Annex A. Ethics approval

Ethics Committee approval
[Photocopy of the letter giving official Ethics Committee approval to be attached]

Respondent Information Sheet for participants involved in key informant interviews, focus group discussions and exit interviews

We would like you to participate in a study about the cost and the problems of using government health services. The purpose of the study is to look at different ways to make it easier for poor people to get free health care at government hospitals and health centres. We want to ask you questions about what happens when you or someone in you family gets sick or needs a doctor. We want to ask you about paying fees when you go to the hospital or health centre, about something called health equity funding, and about health insurance. If you have heard about these things we want to ask for your opinion. This study is being made by the Ministry of Health, the World Health Organization, and an Australian university called RMIT University. We might ask you to answer some questions or to join a group to talk about these things. Your name will not be recorded and you will never be identified, so you can give your opinions and they will not be told to anyone else. If we ask you to be a 'key informant' then you will be identified only by your position and only after you sign the consent form.

Statement of Informed Consent

I have read the Respondent Information Sheet about the study of financial access to health services for the poor and the nature of the study has been explained to me. I understand what the study is about and I understand that I will participate in one of the activities that have been explained to me, as a key informant, as part of a focus group, or as a patient in an exit interview. I give my consent to participate in one of these study activities. I understand that everything I say will be confidential and my name will not be used. If I am a key informant I understand that my position may be mentioned in reports about the study but my name will not be used and I approve of this.

Annex B. Data collection instruments

Key Informant Interview questionnaire for OD, MHD and PHD

1. What are the existing health financing schemes that operate in your facilities (User Fees, exemptions, Contracting, HEF, CBHI)?
2. What are the benefits gained from each of these financing schemes for the health care providers and for patients [direct financial benefits, and indirect benefits like improved perceptions of the population, improved quality of care]?
3. What does your hospital or health centre do to help the poor to access health services?
4. Do you think that all the poor have access to free health care? If not, why not?
5. Do you think that poor people and other patients still go to private health services or to private pharmacies for their medical treatments? If so, why? If not, why not? For what disease especially?
6. Is the official User Fee schedule known to patients? How do patients find out about the fee schedule? Do patients find the fees too high?
7. Has the User Fees scheduled been revised at any time? How many times? When?
8. Why were changes and revisions made to the fee schedule?
9. Who makes the decision about the level of fees and about revisions?
10. Is the User Fee schedule publicized to the community?
11. Is the community consulted about the fee schedule?
12. A recent study in Phnom Penh found that treatment charges at the MH increased for HEF from 2003 to 2004 (e.g. normal deliver 55,000 increased to 57,000). How much is a normal delivery now? Do the walk-in patients [non-HEF, non-SKY] pay the same amount?
13. Do patients often ask for exemptions when they come to the facility?
14. Explain how the exemption system works? Who gives the exemption? How is the exemption processed?
15. What are the main achievements of the Contracting process in your OD?
16. Do you want Contracting to continue?
17. What will happen in the OD when Contracting ends?
18. Do HEF and CBHI provide a good source of revenue for the facility?
19. How is the extra revenue from User Fees, HEF and CBHI used?
20. Have you found any evidence that staff at the facility take under the table charges? From HEF or CBHI patients? From other patients?
21. A recent study in Phnom Penh said that walk-in patients [non-HEF, non-SKY] at the MH probably have to pay under the table charges. Is this true? How much are unofficial fees?
22. A recent study in Phnom Penh said that HEF patients are making up a larger share of MH utilization (e.g. increase in ALOS c.f. walk-in patients). Is this still true?
23. A recent study in Phnom Penh said that there was evidence of over-servicing regarding HEF patients at the MH. Is this still true?
24. Do you think HEF and CBHI have helped poor people and other people to get services they need?

25. Do you think the HEF and CBHI schemes are fair? Do you know of any people with HEF who are not poor? Do you know of any poor people who do not have HEF?
26. For what services do patients usually use their HEF or CBHI cards? Why for these services and not others?
27. Do you find that there are poor walk-in patients [non-HEF, non-SKY] who should have HEF but do not?
28. Do you think that the benefit package included in HEF and or CBHI are good or are some things missing from the package that should be included? Which is missing in the package?
29. Do patients paying User Fees, those with HEF, and those with CBHI all get the same treatment at the hospital or health centre? If not, why not?
30. A recent study in Phnom Penh found that the quality of care at the MH is better for HEF patients than walk-in patients [non-HEF, non-SKY] (e.g. ALOS is longer for HEF). Why is this?
31. Do User Fees provide a good source of revenue for the facility? How is this used?
32. When your hospital or health centre receives money for HEF or SKY patients, how is this money paid? How often? Is it paid in advance or only after the service has been given to patients?
33. Is this for the fees for the services provided or is it a capitation payment?
34. Which payment method do you think is best? Why?
35. Do you think there has been an effective collaboration between service providers, Contracting, HEF and CBHI? How can collaboration be improved?

KII questionnaire for NGO Contractors

1. What are the main aims and purposes of the Contracting method? Have these aims been achieved?
2. Do you think that Contracting has helped to increase people's access to public health service? If so, why? If not, why not?
3. Do you think that all the poor have access to free health care? If not, why not?
4. Does Contracting target the poor?
5. What health financing schemes operate in the Prov. Hospital, Referral Hospital and the Health Centres (User Fees, exemptions, HEF, CBHI)?
6. Is there a schedule of official User Fees at the facility?
7. What activities have there been to publicize the fee schedule among the population?
8. Are patients always charged exactly the amount that is listed on the User Fee schedule when they get treatment at the facility?
9. Has the User Fees scheduled been revised at any time? How many times? When?
10. Why were changes and revisions made to the fee schedule?
11. Who makes the decision about the level of fees and about revisions?
12. Is the User Fee schedule publicized to the community?
13. Is the community consulted about the fee schedule?
14. Do User Fees prevent some people from attending the facility?
15. Have you found any dissatisfaction among patients about the User Fees?

16. Do patients have to pay additional under the table charges?
17. What does the Contractor do to provide access to health services for the poor? Is there any process of targeting the poor for special treatment? How is this done (individual, geographic, category)?
18. Is there a user-fee exemption system for the poor (not including HEF or CBHI)? What other groups are given exemptions? If there are no exemptions for the poor, why not?
19. What is the core target population identified for exemptions? Are these people the poorest of the poor? How is this defined?
20. What is the mechanism for identifying poor people who receive exemptions, and why is this approach used? How did this approach evolve over time?
21. Explain how the exemption system works? Who gives the exemption? How is the exemption processed?
22. What does the exemption pay for (hospitalization, transport, food, other)? Are these full or partial payments?
23. Has the exemptions system been effective in providing access for the poor? What proportion of patients at the PH, RH and HC receive exemptions?
24. Does the Contractor provide or support HEF and/or CBHI in the OD?
25. Do HEF and CBHI increase attendance at the facility?
26. Do User Fees, CBHI and HEF provide good sources of revenue for the facility?
27. When money is paid to the facility for HEF or SKY patients, what method is used? How often is payment made? Is it paid in advance or only after the service is given to patients? Is this for the fees for the services provided or is it a capitation payment?
28. Which payment method do you think is best? Why?
29. What are the gaps or problems in the HEF and CBHI benefit packages? What is missing in each package?
30. Do you think there has been an effective collaboration between service providers, Contracting, HEF and CBHI? How can collaboration be improved?

KII questionnaire for HEF managers

1. What health financing schemes operate at the facilities covered by HEF (User Fees, exemptions, Contracting, HEF, CBHI)?
2. What activities have there been to publicize the fee schedule among the population?
3. Is the User Fee schedule always applied and properly applied at facilities?
4. Do patients find the fees too high?
5. Do patients often ask for exemptions when they come to the facility?
6. Do staff at the facility take under the table charges? For HEF patients? For other patients?
7. A recent study in Phnom Penh said that walk-in patients [non-HEF, non-SKY] at the MH probably have to pay under the table charges. Is this true? How much are unofficial fees?
8. A recent study in Phnom Penh said that HEF patients are making up a larger share of MH utilization (e.g. increase in ALOS c.f. walk-in patients). Is this still true?

9. A recent study in Phnom Penh found that the quality of care at the MH is better for HEF patients than walk-in patients [non-HEF, non-SKY] (e.g. ALOS is longer for HEF). Why is this?
10. What are the strengths and weakness of HEF compared to the CBHI and Contracting?
11. What are the gaps or problems in the HEF benefit package? What is missing in the package?
12. What is the core target population identified for HEF beneficiaries? Are these people the poorest of the poor? How is this defined?
13. What is the mechanism for identifying people who receive HEF, and why is this approach used? How did this approach evolve over time?
14. How is this approach compared to other approaches used in Contracting or CBHI?
15. How does the profile of HEF hospital users compare to the profile of general hospital users? (geographic, socio-economic, gender, age)?
16. Do you think that all the poor have access to free health care? If not, why not?
17. To what extent do people understand about the value of HEF cards and to what extent do they use the cards in accessing health services?
18. Do you think the poor and other patients still go to private health services or to private pharmacies for their medical treatments? If so, why? If not, why not? For what disease especially?
19. What are the relative advantages of pre- and post-identification?
20. Are HEF cards provided both to pre-identified and to post-identified patients?
21. What are the pre-identification costs per household?
22. What does the HEF pay for (hospitalization, transport, food, other)? Are these full or partial payments?
23. When money is paid to the facility for HEF patients, what method is used? How often is payment made? Is it paid in advance or only after the service is given to patients? Is this for the fees for the services provided or is it a capitation payment?
24. Which payment method do you think is best? Why?
25. Do you think there has been an effective collaboration between service providers, Contracting, HEF and CBHI? How can collaboration be improved?

<u>KII questionnaire for CBHI managers</u>

1. To what extent do people understand the philosophy and practice of CBHI?
2. Do you think that all the poor have access to free health care? If not, why not?
3. Does CBHI target the poor?
4. What health financing schemes operate in the facilities covered by SKY (User Fees, exemptions, Contracting, HEF, CBHI)?
5. What activities have there been to publicize the fee schedule among the population?
6. Is the User Fee schedule always applied and properly applied at facilities?
7. Do patients find the fees too high?
8. Do patients often ask for exemptions when they come to the facility?

9. A recent study in Phnom Penh said that walk-in patients [non-HEF, non-SKY] at the MH probably have to pay under the table charges. Is this true? How much are unofficial fees?
10. Do staff at the facility take under the table charges from SKY patients?
11. A recent study in Phnom Penh said that HEF patients are making up a larger share of MH utilization (e.g. increase in ALOS c.f. walk-in patients). Is this true also for SKY?
12. A recent study in Phnom Penh found that the quality of care at the MH is better for HEF patients than walk-in patients [non-HEF, non-SKY] (e.g. ALOS is longer for HEF). Is this true also for SKY patients? Why is this?
13. What is the core target population identified as CBHI beneficiaries?
14. What are the mechanism(s) for identifying CBHI beneficiaries and marketing the SKY scheme? Why is this approach/these approaches used? Have there been changes over time?
15. How are premiums collected from SKY policy holders? How often is this done? Have you made any changes to this procedure over time?
16. Are CBHI identification cards provided to CBHI beneficiaries?
17. How does the profile of CBHI hospital users compare to the profile of general hospital users? (geographic, socio-economic, gender, age)
18. What is the level of premiums paid by CBHI beneficiaries?
19. Are premium payments subsidized in any way by any other group or organization?
20. What patient costs are paid by the CBHI (OPD, IPD, transport, food, other)? Is this full or partial payment?
21. What are the gaps or problems in the benefit package offered by CBHI and other schemes? What is missing in the package?
22. When money is paid to the facility for HEF or SKY patients, what method is used? Who makes the payment? How often is payment made? Is it paid in advance or only after the service is given to patients? Is this for the fees for the services provided or is it a capitation payment?
23. Which payment method do you think is best? Why?
24. Does SKY represent its policy holders in negotiations with the facilities about their health care and treatment needs, and the quality of services given?
25. What is the average CBHI cost of services provided per IPD patient? Per OPD patient?
26. Do you think there has been an effective collaboration between service providers, Contracting, HEF and CBHI? How can collaboration be improved?

<u>Questionnaire for Focus Group Discussion with HEF beneficiaries</u>

1. Have you seen the schedule of official User Fees at the hospital or health centre?
2. Is the User Fee schedule publicized to the community?
3. Is the community consulted about making the fee schedule?
4. Do you always pay exactly the amount that is listed on the User Fee schedule when you get treatment at the hospital or health centre?

5. Do you feel that you cannot go to the hospital or health centre because the User Fees are too high?
6. Do you often hear people complaining about the User Fees at the hospital or health centre?
7. How did you hear about the health equity fund?
8. Were you interviewed for HEF in the village, or when you went to the hospital or health centre?
9. Do you have an HEF card? Who is included on your HEF card?
10. Do you think the process of selecting people for HEF is fair? If so, why; if not, why not?
11. Do you know of any families who are poor but who don't have an HEF card? Why not?
12. Do you know any families who are wealthy but who do have an HEF card? Why?
13. Do you think people are cheating with the system? How?
14. Have you (or any of your family) used the HEF card to get treatment at the hospital or health centre? If not, why not?
15. What sickness did you or your family have when you used the HEF card?
16. Why did you use your HEF card to get treatment for this sickness?
17. Were you satisfied with the treatment you received or not satisfied? If not, why not?
18. Did you have to pay extra money to get the treatment you needed? What for?
19. Before you had your HEF card did you use a hospital or health centre when you were sick? If not, why not?
20. Did you recently receive treatment at the hospital or health centre but did not use your HEF card? Why?
21. Do you think people who use HEF get the same treatment as those who pay the full fee? If not, what is the difference?
22. Do you think the health staff treat patients with HEF differently than non-HEF? If yes, Why?
23. Can you tell the health staff to give you good treatment? If not, why not?
24. Do the HEF representatives help you to talk with the health staff about your treatment?
25. What are the benefits of having the HEF card?
26. Are there any disadvantages to having the HEF card?
27. What things do you want to include in the benefit package that are missing now?
28. When you or someone in your family is very sick where do you go first for treatment [traditional healer, pharmacy store, private practitioner, health staff at home, health centre, referral hospital]?
29. For what sickness? For what kind of treatment? Why?
30. When you or any member of your family chose to go to the private clinic, traditional healer, pharmacy, or a private practitioner coming to treat at home, why do you do this?
31. How do you get the money to pay for medical treatment in the private sector?
32. Do you know any families who have now become very poor because they had to pay a lot of money for a health emergency?
33. Where do people find the money to pay for these big health costs?

34. Do you have debts now for paying health costs in the last 24 months? If so, how much?
35. Have you sold any assets in the last 24 months to get the money to pay for health costs?
36. Now that you have an HEF card, will you need to borrow money or sell assets when you are sick?

Questionnaire for Focus Group Discussion with CBHI beneficiaries

1. Have you seen the schedule of official User Fees at the hospital or health centre?
2. Is the User Fee schedule publicized to the community?
3. Is the community consulted about making the fee schedule?
4. Do you always pay exactly the amount that is listed on the User Fee schedule when you get treatment at the hospital or health centre?
5. Do you ever feel that you cannot go to the hospital or health centre because the User Fees are too high?
6. Do you often hear people complaining about the User Fees at the hospital or health centre?
7. How did you hear about the CBHI scheme?
8. Which members of your family are included on your CBHI card?
9. What does the term “health insurance” mean to you?
10. When did you begin to pay for your CBHI policy? Why did you decide to join CBHI?
11. Where do you get money to pay for the CBHI scheme? Who do you pay to? How much?
12. How much longer in the future will you continue to pay for CBHI?
13. What are the benefits to you of having the CBHI scheme?
14. Are there any disadvantages to having the CBHI scheme?
15. What do you think is missing in the CBHI benefit package that you want?
16. Have you (or any of your family) used the SKY Health Centre or Municipal Hospital in Phnom Penh with your SKY policy? If not, why not?
17. What sickness did you or your family have when you used the CBHI card?
18. Why did you use your CBHI card to get treatment for this sickness?
19. When you used your CBHI card to get treatment, were you satisfied with the treatment you received or not satisfied? If not, why not?
20. How did CBHI pay the money for your treatment? Who did they pay to?
21. Did you have to pay extra money to get the treatment you needed? What for?
22. Before you had your CBHI card did you use a hospital or health centre when you were sick? If not, why not?
23. Are there any sicknesses for which you have received treatment at the hospital or health centre but did not use your CBHI card? Why?
24. Do you think the health centre and hospital staff treat patients with CBHI differently than non-CBHI? If yes, Why?
25. Can you tell the health staff to give you good treatment? If not, why not?

26. Did anyone from CBHI go with you when you went to the health centre or hospital for treatment or help you to solve problems at the health centre or hospital?
27. When you or someone in your family is very sick where do you go first for treatment (traditional healer, pharmacy store, private practitioner, health staff at home, health centre, referral hospital)?
28. For what sickness? For what kind of treatment? Why?
29. When you or any member of your family chose to go to the private clinic, traditional healer, pharmacy, or a private practitioner coming to treat at home, why do you do this?
30. How do you get the money to pay for these services?
31. If CBHI paid the same money for the private sector as well as the government facilities, which one would you go to? Why?
32. Do you know any families who have now become very poor because they had to pay a lot of money for a health emergency?
33. Where do people find the money to pay for these big health costs?
34. Do you have debts now for paying health costs in the last 24 months? If so, how much?
35. Have you sold any assets in the last 24 months to get the money to pay for health costs?
36. Now that you have a CBHI card, will you need to borrow money or sell assets when you are sick?

Questionnaire for Focus Group Discussion with Non-Beneficiaries of HEF or CBHI

1. Have you seen the schedule of official User Fees at the hospital or health centre?
2. Is the User Fee schedule publicized to the community?
3. Is the community consulted about making the fee schedule?
4. Do you always pay exactly the amount that is listed on the User Fee schedule when you get treatment at the hospital or health centre?
5. Do you feel that you cannot go to the hospital or health centre because the User Fees are too high?
6. Do you often hear people complaining about the User Fees at the hospital or health centre?
7. When you pay for User Fees where do you get the money from?
8. Do you ever have to pay extra money for treatment? What for?
9. Do you often ask for an exemption when you go to the hospital or health centre? Is this often given?
10. If you do receive an exemption, how does the system work? Who gives the exemption? How is the exemption processed?
11. Do you know of any schemes that help to pay health centre or hospital charges for poor people? (HEF or CBHI?)
12. How did you hear about these schemes?
13. Do you know any families who have an HEF card?
14. What do you think are the benefits of having an HEF card?

15. Are there any disadvantages to having an HEF card?
16. How are the poor people who get an HEF card identified [in the village or at the hospital or health centre]? Who identifies these poor people?
17. Do you think this process is fair?
18. Do you know any families who are poor, but don't have an HEF card?
19. Do you know any families who are wealthy, but do have an HEF card?
20. What does the term "health insurance" mean to you?
21. Why did you decide not to join the CBHI scheme?
22. What do you think would be the benefits to you of having the CBHI scheme?
23. Do you think there would be any disadvantages to having the CBHI scheme?
24. What do you think still missing in the CBHI benefit package that you want?
25. Do you think people who receive free (or subsidized) treatment with exemptions or HEF or CBHI get good services the same as those who have to pay the full amount?
26. Can you tell the health staff to give you good treatment? If not, why not?
27. When you or someone in your family is very sick where do you go first for treatment (traditional healer, pharmacy store, private practitioner, health staff at home, health centre, referral hospital)?
28. For what sickness? For what kind of treatment?
29. When you or any member of your family chose to go to the private clinic, traditional healer, pharmacy, or a private practitioner coming to treat at home, why do you do this?
30. How do you get the money to pay for the health services you need?
31. Do you know any families who have now become very poor because they had to pay a lot of money for a health emergency?
32. Where do people find the money to pay for these big health costs?
33. Do you have debts now for paying health costs in the last 24 months? If so, how much?
34. Have you sold any assets in the last 24 months to get the money to pay for health costs?

Questionnaire for Exit Interviews at Referral Hospitals and Health Centres

1. What is the age and sex of the patient?
2. What sickness did you have when you came to the hospital?
3. Are you satisfied with the treatment you received or not satisfied? If not, why not?
4. Did you have to pay the official hospital or health centre User Fees?
5. Did you pay other charges as well? What for [unofficial charges, drugs]?
6. Did you know how much the official fees would be before you came here?
7. Did you get an exemption from User Fees? If so, why?
8. Have you heard about a HEF or SKY insurance fund?
9. Will the HEF or SKY insurance fund pay for your treatment?
10. Do you or your family have an HEF card? – IF THE ANSWER IS NO GO TO Q20
    11. Before you had your HEF card did you come to this hospital or health centre when you were sick? If not, why not?

12. Who is included on the HEF card?
13. When do you use your HEF card to get treatment and for what kind of sickness?
14. Did you use your HEF card for this visit? If not, why not?
15. Are you happy with the way the health staff treated you? If not, why not?
16. In the last 12 months have you received treatment at a hospital or health centre but not used your HEF card? Why not?
17. What are the benefits of having the HEF card?
18. Are there any disadvantages to having the HEF card?
19. Do you think the HEF process is fair to everyone? If not, why not?

20. Do you or your family have a SKY card or any other insurance coverage? If not, why not? – IF THE ANSWER IS NO GO TO Q30
    21. Before you had your SKY card did you come to this hospital or health centre when you were sick? If not, why not?
    22. Who is included on the SKY card?
    23. When do you use your SKY card to get treatment and for what sickness?
    24. Did you use your SKY card for this visit? If not, why not?
    25. Are you happy with the way the health staff treated you? If not, why not?
    26. In the last 12 months have you received treatment at a hospital or health centre but not used your SKY card? Why not?
    27. What are the benefits of having SKY insurance?
    28. Are there any disadvantages to having SKY insurance?
    29. Will you <u>stop</u> paying for your SKY card in the future? When? Why?
30. As well as User Fees or HEF or SKY, did you pay more money to get the treatment [including consultation, drugs, transport, food, other]?
31. Do the health staff treat patients with exemptions or HEF or SKY differently than those who pay fees? If yes, Why?
32. During the last 24 months, when you or someone in your family was very sick where did you go <u>first</u> for treatment [traditional healer, pharmacy store, private practitioner, health staff at home, health centre, referral hospital]?
33. If you chose to go to the private clinic, traditional healer, pharmacy, or a practitioner coming to treat at home, why did you do this?
34. How do you find the money to pay for medical treatment at the private sector?
35. Did you borrow money so that you could pay for the cost of treatment for this visit?
36. Do you have debts now for paying health costs in the last 24 months? If so, how much?
37. Did you sell any assets to get the money to pay for your treatment?

Annex C. Data collection schedules

Site visits (Phnom Penh) Oct. 06	Monday 9		Tuesday 10		Wednesday 11		Thursday 12		Friday 13	
	am	pm	am	pm	am	pm	am	pm	am	pm
Travel to site: begin 8am										
Meet with MH Director, MHD, OD										
Collect HIS data from MH records										
Collect HIS data from HC records x 8										
Collect data from URC, USG, GRET										
Interview key informants at the MH, MHD, OD										
Interview key informants at the HCs										
FGD with HEF beneficiaries (2 groups/USG)										
FGD with SKY beneficiaries (2 groups/GRET)										
FGD with non-beneficiaries (2 group/USG)										
Exit interviews of MH patients (50x5 days)										
Exit interviews of HC patients (30x 8 HC)										

Site visit schedule (Ang Roka) Nov. 06	Monday 21		Tuesday 22		Wednesday 23		Thursday 24	
	am	pm	am	pm	am	pm	am	pm
Depart Phnom Penh 6am								
Meet with Swiss Red Cross								
Meet with Takeo PHD								
Interview KI at Takeo PHD								
Collect HIS data from PHD records								
Meet with OD, RH								
Interview KI at Takeo PH								
Interview KI at Ang Roka OD, RH								
Collect HIS data from OD/RH records								
Interview KI at the HCs								
Collect HIS data from HC records x 9								
Arrange FGD with HEF and non-beneficiaries								
FGD with SKY beneficiaries (2 groups/SKY)								
FGD with HEF beneficiaries (2 groups/AFH/CFDS)								
FGD with non-beneficiaries (2 group/SRC)								
Interview KI at SRC								
Arrange exit interviews at 9 HCs								
Exit interviews of AR RH patients (20x5 days)								
Exit interviews of HC patients (10x 9 HC)								
Return to Phnom Penh: depart 2pm								

Annex D. Powerpoint summaries at training workshops

Access Study Training Workshop, Ministry of Health, Phnom Penh, 5-6 October 2006 – Phnom Penh site visit (summary of Powerpoint presentation)

Day 1 Opening
Workshop Agenda
Workshop Opening
Introduction/Summary
Focus Group Discussions
Key Informant Interviews
Exit interviews at facilities

Introduction and Summary
This is the second phase of the Study of Financial Access to Health Services for the Poor that began in July 2005. Phase 2 of the Study began in July 2006 and will finish in June 2007.

Purpose of Phase 2
To test the arguments developed in Phase 1 that:
User fees reduce costs of accessing public health services.
Exemption systems have not worked effectively to protect the poor.
Financial barriers remain for access to services for the poor.
Contracting works to improve the quality of service delivery.
With Contracting, the poor benefit from improved service delivery,
but it does not target the poor.
HEF is the main means for providing access to health services for the poor.
HEF works to relieve the financial burden of health care costs.
There is a need to strengthen HEF management practices and collaboration with facilities.
HEF will be needed for many more years before CBHI/SHI has adequate coverage.
CBHI targets the not-so-poor who have formal- and informal-sector employment.
CBHI and HEF schemes are complementary.
CBHI and HEF give users more 'purchasing power'.
Donors must support Contracting, HEF and CBHI to make them sustainable.

Financing Schemes
Phase 2 will collect data on four different health-financing and pro-poor schemes:
User Fees
Contracting
HEF
CBHI.

Case Studies
Phase 2 will carry out in-depth case studies in a number of health districts:
Phnom Penh (at the Municipal Hospital and 8 health centers)

Ang Roka OD (Referral Hospital and 9 health centers, and Takeo Provincial Hospital)
Other districts if time and resources are available.

Data collection techniques
Quantitative data on utilization, revenues and exemptions collected from the MOH HIS and from NGO implementers.
Key informant interviews with the Facilities, PHD, OD offices, and local and international NGOs.
Focus group discussions with HEF beneficiaries, SKY beneficiaries, and non-beneficiaries.
Exit interviews with patients leaving the health facilities following consultation or treatment.

Ethics Approval
The qualitative data collection must follow procedures laid down by the Ethics Committee:
Respondent Information Sheet
Statement of Informed Consent

Site visit activities
Research calendar: October, November
Interview teams: Quantitative, KII, FGD, EI
Arrangements for site visits
Site visit schedule of activities
Recording and transcription of interviews

Research Calendar
October 9-13 - Phnom Penh site visit to Municipal Hospital and Health Centers
November 17 - One day training workshop for Ang Roka data collection (in Phnom Penh)
November 20-24 - Ang Roka site visit to Takeo Hospital, Referral Hospital and Health Centers

Quantitative Data Collection
Municipal Hospital and Health Centers (MOH)
HEF and CBHI providers (Peter)
Questionnaires
MOH database

Interview Teams
HIS data collection: Eang, Seilaphiang, Bony, Lunsithan
Key Informant Interviews: Peter, Eang, Chean, Sopheada
Focus Group Discussions: CAS x 6 (facilitators and note takers)
Exit Interviews: CAS x 8 interviewers

Arrangements for Site Visit
Begin 8am each day
Meet at Municipal Hospital each morning
Use your own transport; lunch at home

CAS will organize exit interviewers and FGD facilitators
USG/GRET will organize FGD participants
Follow site visit schedule

Site Visit Schedule of Activities
Meet with Hospital Director, MHD, ODs
Collect HIS data from Hospital records
Visit 8 health centers to collect HIS data
Interview key informants at the Municipal Hospital and MHD
Interview key informants at ODs and health centers
Interview key informants at NGOs
Complete exit interviews with Municipal Hospital patients
Complete exit interviews with patients at 8 health centers
Conduct focus group discussions with HEF beneficiaries
Conduct focus group discussions with SKY patients
Conduct focus group discussions with non-beneficiaries

Recording and translation
Key informant interviews: note taking and tape recording; checking notes; summary; translation.
Focus Group Discussions: note taking and tape recording; checking notes; summary; translation.
Exit interviews: coded questionnaire; data base entry.

Focus groups
FGD schedule, location and timing
Focus Group Discussion questionnaire
HEF beneficiaries (arranged by USG)
SKY beneficiaries (arranged by GRET)
Non-beneficiaries (arranged by USG)
Informed consent
Facilitators and note-takers (CAS)
Recording (taping and note-taking)
Transcription and translation

Key Informant Interviews
KII schedule and timing
Municipal Hospital, MHD, ODs (Eang and Peter)
Health Centers (Chean and Peter)
NGOs (Peter and Sopheada)
Semi-structured question guides
Key informants
Informed consent
Recording (tape and note-taking)
Transcription and translation

Exit interviews
Exit Interview schedule and timing
Exit interview arrangements
Exit interview questionnaire
4 interviewers at MH; 2 interviewers per HC
Number of respondents:
  Municipal Hospital – 50/day x 5 days
  Health Centers – 8 HC x 30 patients
  Total sample – 490 respondents
Interview every patient leaving the facility
Informed consent
Coded questionnaire (without taping)

Summary
Coordination
Training workshop
Site visit
Other activities

Access Study Training Workshop, Ministry of Health, Phnom Penh, 17 November 2006 – Ang Roka site visit (summary of Powerpoint presentation)

Introduction
Workshop agenda
Introduction to Ang Roka
Site visit schedule of activities
Travel arrangements to Takeo and use of cars
Accommodation and food
Interview teams: KII and quantitative, FGD, EI
Quantitative data collection: PHD, OD, RH
KII interviewers and arrangements
FGD meetings and arrangements
Exit Interviews sample, arrangements, equipment
Recording and transcription of interviews
Exit interviews: questions and discussion
FGD: questions and discussion
Key informant interviews – training

Ang Roka OD
Takeo Provincial Hospital (CFDS)
Ang Roka Referral Hospital (SRC, HNI, AFH, SKY)
Ang Roka 9 Health Centers (SRC, SKY)
Contracting (SRC)
Health Equity Funding (HNI, AFH, CFDS)
CBHI (SKY)

Site visit activities
Takeo PHD and PH
Ang Roka OD and RH
Key informant interviews and quant. data
Focus Group Discussions
Exit interviews at RH and HCs
Travel, accommodation and other arrangements

Travel and accommodation
Travel to Takeo Monday morning
Meet at Takeo Provincial Hospital
Accommodation at Takeo or Ang Tasom
Meet 7am each day at Ang Roka OD
Cars will take you to data collection sites
Arrangements for food and drinks

Key Informant Interviews

PHD and PH – Peter and Eang
Ang Roka OD and RH – Peter and Eang
9 Health Centres – Bony and Phat
Collect HIS data where available
Follow KI questionnaires and probe for answers
Focus Group Discussions
SKY beneficiaries (Tram Kak and Prey Chuor through GRET)
HEF beneficiaries Takeo PH (CFDS – from hospital patients)
HEF beneficiaries Ang Roka RH (AFH – select from HEF lists)
Non-beneficiaries (see SRC)
Facilitators: Sokha and Long
Organiser: Thikar

Exit interviews
Ang Roka Referral Hospital: each day from Monday afternoon
3 health centres each day: Tuesday, Wednesday, Thursday
Referral Hospital: 20 per day (including bed census)
Health Centres: 10-15 per day
Tables, chairs, refreshments, incentives
Finish remaining RH and HC Friday morning

Ethics Approval
The qualitative data collection must follow procedures laid down by the Ethics Committee
Respondent Information Sheet
Statement of Informed Consent
Recording and transcription

Data collection
Key informant interviews: note taking and tape recording; checking notes; translation.
Focus Group Discussions: note taking and tape recording; checking notes; translation.
Exit interviews: coded questionnaire; data base entry.

Annex E. Respondents and informants

Table E1. Exit Interviews conducted

Location	No. interviewed
Phnom Penh	
Municipal Hospital (RH)	220
Health Centres:	
SKY HC at PPMH	13
7 Makara	34
Red Cross	30
Anlong Kngan	32
Kilo 9	32
Chamkar Doung	34
Toul Kork	33
Pochentong	34
Total number	462
Ang Roka	
Ang Roka RH	95
Health centres	
Ang Roka	20
Trapeang Andaeuk	21
Prey Sbath	11
Prey Chuor	15
Ta Phem	15
Ang Tasom	21
Trapeang Pringh	15
Kous	14
Tram Kak	18
Total number	245

Table E2. Attendance at Focus Group Discussions

Focus Group	Location	Arranged by	Attendance
Phnom Penh			
HEF beneficiaries group 1	Anglong Kngan	USG	14
HEF beneficiaries group 2	Boeungkak and 7 Makara	USG	15
SKY beneficiaries group 1	Formal sector	GRET	13
SKY beneficiaries group 2	Informal sector	GRET	15
Non-beneficiaries group 1	Anlong Kngan	USG	6
Non-beneficiaries group 2	Boeungkak and 7 Makara	USG	15
Ang Roka			
HEF beneficiaries group 1	Doun Keo (Takeo Hosp.)	CFDS	18
HEF beneficiaries group 2	Ang Roka Hospital	AFH	9
SKY beneficiaries group 1	Tram Kak	GRET	15
SKY beneficiaries group 2	Prey Chor	GRET	14

Non-beneficiaries group 1	Doun Keo (Takeo Hosp.)	SRC	15
Non-beneficiaries group 2	Trapeang Chouk	SRC	17
Total number of beneficiaries			166
Average number per group			14

Table E3. Key Informant Interviews conducted

Key Informants	Interviewed by	Number
Phnom Penh		
Provincial Health Department and Municipal Hospital	MOH	4
OD Directors	MOH	4
HC Directors	CAS	7
NGO service providers	PLA	7
Ang Roka		
Provincial Health Department and Provincial Hospital	PLA/MOH	3
OD Directors and District Hospital	PLA/MOH	3
HC Directors	MOH	9
NGO service providers	PLA	5
Total number of Key Informants		42

Table 4.4 Key Informants interviewed

Organisation	Position	Name
Phnom Penh		
Phnom Penh MH	MH Director	Dr Say Sengly
	MH HEF focus person	Ro Bun Heng
	Chief of Maternity	Kim Po Lin
MHD	Director (and HSUP)	Dr Veng Thai
	HSUP Manager	Dr Suor Salan
OD Kandal	OD Director	Nhep Ang Keabos
OD Lech	OD Director	Dr Im Socchat
OD Cheung	OD Director	Lim Kim
OD Tbong	OD Director	Kan Man Prathna
Health Centers:		
7 Makara	HC Director	Thoeung Chhi Leang
Red Cross	HC Director	Nhim Agkebos
Toul Kork	HC Director	Phup Sareth
Pochentong	HC Director	Ouk Narin
Anlong Kngan	HC Director	Rose Nhoeun
Kilometre Lekh 9	HC Director/Vice-Director	Sao Sarin/Chheng Sarat
Chamkar Dong	HC Director	Heng Sereyvuth
SKY HC at PPMH	HC Director	
URC	HEF Director	Tapley Jordanwood
GRET	Director	Cedric Salze
USG	Director and HEF manager Field workers	Lim Phai, Sok Kunthea So Soksan, In Samphirachny
MoPoTsyo	Director	Maurits van Pelt
Total number		24
Ang Roka		
Takeo PHD	PHD Director	Om Sokhom
	Deputy Director/Contracting	Nhea Sithan

Takeo PH	PH Director	Hem Sareth
Ang Roka OD office	OD Director	Prak Bunthoeun
	Deputy Director/HCs	Chan Neary
Ang Roka RH	Director	Heng Thy
Health Centers:		
Ang Roka	HC Director	Yem Limhuon
Trapeang Andaeuk	HC Director	Kuch Ly
Prey Sbath	HC Director	Yun Channarin
Prey Chuor	HC Director	Oung Pheakdey
Ta Phem	HC Director	Phou Phuon
Ang Tasom	HC Director	Keo Sarom
Trapeang Pringh	HC Director	Seang Sophon
Kus	HC Director	Soy Nhoeun
Tram Kak	HC Director	Mam Samnang
SRC	Coordinator	Rob Overtoom
HNI	Coordinator and HEF manager	Fred Griffiths and Sav Chanthy
AFH	Director	Long Leng
CFDS	Director	John Phay
Total number		20

Annex F: Site profiles

A. Phnom Penh

Table F.5 Phnom Penh timeline

1997	Official use fees began at PPMH
1999	HEF began through Options UK
2002	USG contracted to provide HEF services
2003	HEF funding taken over by URC/USAID
2004	HEF pre-identification began in six squatter settlements

Table F.6 Phnom Penh profile

Topic	Description
Population:	Phnom Penh is the capital city of Cambodia and the only major urban centre. With a population exceeding 1 million, it is the major commercial and manufacturing centre in a country where 85% of people live in rural areas.
Poverty: (see note 1)	Officially, poverty stands at 12% of the city population. The poorest areas include a total of 22 different recognized squatter settlements, including six in which HEF is provided (Anlong Kngan, Anlong Kong, Beoung Kak, Bori Kila, Samake, Tonle Bassac).
Referral Hospital:	The Phnom Penh Municipal Hospital (PPMH) is a 'district-level' facility that serves as the referral hospital for the four 'operational health districts (ODs) in the city, including the population within the HEF-supported squatter settlements. It is a CPA3 facility (see note 2) with 150 beds.
Facilities:	The PPMH is the referral hospital for the four ODs of 'Kandal' (with four health centres), 'Cheung' (with five health centres), 'Tbong' (with six health centres), and 'Lech' (with six health centres) and a total of 21 health centres. The HC is the first point of service, with referral to MH.
Financing:	PPMH receives Government funding through the Priority Action Program (PAP) via the Municipal Treasury as well as revenue from official user fees, HEF and CBHI financing and other non-government sources. Routine drugs are provided centrally from the Central Medical Supply (CMS), but walk-in patients frequently buy additional drugs and supplies. Official use fees began at the PPMH in September 1997.
Technical and financial support:	In 1999 Options UK the MHD signed an agreement with the MOH. The first MOU between the PPMH and the USG was signed in October 2004 and witnessed by the MHD. A second MOU was signed in 2006 between the URC, the USG, the PPMH, and ODs. Support for HEF and PPMH activities is provided by the MHD through the MH Director and the Options/DFID Health Service for the Urban Poor (HSUP) Project Director. A Task Force provides support for policy and direction, led by the Municipal Health Director and including. WHO, UNICEF, NGOs, and the MOH. A Steering Committee including the URC, the USG and the Municipal Authorities) guides implementation and further support is provided through the Phnom Penh Government's Poverty Reduction Bureau. With funding from the Rockefeller Foundation the CAS supports pre-identification and conducted a Mid-Term Review. The USG provides additional support to the PPMH for Annual Operational Plans, HIS administration and supervision.
Health Equity Fund:	HEF began in 1999 under the Urban Health Project through Options UK with DFID funding. In December 2002 the Urban Sector Group (USG) took over the project with funding from the MHD through the WHO Health Sector Reform IV project and other sources including the Phnom Penh Municipal Government, but without external funding, which was available only from July 2003 from URC and USAID and from the

	Rockefeller Foundation for the HSUP. HEF services are now provided at seven health centres: 7 Makara, Red Cross, Anlong Kgnan, Pochentong, Chamkar Dong, Toulkork, Kilometer Lech 9.
Pre-identification of the poor:	Began in October 2004 at the six identified squatter settlements, selected as the poorest areas, where poor families were means-tested and pre-identified as beneficiaries. Families were first identified by local authorities; a community-based network of User Groups was established to conduct household interviews; beneficiary data were stored in a computer database; and HEF booklets were distributed publicly to the qualified families. Technical support for the survey came from CAS with funding from the Rockefeller Foundation.
Coverage:	Limited to poor households in the selected settlements, with other settlements are not covered. Exclusion errors (poor families not included) occur because of the high level of in-out migration, and many identified families may not have received ID cards.
Beneficiaries and benefits:	By 2006, 8154 poor households were identified, and USG conducts an ongoing re-identification to update records and correct unreliable data. USG provides 100% coverage of user fees, medical costs, transportation and food for MPA services at health centres and CPA services at the PPHM.
Payment system:	Case payment system: Fee-for-service reimbursement; the PPMH invoices the HEF provider (USG) monthly and receives payment for the actual number of cases times an agreed case rate.
Outreach activities:	Four User Groups (Anlong Kgnan/Cheung OD, Boeung Kak/Lech OD, Samaki/Lech OD, Anlong Kong/Tbong OD) with a total 40 voluntary members provide outreach in the community, including monthly meetings with HC staff. Nine 'Mums Clubs' have been established to promote free maternal care for the pregnant women who participate. The USG employs two Community Outreach Coordinators (COC) to liaise with the community and the health facilities.
Quality of care:	In February 2006, the URC initiated a 'licensing' process at the PPMH to monitor the quality of care, using essentially non-medical indicators related to hygiene and administrative efficiencies.
SKY insurance:	Initiated by GRET with support from GTZ in December 2005 as a pilot project at one site, the SKY Health Centre located within the Municipal Hospital. Funding provided by AFD from 2007. Monthly premiums are charged pro-rata according to family size: single person Riel 16,000, 2-4 persons Riel 20,000, 5-7 persons Riel 24,000, 8 and more persons Riel 28,000.
Beneficiaries and benefits:	Targeted on the not-so-poor formal and informal sector workers (such as motor-cycle taxi drivers and market stall holders); beneficiaries are self-selected through the payment of premiums, with no pre-identification process; will also target formal sector employees. SKY had 1024 families or 5626 enrolled members in Phnom Penh by August 2007. SKY benefits are paid only for SKY HC services and for HC patients referred to the PPMH. Does not cover chronic illnesses (such as ARVs, insulin or cancer treatment) but does cover emergency hospitalization, AIDS-related opportunistic diseases or individual treatment episodes for chronic illness, including emergency surgery. Complex cases may be referred to a National Hospital (Kosamak Hospital) with SKY support
Payment system:	Monthly capitation payment to the SKY HC and the PPMH with provision for referral to a national hospital if necessary.

Notes:
1. While there are no complete records of poverty by district the most consistent estimates are provide by the World Food Program.
2. CPA (Complimentary Package of Activities) defines the service delivery standard for a district referral hospital. CPA1 facilities have no surgery.

Table F.7 Phnom Penh health facilities

Area	Facility	Official fees began (see note 1)	HEF began	SKY began
Municipal	Municipal Hospital*	September 1997	1999 Options UK 2002 USG	December 2005
	SKY Health Centre	December 2005	n.a.	December 2005
Operational Districts	**Health Centres**	**Official fees began (see note 1)**	**HEF began**	**SKY began**
OD Kandal	Red Cross*	June 1998	Post-2002	n.a.
	7 Makara*	August 2000	Post-2002	n.a.
	Phsar Daeum Thkov	August 2000	n.a.	n.a.
	Toul Svay Prey	n.a.	n.a.	n.a.
OD Thbong	Meanchey	August 2000	n.a.	n.a.
	Stung Meanchey	August 2000	n.a.	n.a.
	Chak Ang Re	August 2000	n.a.	n.a.
	Nirouth	n.a.	n.a.	n.a.
	Chamkar Doung*	n.a.	2002 at Anlong Kong settlement	n.a.
	Prey Veaeng	n.a.	n.a.	n.a.
OD Cheung	Kilometer Lech 9*	n.a.	Post-2002	n.a.
	Samdach Ouv	August 2000	2002 Anlong Kngan settlement	n.a.
	Daun Penh	August 2000	n.a.	n.a.
	Chrouy Changva	n.a.	n.a.	n.a.
	Anlong Kngan*	n.a.	Post-2002	n.a.
OD Lech	Tuek Thla	August 2000	n.a.	n.a.
	Toul Kork*	August 2000	2000 at Boeungkak settlement	n.a.
	Pochentong*	August 2000	2002 at Samaki settlement	n.a.
	Khmounh	n.a.	n.a.	n.a.
	Samrong Kraom	n.a.	n.a.	n.a.
	Pong Tuek	n.a.	n.a.	n.a.
Central	MCH Hospital	March 1997	n.a.	n.a.
	Preah Kossamak	March 1997	n.a.	n.a.
	Preah Ang Duong	March 1997	n.a.	n.a.
	NIPH	March 1997	n.a.	n.a.
	Pediatric Hospital	April 1997	n.a.	n.a.
	Center AIDs/STD	August 1997	n.a.	n.a.
	Lab Control	February 1998	n.a.	n.a.
	Sihanouk Hospital	January 2002	n.a.	n.a.

Note:
1. Source: Health Financing Approval, Ministry of Health, 1997-2006
2. * denotes facilities with HEF

B. Ang Roka

Table F.8 Ang Roka timeline

Timeline:	
1999	First Contracting pilot began through AMDA
2001	Official user fees began (RH and HC)
2001	SKY began at one HC, managed by GRET
2003	Pre-identification of households for HEF by CEDAC
2004	Second Contracting project began through SRC
2005	HEF began through AFH with funding from HNI
2005	SKY expanded to all nine HCs

Table F.9 SKY timeline Ang Roka

SKY community-based health insurance	
1998-1999	SKY pilot opened at one location in Kandal Province (two communes)
2000-2001	Opening of a second zone in Takeo province
2002-2004	Small scale implementation of the SKY model in the three pilot zones: (1) From 2002 at Roulos HC in Kandal province; (2) From 2002 at Prey Sbath HC and Ang Roka RH in Takeo province; (3) From 2003 at Prey Rumdeng HC and Kirivong RH in Takeo province, and at Takeo Provincial Hospital
2005-2007	Scaling up phase: coverage in Ang Roka OD increased from one to all nine health centers

Table F.10 Ang Roka profile

Topic	Description
Population:	Ang Roka is a rural district in the province of Takeo two hours drive south-east of Phnom Penh, with an estimated population of 122,416. The population is entirely rural.
Poverty:	CEDAC estimated poverty at 30% of population (2003). Officially, poverty stands at ~50% of the OD population, but this may be an overestimate.
Referral Hospital:	The Ang Roka Referral Hospital (RH) is the referral hospital for nine health centres in the OD. It is a CPA1 facility with 60 beds (30 beds non-TB, 30 beds TB ward) and without a surgery. Complicated cases are referred to the Takeo Provincial Hospital.
Facilities:	Referral Hospital and nine health centers: Ang Roka, Trapeang Andaeuk, Prey Sbath, Prey Chuor, Ta Phem, Ang Tasom, Trapeang Pringh, Kous, Tram Kak; a new HC (the tenth) opened at Nhjeng Nhjang in 2007; one additional Health Post at Bos Phiang.
Financing:	The RH receives routine Government funding via the Provincial budget. Official use fees began in July 2001. Health Equity Fund implemented by Action For Health with HNI funding started in April 2005. CBHI began at one HC in June 2001 through the SKY scheme with GRET support and expanded to 9 HCs in June 2005.
Technical and financial support:	The first Contracting pilot ('Contracting Out') commenced in January 1999 through AMDA, with support for all public health facilities in the district. A second episode of Contracting begun under new arrangements in May 2004 through Swiss Red Cross under the ADB/WB/MOH Health Sector Support Project. SRC provides additional funds for HQ, support and TA costs. Ang Roka RH has Hospital Management Committee and Cost-Recovery Committee.
Health Equity Fund:	Began in April 2005. Managed under contract by AFH and funded by HNI through the HNI-EC HIV/AIDS project and partly by ITM Antwerp funding for HIV/AIDS activities. In 2006, SRC assisted HNI with funding over a 4-6 month period. SRC provides support for HEF members attending health centres.

Pre-identification of the poor:	First household pre-identification survey (proxy means testing through a scored questionnaire with objective indicators) conducted in 2003 by CEDAC. Data was verified and entered into a beneficiary database. Beneficiaries were issued with a blue or red card. The 2003 CEDAC pre-identification survey was incomplete, reaching only 85% of the OD population. Because of a lack of funding CEDAC did not commence HEF. AFH adopted the CEDAC survey and also uses post-identification at the point of admission (though with different and more stringent criteria to CEDAC). Pre-identification was later completed by SRC and Oxfam, providing 100% OD coverage. A re-identification process began in December 2006.
Coverage:	The poorest 29% of the population are registered HEF beneficiaries (HNI data). Dissatisfaction and confusion was caused among beneficiaries when CEDAC promised HEF benefits at both the RH and health centres but AFH later offered benefits only at the RH.
Beneficiaries and benefits:	HEF covers patient treatment only at the Referral Hospital, including standard IPD and OPD services. HEF also covers HIV/AIDS patients for IPD at the Takeo PH and the Ang Roka RH, CD4 testing and control, Transaminas testing and control, TB DOT at health centres that screen for HIV/AIDS, transport costs to get ARV at Takeo PH and Ang Roka RH. Exemptions are provided on two scales: 50% exemption for the not-so-poor (equivalent to half for the user fee and no other benefit); 100% exemption for the poor (equivalent to the full user fee, the cost for transportation from the HC to the RH, meals for a patient family carer, and sometimes funeral costs). The benefits mainly cover acute episodes but not routine care of chronic diseases.
Payment system:	Fee-for-service reimbursement to the Ang Roka RH paid in arrears on monthly and based on the number of cases seen and the cost for each case.
Outreach activities:	AFH provides HEF services at the RH but does not conduct outreach. A constraint on extending coverage of HEF and improving access by the poor is the lack community-based network that serves as information channel between the community and providers.
Quality of care:	The RH provides CPA services not including surgery. Staffing and drug supply are adequate according to regulations. The hospital is officially open 24 hours.
SKY insurance:	Began in June 2001 at Prey Sbath HC through GRET with FMFA funding at one health centre. Expanded to all nine health centres by June 2005, and had 3269 policy holders by January 2006. From 2007, AFD replaced FMFA as the funding agency. SKY covers the whole OD including all nine health centres, the RH and provides for referral of patients to the Takeo Provincial Hospital for the most advanced cases. Family premiums are charged on a sliding scale of monthly fees: Riel 1400 for individuals, Riel 2800 for families of 2-4, Riel 3500 for families of 5-7, Riel 4200 for families with > 7. In October 2006 SRC made a new proposal to the HEF provider, HNI, to revise HEF funding, use HEF to purchase SKY premiums for the poor according to which HEF continues to support pre-identification, post-identification, and transportation and food costs while SKY pays the costs of all user fees.
Beneficiaries and benefits:	SKY does not target the poor, it targets the medium-poor to protect them against catastrophic health expenditures. Coverage is limited to those who pay the SKY premium. SKY had 657 families or 2539 enrolled members by August 2007. The benefit package includes costs for consultation, birth spacing, delivery, minor operation at the HC, referral patient from HC with ambulance to Ang Roka RH (up to 15km), diagnosis and laboratory tests, x-ray, echo, drugs, and food for the patient. There is no limit on the length of stay at the RH. Assistance may also be provided for funeral costs.
Payment system:	Monthly capitation payment in advance to facilities (the Ang Roka RH and all nine health centers) based on the number of insured clients treated per month. For SKY patients referred to the Takeo PH a fee-for-service reimbursement system is used with a third-party payment mechanisms based on a cash advance to the hospital).

Notes:
1. While there are no complete records of poverty by district the most consistent estimates are provide by the World Food Program.

Table F.11 Ang Roka health facilities

Area	Facility	Official fees began (see note 1)	HEF began	SKY began
Takeo town	Takeo Provincial Hospital	1999 with SRC	1999 with SRC May 2005 CFDS	n.a.
Ang Roka OD	Ang Roka RH	July 2001	April 2005 with AFH	June 2001
Ang Roka OD	Ang Roka HC	July 2001	n.a. (see note 2)	June 2001
	Trapeang Andaeuk HC	July 2001	n.a.	June 2005
	Prey Sbath HC	July 2001	n.a.	June 2005
	Prey Chuor HC	July 2001	n.a.	June 2005
	Ta Phem HC	July 2001	n.a.	June 2005
	Ang Tasom HC	July 2001	n.a.	June 2005
	Trapeang Pringh HC	July 2001	n.a.	June 2005
	Kous HC	July 2001	n.a.	June 2005
	Tram Kak HC	July 2001	n.a.	June 2005
	Nhjeng Nhjang HC	[New HC 2007]	n.a.	n.a.
	Bos Phiang Health Post	[Not a formal health centre]	n.a.	n.a.

Notes:
1. Source: Health Financing Approval, Ministry of Health, 1997-2006
2. SRC provides support for HEF card holders at all nine health centres

Annex G. Results of patient exit interviews: all facilities

Indicators		All	Urban PP	Rural AR	Urban MH	Urban HC	Rural RH	Rural HC
Sample size	n =	679	429	250	200	229	100	150
With HEF	n =	143	104	39	50	54	18	21
With SKY	n =	57	21	36	8	13	14	22
Total exemptions	n =	288	171	117	84	87	56	61
Male		30.0	26.8	35.6	21.0	31.9	35.0	36.0
Female		70.0	73.2	64.4	79.0	68.1	65.0	64.0
>5 years		18.6	12.6	28.8	1.5	22.3	10.0	15.3
Women 15-44 years		41.5	46.2	33.6	59.0	34.9	32.0	34.7
Maternal health		20.4	24.7	12.8	42.5	16.1	6.0	17.3
Deliveries		4.6	6.3	1.6	13.0	0.1	0.0	2.7
Vaccination		6.9	7.5	6.0	0.0	14.0	0.0	10.0
Gastric, diahhrea, fever, etc		29.7	21.9	43.2	5.0	36.7	45.0	70.0
Ear, nose, throat		7.7	9.6	3.2	28.5	7.4	1.0	4.0
	n =	300	200	100	200	..	100	..
IPD		34.7	27.0	50.0	27.0	..	50.0	..
OPD		65.3	73.0	50.0	73.0	..	50.0	..
With HEF		21.1	24.2	15.6	25.0	23.6	18.0	14.0
With SKY		8.4	4.9	14.4	4.0	5.7	14.0	14.7
Satisfied with treatment		95.9	95.8	96.0	91.5	99.6	91.0	99.3
Got an exemption from official fees		42.4	39.9	46.8	42.0	38.0	56.0	40.7
	n =	288	171	117	84	87	56	61
- HEF member or NGO support		48.3	57.9	32.5	56.0	62.0	30.4	34.4
- NGO paid		6.3	11.7	0.0	21.4	0.0	0.0	0.0
- SKY member		19.4	12.3	29.9	9.5	14.9	25.0	34.4
- free service		14.6	4.7	26.5	9.5	5.7	26.7	26.3
- poor people		10.8	10.5	11.1	3.6	17.2	17.9	4.9
- other		0.7	3.0	0.0	0.0	0.0	0.0	0.0
Paid more as well as fees		61.1	66.0	52.8	80.0	46.7	75.0	38.0
Paid more as well as fees/HEF/SKY		52.0	55.5	46.0	79.5	34.5	74.0	27.3
Paid more for what?	n =	415	283	132	161	122	75	57
Transport		48.4	45.9	53.0	34.2	61.5	37.3	75.4
Food		24.6	18.0	38.6	26.1	7.4	61.3	8.8
Drugs		18.1	23.3	6.8	29.8	14.8	1.3	14.0
Staff		5.8	8.1	0.8	9.3	6.6	0.0	1.8
Knew fees in advance		38.4	35.2	44.0	16.5	51.5	19.0	60.7
Heard about HEF/SKY		54.9	49.4	64.4	52.5	46.7	58.0	68.7
Have HEF card		21.1	24.2	15.6	25.0	23.6	18.0	14.0
	n =	143	104	39	50	54	18	21
Did not attend prior to having HEF card		23.1	27.9	10.3	30.0	25.9	22.2	0.0
If not, why not	n =	33	29	4	15	14	4	..
- no money		51.5	55.2	25.0	60.0	50.0	25.0	..
- facility is too far		15.2	6.9	75.0	26.7	0.0	75.0	..
- not know where facility is		12.1	13.8	0.0	6.7	21.4	0.0	..
	n =	143	104	39	50	54	18	21
Did not use card this time		9.8	10.6	7.7	10.0	11.1	5.6	9.5
	n =	143	104	39	50	54	18	21
Benefit is reduced cost treatment and transport		97.3	100.0	97.4	100.0	100.0	94.4	100.0
	n =	51	40	11	19	21	..	5
Benefit is better service		27.5	32.5	9.1	26.4	9.0	..	20.0
	n =	143	104	39	50	54		21
The process is fair to everyone		93.0	91.3	97.4	82.0	100.0	100.0	95.2
Have a SKY card		8.4	4.9	14.4	4.0	5.7	14.0	14.7
If not, why not	n =	622	408	214	192	216	86	128
Never heard, don't know, no visit, DK advantage		82.0	92.8	61.2	84.3	99.5	61.6	60.9

Already have HEF, cannot afford		14.8	5.6	31.3	11.5	0.5	36.0	29.9
	n =	9	4	5	4	..	4	..
Already have HEF		55.6	50.0	60.0	50.0	..	75.0	..
	n =	57	21	36	8	13	14	22
Did not attend prior to having card		24.6	47.6	11.1	25.0	61.5	0.0	18.2
If not, why not	n =	14	10	4	2	8	..	4
- used other facility		50.0	40.0	75.0	100.0	25.0	..	75.0
- did not know facility		42.8	50.0	25.0	..	62.5	..	25.0
- no money		7.1	10.0	0.0	..	12.5	..	0.0
	n =	57	21	36	8	13	14	22
Did not use card this time		3.5	0.0	5.6	0.0	0.0	0.0	9.1
	n =	57	21	36	8	13	14	22
Benefit is reduced cost of treatment		98.2	100.0	97.2	100.0	100.0	100.0	95.5
	n =	13	10	3	3	7	..	3
Benefit is good service		76.9	90.0	100.0	100.0	100.0	..	100.0
	n =	57	21	36	8	13	14	22
Stop paying SKY in future		10.5	4.8	13.9	12.5	0.0	14.3	13.6
Staff treat exempt/HEF/SKY no differently		91.8	91.4	92.8	89.0	93.4	94.0	92.0
First point of service last 24 months: RH/HC		62.8	52.9	80.0	39.0	65.1	65.0	90.0
	n =	252	202	50	122	80	35	15
Pay private sector with own money		92.5	93.6	88.0	95.1	91.3	97.1	66.7
Borrow for this visit		20.6	13.3	33.0	13.5	13.1	54.0	19.3
Borrowed in last 24 months		36.8	33.3	42.8	29.0	37.1	69.0	25.3
Sold assets last 24 months		26.4	16.8	42.8	10.5	22.3	44.0	42.0