they will have to pay. There is evidence that Cambodian people sometimes have to sell their cattle or even their house, or to get indebt in order to afford treatment. As a result, people may be reluctant to attend public facilities, which results in low levels of activity within these facilities and consequent ineffectiveness and inefficiency of the public health sector. When evaluating health financing schemes proposals and when supervising these schemes, the Ministry of Health will particularly take care of the implementation of 12.2.

In addition to the above, payments to staff must be related to performance. This is a very important point which reflects one of the major orientations of the health financing reform.

Article 13:

*Performance related payments to staff should be determined by the **Management Committee**, following the advice of the Ministry of Health of the Kingdom of Cambodia, under the guidance of the Interministerial Committee according to The Council of Ministers letter no. 1291 of 22 August 1995. These payments should be linked to **performance** as defined by **workload**, **quality indicators** and **the realisation of objectives**. Payments are not confined to clinical staff but are **also for other staff**.*

Here, salary is not considered as a prerequisite to work, but as the result of health staff performance: the best staff do, the more they earn. By the means of the latter, the Ministry of health is looking forward introducing incentives for staff to deliver services that respond to people's needs.

It is assumed that through such a system, facilities that deliver better services will attract more people, and consequently more money. It is thus expected that staff will be encouraged to do the best they can to provide better services.

As stated in Article 13, performance related payments sould be organised in such a way as to:

- **Remunerate staff according to their workload, i.e. both the quantity of work they do and the responsibilities they have;**
- **Remunerate staff according to the quality of the work they do - *For example, bonus could be paid to health centers that have pertinent referral practices.***
- **Take the realisation of objectives into consideration - *For example, if defined outreach activities are not done, then performance related payment decreases.***

In practice, there are a lot of ways to implement the above. However, it is necessary to limit to simple schemes that do not introduce complex administrative procedures and that are clear to everyone. Whatever system is chosen, it will have to concern all staff in the health facility, i.e. not only clinical staff in contact with patients, but also other staff due to their contribution as part of a team acting under an overall quality improvement objective. To such respect, everyone is important and should be remunerated accordingly. *For example, if cleaners are not fairly paid, buildings will be dirty and patients will prefer to go to private practitioners*.

As mentioned in Article 13, it is up to the Management Committees to decide about performance related payments, which implicitely implies that community representative(s) should be involved in the discussions (see Article 8).

■ ENSURE THAT FINANCING REFORMS ACT AS A SUPPORT TO THE ORGANISATIONAL ASPECTS OF THE OVERALL REFORM OF THE HEALTH SECTOR

Articles 14 and 15 relate to the health financing schemes as tools to support the overall reform of the health system. This refers to both:

- **Modes of financing; and**
- **Levels of fees.**

There are several modes of financing available to implementation, ranging from simple fee per visit to more sophisticated pre-payment or insurance schemes. Two broad categories of modes for payment can be distinguished: direct payment; and pre-payment and insurance through which patients pay in advance.

- **In direct payment, patients pay when coming at the health facility. Several kinds of system may be organised here:**

  1. Flat fee per visit: the patients pay a lumpsum amount each time they come to the health facility, irrespective of the disease they have.

  2. Differenciated fee per visit: each time they come to the health facility, the patients pay an amount of money which depends on the quantity and quality of care they receive. *For example, the price to pay for malaria is different from the price to pay for ARI.*

  3. Payment of drugs: the patient must pay the drugs he receives from the health facility, possibly in addition to a flat (1) or differentiated (2) fee for the consultation service he receives.

  4. Flat fee per episode: same as (1), but payment entitles the patients to receive care until they are completely cured, irrespective of the number of visits they need for an episode of disease to be cured (return visits).

5. Differenciated fee per episode: same as (2) with no further payment for return visits (as in 4).

- **In pre-payment, people buy a card to the health center. This card entitles them to seek care for specified kinds and number of visits/episodes of disease. This card may cover one or several individuals from the same family. Pre-payment schemes may have a subscription or an insurance component, or both:**

  6. Prepayment-subscription relates to health needs of which the occurrence is foreseenable or expected. ***For example, if a woman is pregnant -or if she plans to have a child in the near future- she knows that she will need a medical follow-up, and then delivery and post-natal care. As well, even if one does not know what kind of illness he may have, one can reasonably expect to need health care, let us say, three times in a one year period.*** **In such cases, people may wish to "subscribe" to health services to better secure the satisfaction of their health needs. Through such subscription, people are able to plan their health care expenditures and to cover themselves against the risk of falling sick when they have no money (a long time after they have sold their crop, at the same time as another important expenditure, etc.)**

  7. A prepayment scheme may also cover unforeseen health events. In such a case it is a prepayment-insurance scheme. ***For example, if the prepayment scheme includes prenatal and delivery care at the health center (subscription), risk coverage can be introduced for complicated delivery referred to the hospital (unforeseenable event). In this model no extra payment will be requested at the referral hospital.***

- **8. Insurance consists of a risk sharing system through which people contribute to a fund which pays health care providers for services they deliver to patients. In insurance, people pay in advance irrespective of the care they may need and receive in order to cover themselves against health risks whatever they are.** ***For example, an insured person may need only a three days hospitalisation at the referral (district) hospital or a two months stay in Calmette hospital: both are covered by the insurance scheme for the same contribution to the insurance fund.*** **Insurance is based on the concept of "risk aversion", meaning that every individual knows that he may fall seriously ill or have an accident and consequently need costly health care. Once the latter recognised, it looks better to pay a few dollars now and receive no care because no illness occurs, than taking the risk of having to pay hundreds of dollars if a serious health event occurs. Insurance is also based on the concept of "risk sharing", as the healthy pay for the sick, i.e. if one is able to receive costly health care despite modest contribution to the insurance fund, this is because a lot of other people (who have paid the same contribution) do not fall sick and consequently do not consume any health service.**

The major difference between a prepayment-insurance scheme and an insurance scheme is that insurance introduces a third body which acts as an intermediate between health care providers and health care consumers. Insurance schemes may be organised on a national public or a multiple private basis.

In practice, each of the above options has specific advantages and disadvantages from both the financial and the medical-organisational perspectives (see annex for advanced theoretical considerations on these matters).

Article 14:

The choice of a mode of financing by users (i.e. payment per visit, per episode, prepayment, etc.) depends on ***technical and financial constraints****. It should be designed to facilitate* ***access****, encourage* ***continuity of care****,* ***efficiency*** *and* ***good prescribing practice****. It must be organisationally feasible and be within the framework set by the Ministry of Health.*

Technical constraints refer to the organisational feasibility of the different health financing schemes, including such issues as administrative complexity, people potential willingness to agree the scheme, etc. ***For example, an insurance scheme involves complex relationships between the insurance fund and health care providers to be reimbursed for services they deliver. As well, insurance cannot be installed unless it exists a trust relationship between people and the system, i.e. people must first be confident that they will effectively receive care if they fall sick.***

Financial constraints refer to the amount of money to be collected in order to obtain meaningful cost-recovery and consequent meaningful impact on service quality. ***For example, individuals would not be able to afford a significative share of the cost of a major surgery operation (which may go up to several hundreds of dollars), but most of them can contribute a significative share of an episode of disease treated at the health center.*** **This also refer to administrative costs, which are much higher in such systems as insurance or prepayment than direct payment, due to more sophisticated transactions.**

Facilitate access. Health financing schemes should be designed in such a way as to minimise financial barriers. Financial barriers may be either absolute, temporary or relate to uncertainty.

> ***Absolute financial barriers*** **relate to the level of the price to pay in order to access health care. Such price may be too high for certain people, and it is necessary to install an exemption system in order to guarantee the access of all, as stated in Article 9 of the Charter. It has to be considered here that financial constraints supported by people do**

not only relate to the price to pay in order to receive health care, but come in addition to other expenditures they make, for example, on transportation.

Temporary financial barriers **refer to the fact that people may afford the cost of health care at certain periods of the year, but not at certain others, due to seasonal variations of household income. This problem can be solved by prepayment schemes, provided prepayment cards are sold at the adequate period, for example when people have just sold their rice crop.**

Financial uncertainty barriers **refer to the uncertainty on the price to pay in order to receive health care. Such uncertainty may be very high when people are requested to pay several times for a same episode of disease depending on how serious their disease is and what quantity and quality of service they need. Generally speaking, all should be done in order to make clear to people how much they will have to pay.**

Encourage the continuity of care. This relates to the above point about barriers to access to health care, in particular what we have called "uncertainty barriers". Once a patient may be requested to pay several times within a same episode of disease, he may interupt the treatment that he has been prescribed. ***For example, this may happen in a fee per visit system: the patient makes a first visit to the health center which proves unsuccessful and turns back to the private sector or self-medication instead of coming back to the health center. For the same reason, the patient may decide not to go to the referral hospital to which he has been advised to go, then having less chance to be cured.*** **This kind of problem can be tackled by setting up a fee per episode rather than a fee per visit or a prepayment scheme.**

Encourage efficiency and good prescribing practices. "Efficiency" exists when maximum benefit is obtained from limited resources, or when a given result is obtained at least cost. The design of a health financing scheme has always critical implications on efficiency, and if efficiency is not met, the health system is not able to cure all the patients it could. ***For example, in payment-for-drugs schemes (model n°3 above), health staff may be encouraged to overprescribe drugs in order to make more benefits. For the same reason, systems through which patients are requested to pay proportionaly to the care they receive will tend to over-use laboratory examinations, surgery operations, etc.*** **Here again systems that put incentives to rationalise the use of resources should be prefered.** ***For example, health staff working under a flat fee system will naturally tend to limit drug prescription, because they know that they would lose money if they prescribe too much.***

Efficency considerations also liaise to the organisation of the health system as a whole. Questions that fall here concern such issues as the organisation of the referral system, which is designed in such a way as to rationalise the use of resources. Financial barriers can be set up that encourage people to first consult the health center rather than going directly to the referral hospital (former district hospital) as they are used to (see Article 15).

Also critical for a health financing scheme is the level of fees. This liaises with the same constraints as for the choice of a mode for payment, i.e.:

- **How to both raise enough money and limit financial barriers; and**
- **How to design schemes that support the organisational aspects of the health system reform.**

Again, attention must be paid to such issues as the overall financial accessibility of health services, the protection of target population groups, community involvement, etc. as stated in other articles of the Charter.

Article 15:

*Fee levels are established for financial participation accordingly to **Public Health priorities, guidelines from the Ministry of Health, communities' priorities and the ability of individuals to pay**.*
***15.1.** In public health facilities, fees are maintained within **limits set by the Ministry of Health** of the Kingdom of Cambodia; they may however vary within these limits in order to meet **local choices and conditions**.*

It is incumbent to the Ministry of Health, when evaluating health financing schemes proposals, to judge whether fees proposed are acceptable, regarding both:

- **The nature and quality of services delivered;**
- **The mode for payment chosen; and**
- **The socio-economic characteristics of the area covered by the scheme.**

Standard lists of fees corresponding to different kinds of services and different kinds of mode for payment will be developed later, when sufficient knowledge and experience will have been gained from the first stages of the reform implementation process.

***15.2.** A lower fee may be set for patient care at the first level than for that at the referral hospital. The purpose of this is to **guide demand in accordance to referral system principles** and to limit direct access to referral hospitals as a first option.*
*Patients bypassing the first level of care should pay more than referred patients. Exception will be made for **acute** emergencies.*

Point 15.2 emphasises the role of health financing schemes as a support to the organisation of the referral system. Financing systems should be designed in such a way as to encourage people not to bypass first level health centers. Preferably, the referral outpatient consultation at the referral hospital should be provided free of charge to patients who are referred by health centers and a high prohibitive fee should be charged for patients who have bypassed the health

center. If a fee is charged for referred patients at the outpatient referral consultation, two risks would be faced:

- **People may be reluctant to consult the health center because of financial uncertainty (see above), i.e. they do not know in advance if they will have to pay once or twice;**
- **People may not go to the referral consultation as they are advised to do in order to avoid a second payment.**

Exception must be made in the case of acute emergencies. There is no universal definition of acute emergencies, which liaises to both the objective medical condition of a patient and how the patient perceives his condition. In practice, it may prove quite difficult to judge if having bypassed the health center is justified or not. Whatever, it must be recalled that health center staff will be made competent in providing basic first care in emergency situations, and that they should be bypassed only in exceptional circumptances, i.e. health center closed, distance to the referral hospital shorter than distance to the health center, catastrophic health hasard such as mine injury, etc.

15.3. Fees are established in consultation with the ***community.***

15.4. The list of fees must be ***publicised*** *in health facilities.*

15.5. Fees should be maintained at ***constant levels****, and should be revised only once every 12 months. Exceptions are dependent on Ministry of Health approval.*

In order to ensure that fees are acceptable to people, there is a need for:

- **The community to be involved in their determination;**
- **The level of fees to be made clear to everybody.** ***For example, the list of fees may be posted at the entrance of the health center, in public administrations, pagodas, and published in newspapers*****;**
- **The level of fees not to change often.** ***For example, if fees are increased after a two months period, people may believe that they will increase further and consequently not trust the system. Reversely, if fees remain at a constant level people will get used to them, be able to better foresee their health expenditures and consequently feel more comfortable with the system.***

CHAPTER 4
CONTRACTUAL ARRANGEMENTS AND RELATIONS BETWEEN THE PUBLIC AND PRIVATE SECTORS.

This chapter outlines the possibilities of improving health services through the introduction of contractual arrangements or other such arrangements in both the public or private sectors. These allow 'market orientated' thinking normally seen in the private sector to be used in the management of the public sector. Through the use of incentives they aim to improve the appropriateness, efficiency and quality of the services delivered.

These explanatory notes outline what a contract is and consider why contractual arrangements are beneficial. Each of the articles within chapter 4 are then discussed.

What is a contract ?

A health related contract is no different from any other contract where two parties agree on terms for a certain piece of work. For example a contract with a builder would note the quantity and quality of work expected for a given price. Likewise in Health care the contract would include what outputs are expected (quantity) and of what quality for a given budget.

Example of components in a contract.

The building contract.

Project - Building of an small garden house.

Outputs - Building 8 meters square with good quality brick work and internal plastering. Door of hardwood, varnished and with lock.

Inputs - Materials needed - bricks, mortar, plaster, nails.

Labor cost - Specified

Total cost - Paid in specified payments.

Term of contract - work finished by end of week 6.

In this case, if the contract is broken i.e. the outputs are less than specified or the quality of the work is poor, then the builder has not met the obligations of the contract and will not therefore get paid the full amount (input) unless or until the situation is rectified.

The health facility contract.

Project - Provision of a health service.

Output examples.

a) Provision of the minimum package of activities.

Specifics - ANC clinic - three mornings a week

- U5 clinic and EPI - Five mornings a week.
- Birth Spacing clinic - two mornings a week
- Opening hours - Specified.
- Night cover - specified.
- Quality control - specified.

b) Increase in attendance's / Minimal attendance level.

c) Training outputs - specified.

d) Community meetings - specified.

Inputs.

Materials needed - Drugs and running costs.

Labor / staff costs - Specified

Total cost - _ Paid in specified amounts.

Term of contact - __ months with __ monthly review.

In this case, if the contract is broken i.e. the services are not available as specified, then the money will not be paid in full until such a time as the agreed outputs are forthcoming.

Why contractual arrangements may be beneficial ?

■ What is the problem with the present system ?

At present, budget is linked to activity and released to health facilities in relation to the activity level of the province as a whole and to the province population. It is not however directly linked to the services given at each health facility nor to the quality of those services i.e. it is not specifically linked to performance. In such a situation there is little incentive to even effectively deliver a service, nor to increase client attendance. This can lead to a situation contrary to that hoped for, i.e. a service that is inappropriate, inefficient and of poor quality.

■ How can contracting improve the situation ?

Contracting is a tool which firstly allows services to be delivered as the emphasis is on output. Secondly it enables 'performance related' budget release to be developed by linking the quantity and the quality of specific outputs to budget. Under such a system, if health staff show they can provide certain priority services at defined quality standards and that the facilities are well used, then they will receive a certain allocation of money. However the release of money will no longer be guaranteed. In such a scenario health staff are known as the *providers* of health services and the government, as it provides the money (budget) to run the service is known as the *purchaser* of these services. As this introduces a form of division between the purchaser and the provider, such a situation is known as a '*purchaser provider split'*.

Thus budget is linked to a *package of activities* and to specific performance related criteria. The package itself will be designed according to government health priorities though adapted to local conditions and community decisions as outlined in chapter 2 of the Charter. Minimum standards of quality required will also be included. An extension would be if salaries are also linked to this system to reward performance. The later will be discussed under article 20 below.

Possible components in a *package of activities*.

- **MoH may outline a system whereby provision of specific health services are rewarded financially. If, for example the MoH wants to encourage antenatal care it may provide money for each new case seen. Likewise it may reward immunizations given.**
- **MoH may encourage certain non-service activities. For example training sessions with TBAs may be rewarded or Health education sessions at health centers or community outreach work.**
- **MoH may encourage quality improvements, for example by linking budget to clinic opening hours to rational drug use.**

In Summary contracting is beneficial if it promotes stronger independant management and encourage the reform process. In order to achieve this contracting should act toward:

- **Decentralisation;**
- **Autonomous budget;**
- **Personnel reform; and**
- **Salary structure reform.**

The Charter and contracting.

Article 16:

*Provincial Health Departments, Districts and public service provider units will be given **autonomy** to manage their operations within a given budget.*

The Provincial Health Departments, Districts and public service provider units must meet the terms as laid out in the contract. However, outside of this stipulation, how they manage their operations on a day to day basis is a matter for the unit itself to decide and they will be given the money to do so. This is what we mean by autonomy. Such a situation increases ownership and motivation within the health facilities and focuses on outputs as the indicator of an effective service.

Article 17 :

*The operations of different levels of the public sector may be controlled by a form of service **contract (or annual service agreement)** that specifies a budget and the quantity and quality of services to be provided for that budget.*

This article explains how operations can be controlled by a contract (or annual service agreement) which links the quantity and quality of services to be provided (the output) and the budget (the input) that will be given <u>if</u> such services are provided. This is the principle outlined in the first section of these notes ("what is a contract"). An annual service agreement is a similar but less formal agreement and is between existing public sector structures.

Article 18 :

*The Ministry of Health may contract with Provincial Health Departments to ensure that expenditure is **directed to health priorities and cost-effective services.***

As explained above, though the service provider has autonomy to manage operations within a given budget, the Ministry of Health may contract with the Provincial Health Department to direct services according to the Ministries health priorities.

Example.

MoH may require that the contracts they draw up with provider units reflect their priorities. For example; n,

**** Services provided - Birth spacing - clinic should be provided min of 6 hours per week.***

**** Output - EPI must be increased in catchment area by 10 %***

**** Quality of Care - Staff must be present for 5 hours per day and 5 days per week.***

**** Cost effectiveness - Treatment guidelines must be followed and illness episodes treated at least effective cost.***

Article 19 :

*Provincial Health Departments may contract with district or service provider units to provide the services they require - this **can include private sector services** (for clinical, management, non-clinical or other services). Such contracting will be done to achieve the **best value-for- money** available and such contracts will be made available for inspection by the Ministry of Health.*

This article points out that contracts drawn up between PHDs and the service providers need <u>not</u> be limited to the public sector and that contracts may also be extended to the private sector. This means that not only will the public provider units be competing for the available money as outlined above, but may also be competing with the private sector or benefiting from competition already existing in the private sector. Again this should lead to efficiency gains, as, whoever performs better will receive most money. Those that perform badly and provide few services of poor quality are unlikely to win contracts and will receive little money.

■ **Contracting out of services.**

Here, some of the services provided by facilities are 'contracted out' to private sector companies, who, as they will be competing for these contracts with other private sector companies will 'sell' their service at a competitive rate. The system is similar to gaining quotes from builders. Thus the money is government 'public' money but the provision may be private and in this case, if the services are contracted out, the public sector has no direct role in service provision. Competition for the contracts is expected to promote efficiency. Such contracting may apply to partial services such as patient food, cleaning, or transport but also to total health service provision by the private sector.

Example;

Partial service contract - Many countries have experience of contracting non-clinical services. Nigeria has contracted out laboratory services, Lesotho and Thailand catering and security. Competition between firms providing such services should keep costs down. However no proper evaluation has yet been carried out of these mechanisms. Chapter 5 of the Charter thus puts emphasis on the importance of evaluation of any pilots so that full assessment can be made.

Total service contract - In Namibia private doctors are routinely contracted to provide surgery services in remote rural areas. They get paid by the MoH on the basis of workload and the number of procedures carried out. They cost only 75% of a full time government appointee. In Zimbabwe the MoH contracts with mine hospitals to provide services for the local population. The hospital charges the MoH directly for the service on a fee for service basis.

It should be noted however that information required for contracting out are high and cost studies are needed to determine whether private provision *is* cheaper. Evaluation and audit as outlined in chapter 5 of the charter will be very important in such an assessment. It must be remembered also that one of the main aims is to improve *access* to an effectively run service.

Article 20 :

*The Ministry of Health will consider and test **innovative** contractual arrangements within the public sector and between public and private sectors.*

There may be the possibility to test innovative, in other words any creative and more unusual type of contract and these should be considered. This article is included in order that the MoH is open to new ideas that have been successful elsewhere and which could be tested in Cambodia.

Examples may include but are not limited to the following;

- Contracts with health workers where pay is related to performance as an incentive.

- Contracting in private doctors or others staff into the public sector by allowing some private beds in public hospitals.

- Contracting in of management.

■ **Incentives for health workers.**

Here, Health workers get paid according to their performance and get a budget also according to this i.e. they have incentives to provide a quality service. This could include preventative services given, number of patients seen, hours of clinic opening, availability of staff etc. This budget is given proportional to work actually done and the quality of service provided.

■ **Contracting in.**

Here, the idea is to attract in to the public sector, competencies (skills and human resources) from the private sector in order to improve the public sector.

Example:

Private beds in public hospitals.

By having some private beds in public hospitals doctors are encouraged to stay in the public sector as they can increase their income with private patients. It also serves to bring money into the public sector, to increase patient choice, and to increase competition with the private sector.

Contracting in of management.

Here, the MoH contracts in management of the facility or health catchment area from the private sector. The MoH draws up a contract with potential managers who bid to provide a certain level of service and gives a budget to provide that service. The managers aim to keep costs low as well as cover their own costs and importantly, within the contract, ensure delivery of services. Management would have full control of operations.

Example : The PHD in Kampong Cham has decide to contract in management to improve the delivery of services in one of its ADD areas. Two NGOs and a businessman are interested. They therefore put together a bid in the form of a file where they give an outline of what services they will provide (within MoH guidelines), at what cost and how they will assure quality of care. The PHD will choose the bid which offers the best value for money and the bidder who appears most capable of fulfilling the task.

Article 21 :

*The Ministry of Health will also consider and, where feasible , test other public subsidy options that might include **voucher schemes, franchising** of services and other **subsidized private delivery** of Health care.*

This article is included in order to open options to involve the private sector in the reform process. Such options will be of benefit to both sectors and specifically will increase the cooperation between the two. The following options give examples of how this mutual beneficial process may work.

■ **Voucher schemes.**

Vouchers are a pre-payment method whereby clients buy from defined outlets a number of vouchers in advance (often at a low cost) which can then be used to seek health care at a later date. Such vouchers should be able to be used at any health facility, that is in both the public and the private sector. Thus the money follows the patient. However the MoH would need to approve the health facilities first by setting up guidelines for accreditation which would include

presence of certain quality criteria. The MoH or an association appointed by the MoH will then reimburse the facility for services given. Such a system would have a number of advantages;

*** Health facilities will compete with each other for clients and this will lead to improved services.**

*** Private clinics need to fulfill certain minimum criteria in order receive vouchers.**

*** Vouchers may be given free of charge to vulnerable groups thus improving their access to care.**

Franchising.

This is a method whereby the State or private providers try to improve the quality of the private sector by creating and advertising a 'quality label' which the providers can only display if they fulfill certain criteria. The government will formulate an agreement with these private facilities whereby they agree to provide and maintain certain quality standards in return for being able to use the 'quality label'. The public will be made aware that such providers have reached a basic minimum standard. The public is expected to prefer these upgraded services and non-franchised providers thus have an incentive to adjust their standards in order to compete.

Example.

Private practitioners or pharmacies may be able to apply for a special quality label which they can display and advertise to potential clients. However in order to obtain such a label they will need to fulfill certain criteria. For example a private doctor who has beds will need to show he has adequate staff, and equipment before being allowed to use the 'label'. Likewise the pharmacist may need to review the drugs he/she has on sale. Consumer awareness also needs to be raised as to the quality to be expected from franchising. Regulation mechanisms also need to be in place.

■ **Other subsidized private delivery of health care.**

The MoH may want to encourage delivery of certain services in the private sector in accordance with MoH priorities. For example there are a number of services that are a great benefit to the health of the population such as public health activities and immunizations and which the government wants to encourage. Schemes may be developed therefore, where, for example, private health facilities agree to provide certain services free to their catchment population and in return the MoH reimburses their costs possibly with a small incentive.

Article 22 :

*In order to provide and develop such options the Provincial Health Directorates will have to be **strengthened** in their role as **commissioners** and **regulators** of health services.*

This article is a recognition of training needs and capacity building arising from the fact that such contractual and other such arrangements in both the public and private sectors are a new concept within the health field of Cambodia. The Provincial Health Department will play an important role both as regulators and purchasers of health care and as such their role need to be strengthened. Thus they will act as authorities controlling contracts and policing the process. Such strengthening may take the form of skills training, the formulation of guidelines, and supportive visits as well as an upgrading of administrative capacity.

Article 23 :

*The Ministry of Health will encourage the development of **appropriate standards and legislation** with which to regulate contracts - especially those with the private sector - to ensure minimum quality standards.*

The aim of contracting is to increase the level of service delivery within Cambodia. To accomplish this however there needs to be in place a strong system of regulation which is supported with appropriate legislation. Regulation should include standards for monitoring and evaluation of the contract together with provisions designed to deal with problems in contract implementation. Legislation will then detail specific legal action that will be taken in the event of non - fulfillment of contract. The success of such regulatory mechanisms are essential for the accomplishment of the financing reforms.

CHAPTER 5
FOLLOW-UP AND EVALUATION OF HEALTH FINANCING SCHEMES.

In many ways, evaluation is the most important section of the charter as building a policy is an process and one that will need successive adjustments to perfect. The explanatory notes therefore begin with consideration as to why follow -up and evaluation is so important and what are the areas that need assessment. Within the Charter this chapter has three articles explaining who is responsible for monitoring and evaluation, what will be involved, and how the results will be acted on.

Why Follow-up and evaluation is important.

If any new scheme is to be successful there must be follow-up. Many schemes have failed simple because this element is lacking. But why is it so important ? There are a number of reasons:

- **The design of schemes are never perfect and it is only by beginning implementation that we find out what will and will not work. Follow-up is important in order to make relevant changes in design.**
- **The initial schemes will be carried out on a pilot basis and standard follow-up will be needed for comparison.**

- **Monitoring and evaluation is a valuable way of training and capacity building amongst those involved.**
- **Monitoring and evaluation gives an opportunity for all involved to voice their concerns. Many of the proposed pilots have been successful in other countries. However success is often based on country specifics and opportunities and constraints may be different.**
- **If there are difficulties these need to be identified and rectified as soon as possible.**

What are we trying to assess ?

A) Has the process of implementation been correct ?

If there have been problems in implementing the reforms this is as much a criticism of the designers as of the implementers. Thus analysis of whether the process of reform is correct is one of particular interest to policy makers. Questions they may ask with some examples are as follows;

*** *Have the intended institutional reforms in the sources and management of health finance and in the provision of services occurred ?***

For example;

Is an appropriate amount of money coming from government and consumer fees ?

Is the central MoH acting as intended as support to PHDs ?

Are PHDs acting as intended as commissioners and regulators of any contracts ?

At what level are decisions on resource allocation and use made ?

*** *Are finances flowing as intended ?***

For example;

Is the appropriate amount of money used for salary supplements and quality improvements?

Is the government budget being dispersed as intended ?

*** *Are incentives functioning as intended ?***

For example;

Are incentives being paid to facilities or staff performing well ?

Are private facilities offering subsidised services ?

Are private facilities applying for franchise ?

Are quality improvements evident in public and private facilities ?

*** *What unanticipated changes have occurred ?***

For example;

What changes have occurred that were not considered, either beneficial or otherwise ?

**** Has the policy making process changed appropriately ?***

For example;

Are decisions being made at the appropriate level ?

**** Has the capacity to analyze reforms strengthened ?***

For example;

How far is the central MoH leading the process of policy making and making decisions based on information from the field ?

**** Is the reform process owned by the implementers ?***

For example;

Do policy makers own the reforms and feel able to act appropriately in the event of any irregularity.

Is the MoH active in pushing forward progress at provincial level ?

**** Can the cost involved in setting up the process be sustained ?***

For example;

Are the costs involved in implementing the reforms (transaction costs), greater than the amount of money received from cost recovery ?

Can the increased costs resulting from increased utilisation be covered by the MoH in the long term in accordance with predicted economic growth.

B) Assessments of the effects of the financing reforms.

The reforms need to be assessed in terms of the overall objectives and in particular there is a need to assess the following four areas.

Equity **- here an assessment needs to be made of how much people are paying for health services and whether those who are poor are paying less, as intended. This could be done by looking at the income and asset level of clients who pay and do not pay. Also needed is an assessment of whether those with the greatest need are in fact using the services more. Part of this assessment for example can be a demand survey. First an assessment is made of the determinants of demand for health care and the level of this demand. Changes that occur after the introduction of pilot schemes are then carefully monitored and the effect noted on demand over time in different income groups.**

Efficiency **- Here there is a need to assess whether health services are being used in the most cost effective way and if resources are being allocated to maximize efficiency ? This would include an**

assessment of allocative efficiency, for example, how the MoH budget is allocated and its effects. Also it would cover technical efficiency, the cost effectiveness of care. For example this could include the number of drugs prescribed per outpatient visit or the percentage of people receiving injections.

***Sustainability* - The reforms need to be both financially sustainable and institutionally sustainable. For example the cost recovery rate needs to be monitored and the gap between revenue and costs funded by external agencies. Also the capacity of health staff to manage the reforms and the adequacy of human resources and institutional structures to support the changes.**

***Acceptability* - A Health service will only be acceptable to clients if quality improvements are forthcoming. However what is deemed to be a quality service by the community may differ from that perceived by health professionals and this must be considered. Consumer satisfaction and choice therefore must be assessed. Finally of prime importance is how acceptable the reforms are to the providers and purchasers of health care themselves. If it is not the system will simply be blocked.**

Some of the above can be assessed by on-going data collection and periodic review at the health facility level but others will require community surveys and more detailed scientific assessment.

The Charter and follow-up and evaluation.

Article 24 :

The evaluation and monitoring of the health financing schemes are the responsibility of provincial and national health authorities.

24.1. *Follow-up depends on the development of* ***appropriate indicators*** *developed for this purpose - for example quality of care indicators, attendance at health facilities, their financial performance as well as on the analysis of data collected by the Health Information system of the Ministry of Health of the Kingdom of Cambodia.*

24.2. *Regular* ***supervision*** *visits will be organized that will aim to evaluate the technical and managerial performance of health facilities involved in health financing schemes.*

24.3. *Supervision and monitoring will be the subject of periodic evaluation reports and an annual summary report.*

24.4. *Results of evaluation will be* ***shared with communities****.*

The people responsible for evaluation and monitoring will be provincial and central health departments, but also the hospitals and health centres themselves. To enable this to occur, the following will be developed;

- *Indicators* - article 24.1 notes some of the indicators that could be used. They go beyond the present Health information system and highlight those areas which are of particular importance to financing. Thus quality of care indicators will need to be developed and also simple analysis of financial performance.

- *Supervision* - It is important to the success of any programme that it is adequately supported to ensure that the health facility staff have the capacity to carry out the reforms and receive training to do so.

- *Evaluation reports* - Reports will need to be compiled on a regular basis to assess progress at national level and to compare the progress of the different units and programmes. This work is also essential to enable MoH to decide which of the pilots should be tried out on a larger scale.

- *Community and evaluation* - The results of any evaluation should be widely disseminated within the catchment population so the process is as open as possible. This could be through community meetings and should not be limited to the community representatives of the management committee.

Article 25 :

Management committees will be fully involved and participate in all monitoring and evaluation of health financing schemes.

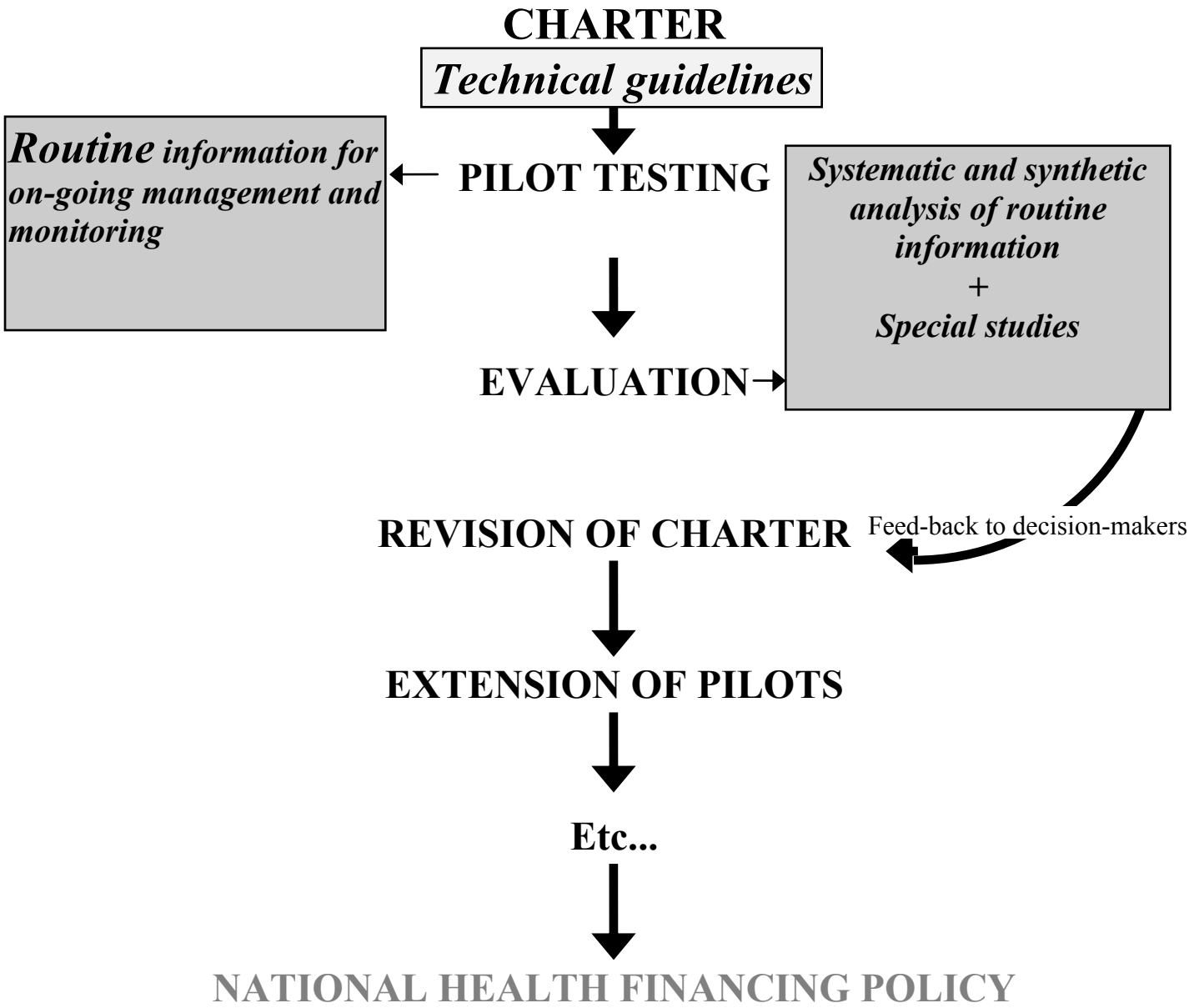
As explained in chapter 2 the management committee will be made up of health staff and also members of the community. To encourage transparency and obtain views from <u>all</u> involved, the management committee must be the leading players in the process.

Article 26 :

The Ministry of Health of the Kingdom of Cambodia can bring to an end, unilaterally and at any time, all or any part of an agreed health financing scheme or project if it does not meet the conditions stated in the present charter or for any reason that is deemed appropriate by the Ministry of Health.

This simply states that if, as a result of evaluation it is shown that the conditions of the charter are not fulfilled or there is any other problem as defined by the MoH with any one scheme, the MoH can take action to bring to an end such a scheme.

CHAPTER 6
APPLICATION AND REVISION OF THE CHARTER



The first objective of the Charter is to " develop a *framework* in which a variety of Health financing schemes can be developed, systematically *tested and evaluated*, in conformity with and as support to the organisational reform of the Cambodian health system."

Thus the Charter is simply that - A *framework that will be developed, tested and evaluated. - In other words it is the beginning of a process.*

Chapter 6 explains with whom responsibility lies in this process ;

- Who has the remit to amend the Charter ?
- What is the process for revision ?
- Who will move the process forward ?
- How will this be done ?

Article 27 for example puts the responsibility firmly with the Ministry of Health to interpret and guide others in the contents of the Charter.

Article 27:

The Ministry of Health of the Kingdom of Cambodia is responsible for all decisions relating to the ***interpretation*** *of the contents of the present Charter.*

Article 28 gives the procedure for partial or total revision, extension or revision. If any changes are needed to the Charter these will first be discussed with the inter-Ministerial Committee but the actual changes will be made by the Ministry of Health.

Article 28:

The extension of the present Charter, as well as the partial or total revision or deletion of any of its component parts will be taken at the initiative of the Ministry of Health, after submission to the Inter-Ministerial Committee.

Article 29 is explicit in that it reads that no third Ministry can amend the Charter unless the request first goes through the Council of Ministers.

Article 29:

*No request for the **amendment** of the present Charter from a third Ministry will be considered by the Ministry of Health unless emanating from the Council of Ministers of the Kingdom of Cambodia.*

The final article, article 30, refers to the responsibility for moving the process further. Thus it highlights that it is the responsibility of the Ministry of Health to produce and disseminate technical guidelines as are necessary to aid the implementation.

Article 30:

It is incumbent on the Ministry of Health to produce and disseminate technical guidelines as necessary to implement the current Charter.

In summary.

The Ministry of Health has the following responsibilities;

- Interpretation of the Charter and decisions related to such interpretation.

- Revision of the Charter *after* submission to the Inter-Ministerial Committee.

- Production and dissemination of technical guidelines to *Implement the Charter.*

The Council of Ministers has the following responsibility;

- To consider any request from a third Ministry for amendment of the Charter *before* it is considered by the Ministry of Health.

The inter-Ministerial Committee has the following responsibility;

- To consider any revision, extension or deletion submitted by the Ministry of Health.

ANNEX

Criteria for funding situation	**Direct payment (consultation /episode)**	**Insurance (National Public)**	**Insurance (Multiple Private)**	**Prepayment-subscription**	**Prepayment-insurance**	**Public Financing (Free)**
Costly, unforeseen and rare events	Low recoverable portion, unless considerable inequalities are accepted	Particularly indicated, because of risk sharing		Not applicable	Difficult to implement because no intermediary	The State is less and less able to assume the costly events in an adequate **way**
Inexpensive and unforeseen events	Appropriate, but no precautio-nary savings from the patient	Not suitable because administrative costs are too high.		Not applicable	Particularly well adapted	The State's diminishing means can lead to bad quality services
Inexpensive and foreseen events	Appropriate, but no precautio-nary savings from patient - Under-used	This no longer comes under the logic of insurance		Strongly recommended	Not applicable	The State's diminishing means can lead to bad quality services

Relating to decentralization strategy	Appropriate if funds are managed by the local collectivity	Contradiction	No harmony because of different geographi-cal zones	Appropriate; if funds are managed by the local collectivity	Appropriate if budgetary decentralization
Relating to community participa-tion	Appropriate	Contradiction		Appropriate	Possible, but less real interest by the popula-tion

Difficulty in the design and setting-up of the system	Quite easy, especially at time of each consultation	Very difficult	Requires an already existing and performing network	Not too difficult if health care package is well defined	Requires a detailed analysis of costs by competent staff	Not applicable
Difficulty in putting into practice by health personnel	Quite easy	If directly reimbursed to user, identical to direct payment. If reimbursed to institution, a strict book-keeping and follow-up required		Important factors are time and collection of funds, but no reimbursement involved and no invoicing (except in case of limited level of reimbursement)		Not applicable
Risk of misappro-priation of funds	Staggered payment system restricts the amount available at a given time.	Risk of "misappropriation" or "loan" from the State	No, except in the case of bankruptcy	Tempting, particularly if premiums are all collected at the same time (for example the crop season)		Not applicable

Administra-tive costs per consultation	Low	Low for expensive consultations, but very high for inexpensive consultations	Low	Not applicable

between patients	Yes, if tariffs are related to the type of illness and not	Not applicable, unless by means of a co-payment, or by introducing criteria of exposure to risk (such	Normally no, if package of services is limited	Not applicable except through limited level of	

	to cost	as smokers)			reimbursement	
in the whole population	Not possible	This is the whole purpose of risk-sharing		No, or very little	Yes, risk-sharing	
in a given group of population	Not possible	Not applicable	Yes, namely, community schemes	Yes, if subscription is defined in relation to a group	No, this is not the objective	

As far as a health center is concerned, this is not appropriate since it is free (but in case of scarcity, it can organize a sort of spreading its limited resources, depending on criteria of solidarity)

Vertical solidarity	Tariff relating to individuals' characteristics (differentiation between children, women, the poor, but difficult to adjust according to income)	Premiums correspon-ding to individuals' characteristics Yes, if insurance is compulsory, but difficult if salaries are low	Premiums correspon-ding to individuals characteristics Possible but more limited (except in the case of private insurance)	Yes, particularly if the management committee with community participation is able to establish criteria as a result of its intimate knowledge of the population	

At national level, the collection of State financial resources is taking criteria of vertical solidarity into account

Table from J. Perrot, WHO/HQ/ICO, Presentation at the National Health financing Conference, Phnom Penh, 5-9 February 1996.