Determinants of Non-Utilisation of Public Health Services among Poor Households Covered by a Social Health Protection Scheme

An Evaluation in Kampot Operational District, Cambodia

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Published by:
Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH
PO Box 1238, Phnom Penh, Cambodia
T +855 23 884 476
F +855 23 884 976
E giz-kambodscha@giz.de
I www.giz.de

Responsible: Adélio Fernandes Antunes

Authors: Itay Noy & Hay Saing

Layout: Justin Pearce-Neudorf, CamPOP Media

Cambodia, November 2012

កត្តាដែលនាំដល់ការមិនប្រើប្រាស់សេវាកម្មសុខាភិបាលសាធារណៈក្នុងចំណោមគ្រួសារក្រីក្រដែលស្ថិតក្រោមការគ្របដណ្តប់នៃគំរោងគាំពារសុខភាពសង្គម

ការវាយតម្លៃក្នុងស្រុកប្រតិបត្តិកំពត
ខេត្តកំពត
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ដោយ

លោក Itay Noy និង លោក សាំង ហៃ

ខែធ្នូ ឆ្នាំ 2012

Acknowledgements

We would like to thank Dr Nhea Bunthan, the director of Kampot's provincial health department, and Dr Tann Chheng, the chief of the department's technical bureau, for their cooperation, assistance and supervision. We also want to thank the staff of the Cambodian-German Social Health Protection Programme, Groupe de Recherche et d'Echanges Technologiques (GRET), Sokhapheap Krousar Yeung (SKY; "Health for Our Families"), and the public health facilities in Kampot, as well as the community council and village chiefs in Kampot, for their informational and logistic support. Thanks also to Dr Peter Annear for his useful comments during the design and conducting of the evaluation. Finally, we are grateful to the participants in interviews and focus groups for their invaluable information, and for taking the time to share their experiences and views.

The report was edited by Mr John Paul Nicewinter. Design, layout and illustration were done by Mr Justin Pearce-Neudorf, CamPOP Media (http://www.campop-media.com).

The results of the evaluation were presented in the community-based health insurance steering committee meeting at Kampot's provincial health department on 12 October, 2012. We would like to thank the participants of the meeting for their helpful remarks towards the revision of the evaluation report's draft.

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SKY អង្គការសេកម្មភាពដើម្បីសុខភាព (AFH) ទីភ្នាក់ងារ
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ស្ថិតក្រោមគម្រោងគាំពារសុខភាពសង្គមរួមនេះ ប្រ
ជាពលរដ្ឋដែលមានជីវភាពខ្សត់ខ្សោយ មធ្យម និង

ធូរធារ អាចចូលរួមជាសមាជិកនៃគម្រោងនេះដោយស្ម័គ្រចិត្ត តាមរយៈការបង់ភាគទានប្រចាំខែយ៉ាងសម្រាប់ការទទួលបាននូវ សេវាកម្មថែទាំនិងព្យាបាលជម្ងឺនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈចាប់ពីមណ្ឌលសុខភាពរហូតដល់មន្ទីរពេទ្យបង្អែក។ គ្រួសារប្រជាពលរដ្ឋដែលត្រូវបានចាត់ទុកថាជាគ្រួសារក្រីក្រតាមរយៈការធ្វើអត្តសញ្ញាណកម្មគ្រួសារក្រីក្រដោយក្រសួងផែនការបានត្រូវចាត់បញ្ចូលទៅក្នុងសមាជិកមូលនិធិសមធម៌ដែលក្រុមនេះទទួលបានទទួលបានការជួយឧបត្ថម្ភសម្រាប់ការធានារ៉ាប់រងសុខភាព ដូចក្រុមប្រជាពលរដ្ឋដែលទិញធានារ៉ាប់រង ដោយខ្លួនឯងដែរ គឺទទួលបានសៀវភៅធានារ៉ាប់រងសុខភាពដូចសមាជិកដទៃទៀតដែរ។

ដោយសារតែការចូលទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលសាធារណៈ មានលក្ខណៈខុសគ្នាខ្លាំង រវាងគ្រួសារប្រជាពលរដ្ឋ ដែលមាន កម្រិតសេដ្ឋកិច្ចខុសគ្នា គោលបំណងនៃគម្រោងគាំពារសុខភាពសង្គមនេះ គឺមិនគ្រាន់តែជម្រុញការប្រើប្រាស់សេវាកម្មសុខាភិបាលនោះទេ តែវាក៏ដើម្បីកាត់បន្ថយគម្លាតការប្រើប្រាស់សេវាកម្មសុខាភិបាលរវាងក្រុមប្រជាពលរដ្ឋក្រីក្រនិងមិនក្រីក្រ ដែលនេះជាគោលបំណងក្នុងការលើកកម្ពស់សមធម៌នៃការទទួលបានការថែទាំសុខភាព។ លក្ខណៈចម្បងពីរយ៉ាងដែលជម្រុញឲ្យគម្រោងនេះសម្រេចបានតាមគោលបំណងគឺ:

- ការផ្តល់ឲ្យបន្ថែមនូវការអត្ថប្រយោជន៍មិនមែនវេជ្ជសាស្ត្រ ដូចជាការឧបត្ថម្ភលើ ថ្លៃធ្វើដំណើរទៅទទួលការព្យាបាល ថ្លៃអាហារក្នុងរយៈពេលសម្រាកព្យាបាលជម្ងឺក្នុងមន្ទីរពេទ្យ។ ការជួយឧបត្ថម្ភនេះគឺដើម្បីកាត់បន្ថយនូវឧបាំងហិរញ្ញវត្ថុដែលបណ្តាលមកពីការស្វែងរកការព្យាបាលជម្ងឺ

- ការប្រើប្រាស់សៀវភៅធានារ៉ាប់រងសុខភាពដូចគ្នាសម្រាប់ប្រជាពលរដ្ឋក្រីក្រនិងអ្នកដែលទិញធានារ៉ាប់រងខ្លួនឯងដើម្បីកាត់បន្ថយការរើសអើងចំពោះប្រជាពលរដ្ឋក្រីក្រ

ទិន្នន័យពីការអនុវត្តន៍គម្រោងក្នុងសុក្រប្រតិបត្តិកំពតដែលបានអនុវត្តគម្រោងនេះតាំងពីឆ្នាំ 2008 មកបង្ហាញនូវទិន្នាការ នៃការប្រើប្រាស់សេវាកម្មសុខាភិបាលនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ។ អត្រានៃការប្រើប្រាស់សេវាកម្មសុខាភិបាល នៅតាម មូលដ្ឋានសុខាភិបាលសាធារណៈក្នុងចំណោមសមាជិកមូលនិធិសមធម៌ និង សមាជិកធានារ៉ាប់រងមានការកើនឡើងលើសពីកម្រិតមធ្យមដែលកំណត់ឡើងដោយថ្នាក់ជាតិ។ ទោះបីជាយ៉ាងនេះក៏ដោយ គេនៅតែសង្កេតឃើញមានគម្លាតខ្លាំងនៃការប្រើប្រាស់សេវាកម្មសុខាភិបាល រវាងក្រុមសមាជិកមូលនិធិសមធម៌ និង សមាជិកធានារ៉ាប់រងសុខភាពសហគមន៍ គឺក្រុមសមាជិកមូលនិធិសមធម៌ បានប្រើប្រាស់សេវាកម្មសុខាភិបាលទាបជាងក្រុមសមាជិកធានារ៉ាប់រងសុខភាពសហគមន៍ប្រហែលពីរដង។ លើសពីនេះទៅទៀត ទិន្នន័យពីការប្រើប្រាស់សេវាបង្ហាញថា 1 ភាគ 5 នៃសមាជិកមូលនិធិសមធម៌មិនដែលបានទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលទេតាំងពីគម្រោងចាប់ដំណើរការក្នុងឆ្នាំ 2008 មកទល់នឹងឆ្នាំ 2011 ។ ការមិនមកប្រើប្រាស់នេះហាក់ដូចជាមានការទាក់ទងទៅនឹងគម្លាតនៃការប្រើប្រាស់នេះនិងជាទូទៅគឺពាក់ព័ន្ធទៅនឹងសំណួរអំពីឥទ្ធិពលនៃគម្រោងនេះទៅលើសមាជិកដ្ឋក្រីក្រ។

មួយផ្នែកនៃការប្រើប្រាស់ក្នុងកម្រិតខ្ពស់ក្នុងចំណោមសមាជិកធានារ៉ាប់រង គឺដោយសារតែប្រជាជនក្រុមនេះបានទិញសេវាធានារ៉ាប់រងដោយខ្លួនឯងដែលផ្ទុយពីសមាជិកមូលនិធិសមធម៌។ ចំណែកឯក្រុមសមាជិកមូលនិធិសមធម៌វិញ ទោះបីជាការធានារ៉ាប់រងសុខភាពនេះត្រូវបានគេទិញឲ្យក៏ដោយ ក៏ពួកគាត់មិនសូវចូលទៅប្រើប្រាស់សេវាសុខាភិបាលទេ ដែលចំណុចនេះទាមទារឲ្យមានការយកចិត្តទុកដាក់ស្វែងយល់ នូវកត្តាដទៃទៀតដែលអាចជាកត្តារារាំងដល់ការចូលទៅ ប្រើប្រាស់សេវាសុខាភិបាលសាធារណៈនេះ។ គេសង្កេតឃើញផងដែរថាទោះបីជាមានការជួយឧបត្ថម្ភថ្លៃធ្វើដំណើរ ថ្លៃអាហារនិងការប្រើប្រាស់សៀវភៅធានារ៉ាប់រងដូចគ្នា និងប្រជាពលរដ្ឋដទៃទៀតក៏ដោយ ក៏ប្រជាពលរដ្ឋក្រីក្រនៅជួបប្រទះនឹងឧបសគ្គក្នុងការចូលទៅប្រើប្រាស់សេវាសុខាភិបាលសាធារណៈដែរ។

មានការសិក្សាជាច្រើនស្តីអំពី របាំងដែលរារាំងការចូលទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលក្នុងចំណោមប្រជាពលរដ្ឋក្រីក្រនិងប្រជាពលរដ្ឋដែលរស់នៅតាមទីជនបទដាច់ស្រយាលក្នុងប្រទេសកម្ពុជា និងក្នុងប្រទេសកំពុងអភិវឌ្ឍន៍ដទៃទៀត ក៏ប៉ុន្តែការសិក្សាទាំងនោះ ពុំសូវបានបង្ហាញអំពីកត្តាកំណត់នៃការមិនចូលទៅប្រើប្រាស់សេវាកម្មសុខាភិបាល នៅក្នុងចំណោមប្រជាពលរដ្ឋដែលត្រូវបានគ្របដណ្តប់ដោយគម្រោងគាំពារសុខភាពសង្គម។ ដូចគ្នានេះដែរគេពុំសូវឃើញមានការសិក្សាពិនិត្យមើលអំពីយន្តការនៃការសំរេចដែលជាមូលហេតុនៃការមិនទៅប្រើប្រាស់សេវាក

ម្មសុខាភិបាល (Matsuoka et al. 2010) ។ ការវាយតម្លៃនេះ
មានគោលបំណងស្វែងរកឲ្យឃើញ នូវកត្តាកំណត់ដែលនាំដល់
ការមិនទៅប្រើប្រាស់សេវាកម្មសុខាភិបាល
ក្នុងចំណោមសមាជិកក្រីក្រ ដែលត្រូវបានគ្របដណ្តប់ដោយ
គម្រោងគាំពារសុខភាពសង្គមដែលបានដំណើរការនៅក្នុងស្
រុកប្រតិបត្តិកំពត។ ជាក់ច្បាស់ជាងនេះទៅទៀតនោះគឺ ការ
វាយតម្លៃនេះធ្វើការស្វែងយល់កត្តា និង របាំងមួយចំនួន
ដែលរារាំងដល់ការមិនទៅប្រើប្រាស់ សេវាកម្មសុខាភិបាលដោយ
សង្កត់ធ្ងន់លើទស្សនៈផ្ទាល់ខ្លួន និង ក្តីកង្វល់របស់ប្រជាពលរដ្ឋក្
រីក្រដែលមិនដែលបានទៅប្រើប្រាស់សេវាកម្មទាំងនោះ។ លទ្ធផ
លនៃការវាយតម្លៃនេះចូលរួមដល់ការឈ្វេងយល់ឲ្យកាន់តែច្បាស់
ពីឥទ្ធិពលនៃគម្រោងគាំពារសុខភាពសង្គមលើអ្នកទទួលផលដែ
លជាប្រជាពលរដ្ឋក្រីក្រ និងឥរិយាបទក្នុងការស្វែងរកនិងប្រើប្រា
ស់ សេវាកម្មសុខាភិបាល របស់ពួកគេ។ លទ្ធផលទាំងនេះនឹងត្រូវ
ប្រើប្រាស់សម្រាប់តាក់តែងអន្តរាគមន៍ ដើម្បីបង្កើនការប្រើប្រាស់សេ
វាកម្មសុខាភិបាល និងលើកកំពស់ការប្រើប្រាស់សេវាកម្មសុខាភិបា
លប្រកបដោយលក្ខណៈសមធម៌។

ការវាយតម្លៃនេះបានប្រើប្រាស់នូវវិធីសាស្ត្រទាំងបែបបរិ
មាណនិងបែបគុណភាព។ វិធីសាស្ត្រតាមបែបបរិមាណត្
រូវបានប្រើប្រាស់ដើម្បីវិភាគលើទិន្នន័យដែលមានស្រាប់
ពីប្រតិបត្តិករ នៃគម្រោងគាំពារសុខភាពសង្គមដែលបាន
គ្របដណ្តប់លើប្រជាពលរដ្ឋចំនួន 4,047 គ្រួសារចាប់តាំងពីឆ្នាំ
2008 (ការចាប់ផ្តើមអនុវត្តគម្រោង) រហូតដល់ឆ្នាំ 2011 (ជាពេល
ដែលទិន្នន័យអាចយកមកប្រើប្រាស់បាន)។ ការវិភាគបែបបរិមាណ
គឺដើម្បីពិនិត្យមើលតាមលក្ខណៈស្ថិតិនៃភាពខុសគ្នារវាងប្រជាសាស្
ត្រនិងសង្គម ស្ថានភាពភូមិសាស្ត្រ និងកត្តាដែលធ្វើឲ្យបម្រែបម្រួល
ដែលពាក់ព័ន្ធជាមួយនឹងមូលដ្ឋានសុខាភិបាល ដែលអាចនាំឲ្
យប្រជាពលរដ្ឋក្រីក្រមិនទៅប្រើប្រាស់ សេវាកម្មសុខាភិបាល។
វិធីសាស្ត្របែបគុណភាព ត្រូវបានប្រើប្រាស់ដើម្បីឈ្វេងយល់អំពី
ឧបសគ្គនិងកត្តានានាដែលបានរារាំងដល់ការចូលទៅប្រើប្រាស់
សេវាកម្មសុខាភិបាលសាធារណៈនៃប្រជាពលរដ្ឋក្រីក្រ និងកត្តាដែ
លជម្រុញពួកគេឲ្យទៅប្រើប្រាស់នូវសេវាកម្មសុខាភិបាលឯកជន។
វិធីសាស្ត្រទាំងនេះមានរួមបញ្ចូលនូវកម្រងសំណួរមិនពេញ
លេញ ការសម្ភាសដែលមានលក្ខណៈស៊ីជម្រៅ និងការពិភា
ក្សាផ្តោតលើក្រុមដែលជាសមាជិកមូលនិធិសមធម៌ ដែលមិ
នដែលបានទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលសាធារណៈ
រួមនិងការសន្ទនាពិភាក្សា ជាមួយបុគ្គលិកមណ្ឌលសុខភាព។
សរុបទាំងអស់ ទិន្នន័យដែលប្រមូលតាមបែបគុណភាពគឺត្រូវបានប្
រមូលមកពីសមាជិកមូលនិធិសមធម៌ចំនួន 63 នាក់ ពីក្នុងភូមិចំនួន
11 នៃក្នុងឃុំចំនួន7 ដែលស្ថិតនៅក្រោមការគ្របដណ្តប់របស់ម
ណ្ឌលសុខភាពចំនួន 4 ដែលបានជ្រើសរើសដោយផ្អែកលើអត្រា
ខ្ពស់នៃការមិនទៅប្រើប្រាស់សេវាកម្មសុខាភិបាល។ សមាសភាព
នៃប្រជាពលរដ្ឋដែលត្រូវបានធ្វើការសម្ភាសគឺមានទាំងជនជាតិខ្មែរ
និងខ្មែរអ៊ីស្លាម ដែលរស់នៅក្នុងភូមិដែលមានចម្ងាយខុសៗគ្នាពីម
ណ្ឌលសុខភាព។ ការវាយតម្លៃនេះគឺត្រូវបានធ្វើឡើងដោយអ្នកឯក
ទេសសង្គមផ្នែកនរវិទ្យា និងទីប្រឹក្សាត្រួតពិនិត្យ-វាយ តម្លៃនៃអង្គការ
GIZ គម្រោងគាំពារសុខភាពសង្គម។

ជាចុងបញ្ចប់ ការវាយតម្លៃនេះមានបំណងដើម្បី ប្រើប្រាស់ជាការ
ពន្យល់សម្រាប់មូលដ្ឋាន សម្រាប់ការសិក្សាមួយទៀត ដែលពាក់
ព័ន្ធនឹងបញ្ហានៃការមិនទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលសាធារ
ណៈនៅក្នុងស្រុកប្រតិបត្តិកំពង់ធំដែលជាគម្រោងអនុវត្តផ្សារភ្ជាប់
គ្នាមួយទៀតនៃគម្រោងមូលនិធិសមធម៌ និង គម្រោងធានារ៉ាប់រង
សុខភាពសហគមន៍។

លទ្ធផល

លទ្ធផលពីការវិភាគតាមបែបបរិមាណ

លទ្ធផលចម្បងៗពីការវិភាគតាមបែបបរិមាណបង្ហាញថា:

- គ្រួសារដែលមានសមាជិកតិចនិងមានមេគ្រួសារជាមនុស្សចាស់
បានទៅប្រើប្រាស់សេវាសុខាភិបាលសាធារណៈតិចជាងគ្រួសារ
ដែលមានសមាជិកច្រើននិងមានមេគ្រួសារជាមនុស្សវ័យក្មេង

- បុគ្គលវ័យចំណាស់និងបុរសគឺហាក់ដូចជាទៅប្រើប្រាស់សេវាតិច
ជាងបុគ្គលវ័យក្មេងនិងស្ត្រី

- ចំពោះមណ្ឌលសុខភាពដែលនៅកាន់តែឆ្ងាយពីភូមិដែលប្រជាព
លរដ្ឋក្រីក្ររស់នៅ និងមណ្ឌលសុខភាពដែលមានពិន្ទុវាយតម្លៃ
ទាបការប្រើប្រាស់សេវាកម្មមណ្ឌលសុខភាពហាក់ដូចជាថយចុះ

ការវិភាគតាមបែបគុណភាព

លទ្ធផលនៃការវិភាគតាមបែបគុណភាព គឺត្រូវធ្វើឡើងដើម្
បីស្វែងរកបញ្ហា ដែលពាក់ព័ន្ធនឹងគម្រោង បញ្ហាពាក់ព័ន្ធទង
នឹងការផ្តល់សេវាកម្ម ក៏ដូចជាបញ្ហាពាក់ព័ន្ធនឹងតម្រូវការដែរ

ដើម្បីទទួលបាននូវការយល់ដឹងទូទៅលើឧបសគ្គនានាដែលជើរតួនៅក្នុងផ្នែកនីមួយៗ។

បញ្ហាពាក់ព័ន្ធនឹងគម្រោងដែលបានលើកឡើងដោយប្រជាពលរដ្ឋដែលបានសម្ភាស គឺបញ្ហាហិរញ្ញវត្ថុដែលទាក់ទងដល់ការចំណាយនានា ដែលកើតមាននៅពេលទៅស្វែងរកការព្យាបាលជម្ងឺ។ ចំណាយទាំងអស់នេះនៅតែបង្កជា ឧបសគ្គដល់ការទៅទទួលសេវាកម្ម ទោះបីជាមានការជួយឧបត្ថម្ភបន្ថែម លើចំណាយសំរាប់ការធ្វើដំណើរនិងអាហារក៏ដោយ។ ចំណាយសម្រាប់ការធ្វើដំណើរទៅកាន់មូលដ្ឋានសុខាភិបាលសាធារណៈគឺនៅតែជាបញ្ហាដ៏ចំបងមួយ និងការចំណាយសម្រាប់ការហូបចុកនៃអ្នកជម្ងឺនិងអ្នកកំដរដោយបញ្ហាបន្ថែមមួយទៀតនៅពេលសម្រាកព្យាបាលនៅក្នុងមន្ទីរពេទ្យ។

ចំណាយសម្រាប់ការធ្វើដំណើរទៅកាន់មូលដ្ឋានសុខាភិបាល:

- អ្នកទទួលផលភាគច្រើនបានអោយដឹងថា ពួកគេមិនទទួលបាននូវការទូទាត់ថ្លៃធ្វើដំណើរទេនៅពេលដែលពួកគេទៅប្រើប្រាស់សេវានៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ ឬក៏ពួកគេមានការបារម្ភថានឹងមិនទទួលបាននូវការជួយឧបត្ថម្ភទាំងនោះទេ។

- ការចូលរួមមួយចំនួនទៀត ជាពិសេសអ្នកដែលរស់នៅឆ្ងាយពីតំបន់ទីប្រជុំជនបានគូសបញ្ជាក់ថាការឧបត្ថម្ភមានចំនួនមិនគ្រប់គ្រាន់ដើម្បីផ្គត់ផ្គង់ការចំណាយសម្រាប់ការធ្វើដំណើរទៅកាន់មណ្ឌលសុខភាពឬមន្ទីរពេទ្យទេ។ ការឧបត្ថម្ភសោហ៊ុយធ្វើដំណើរត្រូវបានផ្តល់បន្ទាប់ពីទទួលបានការព្យាបាលរួច ចំណែកឯការបង់ប្រាក់ឲ្យម៉ូតូឌុបគឺនៅពេលទៅដល់មន្ទីរពេទ្យឬមណ្ឌលសុខភាព។ ប្រាក់ឧបត្ថម្ភទាំងនេះគឺទទួលបានតែនៅពេលណាដែលមានវត្តមានបុគ្គលិក SKY ប្រចាំការនៅតាមមូលដ្ឋានសុខាភិបាលប៉ុណ្ណោះហើយជាទូទៅតែនៅពេលព្រឹកប៉ុណ្ណោះ។ បញ្ហាទាំងនេះបានបង្ហាញឲ្យឃើញពីយន្តការទូទាត់ដែលមានលក្ខណៈមិនសមស្របទៅតាមស្ថានភាពជាក់ស្តែង។

ចំណាយលើថ្លៃអាហារសម្រាប់អ្នកកំដរជម្ងឺនៅឯមន្ទីរពេទ្យ

- គម្រោងក៏បានផ្តល់ផងដែរនូវ ការឧបត្ថម្ភសម្រាប់ការចំណាយលើថ្លៃអាហារដល់អ្នកកំដរជម្ងឺនៅពេលសម្រាកព្យាបាលនៅក្នុងមន្ទីរពេទ្យ ក៏ប៉ុន្តែអ្នកចូលរួមការសម្ភាសបាននិយាយថានៅពេលដែលពួកគេកំដរសាច់ញាតិ សម្រាកព្យាបាលក្នុងមន្ទីរពេទ្យ ជួនកាលពួកគេមិនបានទទួលការឧបត្ថម្ភថ្លៃអាហារទេ ជួនកាលពួកគេទទួលបានការជួយឧបត្ថម្ភ ក៏ប៉ុន្តែមានចំនួនមិនគ្រប់គ្រាន់សម្រាប់ការចំណាយលើអាហារទេដែលជាហេតុនាំឲ្យមានការចំណាយបន្ថែមចេញពីគ្រួសារ។

បញ្ហានៃការផ្តល់សេវាកម្មសុខាភិបាល គឺវាពាក់ព័ន្ធទៅនឹងវត្តមានអ្នកផ្តល់សេវានិងសេវាកម្មដែលមាននៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ ដែលបញ្ហាទាំងពីរនេះ គឺពាក់ព័ន្ធដល់គុណភាពសេវាកម្ម។ចម្លើយពីការសម្ភាសបានបង្ហាញពីការប្រៀបធៀបរវាងអ្នកផ្តល់សេវាសាធារណៈ និង អ្នកផ្តល់សេវាកម្មឯកជន ហើយក៏បានបង្ហាញពីចំណុចល្អនៃអ្នកផ្តល់សេវាកម្មឯកជន។

វត្តមានរបស់បុគ្គលិកមណ្ឌលសុខភាព

- អ្នកចូលរួមការសម្ភាសបានគូសបញ្ជាក់ពីអវត្តមានបុគ្គលិកមណ្ឌលសុខភាព ឬ ការមកធ្វើការយឺតយ៉ាវរបស់បុគ្គលិក ដែលជួនកាលពួកគេខំធ្វើដំណើរយ៉ាងឆ្ងាយពីភូមិទៅដល់មណ្ឌលសុខភាពក្នុងម៉ោងធ្វើការតែមណ្ឌលសុខភាពគ្មានបុគ្គលិកធ្វើការ។

រយៈពេលរងចាំ

- ប្រជាពលរដ្ឋដែលចូលរួមបទសម្ភាសទាំងអស់នោះបានលើកឡើងថាពួកគេរងចាំរយៈពេលយូរ មុននឹងទទួលបានការពិនិត្យព្យាបាលនៅមូលដ្ឋានសុខាភិបាលសាធារណៈដែលមិនដូចជានៅតាមពេទ្យឯកជន។

មោងធ្វើការមានរយៈពេលខ្លី

- ប្រជាពលរដ្ឋបានលើកឡើងថាពួកគេមិនអាចប្រើប្រាស់សេវាកម្មសុខាភិបាលនៅតាម មណ្ឌល សុខភាពសម្រាប់ករណីជម្ងឺដែលកើតមានឡើងនៅពេលរសៀលឬពេលយប់ទេ ពីព្រោះមណ្ឌលសុខភាពមិនសូវផ្តល់សេវាកម្មនៅក្នុងរយៈពេលទាំងនេះទេ។ ចំណុចទាំងនេះគឺវាផ្ទុយគ្នាពីក្រុមអ្នកផ្តល់សេវាកម្មនៅតាមពេទ្យឯកជនដែលផ្តល់សេវាកម្មស្ទើរតែគ្រប់ពេលវេលាទាំងអស់។

ឥរិយាបទរបស់បុគ្គលិកសុខាភិបាល

- អ្នកចូលរួមការសម្ភាសបានលើកឡើងពីឥរិយាបទមិនរាក់ទាក់ និង មិនសមរម្យរបស់បុគ្គលិកធ្វើការនៅឯមន្ទីរពេទ្យ។

- ស្ថិតនៅក្រោមគម្រោងតែមួយ សមាជិកទាំងអស់ប្រើប្រាស់សៀវភៅធានារ៉ាប់រងសុខភាពដូចគ្នាតែមួយ ដើម្បីកាត់បន្ថយនូវភាពរើសអើងដល់ក្រុមនីមួយៗ។ ប្រជាពលរដ្ឋដែលចូលរួមទាំងអស់នោះបានបង្ហាញ អំពីការរើសអើងដោយផ្ទាល់ មកលើពួកគេទេ បើប្រៀបធៀបទៅនឹងក្រុមដែលបង់ថ្លៃព្យាបាលដោយខ្លួនឯង។ ប្រជាពលរដ្ឋទាំងនោះបានបង្ហាញថា ពួកគេតែងតែទទួលបានការពិនិត្យព្យាបាលក្រោយក្រុមដែលបង់ថ្លៃព្យាបាលដោយខ្លួនឯង និងមានពេលខ្លះទៀត ពួកគេត្រូវបានបុគ្គលិកពេទ្យមិនអើពើរចំពោះពួកគេ ឬក៏បដិសេធការព្យាបាលតែម្តង។

ការយល់ឃើញអំពីគុណភាពនៃការព្យាបាល

- ចំណុចនេះគឺជាបញ្ហាចម្បងដែលបានលើកឡើងដោយក្រុមអ្នកទទួលផលទាំងនោះ ដោយពួកគេបានសម្តែងមតិអំពីការព្យាបាលដែលពួកគេចង់បាន។ ទស្សនៈអវិជ្ជមានក៏បានបង្ហាញផងដែរ អំពីប្រសិទ្ធភាព នៃឱសថនៅតាម មណ្ឌលសុខភាព ការចាក់ថ្នាំដែលពួកគេមានការពេញនិយម មិនសូវបានផ្តល់អោយទេ ការពិនិត្យជម្ងឺមិនបានគ្រប់ជ្រុងជ្រោយនិងគ្មានឧបករណ៍គ្រប់គ្រាន់សម្រាប់ការពិនិត្យជម្ងឺ មុខឱសថនៅមានកម្រិតខ្លាំង ការមិនអាចបាននូវមុខឱសថដែលត្រូវការ និងការផ្តល់ឱសថប្រភេទដូចគ្នាចំពោះជម្ងឺប្រភេទផ្សេងគ្នាជាដើម។

បញ្ហាពាក់ព័ន្ធនឹងតម្រូវការដែលមានដូចជាបញ្ហានៃការយល់ដឹងនិងព័ត៌មាន ស្ថានភាពភូមិសាស្ត្រ និងការចូលទៅប្រើប្រាស់តម្លៃដែលបាត់បង់ដោយសារការទៅព្យាបាលជម្ងឺ ក៏ដូចជាឧបស័គ្គវប្បធម៌សង្គម និងឧបស័គ្គផ្នែកចិត្តសាស្ត្រ។

គម្រោងនិងការប្រើប្រាស់សៀវភៅធានារ៉ាប់រង

- ការផ្សព្វផ្សាយព័ត៌មានអំពីគម្រោងគាំពារសុខភាពសង្គម និងការចែកចាយសៀវភៅធានារ៉ាប់រងសុខភាពដោយប្រតិបត្តិករ ហាក់ដូចជាមានលក្ខណៈល្អប្រសើរក៏ប៉ុន្តែមានសមាជិកមួយចំនួនមានការយល់ដឹងមិនច្បាស់លាស់អំពីគម្រោង ឬ មានការយល់មិនច្បាស់អំពីកញ្ចប់ភាគផលដែលគម្រោងបានផ្តល់ជូន ក៏ដូចជាការយល់ខុសទាក់ទងនឹងការទទួលបានសៀវភៅធានារ៉ាប់រង និងមូលដ្ឋានសុខាភិបាលដែលសៀវភៅធានារ៉ាប់រងមានសុពលភាព។ ទោះបីជាយ៉ាងនេះក៏ដោយការយល់មិនច្បាស់លាស់នេះគឺបណ្តាលមកពីស្ថានភាពផ្ទាល់ខ្លួននៃសមាជិក។

- អ្នកចូលរួមជាច្រើនបានអធិប្បាយពីករណីដែលពួកគេបានទៅមូលដ្ឋានសុខាភិបាលសាធារណៈតែពួកគេភ្លេចឬក៏មិនបានយកទៅជាមួយនូវសៀវភៅធានារ៉ាប់រងសុខភាព ដោយសារតែករណីបន្ទាន់នៃស្ថានភាពជម្ងឺរបស់ពួកគេ។

ការធ្វើដំណើរទៅកាន់មូលដ្ឋានសុខាភិបាល

- ចម្ងាយទៅមណ្ឌលសុខភាព ត្រូវបានលើកឡើងជាញឹកញាប់ថាជាមូលហេតុនៃការមិនទៅប្រើប្រាស់សេវាកម្ម ចំណែកឯភាពងាយស្រួលក្នុងការទិញឱសថនៅតាមតូបលក់ចាប់ហ្វិយក្នុងភូមិជម្រុញឲ្យពួកគេទិញឱសថនៅទីនោះ។

- ការលំបាក ក្នុងការរៀបចំមធ្យោបាយធ្វើដំណើរទៅកាន់មូលដ្ឋានសុខាភិបាល ក៏ត្រូវបានលើកឡើងផងដែរ។ ចំណុចនេះគឺមានលក្ខណៈច្បាស់ ចំពោះប្រជាពលរដ្ឋដែលរស់នៅក្នុងភូមិដាច់ស្រយាល និងចំពោះប្រជាពលរដ្ឋវ័យចំណាស់ឬក៏អ្នកដែលមានពិការភាព។

ការចាកចោលការងារនិងផ្ទះសម្បែង

- ការចាកចោលការងារ និង ការទុកចោលកូនតូចៗនៅផ្ទះក៏ជាឧបស័គ្គផងដែរដែលរារាំងដល់ការទៅប្រើប្រាស់សេវា។ អ្នកជម្ងឺមួយចំនួនមានភាពអស់អែកក្នុងការសម្រាកព្យាបាលយូរនៅក្នុងមន្ទីរពេទ្យដោយសារតែគ្មានអ្នកនៅកំដរថែទាំ។

កង្វល់អំពីការប្រើប្រាស់សេវាសុខាភិបាលសាធារណៈ

- មានអ្នកចូលរួមមួយចំនួនតូចមិនហានទៅប្រើប្រាស់សេវាញឹកញាប់ទេ ដោយមូលហេតុខ្លាចបុគ្គលិកពេទ្យរអ៊ូថាមកប្រើប្រាស់សេវាញឹកញាប់ពេក។

- ជាការគួរឲ្យចាប់អារម្មណ៍ផងដែរថា សមាជិកមួយចំនួនបានទៅប្រើប្រាស់សេវាសុខាភិបាលនៅតាមមណ្ឌលសុខភាព ប៉ុន្តែមិន

បានប្រើប្រាស់សៀវភៅធានារ៉ាប់រងសុខភាពទេដោយសារមានការបារម្ភថា ពួកគេនឹងមិនទទួលបានការព្យាបាលទេនៅពេលបង្ហាញសៀវភៅធានារ៉ាប់រងនេះ ដូច្នេះពួកគេត្រូវបង់ថ្លៃព្យាបាលដោយខ្លួនឯង។

ឥរិយាបទចំពោះជម្ងឺនិងការព្យាបាល

- អ្នកចូលរួមមួយចំនួនមិនចង់ប្រាប់ពីស្ថានភាពជម្ងឺរបស់ពួកគេដល់អ្នកជំទែទេ ដូច្នេះពួកគេមួយចំនួនមិនទៅស្វែងរកការព្យាបាលទេដើម្បីកុំឲ្យគេដឹងថាពួកគាត់មានជម្ងឺ ឬក៏មិនសូវរកការជួយឧបត្ថម្ភទេនៅពេលទៅទទួលសេវានៅមណ្ឌលសុខភាព។ មានអ្នកជម្ងឺវ័យចំណាស់មួយចំនួនតូចនិយាយថាពួកគាត់មានភាពអៀនខ្មាស់ ក្នុងការពិភាក្សាអំពីស្ថានភាពជម្ងឺ របស់ពួកគាត់ជាមួយគ្រូពេទ្យ ឬបុគ្គលិកពេទ្យ។

- មានទំនោរក្នុងចំណោមសមាជិកជាច្រើនក្នុងការទ្រាំនឹងជម្ងឺ ហើយមិនទៅស្វែងរកការព្យាបាលក្នុងរយៈពេលយូរដែលអាចទ្រាំបាន ដែលចំណុចនេះតែងតែកើតមានឡើងចំពោះមនុស្សចាស់ ហើយពួកគេនឹងទៅទទួលការព្យាបាលតែនៅពេលដែលស្ថានភាពជម្ងឺ មានសភាពធ្ងន់ធ្ងរដែលមិនអាចទ្រាំតទៅទៀតបាន។ បើស្ថានភាពជម្ងឺនៅមានសភាពស្រាលនៅឡើយ អ្នកជម្ងឺភាគច្រើនតែងតែស្វែងរកការព្យាបាលតាមបែបបុរាណ ឬបើក្នុងករណីដែលមិនធូរស្រាលទើបពួកគេចាប់ផ្តើមទិញឱសថសម័យដែលមានលក់នៅជិតក្បែរផ្ទះ។

ការពិភាក្សា

ភស្តុតាងភាគច្រើនពី របកគំហើញអំពីកត្តានៃប្រជាសាស្ត្រ-សង្គម ដែលត្រូវបានបញ្ជាក់ដោយការវិភាគ
ទាំងផ្នែកបរិមាណនិងគុណភាព បង្ហាញថាមនុស្សវ័យចាស់ជរាមិនសូវទៅទទួលការព្យាបាលនៅតាម
មូលដ្ឋានសុខាភិបាលសាធារណៈទេ
និងពួកគាត់ជួបបញ្ហាប្រឈមបន្ថែមជាច្រើនទៀតក្នុងការចូលទៅប្រើប្រាស់សេវាកម្ម។ របកគំហើញបន្ថែមទៀតដែលត្រូវបានគាំទ្រដោយការវិភាគទាំងពីរគឺបញ្ហាប្រទាក់ក្រឡាគ្នានៃការចូលទៅប្រើប្រាស់មូលដ្ឋានសុខាភិបាលសាធារណៈដែលមានដូចជា បញ្ហាតម្លៃចម្ងាយមធ្យោបាយធ្វើដំណើរ លទ្ធភាពក្នុងការធ្វើដំណើរ ដែលបញ្ហាទាំងអស់នេះបង្កើតបានឧបសគ្គចម្បងដល់ការទៅប្រើប្រាស់សេវាកម្មសុខាភិបាលនៃអ្នកចូលរួមការសម្ភាស។

បញ្ហាទីពីរ គឺការទំនុកចិត្តនៃសមាជិកគម្រោងដែលជាប្រជាពលរដ្ឋក្រីក្រ ទាំងនៅក្នុងគម្រោង និងជាមួយអ្នកផ្តល់សេវាព្យាបាល។ ករណីនៃដំណើរការមិនពេញលេញ ឬការផ្តល់អត្ថប្រយោជពីគម្រោងមិនបានគ្រប់គ្រាន់ផ្អែកតាមទស្សនៈវិស័យនៃសមាជិកដែលទទួលផល ឧទាហរណ៍ដូចជាការឧបត្ថម្ភដល់សោហ៊ុយធ្វើដំណើរដោដើម អាចធ្វើឲ្យប៉ះពាល់ដល់ទំនុកចិត្តរបស់ពួកគេលើគម្រោង។ ក្នុងនាមនៃអ្នកផ្តល់សេវាកម្ម ករណីជាយថាហេតុ នៃឥរិយាបទមិនគួរសម របស់បុគ្គលិក និង ភាពរើសអើងនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ អាចបង្កជាមូលហេតុ នៃការមិនទុកចិត្តគ្នាជាមួយ អ្នកផ្តល់សេវាកម្មព្យាបាលនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈទាំងអស់។ ម៉្យាងវិញទៀត ការលើកឡើងពីការយកចិត្តទុកដាក់ពីសំណាក់អ្នកផ្តល់សេវាឯកជន ក៏ដូចជា ការអនុញ្ញាតិពន្យាពេលបង់ថ្លៃព្យាបាលទៅពេលក្រោយដែលបង្ហាញពីនិមិត្តរូបនៃការបង្កើនទំនាក់ទំនងផ្អែកចិត្តសាស្ត្រ (Bloch 1973) អាចបង្កើនទំនុកចិត្តពីអ្នកជម្ងឺចំពោះពួកអ្នកផ្តល់សេវាឯកជនទាំងនោះ។

ចំណុចទីបី គឺការលំបាកក្នុងការចូលទៅប្រើប្រាស់សេវាដែលបានលើកឡើងដោយអ្នកចូលរួម គឺកង្វះខាតការជួយជ្រោមជ្រែងពីអ្នកជំទែទៀតក្នុងគ្រួសារឬក្នុងសហគមន៍។ នេះគឺជាការវិភាគដែលមានការទាក់ទងទៅនឹងរចនាសម្ព័ន្ធសង្គមនៅតាមទីជនបទនៃប្រទេសកម្ពុជា ដែលបង្ហាញពីភាពខ្សោយនៃការជួយគ្នាទៅវិញទៅមកនៅក្នុងសង្គម។ នៅក្នុងបរិបទដូចគ្នានេះដែរ អ្នកចូលរួមបង្ហាញពីភាពមិនហានពឹងពាក់ដល់អ្នកជំទែដើម្បីជួយទេនៅពេលមានជម្ងឺ ទោះជាអ្នករស់នៅក្នុងភូមិជាមួយឬក៏អ្នកភូមិជំទែទៀតក៏ដូចជាការសាកសួរដល់បុគ្គលិកគម្រោងនិងបុគ្គលិកសុខាភិបាល ដើម្បីបញ្ជាក់ពីអត្ថប្រយោជន៍ដែលត្រូវទទួលបាន។ ចំណុចពីរចុងក្រោយនេះ គឺអាចបណ្តាលមកពីអ្នកជម្ងឺពុំសូវមានការយល់ដឹងអំពីសិទ្ធអតិថិជន។

ចំណុចចុងក្រោយគឺទាក់ទងទៅនឹង
ការសម្រេចចិត្តរបស់សមាជិកទទួលផល ក្នុងការទៅស្វែងរកការព្យាបាល ដែលស្របជាមួយនឹងរបកគំហើញពីក្រុមពលរដ្ឋដែលមិនមែនជាសមាជិក មូលនិធិសមធម៌ នៅក្នុងប្រទេសកម្ពុជា (Khun & Manderson 2007; Ozawa & Walker 2011)។ របកគំហើញទាំងនេះបង្ហាញថាការសម្រេចចិត្តទៅស្វែងរកការព្យាបាលគឺជំបូងកំណត់ដោយភាពធ្ងន់ធ្ងរនៃស្ថានភាពជម្ងឺ។

ចំពោះករណីជម្ងឺមិនធ្ងន់ធ្ងរ ពួកគេតែងតែធ្វើការព្យាបាលដោយខ្លួន

ឯង និងជាមួយអ្នកផ្តល់សេវាដែលគ្មានចំណេះដឹងវេជ្ជសាស្ត្រត្រឹមត្រូវ (ឧ.អ្នកលក់ថ្នាំនៅតាមតូបចាប់ហ៊ុយជាដើម)។ ការទៅទទួលយកការព្យាបាលជាមួយអ្នកផ្តល់សេវាប្រភេទនេះ គឺជាទូទៅគេបានលើកឡើងថាមានភាពងាយស្រួល និងនៅក្បែរផ្ទះហើយចំណាយពេលវេលាតិច។

ជាមួយនឹងភាពផ្ទុយគ្នាដែលគួរឲ្យកត់សម្គាល់នេះ ទាំងមូលដ្ឋានសុខាភិបាលសាធារណៈ និង គម្រោងគឺមានទំនាក់ទំនងទៅនឹងស្ថានភាពជម្ងឺធ្ងន់ធ្ងរ។ សេវាឯកជនក៏ត្រូវបានប្រើប្រាស់ផងដែរសម្រាប់បញ្ហាសុខភាពធ្ងន់ធ្ងរ ហើយដែលអ្នកជម្ងឺខ្លួនឯងយល់ថាវាបានឆ្លើយតបទៅនឹងការចង់បានរបស់ខ្លួន ដូចជាការចាក់ថ្នាំ ផ្តល់សេវានិងឱសថទៅតាមការចង់បានរបស់ខ្លួនជាដើម។ ក្នុងគ្រប់កាលៈទេសៈទាំងអស់ ខណៈពេលដែលបញ្ហាហិរញ្ញវត្ថុ បានដើរតួយ៉ាងសំខាន់ក្នុងការជ្រើសរើសយកអ្នកផ្តល់សេវា ភាពងាយស្រួលក្នុងការចូលទៅប្រើប្រាស់ពេលវេលាដែលត្រូវចំណាយទៅស្វែងរកការព្យាបាល និង ការយល់ឃើញអំពីគុណភាពនិងរបៀបរបបព្យាបាល គឺជាកត្តាដែលជម្រុញឲ្យប្រជាពលរដ្ឋចង់ទិញសេវាពីផ្នែកឯកជន (ដរាបណាសេវាទាំងនោះមានតម្លៃសមល្មមអាចលៃលកបាន) ទោះបីជាសេវានៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈត្រូវគេផ្តល់ឲ្យដោយមិនគិតថ្លៃក៏ដោយ។

ការផ្តល់ជាអនុសាសន៍

ផ្អែកតាមរបកគំហើញទាំងអស់ ការផ្តល់ជាអនុសាសន៍សំខាន់ៗមានដូចខាងក្រោម:

ចំពោះគម្រោង

- ត្រួតពិនិត្យមើលអំពីការផ្តល់ប្រាក់ឧបត្ថម្ភសោហ៊ុយធ្វើដំណើរឲ្យបានជិតដល់ ហើយគួរតែធ្វើការពិនិត្យមើលឡើងវិញផងដែរ អំពីចំនួនប្រាក់ឧបត្ថម្ភដោយផ្អែកតាមទីតាំងភូមិសាស្ត្រ ដែលប្រជាពលរដ្ឋរស់នៅនិងទីតាំងនៃមណ្ឌលសុខភាព។

- គិតគូរឡើងវិញអំពីចំនួនប្រាក់ឧបត្ថម្ភថ្លៃអាហារសម្រាប់ករណីសម្រាកព្យាបាលនៅមន្ទីរពេទ្យ។

- បង្កើតយន្តការផ្លូវការមួយ ដែលសមាជិកអាចស្នើសុំធ្វើការផ្លាស់ប្តូរ មណ្ឌលសុខភាព ដែលអាចជួយសម្រួលដល់ការចូលទៅប្រើប្រាស់សេវា នៅមណ្ឌលសុខភាព ហើយយន្តការនេះត្រូវមានលក្ខណៈវិនិច្ឆ័យច្បាស់លាស់ក្នុងការផ្តល់ឲ្យមានការផ្លាស់ប្តូរឬមិនឲ្យធ្វើការផ្លាស់ប្តូរ។

- បង្កើតប្រព័ន្ធប្រាស្រ័យទាក់ទងជាមួយនឹងសមាជិកឲ្យបានល្អប្រសើរ។ ធ្វើការជូនដំណឹង ធ្វើការបកស្រាយបំភ្លឺ និងធ្វើការពន្យល់ពួកគេឲ្យបានច្បាស់ថាហេតុអ្វីបានជាចំណាត់ការមួយចំនួនត្រូវបានគេធ្វើឡើង រួមទាំងការពន្យល់ឲ្យដឹងច្បាស់អំពីអត្ថប្រយោជន៍នានាដែលពួកគេមានសិទ្ធនឹងទទួលបាន។

- ផ្តោតការសង្កត់ធ្ងន់លើ ការលើកកម្ពស់ការយល់ដឹងរបស់សមាជិកអំពីគុណភាពនៃការព្យាបាលនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ។ សកម្មភាពនេះទាមទារឲ្យមានការរួមបញ្ចូលនូវការផ្តល់ព័ត៌មានតាមរយៈការប្រជុំ និងការប្រាស្រ័យទាក់ទងជាទៃទៀតជាមួយនឹងសមាជិកដែលត្រូវទទួលផលទាំងនោះ និងផ្តោតការយកចិត្តទុកដាក់លើការអប់រំសុខភាព ជាពិសេសលើចំណុចដូចខាងក្រោម:

  - ធ្វើការពន្យល់- លើសពីការជូនដំណឹងតាមបែបសាមញ្ញ គេត្រូវតែពន្យល់ឲ្យច្បាស់លាស់អំពីជម្រើសនៃការព្យាបាលនៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ និង ពន្យល់អំពីការព្យាបាលដែលត្រឹមត្រូវតាមបែបវេជ្ជសាស្ត្រ ក៏ដូចជាការពន្យល់អំពីភាពមិនចាំបាច់នៃការផ្តល់ឱសថមួយចំនួនដែលមិនចាំបាច់ ហើយដែលតែងតែផ្តល់ឲ្យដោយអ្នកផ្តល់សេវាឯកជននិងអ្នកដែលគ្មានវិជ្ជាជីវៈវេជ្ជសាស្ត្រត្រឹមត្រូវ។ បញ្ហាមួយចំនួនដែលលើកឡើងដោយអ្នកចូលរួមការសម្ភាស គួរត្រូវធ្វើការបកស្រាយពន្យល់ឲ្យបានច្បាស់លាស់ដូចជាហេតុអ្វីបានជាមិនផ្តល់ថ្នាំចាក់នៅតាមមណ្ឌលសុខភាព និងហេតុអ្វីបានជាឱសថដូចគ្នាអាចព្យាបាលជម្ងឺខុសគ្នាបានជាដើម។

  - សង្កត់ធ្ងន់លើឥរិយាបទវិជ្ជមាន ក្នុងការស្វែងរកការព្យាបាលជម្ងឺ តាមរយៈការពន្យល់អំពីសារសំខាន់នៃការធ្វើរោគវិនិច្ឆ័យនិងព្យាបាលបានទាន់ពេល អំពីរោគសញ្ញាសាមញ្ញដែលចង្អុលបង្ហាញពីភាពធ្ងន់ធ្ងរនៃជម្ងឺ អំពីជម្ងឺរាំរ៉ៃដែលមិនឆ្លងដូចជាជម្ងឺទឹកនោមផ្អែម ជម្ងឺលើសឈាម និងផលចំណេញនៃការប្រើប្រាស់មណ្ឌលសុខភាពក្នុងការព្យាបាលជម្ងឺស្រាលៗ ធ្វើយ៉ាងណាដើម្បីជម្រុញឲ្យមានការផ្លាស់ប្តូរទំ

លាប់ក្នុងការប្រើប្រាស់សេវា។

ទិដ្ឋភាពនៃការអប់រំសុខភាពបែបនេះគឺ គួរតែធ្វើឡើងបន្ថែមដោយបុគ្គលិកពេទ្យនៅឯមូលដ្ឋានសុខាភិបាលដោយពួកគេគួរតែចំណាយពេលឲ្យបានច្រើនបន្តិចក្នុងការពន្យល់ដល់អ្នកជម្ងឺ។

- ផ្តោតការយកចិត្តទុកដាក់លើសមាជិកវ័យចាស់ ដោយសារតែពួកគាត់ជួបប្រទះនូវបញ្ហាប្រឈមបន្ថែមក្នុងការចូលទៅប្រើប្រាស់សេវា នៅតាមមូលដ្ឋានសុខាភិបាលសាធារណៈ ដោយសារតែរាងកាយមានភាពទន់ខ្សោយ។

- ការទូទាត់ប្រាក់ពីគម្រោងទៅឲ្យអ្នកផ្តល់សេវាត្រូវផ្សារភ្ជាប់នឹងការប្រតិបត្តិការងារ និងពិន្ទុនៃការវាយតម្លៃមណ្ឌលសុខភាព ការធ្វើដូច្នេះគឺដើម្បីបន្ថយបញ្ហាអវត្តមានបុគ្គលិកក្នុងម៉ោងធ្វើការ និងការរើសអើងចំពោះសមាជិកគម្រោងគាំពារសុខភាពសង្គម។

ចំពោះការផ្តល់សេវាព្យាបាល

- ត្រូវត្រួតពិនិត្យ និង ឃ្លាំមើលឲ្យបានហ្មត់ចត់លើគុណភាពឱសថនៅមណ្ឌលសុខភាពនិងធ្វើការពិនិត្យការអនុវត្តន៍យុទ្ធសាស្ត្រកែលំអគុណភាព។

- គិតគូរពិចារណាអំពីការទាមទារចង់បានការចាក់ថ្នាំពីសមាជិកភាគច្រើន និង ព្យាយាមធ្វើការ ដោះស្រាយកង្វល់ដទៃទៀតដែលបានលើកឡើងដោយសមាជិក។

- សំណូមពរដល់បុគ្គលិកសុខាភិបាល ឲ្យចំណាយពេលវេលាឲ្យបានច្រើនបន្តិច ជាមួយអ្នកជម្ងឺ ដើម្បីអាចពន្យល់អំពីការប្រើប្រាស់ឱសថ និងអប់រំសុខភាព សំដៅធ្វើយ៉ាងណាបង្កើនការផ្លាស់ប្តូរឲ្យមានភាពវិជ្ជមាន អំពីការព្យាបាលនៅឯមូលដ្ឋានសុខាភិបាលសាធារណៈ ក៏ដូចជាពង្រឹងភាពស្និតស្នាលរវាងអ្នកផ្តល់សេវា និងអ្នកជម្ងឺដើម្បីបង្កើនភាពទុកចិត្តលើអ្នកផ្តល់សេវា (Ozawa & Walker 2011).

ចំពោះតម្រូវការ

ពិចារណាចាត់ចែងដោយធ្វើសហការជាមួយសហគមន៍:

- រួមផ្សាភ្ជាប់ជីកជញ្ជួន
ទៅកាន់មូលដ្ឋានសុខាភិបាលសាធារណៈ សម្រាប់សមាជិកដែលរស់នៅក្នុងភូមិដាច់ស្រយាល។

- ចរចារជាមួយអ្នករត់ម៉ូតូឌុបក្នុងការទូទាត់ថ្លៃឈ្នួលបន្ទាប់ពីសមាជិកទទួលបានប្រាក់ឧបត្ថម្ភ។

- បង្កើតប្រព័ន្ធគាំទ្រក្នុងសហគមន៍មួយ ដែលជម្រុញឲ្យប្រជាពលរដ្ឋជួយគ្នាទៅវិញទៅមក ដូចជាការជួយមើលកូនតូចៗ មនុស្សចាស់ជរា ឬក៏ជួយមើលផ្ទះសម្បែង នៅពេលគ្រួសារណាមួយមានជម្ងឺត្រូវទៅព្យាបាលចោលផ្ទះ។

ការសិក្សានាពេលអនាគត

- ពិចារណាប្រើប្រាស់វិធីសាស្ត្រអង្កេត ដើម្បីសិក្សាបន្ថែមលើទិន្នន័យដែលប្រមូលបានតាមបែបគុណភាពនៃការវាយតម្លៃនេះ។ កម្រងសំណួរអង្កេតគួរតែទាក់ទងគ្នាជាមួយនឹងលទ្ធផលនៃការវិភាគតាមបែបគុណភាព ហើយការអង្កេតនេះគួរតែធ្វើឡើងលើប្រជាពលរដ្ឋក្នុងចំនួនច្រើនជាងនេះ ហើយការអង្កេតនេះគួរប្រមូលនូវទិន្នន័យប្រជាសាស្ត្រសង្គម ដើម្បីគាំទ្រលើរបកគំហើញពីការវិភាគតាមបែបគុណភាព។

- ពិចារណាបញ្ចូលក្រុមសមាជិក ជានាព៌ប់រងសុខភាពសហគមន៍ទៅក្នុងការសិក្សានេះដែរដើម្បីឈ្វេងយល់អំពីទស្សនៈ និង បទពិសោធន៍របស់ពួកគេចំពោះមូលដ្ឋានសុខាភិបាលដោយប្រៀបធៀបជាមួយនឹងសមាជិកមូលនិធិសមធម៌។ ការធ្វើបែបនេះអាចឲ្យគេធ្វើការវិភាគប្រៀបធៀបក្នុងចំណោមក្រុមទាំងពីរនេះ ដើម្បីសិក្សាមើលពីកត្តាដែលជម្រុញដល់ការប្រើប្រាស់ក្នុងកម្រិតទាប និង ការមិនទៅប្រើប្រាស់សេវាសោះ។

Executive Summary

Introduction

The Royal Government of Cambodia, aware of the challenges that direct and indirect health expenditures pose to the population, particularly for poor and vulnerable groups, is committed to ensuring equitable access to quality health services for all Cambodians. As part of this vision, the draft Social Health Protection Master Plan and the Strategic Framework for Health Financing foresee the parallel development of various social health protection (SHP) schemes targeting different segments of the population, as a way to build an effective system that will enable moving towards universal health coverage.

One of the strategies under this policy is to integrate existing SHP schemes, and specifically to link together health equity funds (HEFs) and community-based health insurance (CBHI). HEF is a pro-poor health financing scheme that targets pre-identified poor households and covers their health costs at public health facilities; CBHI is a voluntary health insurance scheme organised at the community level, aimed at near-poor informal sector workers who can afford small, regular premium payments. Until recently, HEF and CBHI existed as two complementary but fragmented schemes implemented by the government with support from health partners. Major stakeholders in the health field, however, agree that linking these two schemes has numerous advantages in promoting equity in access to health care, quality improvement and a sustainable form of health financing.

The German Government supports the implementation of this important policy through the Cambodian-German Social Health Protection Programme (SHPP). In its framework, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) has supported the development and implementation of the HEF and CBHI linkage into an integrated SHP scheme in Kampot and Kampong Thom operational health districts (ODs) in 2008 and 2011 respectively, with the overall objective of improving access and equitability of affordable, quality health care for the poor and near-poor.

This linkage project was implemented in collaboration with various local and international partners including the Ministry of Health, the Second Health Sector Support Programme, the Australian Agency for International Development (AusAID), the Kampot and Kampong Thom provincial health departments, the district health authorities of Kampot and Kampong Thom ODs, Action for Health (AFH), Groupe de Recherche et d'Echanges Technologiques (GRET), and Sokhapheap Krousar Yeung (SKY; "Health for Our Families").

Under the integrated SHP scheme, near-poor and better-off households voluntarily join the scheme as CBHI members, and through monthly payments purchase a package of medical benefits including treatment at a designated local public health centre and the provincial referral hospital. The HEF population in the scheme, on the other hand, is composed of poor households, pre-identified through national tools, which receive access to health insurance (with the same insurance booklet as CBHI members) through subsidisation of their benefits.

In light of the marked difference in utilisation of public health services between households in different economic quintiles across Cambodia, one of the objectives of the integrated SHP scheme is not only to increase overall utilisation, but also to reduce the 'utilisation gap' between poor (HEF) and better-off (CBHI) scheme members, in order to promote more equitable healthcare consumption. Two features included in the scheme for achieving this are:

- the provision of additional non-medical benefits to the poor, such as transport vouchers to health facilities and food allowance for beneficiaries' caretakers during inpatient hospital treatment, in order to reduce the barrier of indirect costs;

- the use of a single insurance booklet and access mechanism to health facilities for both the poor and voluntary members, in order to reduce discrimination against the poor from service providers.

Data from the scheme operator in Kampot OD, where the integrated SHP scheme has been operating since 2008, provides a perspective on health facility utilisa-

tion trends. Contact rates at public health facilities by both HEF and CBHI members have increased and are well above the national average, and the utilisation gap between the two subgroups has been slightly reduced. At the same time, however, this gap remains significant, with contact rates among the HEF population being more than two times lower than those among the CBHI population. Furthermore, utilisation data indicates that one-fifth of HEF households have not used health services at least once since the beginning of the scheme (in 2008) and the end of 2011 (the point up to which utilisation data was available at the time of the evaluation). Such non-utilisation seems to be linked to the utilisation gap, and more generally to the question of the scheme's effect on its poor members.

In part, higher utilisation among CBHI members can be attributed to the fact that they – unlike HEF members – purchase their own insurance. But this is also the reason that HEF beneficiaries, as a more vulnerable population without the motivation to make use of a service that have actively paid for, require attention to address the factors that deter them from accessing public health services. It seems that even with the SHP scheme covering user fees, providing additional benefits of transport and food allowances, and reducing discrimination against the poor through the use of a single insurance booklet for all scheme members, barriers to health care at public facilities for HEF beneficiaries still exist.

While there is ample literature on the barriers to public health service utilisation among poor and rural residents in Cambodia and other developing countries, much less is known about the determinants of non-utilisation among populations covered by an SHP scheme. Also far less studied are the actual considerations and decision-making processes that underlie non-utilisation (Matsuoka et al. 2010). This evaluation aims to identify determinants of non-utilisation among the poor HEF members of the SHP scheme in the intervention area of Kampot OD. More specifically, it seeks to understand the factors and barriers that result in this non-utilisation, while placing an emphasis on non-users' own perspectives and concerns. This should contribute to a better understanding of the impact of the SHP scheme on its poor beneficiaries and their health-seeking behaviour, and to the design of interventions for increasing utilisation and promoting equitable consumption of public health services.

This evaluation made use of both quantitative and qualitative methods. Quantitative techniques were employed to analyse existing utilisation data from the scheme operator, which covered 4,047 households from 2008 (the beginning of the scheme) to 2011 (the point up to which data was available) in order to examine the statistical effect of different socio-demographic, geographical and public health facility-related variables on the likelihood of non-utilisation. Qualitative methods were employed to collect detailed data from HEF beneficiaries on barriers and factors that deter them from seeking care in public facilities, as well as encourage them to seek care from other providers. These methods included semi-structured, in-depth interviews and focus group discussions with the members of HEF households identified as non-users of public health services, and were accompanied by conversations with health centre staff and ongoing observations. Altogether, qualitative data was collected from 63 HEF beneficiaries in 11 villages pre-selected for high non-utilisation rates, located in seven communes and four health centre catchment areas. The villages included both ethnic Khmer and Cham populations, and were at diverse distances from the health centre in their catchment area. The evaluation was conducted by a social anthropologist and a monitoring and evaluation advisor, both from SHPP.

Finally, the present evaluation intends to serve as an exploratory 'pre-study' for later research on utilisation issues to be undertaken in Kampong Thom OD, the second OD where the linkage project was implemented, which will build on the experiences and findings of the current evaluation.

Results

Quantitative analysis

The main results of the quantitative analysis indicate that:

- Households with fewer members and those with older heads are less likely to use public health services than households with more members and those headed by younger persons.
- Older individuals and males are less likely to visit public facilities than younger individuals and females.
- Increased distance to the health centre, and a lower health centre quality assessment score, reduce the likelihood of health centre utilisation.

Qualitative analysis

The results of the qualitative analysis are presented according to scheme-related, supply-related, and demand-related issues, in order to obtain an overview of the barriers that play a role in each area.

Scheme-related issues brought up by the evaluation's participants were mostly financial, and concerned the indirect costs of visiting public health facilities, which seemed to remain a difficulty despite the scheme's additional non-medical benefits that are intended to address these points. The cost of transport to the public health facility was a main issue; an additional point was the cost of food for caretakers at the hospital.

The cost of transport to facilities:

- Several beneficiaries reported that they had either not received the included transportation reimbursement when they visited the public facility, or that they are concerned they will not receive it.
- Some participants, especially those who live farther away from the central area of the village, complained that: the reimbursement is not sufficient to cover the cost of the journey; the transportation reimbursement is provided only after using the service at the public facility, whereas moto-taxis (*motodups*) normally have to be paid upon arrival; and, the reimbursement is available solely when the scheme operator's (SKY) staff are present at the facilities, which is only in the mornings. While the previous point might indicate a possible inadequate functioning of the reimbursement mechanism, the current point pertains to the way this mechanism is designed.

The cost of food for caretakers at the hospital:

- While the scheme also includes a food allowance for the caretakers of hospitalised beneficiaries, a few participants stated that when accompanying relatives at the hospital's inpatient department, they had either not received the food allowance, or it had been insufficient and they had to spend their own money on food.

Supply-related issues had to do with, first, the availability of care at public facilities; and second, the service, in terms of both the conduct of staff and the perceived quality of medical treatment. In their responses, participants often compared public health providers to non-medical or private ones, and depicted the respective advantages of the latter.

Availability of health centre staff:

- Interviewees voiced complaints about health centre staff being absent or late, and described how they travelled to the health centre during the official operating hours only to find it unstaffed.

Wait times:

- Some beneficiaries also mentioned having to wait a long time for treatment at public health facilities, unlike at private clinics.

Restricted operating hours:

- Beneficiaries said they could not use health centres for ailments occurring in the evening or at night, since they do not offer full services at these times. This was contrasted with private providers, such as private clinics and doctors, which are available at almost any time.

Health staff behaviour:

- Participants depicted incidents of unfriendly or impolite hospital staff behaviour.
- Under the scheme, CBHI and HEF members use the same insurance booklet, with the objective of preventing discrimination between the two subgroups. While this kind of discrimination was indeed not reported, participants did describe cases of direct discrimination against them in the hospital when compared with self-paying patients (i.e., between poor scheme members and people who are paying their own treatment fees, as well as possibly under-the-table payments). Several beneficiaries reported being treated only after self-paying patients, ignored by the health staff, or refused treatment altogether.

Perceived quality of treatment:

- This arose as a central issue for beneficiaries; many participants had strong opinions about the treatments they would like to receive. Negative views were expressed on: the effectiveness of medicines at the health centre; the fact that injections, which are popularly demanded, are not often administered; inadequate medical examinations and equipment; the limited variety of medicine, and inability to provide specific requested medicine; and, the prescription of the same medicine for different ailments.

Demand-related issues included problems of knowledge and information, geographical and physical access, and opportunity costs, as well as socio-cultural and cognitive/psychological barriers.

The scheme and insurance booklet:

- While distribution of information about the SHP scheme and insurance booklet by the operator seemed to be generally good, a few beneficiaries nevertheless had only partial knowledge or a vague understanding of the scheme's benefits, as well as specific misinformation regarding how to obtain the booklet and where it was valid. However, this misinformation was not very common, and usually stemmed from beneficiaries' own circumstances.
- Several participants described cases in which they went to the public health facility, but forgot or did not think to take their insurance booklet with them, due to the perceived urgency of their health problem.

Travelling to the health facility:

- The distance to the health centre was a frequently-cited reason for not utilising its services, whereas the convenient location of the grocery store in the village encouraged people to purchase drugs from it.
- Difficulties in arranging transportation to the health facility were also reported. This was especially true for people in more remote villages and older beneficiaries or others with a weak physical condition.

Leaving work and home:

- Taking time off work and having to take care of children or other household members were both cited as barriers to utilisation as well. There was reluctance among beneficiaries to stay in the hospital for longer treatment, mostly due to the possible lack of caretakers.

Concerns about utilising public services:

- A few participants refrained from going to the public health centre due to their worries that the staff might complain that they come 'too often'.
- Interestingly, other beneficiaries said they visited the health centre, but did not use their insurance booklet due to concerns that they will not receive treatment when presenting the booklet (as opposed to paying for the service themselves).

Attitude toward health problems and treatment:

- Some participants did not want to 'share' their illness with others (i.e., let others know that they have a health problem) which caused them to either not go to the public facility in order not to expose the illness, or not to ask for needed assistance with visiting the health centre. A small number of older beneficiaries said they were ashamed to discuss their illness with a doctor, or afraid of the health staff.
- There was a tendency among beneficiaries to tolerate or accept ailments for as long as possible – again, particularly among aged beneficiaries – and for going to the public health facility only when the illness was perceived as severe and no longer bearable. If the illness was mild or ordinary, beneficiaries usually used traditional home care practices or, in case these did not help, purchased medicine from a local shop.

Discussion

The most evident finding in terms of socio-demographic factors, which was confirmed by both the quantitative and qualitative analyses, regarded elderly beneficiaries. This group is less likely to visit public facilities, and faces additional and particular challenges for utilisation. A further finding supported by both analyses is the multifaceted problem of access to public facilities, which encompasses the aspects of cost, distance, means of transport, and ability to travel, and which constitutes a central utilisation barrier for the evaluation's participants.

A second issue is the trust of the poor scheme members, both in the scheme and in public health care providers. Cases of inadequate functioning or fulfilment of scheme benefits from the perspective of beneficiaries – for example, with regard to transport reimbursement – may damage their trust in the scheme. In terms of providers, incidents of impolite staff behaviour and discrimination at public facilities could cause a lack of interpersonal trust in all public providers. On the other hand, reported attentiveness from private providers, as well as the possibility they often offer to defer payment, which has been argued to be a symbol of a moral relationship (Bloch 1973), may increase patients' trust in them.

A third point that arose from multiple utilisation difficulties brought up by participants is the lack of help from others in the family or community. This is analysed in relation to the social structure of rural Cambodia, which

displays weak mutual social support. In the same context, participants tend to refrain from 'bothering' others; whether it is other villagers with requests for assistance when ill, the scheme operator staff with questions or requests for clarification about benefits, or health staff at facilities with frequent visits. These last two last issues may also have to do with a lack of awareness of 'consumer rights'.

Finally, with regard to beneficiaries' healthcare decision-making processes, and in line with findings about non-HEF groups in Cambodia (Khun & Manderson 2007; Ozawa & Walker 2011), the choice of treatment option was first determined by the illness's perceived severity. Care sought for minor ailments was usually through self-treatment and non-medical providers (e.g., grocery stores). Going to these non-medical providers was generally perceived by respondents as more convenient, mostly in terms of accessibility and time.

In sharp contrast, both public facilities and the linkage scheme were associated almost exclusively with severe illnesses. Private providers were also used for more serious health problems, and provided the important advantage, from the beneficiaries' point of view, of following their treatment preferences (e.g., administering injections and being able to provide specific kinds of medicine upon request). All in all, while financial considerations certainly played an important role in the choice of provider, the aspects of convenience, accessibility, time, and the perceived quality and modality of treatment, were ones for which beneficiaries' were willing to pay (as long as this was affordable for them), despite the ability to receive treatment at public facilities for free.

Recommendations

Based on the findings, the main recommendations suggested in the report include the following points.

In terms of the scheme:

- Monitor the provision of the transport reimbursement more closely, and reassess its value while taking into account the relative locations of households to their designated health centre.
- Reassess the value of the food allowance for caretakers of inpatients at the hospital.
- Establish an official procedure whereby beneficiaries could request to change the health centre they are assigned to (due to problems of distance and transportation), with agreed criteria for the approval or denial of such requests.
- Establish better communication with beneficiaries. Inform, clarify, and explain to them why certain actions are taken, the exact benefits they are entitled to, and why.
- Place an emphasis on improving beneficiaries' perceptions about treatment quality at public health facilities. This could include information meetings and other interactions with beneficiaries, and a focus on health education, specifically on the following topics:
  - » Explain – rather than simply inform about – the treatment options at public health facilities, and raise awareness about appropriate treatment (i.e., why medicines from non-medical or private providers are not necessarily more effective or adequate). Specific issues that were brought up by the evaluation participants could also be addressed, such as why injections are not often administered at health centres, or why the same medicine might be given for different ailments.
  - » Stress positive health-seeking behaviour through increased awareness of: the importance of early diagnosis; how simple symptoms can be indicative of severe illnesses; non-communicable diseases such as diabetes and high blood pressure; and, the advantages of using the health centre for minor illnesses, in order to encourage a habit of utilisation.
- Such aspects of health education should be accompanied by health staff at facilities spending more time on these issues when receiving and treating beneficiaries (see below).
- Give particular attention to older beneficiaries, who face additional challenges in accessing public facilities due to physical weakness.
- Link scheme payments to public facilities' performance and quality assessment score, in order to reduce phenomena such as the absence of staff during operating hours, and discrimination against SHP scheme members.

In terms of supply:

- Better monitor and supervise the quality of medicine at health centres, and implement additional quality improvement strategies.

- Take into consideration the widespread demand for injections, and try to provide other concrete expressions of care.

- Instruct health staff to spend more time with patients explaining the medicine that is given, and why. This could contribute to increased health education among beneficiaries, and building positive perceptions about treatment at public facilities, as well as strengthening interpersonal relationships and building beneficiaries' trust in public providers (Ozawa & Walker 2011).

In terms of demand:

Consider arranging, in collaboration with the community:

- Joint transport to the public facility, for beneficiaries residing in more remote villages.

- Moto-taxis or other forms of transport where the drivers agree to be paid after the visit to the facility, and do not require payment before beneficiaries receive their reimbursement.

- A system of communal support in villages where people would mutually volunteer, for example, to help take care of children or older household members when there is a serious illness.

Future research:

- Consider using a survey method as a follow-up to the qualitative data collection in the current evaluation. The survey questionnaire should be informed by the results of the present evaluation's qualitative analysis, conducted on a larger amount of people, and collect socio-demographic data; this will allow a quantification of the qualitative data as well as its sorting and analysing according to socio-demographic characteristics and groups.

- Consider including CBHI members in the study, in order to gain knowledge on their perspectives and allow a comparison between this subgroup and HEF beneficiaries in terms of factors affecting utilisation.

Introduction

1 Background

Direct and indirect health expenditures, such as user fees and out-of-pocket payments, present significant challenges to Cambodia's population and pose a major barrier to the access of health services, especially for poor, near-poor and vulnerable groups. In its commitment to address these challenges, and ensure equitable access to quality health services for all Cambodians, the Royal Government of Cambodia, through the draft Social Health Protection Master Plan and the Strategic Framework for Health Financing, foresees the parallel development of a number of social health protection (SHP) initiatives targeting different segments of the population, as part of the process of building an effective system that will enable moving towards universal health coverage.

Until recently, complementary but fragmented SHP schemes were implemented by the government with the support of health partners. Two such main schemes are health equity funds (HEFs) and community-based health insurance (CBHI), which target the poor and the near-poor respectively. HEF is a pro-poor health financing scheme that targets pre-identified poor households, and covers their health costs at public health facilities; CBHI is a voluntary health insurance scheme organised at the community level, aimed at near-poor informal sector workers who can afford small, regular premium payments. The Ministry of Health (MoH) and major stakeholders in the health field agree that the integration of these two SHP schemes has numerous advantages in promoting equity in access to health care, quality improvement and a sustainable form of health financing.

The German Government supports the implementation of these important policies through the Cambodian-German Social Health Protection Programme (SHPP). In the framework of the programme, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) has been carrying out a joint project fostering the linkage of CBHI and HEF into a single, integrated SHP scheme in the operational (health) districts (ODs) of Kampot and Kampong Thom provinces since 2008 and 2011, respectively. The linkage project has the overall objective of improving access and equitability of affordable, quality health care for the poor and near-poor.

Under the integrated SHP scheme, near-poor and better-off households voluntarily join the scheme as CBHI members, and through monthly payments purchase a package of medical benefits including treatment at a designated local public health centre and the provincial referral hospital. The HEF population in the scheme, on the other hand, is composed of poor households, who have been pre-identified by the Cambodian Identification of Poor Households Programme (IDPoor), and are given access to the same health insurance scheme as CBHI members (with the same insurance booklet) through subsidisation of the their medical benefits. Moreover, HEF beneficiaries receive additional non-medical benefits, which include reimbursement for transport to public health facilities, and food allowances for beneficiaries' caretakers during inpatient hospital treatment.

The 'linkage project' was implemented in collaboration with various local and international partners including MoH, the Second Health Sector Support Programme, the Australian Agency for International Development (AusAID), the Kampot and Kampong Thom provincial health departments, the district health authorities of Kampot and Kampong Thom ODs, Action for Health (AFH), Groupe de Recherche et d'Echanges Technologiques (GRET), and Sokhapheap Krousar Yeung (SKY; "Health for Our Families").

1.1 Utilisation gap and non-utilisation

In light of the marked difference in utilisation of public health services between economic quintiles across Cambodia, one of the objectives of the integrated SHP scheme is not only to increase utilization, but also to reduce the 'utilisation gap' between poor (HEF) and voluntary (CBHI) scheme members, in order to promote more equitable healthcare consumption. Two features are included in the scheme specifically to achieve this: the provision of additional non-medical benefits to the poor, in order to reduce

the barriers of indirect costs; and, the use of a single insurance booklet for all scheme members, in order to reduce discrimination against the poor from service providers.

While the integrated SHP scheme in Kampong Thom OD has only been implemented since 2011, the scheme in Kampot OD has been operating since 2008 and thus provides a longer perspective on health facility utilisation trends. The current evaluation, which deals with utilisation issues, therefore focuses on Kampot. A further evaluation on utilisation in Kampong Thom OD is planned for a later stage.

Since the launch of the linkage scheme in Kampot OD in 2008 and until the end of 2011 (the point up to which utilisation data was available from the scheme operator at the time of the evaluation), contact rates at public health facilities by both HEF and CBHI members in Kampot have increased, and are well above the national average. At the same time, however, while the utilisation gap between the two subgroups has slightly decreased (see Annex 2), it remains significant. Whereas average utilisation rates of the HEF members have generally risen over time, reaching 1.35 contacts per member per year at health centres and 0.045 contacts per member per year at the referral hospital in 2011, they are still less than half the utilisation rates of the CBHI members, which are 3.15 health centre contacts and 0.096 referral hospital contacts per member per year (Chart 1). A similar trend is visible when looking at utilisation rates by health centre (Chart 2).[1]

The significant utilisation gap between the two populations in the scheme is also evident at the household level. Between 2008 and 2011, the mean number of health centre contacts per household per year by CBHI households was 26, whereas for HEF households it was only 12.8. This difference has been shown to be statistically significant (see Annexes 3 and 4).

Moreover, utilisation data retrieved from Sokhapheap Krousar Yeung (SKY; "Health for Our Families"), the linkage operator in Kampot OD, shows that a considerable amount of HEF households have not used any subsidised health services from the beginning of the linkage project in 2008 until the end of 2011. During this period, approximately one in every five households covered by the HEF as part of the integrated SHP scheme did not visit a health centre (or referral hospital) at least once. Among the CBHI population, the percentage of households not using any insurance-covered health services was about 10%, less than half the number of similar HEF households (Table 1).

Table 1: Percentage of households ever utilising the health centre under the scheme, 2008–2011 (in % and actual figures) [source: scheme operator's data on membership and utilisation; National Health Statistic reports]

	HEF population (n=4047 households)	**CBHI population** (n=1256 households)
Never visited the health centre	20.8% (843 households)	10.2% (128 households)
Visited the health centre at least once	79.2% (3204 households)	89.8% (1128 households)

Among the Kampot OD health centres, non-utilisation by HEF households ranged from 17% to 28%. For HEF members living in specific villages, the non-utilisation rate rises as high as 50% (Chart 3; see Annex 5 for the complete table). All in all, non-utilisation among HEF members seems to be intrinsically linked to the significant CBHI-HEF utilisation gap. Moreover, the issue of non-utilisation also more generally questions the effect of the HEF mechanism on the SHP scheme's poor beneficiaries and their health-seeking behaviour. It thus stands at the focus of the current evaluation.[2]

Various factors that affect people's overall health care-seeking behaviour and choice of health care provider have been identified in Cambodia as well as other developing countries. These include socio-demographic factors as well as perceived obstacles for the rural poor to use public health facilities, such as indirect costs, distance and transport limitations, limited operating hours and long wait times at facilities, low quality of service and care, inadequate knowledge and information about services and

1 When comparing utilisation by different population groups, it should be noted that such groups may also have different disease patterns. However, an analysis of these patterns is beyond the scope of the current evaluation.

2 It should be noted that higher utilisation among CBHI members can perhaps be attributed to the fact that they – unlike the HEF group – pay for their own insurance. But this is the reason that HEF beneficiaries, as a more vulnerable population without the motivation to make use of a service they have actively paid for, require more attention to improve their utilisation of public health services.

Chart 1: Average public health facility utilisation rates, 2008–2011 (in contacts per member per year) [source: scheme operator's utilisation data]

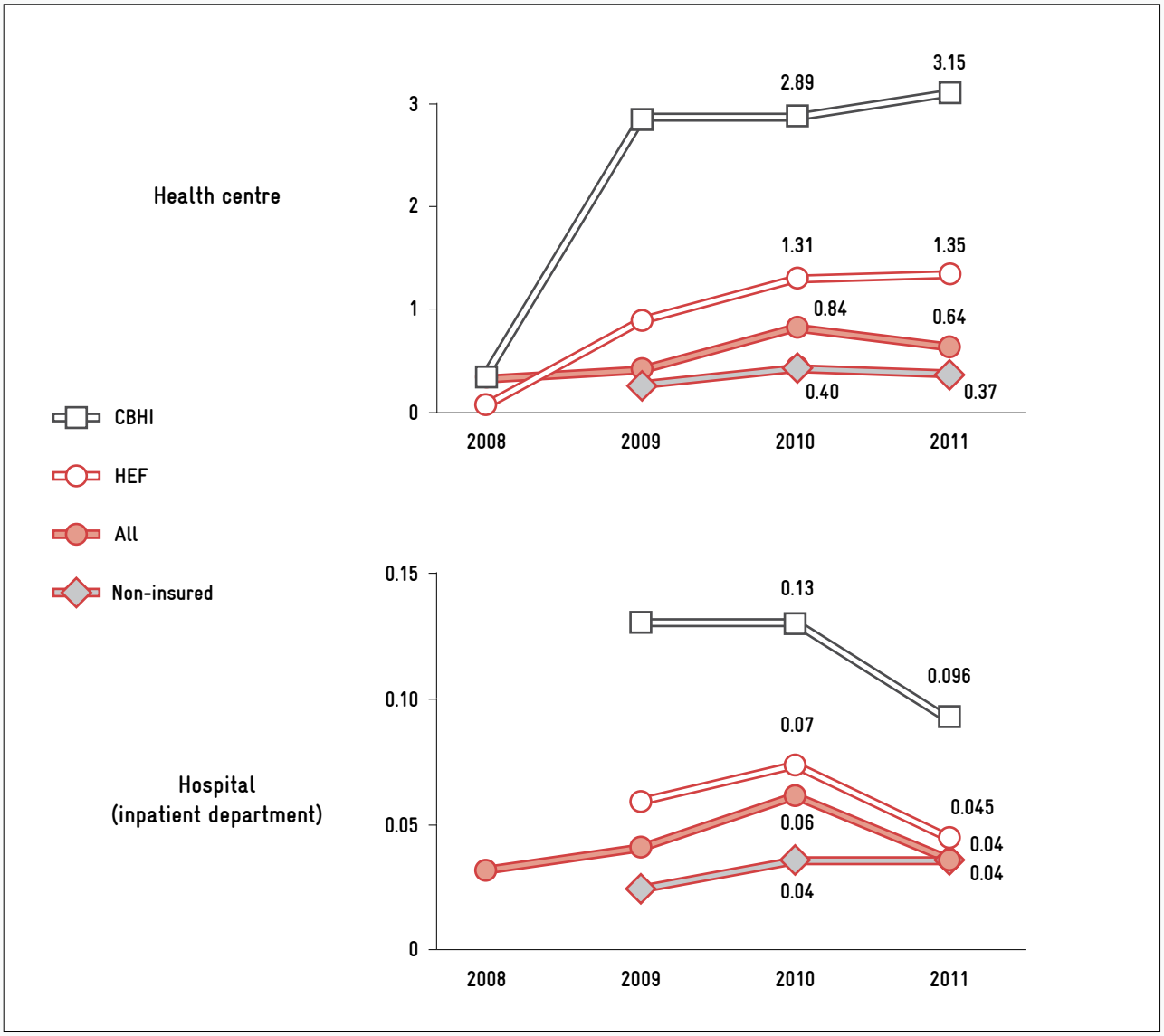


Chart 2: Average utilisation rates by health centre, 2011 (in contacts per member per year) [source: scheme operator's utilisation data]

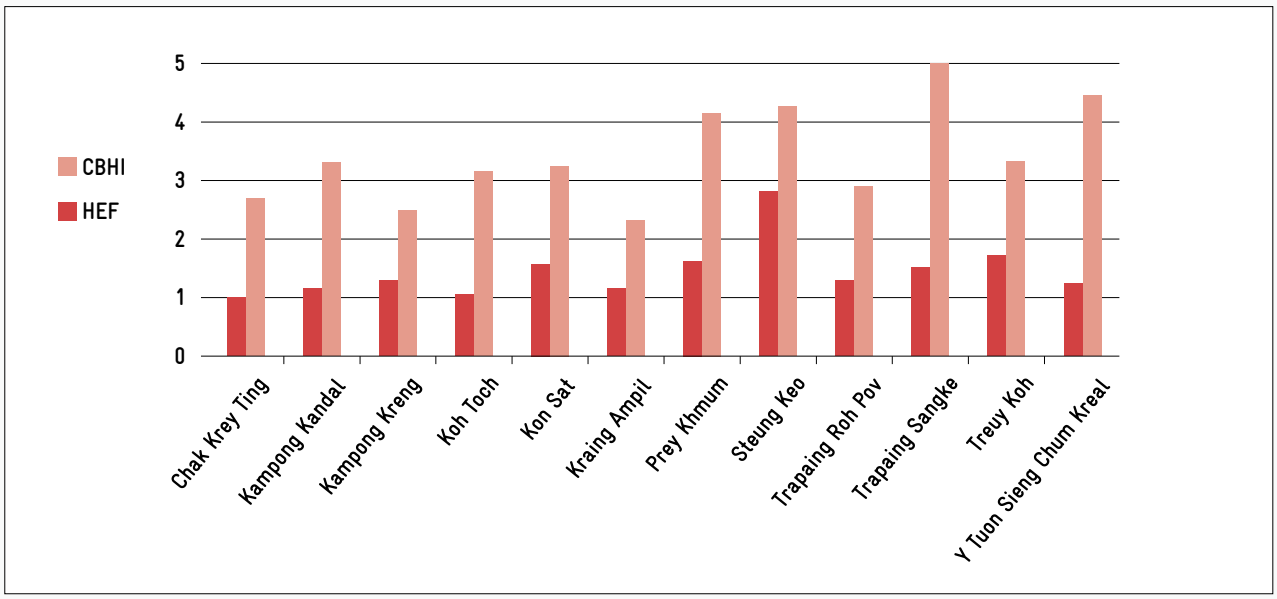
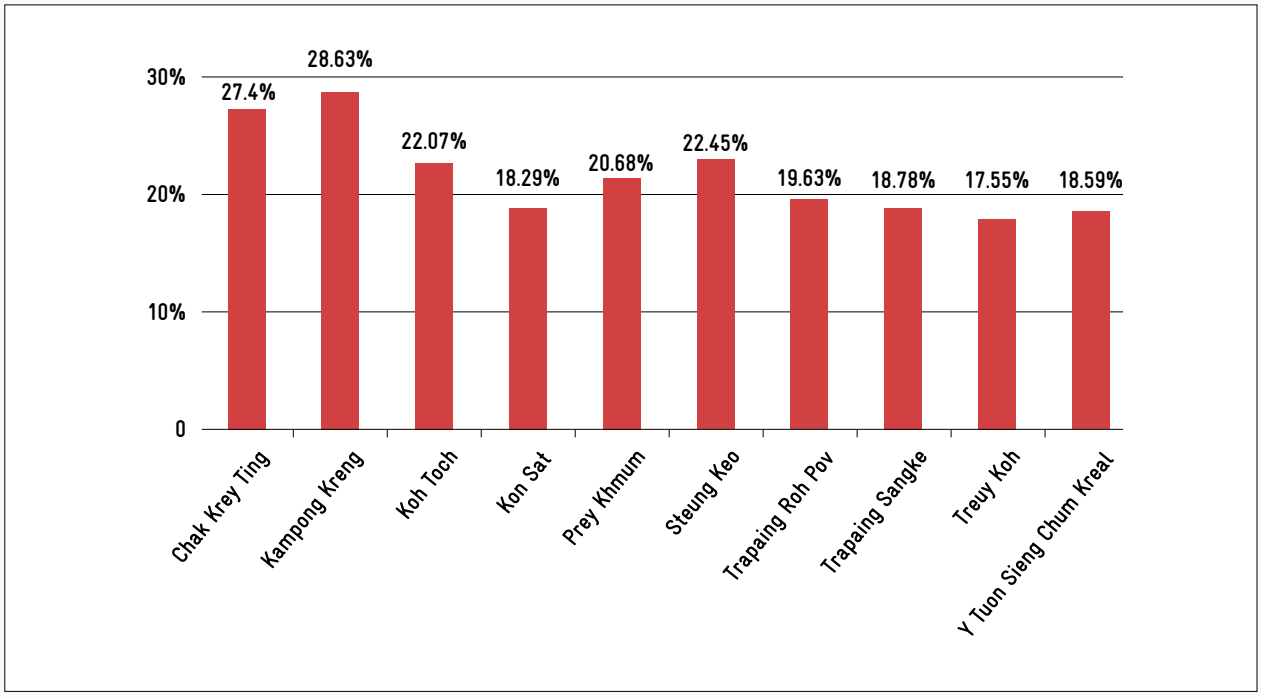


Chart 3: Percentage of non-utilisation by HEF households, by health centre, 2008-2011 (in %)* [source: scheme operator's membership and utilisation data]



*Calculated as the share of non-using HEF households from the number of HEF households covered by the health centre.

benefits, lack of perceived need for treatment, lack of trust in facility staff, and socio-cultural preferences and norms (Annear 2006; Das et al. 2001; Grundy & Annear 2010; Matsuoka et al. 2010; MoH 2011a; Niraula 1994; O'Donnell 2007; Ovesen & Trankell 2012; Ozawa & Walker 2011; Shaikh & Hatcher 2005; Shaikh et al. 2008; World Bank 2001).

Far less studied, however, are the specific factors, barriers and difficulties that affect populations covered by a HEF mechanism as part of an SHP scheme. Also much less known are the actual decision-making processes that underlie non-utilisation of public health facilities (Matsuoka et al. 2010). In the Cambodian setting, this also relates to the issue of why people generally prefer to seek treatment from alternative providers (Annear 2006; Jacobs and Price 2006; Ministry of Health 2011). These include both private health care providers, such as pharmacies, private clinics,[3] and private doctors, and non-medical providers, such as grocery stores and shops that sell drugs alongside other goods.

3 While this was the term that was most commonly used by the evaluation's participants, and which is consequently used in the report, in rural areas it in fact usually refers to a small-scale facility with only a consultation room and a medical cabinet.

It seems that even with the SHP scheme in Kampot OD covering user fees, providing additional benefits of transport and food allowances, and reducing discrimination against the poor through the use of a single insurance booklet for all scheme members, barriers to health care at public facilities for HEF beneficiaries still exist.

2 Objectives

The overall objective of this evaluation is to explore determinants of non-utilisation of public health services among HEF members within the SHPP-implemented SHP scheme in Kampot OD. The evaluation set out to identify the factors and barriers leading to non-utilisation in the context of an SHP scheme, with an emphasis – in the qualitative section – on non-users' own viewpoints, worries and concerns.

Further objectives included acquiring an understanding of HEF non-users' perspectives and preferences in relation to public facilities and other health care providers, attitudes toward health problems and treatment, and the considerations and reasoning employed in making health care-related decisions in a HEF context.

All in all, the effort to understand the factors involved in non-utilisation among HEF members should fill an impor-

tant gap in the existing knowledge about the influence of HEFs, as part of an integrated SHP scheme, on poor beneficiaries and their health-seeking behaviour. Moreover, it should contribute to recommendations for designing appropriate interventions that increase utilisation and improve equity in the utilisation of public health services.

Finally, the present evaluation is supposed to serve as an exploratory 'pre-study' for later research on utilisation issues to be undertaken in Kampong Thom OD, the second OD where the linkage project is implemented, which will build on the experience and findings of the current evaluation. It thus also includes recommendations for further research.

3 Methods

The evaluation employed both quantitative and qualitative research methods. Quantitative techniques were used to analyse existing data in order to statistically examine the effect of available variables on the likelihood of non-utilisation. The qualitative analysis took the form of ethnographic data collection, and was used to gather detailed data on the causes that deter beneficiaries' from seeking care in public health facilities. The evaluation population comprised HEF beneficiaries in Kampot OD. The quantitative analysis was conducted by a monitoring and evaluation advisor, and the qualitative analysis was carried out by a social anthropologist, both from SHPP.

The quantitative and qualitative analyses were conducted in parallel, during March and April 2012. The two analyses are presented separately; in the discussion section, results from both the quantitative and qualitative analyses are combined.

3.1 Quantitative phase

Using statistical tools such as bivariate association, multiple logistic regression, and clustering, the quantitative analysis attempted to recognise the influence of socio-demographic, geographical, and service delivery-related factors on the probability of non-utilisation. Data was taken mainly from SKY databases on scheme membership and utilisation (from patient registration records at health centres and the referral hospital), covering 4,047 HEF households between 2008 (the beginning of the scheme) and December 2011. Additional data was retrieved from Kampot's provincial health department and SHPP.

3.2 Qualitative phase

Fieldwork took place in eleven pre-selected villages located in seven communes and four health centre catchment areas. Qualitative methods used to collect data included semi-structured, in-depth interviews, focus group discussions (FGDs), conversations with health staff at health centres, and ongoing observations. The individual interviews and FGDs were conducted with members of HEF households that were pre-identified as non-users according to SKY administrative data. 31 individual interviews were conducted in seven villages, with 4-5 people per village. One FGD was organised in each of four additional villages, and included 6-10 participants each (for a total of 32 participants). Altogether, qualitative data was collected from 63 HEF beneficiaries.

The selection of specific non-utilisation HEF members for interviews and FGDs within the villages was random. The villages in which to collect data, however, were purposively selected. Using both SKY and IDPoor databases, it was possible to calculate non-utilisation percentages, as the number of non-utilisation households out of the total number of HEF beneficiary households, for most villages in the OD (for a few villages, data from either SKY or IDPoor was unavailable). Villages for qualitative data collection were then selected on the basis of having both a high rate of non-utilisation and a significant number of non-utilisation households. Based on the quantitative data, these were set at 25% and above and 20 households and above, respectively. Further considerations included including villages that are the catchment areas of multiple health centres, villages that are predominately ethnic Khmer (Buddhist) and ones that are predominately Cham (Muslim), and villages that are at different distances from the health centre in their catchment area (ranging from 1 to 13 kilometres).

It should be noted that during the interviews and FGDs, it was discovered that a few of the participants selected for their lack of utilisation, actually had experience with public health facilities when involved in the scheme. Besides indicating possible errors in SKY's data, this fact allowed the evaluation to include those respondents' experiences with the scheme, and with public facilities, and to see how these experiences affected beneficiaries' health-seeking behaviour and might have contributed to their reluctance to further use public facilities.

Using a general interview guide developed by the evaluators, participants were asked:

- whether they possessed an insurance booklet (which identifies them as SHP beneficiaries);
- their knowledge of the HEF benefits to which they are entitled;
- their knowledge of the local HEF-partnered public health facilities (e.g. their location, operating hours, and available treatments);
- their experiences at public facilities, if any;
- their experiences with using the scheme insurance booklet and receiving scheme benefits, if any;
- use of alternative providers or forms of care, and the reasons for this;
- opinions on treatment at public facilities and with other providers;
- barriers to and difficulties accessing public facilities;
- health-seeking decisions and choices (i.e., where care is sought for what health problems and why).

The responses and discussions from the interviews and FGDs were transcribed and entered into word processing software. In line with the framework approach (Pope et al. 2000), analysis took place by coding and indexing the data according to the identification and categorisation of key issues, themes and phrases. This procedure drew on issues and questions stemming from the aims of the evaluation, issues brought up by the participants themselves, and views and experiences that reappeared in the data (ibid). In line with the ethnographic nature of the qualitative phase, the qualitative results were not quantified; the sample size was relatively small, and the purpose of the qualitative analysis was to inform.

3.3 Limitations

The quantitative analysis was restricted by the limited amount of socio-demographic data on HEF beneficiaries included in the SKY databases. The IDPoor databases potentially include more socio-demographic variables; however the SKY databases could not be linked with those of IDPoor due to SKY's use of unique household/person codes. The quantitative analysis was thus restricted to those types of data that were available from SKY. In some cases, the SKY data at the household and individual level could also not be matched, and data for some households and individuals was missing.

With regards to the qualitative analysis, while an attempt was made to have variance in the sample of villages (in terms of ethnicity and distance from the health centre), practical constraints in the field also had to be considered. Furthermore, the selection of non-utilisation households for interviews and FGDs in the different villages was mediated through village leaders, and largely determined by people's availability. This might have exposed the procedure to a selection bias.

II Results

4 Quantitative analysis[4]

The quantitative analysis tested the effect of seven different variables on the likelihood of HEF households to seek care from a health centre. The dependent variable of the analysis was thus whether or not a household has ever visited the health centre under the scheme. The independent variables comprised: the socio-demographic factors of the sex and age of the household head, household size, if the household contains a member aged 60 and above; the geographical factor of the distance between the household's village and the health centre; and the public facility-related factors of the health centre's quality assessment score[5] and number of staff. The data included 4,047 HEF households, and encompassed the period between 2008 and 2011.

Socio-demographic factors:

- Households that are smaller (i.e., have fewer members), and those with older household heads, are less likely to seek treatment at public health facilities than households with more members and households headed by younger persons.
- Older individuals and male individuals are also less likely to utilise the public health facility than younger beneficiaries and female beneficiaries.
- The households head's sex and whether of not the household has a member aged over 60 are not significant in terms of the likelihood of utilisation.

Geographical factors:

- Households located at a greater distance from the health centre are significantly less likely to visit it than those located closer to the facility. For every additional kilometre away from the health centre, HEF households are 0.94 times less likely to seek treatment there.

Health centre factors:

- Surprisingly, a higher number of staff at the health centre was found to reduce the likelihood of utilisation. A higher health centre quality assessment score, on the other hand, increases utilisation; this was also the most important variable in predicting the probability of utilisation.

5 Qualitative analysis

Barriers to accessing public health services are often presented following a classification framework divided according to physical, financial, socio-cultural, knowledge-related, and service-related issues (Annear 2006; Doung et al. 2004; Bigdell & Annear 2009; Simkhada et al. 2008; Shaikh & Hatcher 2005). Table 7 at the end of the Results section presents a summary of the perceived barriers according to this more traditional classification scheme.

For this evaluation, however, it was decided to use a slightly different structure. As the evaluation was concerned with utilisation barriers specifically in the context of an integrated social health protection intervention, the results of the qualitative analysis have been primarily organised according to issues that are scheme-related, supply-related, and demand-related. Scheme-related issues are those linked with the SHP scheme, as operated in Kampot OD. Supply-related issues are those associated with health service delivery and treatment (public, private, and non-medical). And demand-related issues are those that stem from beneficiaries' own behaviours and circumstances, which can be considered as exogenous factors to a certain extent.

The advantage of using this classification is that is enables a realignment of the more traditional categories of barriers – to which, following Matsuoka et al. (2010) the category of cognitive/psychological barriers has been added

4 The current section presents only the main results of the quantitative analysis; the detailed statistical analysis and outputs can be found in Annexes 6 and 7.

5 The assessment score includes parameters such as organisation and presentation of staff and ward, hygiene, and equipment and supply.

– according to the areas of scheme, supply, and demand. This allows us to understand the kinds of barriers that influence each of these domains. As can be expected, many of the findings are interrelated and overlap across categories. The division could thus not always be clear cut, and some themes reappear in different categories.

Lastly, it should be emphasised that, as this evaluation was intended to increase the knowledge of HEF beneficiaries' perspectives on public health care, the findings mainly refer to the participants' experiences, impressions, opinions and perceptions. Thus, these findings are subjective, and no official opinion or judgment is intended.

5.1 Scheme-related issues

The first two subsections in this section concern participants' possession of an insurance booklet and knowledge of the SHP scheme's benefits. Both of these are prerequisites for the opportunity to utilise public health services under the current scheme. The subsequent sections then present specific barriers related to the functioning and design of the SHP scheme.

5.1.1 Ownership of the insurance booklet

All participants except one declared that they received their insurance booklets. In two cases, however, the booklet was not with them at the time of the evaluation. One woman stated that her booklet was withdrawn by the village chief in order for SKY to 'do something with it'. She did not know any more details, nor when she is supposed to get the booklet back. Another woman said that SKY staff took away her booklet in order to update it (for adding more members to it). This was, however, already 2-3 months ago, and SKY had yet to return it.

Another issue was the photographs of household members, which need to be part of the booklet in order to allow them to use it. In several households, the photo that appeared in the booklet did not include all of the family's members, since some of them were away from the house when the photos were taken.

After comparing several respondents' statements with their actual booklets, the impression is that SKY data contains some errors. In some cases, participants' booklets contained some entries, despite them being listed in the SKY database as having no contacts at public health facilities. Some of the entries were also difficult to decipher, as the recorded dates did not seem to make sense. All this seems to indicate that errors have been made by both staff at the health facilities and SKY.

5.1.2 Knowledge about scheme benefits and public health facilities

With regard to the core benefits offered by the scheme, the absolute majority of participants knew that the insurance booklet provides them with free treatment at public health facilities. Explanations of the benefits entitled by the booklet included 'treatment for free', 'free medicine', and 'go to the health centre when I'm sick and get treatment without having to pay'. One participant commented that the booklet allows them to receive free treatment and other benefits when seriously sick (emphasis added), a statement that is already indicative of the way in which the participants think about the booklet, which is discussed later on.

Focus group discussions with beneficiaries

Most of the participants also knew about transport reimbursement, namely 'money for transport' or 'travel support'. However, mention of this additional benefit was less automatic and often had to be prompted by the interviewer. Some participants also mentioned receiving a food allowance – an additional benefit that is offered for caretakers accompanying HEF members who are inpatients at the referral hospital.

Generally, the HEF beneficiaries who took part in the evaluation had a good grasp of the main benefits linked with the insurance booklet, and basic information seems to be quite well disseminated. While some people only heard about the benefits from others, most participants received the information in public meetings with SKY, which they usually attended more than once. The majority of participants knew the location of their SHP-partnered health centre, and the official operating hours. The public facility services most often mentioned were treatment of colds, malaria and tuberculosis, and delivery of babies.

The dissemination of information about the scheme's benefits and public facilities from SKY seems to be generally good. Problems that are related to knowledge about benefits, but that do not directly stem from the operator's informational activities, are discussed under demand-related issues.

5.1.3 Transportation to public facilities

Transportation to the public facility, coupled with distance, was one of the most commonly mentioned problems by this evaluation's participants. In the current section, only issues that are linked with the scheme's travel voucher system are presented; further difficulties related with transportation and distance are discussed under demand-related issues.

5.1.3.1 Transport reimbursement

As mentioned, some of the interviewees had some experience with visiting public health facilities as scheme members, despite being selected for their non-utilisation. Thus, they could also share the problems they encountered with different elements of the scheme (as well as with the health facilities themselves, which are included in the next section).

Some of the people interviewed stated they had not received the transport reimbursement for traveling to the health centre or referral hospital. One participant, whose village was located four kilometres from the health centre, commented that, 'I never received the money for travel, because SKY staff said I don't live far enough, so I had to pay for transportation myself'. Under the scheme, all HEF beneficiaries are entitled to a certain number of travel vouchers, regardless of the location of their village in relation to the health centre. (Short) distance to the public facility is not a valid reason for SKY staff to deny transport reimbursement.

Another participant described how she had to borrow money to get to the health centre, since she received no travel support from SKY. When asked to clarify the reason for not receiving the reimbursement, she replied that 'SKY's staff didn't pay any attention to me'. Another participant said, 'When I went to the health centre for the first time, I got the reimbursement for transport; but when I went the second time, for my husband's swollen throat, we didn't get any reimbursement, maybe because it wasn't the time or day when this is given'. Likewise, one participant said he had received travel support from the health centre, but not from the referral hospital.[6]

Concerns regarding transport reimbursement were also expressed by participants who did not have any experience with it. One interviewee said, 'I think I may or may not receive the money for transport, and since I cannot afford transport without it, I don't want to take the chance'. Another respondent commented that when she had gone to health centre once before having the booklet, she had to pay a lot of money for transportation. Now, she is not sure whether she will receive the reimbursement, and is afraid to spend money on transport and then find out she cannot get it back. In this happens, she will be 'left without money', and hence does not even want to try. When going to the nearby grocery store, on the other hand, she stated that there is no need to spend money on transport.

5.1.3.2 Value of the travel vouchers

While the previous subsection dealt with transport-related difficulties that seem to stem from possible problems in the functioning of the scheme, when HEF beneficiaries are not getting the reimbursement they are supposed to, this subsection and the next present issues concerning the way in which the scheme and the travel support mechanisms were designed.

6 In order to receive transportation reimbursement to the hospital, it should be mentioned, one has to have a reference letter from the health centre. It was unclear whether this participant had such a letter or not.

Transportation allowances under the scheme were deliberately kept low, so that they cover the cost of travel as far as possible but do not create a moral hazard or incentives to try to profit from the scheme. However, several respondents complained that the travel vouchers in fact did not fully cover the cost of transport. '[The vouchers were] not enough to pay for the journey,' one participant said. Another explained that she does not go to the health centre under which she is covered because 'I have to spend KHR 5,000-6,000 on transportation, but the reimbursement covers only KHR 4,000, not the whole cost'. She then described how she goes to a closer health centre instead, where she cannot use her booklet because it's not her official health centre.

Following this last comment, it should be clarified that while HEF beneficiaries were initially assigned to health centres by SKY according to the location of their village, beneficiaries can ask to transfer to another health centre. Such a request can be made by approaching SKY staff, and explaining that the assigned health centre is too far, and that another health centre is in fact nearer. The request can be then approved or declined. However, there are no formal guidelines for what constitutes a 'valid' request for a transfer. Decisions, then, are not systematic but subjective, and are made on a case-by-case basis. Moreover, even if a request is accepted, it can take a while for the member's booklet to be actually updated.

With regards to why the vouchers are not sufficient, one interviewee commented that 'transportation reimbursement is by kilometre, but moto-taxi (*motodup*) prices fluctuate according to the price of gasoline'. Regardless of whether this indeed plays a role in the ability of vouchers to cover the cost of the journey, what was evident from visiting different families in the villages is that the official distance used to calculate the value of the transport vouchers – which is in fact the distance from the centre of the village to the health centre – applies only to certain households. As some of the villages are quite spread out, some families live far away from the health centre, and the cost of transport is considerably higher.

5.1.3.3 Transport reimbursement's dependency on scheme operator staff's presence

A further difficulty with the travel support that was often cited is that, in order to receive the reimbursement for transportation to the health centre, it is necessary to visit it when a SKY facilitator is in attendance. Under the scheme, however, SKY staff are not always present at the health centres during all operating hours. While health centres are generally open in the morning and afternoon, SKY staff are only at the facilities in the mornings. The reasons for this arrangement include: encouraging patients to come to the health centres earlier; the fact that SKY facilitators also have the tasks of community outreach and recruitment of CBHI members; and limited resources.

As explained by a SKY staff member, since monitoring reimbursement retrospectively (i.e., when it is not handled by a SKY facilitator as it occurs) is a time-consuming and complex process, HEF members who come to the health centres in the afternoon, when SKY staff are not in attendance, are generally not reimbursed for transport. This was mentioned as a difficulty and deterring factor by some of the participants.

Several people said that when they encounter health problems or need medicine in the afternoon, they refrain from going to the health centre, since 'SKY's people are not there' and they thus cannot receive the reimbursement for transport. One woman commented, 'I don't want to go to the health centre in the afternoon, when SKY staff is not there, because then I don't get the money for travel. So whenever I'm feeling sick at this time, I buy medicine at the grocery store'. Another person said, 'SKY staff are only at health centre in the morning, but my children have to work then and can go to the health centre only in the afternoon, so they cannot get any reimbursement for transport'.

Another participant described how SKY staff presence at the health centre can be a problem, even in the morning:

> I went to the health centre in the morning, but didn't see any SKY people there, so I couldn't get any travel reimbursement. I had no money to pay for transportation, and had to walk back home. Another time, I did see SKY staff at the health centre, went to get some medicine there, and when I came back SKY's people were gone, so that I couldn't receive the reimbursement. But I know SKY staff can be busy…

5.1.3.4 Timing of the reimbursement

Under the scheme, reimbursement of transport costs takes place after receiving the service at the public facility. The motodup people use to travel to the facility, however, normally has to be paid already upon

arrival. This was cited as an obstacle by a few respondents, who noted that they do not have the money to pay the driver. One woman stated:

> I don't have the money to pay the motodup up front. Drivers don't want to wait for their payment until after the visit to the health centre [when the reimbursement is given] and also don't want to take me to the health centre the next time. Because of this I have to go to the health centre, but I'm lazy to do this.

5.1.4 Food allowance at the referral hospital

The SHP scheme includes a food allowance for the caretakers of HEF inpatients at the provincial referral hospital, set at KHR 4,000 per day. Nevertheless, some people referred to the need to pay for food as a problem they encountered when staying in the hospital with hospitalised relatives. Participants made the following comments:

- 'While staying there [at the referral hospital] with a relative, I received KHR 4,000 for food allowance every two-three days [less than the intended amount], which was not enough, so I also had to bring own food.'
- 'It's difficult to stay at the hospital for a long time [with somebody] because you have to pay for food.'
- 'When my sister was in the hospital for a week, I had to bring food for both her and me.'

Box 1: Summary of scheme-related barriers

- Financial: Transportation → Beneficiaries do not receive the travel reimbursement.
- Financial: Transportation → Reimbursement does not cover the whole cost of the journey.
- Financial: Transportation → Reimbursement is given only when SKY staff are present at the public facility.
- Financial: Transportation → Reimbursement is given only after having to pay the motodup.
- Financial: Food → Caretakers do not receive food allowance at hospital, or food allowance is insufficient.

5.2 Supply-related issues

5.2.1 Absence of health centre staff

Despite the acknowledged improvement in the functioning of health centres since the beginning of the SHP scheme – as one interviewee put it, 'The health centre was built a long time ago, but has only run successfully since the establishment of SKY' – participants expressed complaints about staff being late or absent. Several of them detailed how they travelled to a health centre (during normal operating hours) but no one was there.

One man said in an interview, 'My child was shaking and I took him to the health centre, but no staff was there. So I went to see a private doctor who was near the health centre and borrowed money from people in the village to pay for this'. Another respondent

Visiting health centres and talking with staff

described the following situation, 'Usually there is a person stationed at the health centre, but no medical staff. When you need the doctor, you have to ask the person for his phone number and call the doctor with the payphone, which also costs KHR 1000'. A similar statement was also made in an FGD: 'I went to the health centre, but there was no staff there. I had to call someone from the staff to come and clean my husband's wounds. After calling four times somebody finally arrived'.

Some HEF beneficiaries also mentioned having to wait a long time for the health centre staff when they were late. One woman described how she went to the health centre with her sick children, but had to wait for the staff to arrive as her children's fever increased. Since then, she has been getting medicine from the grocery store, where there is 'no need to wait for staff to arrive'. Another woman stated, 'I know that the grocery store will be open, while I cannot be sure that the health centre will be open and staff will be present'.

5.2.2 Wait times

Apart from the hurdle of having to wait for health centre staff to arrive at the facility, some people also mentioned having to wait a long time to be treated. One woman heard from others that getting treatment at the public facility takes almost all day because of the number of patients. Long wait times were also attributed, by another interviewee, to her having to wait longer than others. 'I was treated only after people who paid by themselves, even if I arrived before them', she said. This factor is related to the discrimination that was experienced by some of the participants, and is described further on in this section.

Aside from being generally time-consuming, long wait times were mentioned as problematic by some respondents due to the need to leave one's work or household for a long time. One respondent stated, 'Wait times at the health centre are too long, and I don't have anyone to take care of my shop during this time'.[7]

Another participant commented that there is no one to take care of her mother. In some of the conversations, the issue of long wait times also brought up the advantages of private clinics. 'I'm lazy to wait long', one respondent said. 'It's faster to go to the private clinic because fewer people go there'. Another stated, 'When I'm busy and need to get treatment quickly, I go to the private clinic'.

5.2.3 Operating hours

The limited work times were pointed out by several HEF members as a barrier to utilisation, specifically the fact that there is no service in the evening and at night. Health centres' designated operating hours are generally from 7.30 am until 11.30 am, and from 1.30 pm until 5.30 pm. In theory, outside these official operating times health centres are supposed to always have one staff member on duty, but without full services. From respondents' comments, it seems that this is not always the case in practice.

'When I got sick at night time', one participant said, 'I couldn't go to the health centre and I used the private doctor, who treats patients even at night time'. Also here, then, respondents referred to the respective advantages of other providers, in this case in terms of the times of available treatment. Many respondents stated that, unlike health centres, the private doctor is available at any time, the private clinic is also always open, and people can go there in the evening or at night.

5.2.4 Health staff behaviour

Most respondents who had a personal experience with health centres expressed positive impressions regarding the behaviour of staff. While one woman commented that the workers did not approach her and did not answer any

7 The fact that two participants in the evaluation mentioned that they have a shop, and that others stated that they go to the private clinic (even if this is in fact only a small examination room and medical cabinet), raises possible doubts about all HEF beneficiaries indeed being poor enough to be included in the scheme. When asked how they can afford private clinics, for example, participants mentioned receiving money from their children or other relatives that are part of other households (and may have married into better-off families) or the extended family. The fact that a person was identified as poor and is consequently an HEF beneficiary, then, does not seem to always mean that he or she necessarily cannot receive financial help from other sources.

of her questions, the majority of people said that the staff gave them a warm welcome, were friendly and honest, and had 'explained about how to take the medicine', and generally 'paid attention' to the patients.

With regards to the referral hospital, however, the picture was quite different. Among those who visited this facility, many complaints were articulated regarding the conduct of the medical staff. One man described how the referral hospital staff didn't pay attention to him and told him 'to ask SKY staff for treatment'. Another said that, 'Hospital doctors ignore the patients and leave them untreated'. In an interview, a woman who accompanied her husband to receive treatment made the following statement:

> It was the weekend, and the health centre had no medical staff, so my husband was immediately referred to the hospital, where he stayed for a week. I always looked for the doctor but he scolded me, and nobody checked or treated my husband at night although he was in a critical condition. He could not breathe but the doctor didn't pay attention to him. After a week in which he didn't get any better, I decided to take him home.

In this context, and in contrast to the referral hospital, a reason that was mentioned for going to a private clinic was that the staff give the patients more attention.

5.2.4.1 Discrimination

The move to the use of a single insurance booklet for both HEF and CBHI members, introduced by the integrated SHP scheme, was intended to eliminate discrimination between the two subgroups, among other reasons. This kind of discrimination was not reported by the participants. People did describe, however, cases of discrimination against them as SHP members and not self-paying patients.

With regards to the health centres – as already mentioned in relation to wait times – one woman described how self-paying people are treated first, and SHP members are only treated second, even if they arrived first. The same woman also commented that this is also a reason why voluntary (CBHI) members are dropping out of the scheme.

Also here, the majority of discrimination cases described concerned the referral hospital. One person commented, 'The hospital staff didn't pay attention to me with my booklet, and generally didn't want to treat and take care of people with booklets'. This statement was reinforced by a village chief, who noted that 'people carrying the insurance booklet are ignored at the referral hospital'. Another woman went as far as to say that, if necessary, she would spend money on treatment 'because the insurance booklet cannot help'. Finally, a woman told the following anecdote in a FGD:

My mother-in-law, aged 70, went to the Kampot hospital. The doctor said that she has a problem in her womb, and that she has to return to the hospital the following day for surgery and bring along some relatives in case a blood transfusion is needed. Next day, she and the relatives went to the hospital with the blue book [the insurance booklet], and when the doctor saw she was holding the booklet, he told her to come tomorrow instead. My mother-in-law came back the day after, but the doctor said he was not available too, and asked her to come another day. She did not go to the hospital again.

Further statements by participants made a direct link between negative staff attitudes toward booklet holders and the fact that they are not paying for the services:

- 'Hospital staff said bad things to me because I had no extra money to pay; they give less attention to people who can't pay them something'.
- 'The doctor [at the referral hospital] wasn't friendly and shouted at my sister; if I had had some money to give him, he would have paid attention'.
- 'My neighbours saw a pregnant woman who was left untreated. But those who have the money get treated easily'.

5.2.5 Perceived quality of treatment

Inquiries about participants' impressions of the treatment and medicine offered at public health facilities, as well as by other providers, revealed different opinions. It is these subjective opinions, it should be stressed, that measure the quality of health care as presented here.

Some people spoke about treatment at health centres in positive terms. They stated that the staff are qualified and have a medical background, unlike shopkeepers at the grocery store, who might sell certain medications but have no knowledge or background in medicine. They also stated that staff 'check the patient and gather information before giving the medicine', and that the medicine they give is better than at the local shop.

Other respondents expressed more neutral opinions. According to them, medicine at the health centre and the grocery store was the same. One man said that while 'the health centre can offer better treatment for serious illnesses, […] for mild illnesses there is no different between the medicine it gives and what you get from the grocery store'. In terms of skills, it was stated that 'staff at the pharmacy and private clinic have medical background, just like the staff at the health centre', and that, 'as long as there is medicine to get, it does not matter whether the people offering it have a medical background or not'.

Finally, and relevantly for the framework of factors deterring utilisation, many participants also expressed numerous negative opinions about different aspects of treatment at the public facilities.

5.2.5.1 Effectiveness of medicine

Some people stated, based either on their own experience or what they had heard from others, that the medicine from the health centre was not effective. In some cases and to a certain extent, this in fact might be correct, as there are incidents of corruption in procurement that result in low quality of medicine in public facilities. Respondents said that the pills given at the health centre do not work, have no effect, or take longer to work in comparison with those from other providers. The private clinic, on the other hand, has more effective medicine than the health centre and so do 'pharmacies in Kampot'. One participant commented that 'pills from the pharmacy for KHR 2,000 are not a huge expense, and it is worth paying for more effective medicine, especially since it's possible to owe the pharmacy some money and pay later'.

5.2.5.2 Method of treatment

It was evident that most of the respondents perceived injections as a form of treatment that is superior to, and more efficient than, oral medication. At the health centre, however – and according to MoH regulations – injections are generally not given, and this point was brought up by participants. People complained that 'the health centre provides no injections, only pills,' and only a few of them – which was perceived as insufficient medication. Injections were also stated to be better for children, since pills are difficult for them to take. In contrast, a reason that was mentioned for using the services of a private clinic or doctor is that they administer injections frequently.

5.2.5.3 Adequate medical examination and equipment

Several participants also expressed dissatisfaction with the equipment and examinations performed at health centres. They perceived them as having less medical equipment, which was associated with a lower quality of care. 'When I took my child to the health centre,' one woman said, 'there was no diagnosis, so the staff didn't give the right medicine for the right illness. Blood tests were also not available. At the private clinic, they diagnose the patients before giving medications'. Another woman stated, 'Staff at the health centre don't examine the patient carefully. I took my son to a private clinic because it provided thorough examination, and had the medical tools to examine his throat. At the health centre, there were no such tools'.

Another woman told how when she had gone with her sick daughter to the health centre, she wanted the staff 'to check the daughter's blood, but they didn't do this and only gave her some medicinal powder in water'. Health centre staff, in other words, did not conduct what the woman saw as a comprehensive examination. Moreover, they did not follow her request. 'Since then', the woman continued, 'I haven't been going to the health centre anymore, but to a private clinic in Kampot, where they do what I ask for'.

5.2.5.4 Variety of medicine

Further complaints concerned the variety of medicine available at the health centre. First, several people remarked that the same medicines are given for different health problems. This may be correct – the variety of medicine as dictated by MoH is indeed limited – but of course not necessarily inadequate. It remains unknown, in the cases described by participants, whether there was an actual problem with the appropriateness of the medicine provided, and whether patients received an appropriate explanation from the staff on what medicine was provided and why. In any case, the use of the same drugs for different ailments was perceived negatively by participants in terms of treatment, and played a role in the preference to seek treatment from other providers.

One person described how she had taken her son to the health centre twice – one time because of fever and another because of asthma – but he was given the same medicines each time. Another participant told how her grandson, who had broken his arm, 'was given at the

health centre the same tablet [a pill of the same colour and size] that is given for a cold.' The same woman commented that 'at the private clinic, they have a larger selection and different kinds of medicine, and they can also mix them and give specific medications for different problems'.

Second, some people remarked how at the health centre, they could not get the specific medicine they wished to have. One woman described how she had once received medicine for her heart problem from the private clinic, which she has been using ever since. The reason stated by her for not going to the health centre is that she cannot get the exact same medicine there. Similar statements by participants included:

- 'At the health centre, I could not get the exact brand of medication I needed [based on the old, empty medicine package that the participant takes with her]. Since then, I have been going to a private clinic in Kampot, where they give me exactly the medicine I want'.
- 'I am satisfied with the medicine I bought in the market, and don't expect the health centre to have the exact same thing, to which I'm used to already'.
- 'The health centre could only give me a different kind of medicine, whereas at the pharmacy I can get the exact kind of pills I want [again by showing the staff the package]'.

Box 2: Summary of supply-related barriers

- Service: Availability → Absence of health staff.
- Service: Time → Long waiting times.
- Physical: Availability → Restricted opening hours.
- Service: Staff conduct → Negative staff behavior and discrimination against booklet owners.
- Service: Treatment → Perceived low effectiveness of medicine, modality of treatment, inadequate medical examination and equipment, and limited variety of medications.

5.3 Demand-related issues

5.3.1 The scheme and insurance booklet

5.3.1.1 Knowledge of scheme benefits and public health facilities

As was mentioned under scheme-related issues, respondents' familiarity with the SHP scheme's main functions, following dissemination of information by SKY, was generally good. Nevertheless, there were a number of cases in which people had only partial knowledge of the benefits, or misinformation regarding more specific matters. These cases seemed to have less to do with SKY's information activities and more with the participants themselves, and they thus appear in this section.

Interviews with beneficiaries

A few of the respondents knew of the possibility of free treatment, but were not aware of any other benefits (such as the transport reimbursement or food allowance), or were not exactly sure what these benefits referred to. When asked whether she knows about any additional benefits, for example, one woman replied that she thinks 'you get some money from SKY'. The reason for this lack of clarity was that she had attended the SKY information meeting a long time ago, and does not remember exactly what was said.

Moreover, in one village several people complained about the circulation of information about the health centre. The village chief commented, 'Some people may miss the information meetings, and houses in the village are located far away from each other, so that the spread of information between people is not good'.

Perhaps more significantly, one interviewee knew that the booklet is 'for getting treatment at the health centre', but did not know the treatment is free. She stated that she cannot read, and thus does not know how to use the booklet. Another participant had 'heard from others that the booklet is for recognising people as poor and allows getting different gifts from different institutions'. This participant also stated that she had attended an information meeting, but that she couldn't really understand what was said because of her hearing loss.

Finally, there were also some specific problems of misinformation. First, one woman who was interviewed did not have an insurance booklet at all because, as she stated, she thought that the booklet had been given out only on a specific date, which she missed. 'On this day', she said, 'I didn't have time to go and receive the booklet because I was too busy at the market. If I did have the booklet, I would prefer to go to the health centre, since it is actually close by where I usually buy food'. While insurance booklets are distributed in a meeting with HEF beneficiaries in the village that is organised on a specific data and time, people who could not attend the meeting still have the possibility of receiving the booklet. For these persons, the booklet is usually kept in the local SKY office or with the village chief, who should be contacted in order to receive it.

Second, one participant told how she had gone to a different health centre than the one she is officially covered by, due to it being closer to her house, but did not use her booklet there (and thus had to pay) because she thought the booklet would not be accepted in this health centre. In reality, however, following people's requests and as approved by SKY, other HEF members from the woman's village were allowed to use their booklets in the unofficial yet closer health centre.

5.3.1.2 Carrying the insurance booklet

Several people described cases in which they had gone to the public facility but did not take their insurance booklet with them due to the perceived urgency of the health problem experienced. These people made the following statements:

- 'When I had my stomach problem, my first and more urgent thought was about getting treatment, not about the booklet. When I was at the health centre, I was asked to pay, and preferred to already do this than go back home and bring the booklet'.
- 'When I took my children to the health centre to get short after they were bitten by a dog, I had to rush and didn't think about the booklet'.
- 'When I took my daughter to the hospital [because of a seizure she had], I forgot and didn't take the booklet because the situation was urgent and I was in panic, so I had to pay'.
- 'I couldn't think of the booklet at that time [when she fell off a hammock and cut her head], because the situation was critical'.

A possibly related issue was the insurance booklet's readiness to hand. When asked about their booklets, one participant replied that he is not sure where it is, and another said that she couldn't find it.

5.3.2 Travel to the health facility

5.3.2.1 Distance

Distance to the health centre was a frequently-cited reason for not utilising its services. The health centre was said to be 'far away' and 'too distant', and getting to it and back thus 'takes a long time'. Several people remarked that they are either too busy or too lazy to make the journey. 'If the health centre were nearby,' one interviewee commented, 'for example in the commune building of the village, I would go there in order not have to spend money.

But as the health centre is far away, you have to spend the whole morning to go there'.[8]

In contrast, the grocery store in the village – as well as in some cases the private clinic – was stated to be nearby. One respondent commented, 'It's closer and easier to go to the local store, and the short way there is more convenient. So for small things like headaches, getting pills in the store for KHR 200-300 is more convenient'. Another said, 'For mild illnesses, KHR 400-500 are worth spending in the grocery store in order not to have to travel to the health centre, which is distant'.

Moreover, alternative providers were also mentioned by participants to be in the vicinity of their daily activities. One woman described how 'it is practical to go to the grocery store' when she is 'out for breakfast or shopping in the morning'. Another told how she had bought medicine in the pharmacy in Kampot since she 'used to help relatives sell fish at the market there, so it [the pharmacy] was easily accessible'. Also in one FGD, a few participants stated that they work in Kampot and thus simply buy medicine there, which is 'easier and faster'. Such considerations also do not necessarily apply only to non-public providers: One interviewee described how she had purchased medicine from the hospital in Kampot (without using her insurance booklet, which she did not have with her), because she accompanied her sister to the hospital so she was already there.

A related difficulty that was mentioned is the road condition. 'The road to the health centre is bad so it takes a long time to get there,' one interviewee said. Another complained about the road being in a poor state during the rainy season. In an FDG, a woman stated, 'I often buy drugs at the drug store because the road there is better [then the one to the health centre], and the cost of drugs is not too high'. Finally, a member of SKY staff added, 'If people want to go to the health centre in the morning [when it more likely to be open and when beneficiaries can receive the transportation reimbursement], they sometimes must leave very early in the morning because they have to travel on bad roads, and this takes time'.

8 The official distance from the interviewee's village to the health centre is two kilometres; however her house was located somewhat farther away from the village's centre, the point from which the distance to the health centre is calculated under the scheme.

5.3.2.2 Means of transport

Difficulties arranging transportation to the health facility were also reported. Especially in the more remote villages, participants stated that it is hard to find a motodup. 'It's difficult to find a motodup because the village is far away', one woman said. 'So it's easier to walk to the village chief's house [where the village chief's wife, who works as a midwife in a health centre, sells medicine]'. Another participant stated, 'There are no motodups to hire – they drive around Kampot but not around here – and it's difficult to ask another villager to take you to the health centre as a favour'. This woman didn't feel comfortable asking for help for small illnesses; it was only in the case of a serious illness or emergency that she would do this, since she would then have no choice.

5.3.2.3 Ability to travel

Several respondents cited their own condition as a reason for not being able to travel to the public facility. One woman described how she suffered from severe dizziness, and could not go to the health centre since she 'could not really move in this condition'. Instead she called a private doctor, who came to her house.

It was among older participants, however, that the problem of personal inability to travel was most commonly reported. This problem was usually coupled with not having anyone to take or accompany them to the public facility. One elderly woman stated, 'There is no one to take me or go with me to the health centre, so I have to walk there, but I'm afraid I'll collapse on the way'. Another commented: 'I don't want to walk to the health centre of take a motodup by myself – I'm 78, confused and sometimes forget things, and there is no one to take me'. Similar statements were made in an FGD:

- 'I'm too old to walk to the health centre, so I usually call the doctor to come to my house'.
- 'The health centre is actually only one kilometre from my house, but I'm too old and don't have the strength to walk'.

In the same context, an older woman commented that she usually asks her nephews to get the medications for her, from the grocery shop or pharmacy. This is not possible to do with the health centre, where one cannot get medicine for other people. The daughter of another elderly woman stated that a problem with the health centre is that she cannot get medicine there for her mother, who has difficulties mov-

ing. Instead, she asks a private doctor to come to their house, since this way she does not have to move her mother. 'It would be better', the woman concluded, 'if it were possible in the health centre for people to get medicine for others'.

5.3.3 Leaving work and home

5.3.3.1 Work time

Some respondents remarked they have no time to go to the health centre, as this implies missing work. One participant said, 'Going to the health centre takes a long time, in which I have to work'. Another stated, 'I can't spend the whole morning going to the health centre, because this is my working time. If I did this, it would mean a loss of a whole working day, and I live from day to day, so I wouldn't have money for the next day'.

5.3.3.2 Taking care of household members

Several people stated they cannot go to the public facility because of the need to take care of their children or other relatives living in the household, and since there is no one else who could do this instead of them. With regard to this point, the following comments were made:

- 'I don't want to go to the health centre because I have a nephew whose mother died, and there is no one but me to take care of him and the house. People in the village are busy with their work and cannot help with taking care of him'.
- 'I don't have time to go to the health centre. I've heard from others that it takes almost all day because of the number of patients, and then there's no one to take care of my mother'.
- 'There is no one to take care of the small children at home if I go to the health centre. The neighbours are busy with their own things'.
- 'I have only one daughter, and if she took me to the hospital, there wouldn't be anyone to take care of her children'.
- 'What happens if the staff asked me to stay for treatment for a few days? Then the children wouldn't have anyone to take care of them. If I have to spend a longer time at a public health facility, the children have to take days off from school to provide for themselves'.

5.3.3.3 Staying for longer treatment

The last quote in the previous subsection also brings up the general reluctance of participants to stay at health facilities for a longer period, which was mentioned by several people. Since private clinics, unlike public hospitals, generally do not contain inpatient departments, this reluctance in practice translated into a disinclination to visit a public facility due to the possibility of having to be hospitalised.

'When I went to the hospital', one person said, 'the staff wanted me to stay there for some days for extended treatment, but I refused'. Another stated, 'I don't want to stay at the hospital, but just get medicine and stay at home'. One woman even cited the mere possibility of being asked to stay in the public facility for some days as a reason for not going to the health centre in the first place. 'I'm afraid that if I go to the health centre', she said, 'I will be referred to the hospital and will have to stay there for longer treatment'. Finally, one interviewee kept emphasising how difficult it is 'to stay at the hospital for a long time, with people having to stay there with you, pay for food, and go back and forth between their home and the hospital'.

In relation to this last statement, the most common reason that was mentioned for not wanting to stay at the hospital is lack of (non-medical) caretaking from others. An older woman who stated to be suffering from loss of hearing and sight said, 'I don't go to the public facility because I don't have anyone to take care of me there, and don't want anyone to go with me there. My husband is older than me and he has to work, and my daughter needs to take care of her children'. Another woman commented, 'I thought to go to the health centre, but then realised I live alone and have no one to look after me if I have to stay at the hospital. Everyone is busy and no one can be asked [to help]'.

5.3.4 Concerns about utilising public services

A number of HEF beneficiaries expressed worries about using services at the health centre too frequently under the scheme, while others had doubts about receiving treatment when using the booklet. These concerns, according to the participants, were not based on any actual experience, but were rather thoughts or assumptions that they had.

5.3.4.1 Frequency of visits

As a reason for not wanting to go the health centre, one respondent commented that she is afraid that 'the staff might complain' if she goes to the health centre 'for every small thing' and 'too often'. Another participant stated, 'I'm afraid the staff at the health centre will say that now when I have the booklet, I go to the health centre for every little ailment, and that they will complain that I'm coming too frequently, to get the money for transportation'.

5.3.4.2 Receiving treatment

Interestingly, a few participants stated they had visited the health centre, but knowingly did not use their insurance booklet. One such person said, 'Earlier, I used to pay at the health centre, and received good service. But with the booklet I have no experience and I'm not sure I will get good service when using it'. Another participant commented that she is 'afraid' that with the booklet, she 'won't get treatment' or the staff 'won't pay attention' to her. She consequently said, 'For small ailments, when treatment at the health centre is not a too big expense, it's not necessary to use the booklet'.

5.3.5 Attitudes toward health problems and treatment

5.3.5.1 'Sharing' one's illness

In some cases, not utilising the public facility was related to an unwillingness to 'share' the existence of a health problem or expose it to others, e.g. family members, either in order not worry them or because the illness was not given much significance. One woman who stated she is suffering from 'dizziness and pains in the heart' (heart problems) said she does not go to the health centre because she does not want to get diagnosed and thus have her children know about the illness. The woman commented, 'I don't want my children to know I'm going there. They are young and I don't want to burden them. I've never told them about my sickness and I want to hide it from them. When I'm feeling dizzy, I say it's only a headache or a common cold'.

Another, older woman reported having chronic stomach problems, for which she regularly buys medicine from the grocery store. The woman said she does not try to receive the medication from the health centre because she cannot go there by herself. Although she has a grown-up grandchild who, according to her, could possibly take her to the health centre, she did not tell them about her condition since she did not deem it as important or serious.

5.3.5.2 Tolerance of health problems

Some participants commented that although their health is not good, they do not seek treatment from a public facility – or, in certain cases, from any other provider – because the pains or symptoms are endurable and can be tolerated. One woman, for example, said that her daughter has been having epilepsy-like seizures. The first time the seizures happened, she took the daughter to the hospital. The seizures nonetheless recurred, but no further treatment was sought since the daughter 'got used to them, because they happened often'.

Another woman, who claimed to be suffering from pains in her arms and legs, dizziness, and headaches, commented that she can bear the pain, is too lazy to get treatment, and would rather just stay home. A further female participant described her mother as having 'chronic coughing and high blood pressure,' and as being 'already half paralysed'. The woman called in a private doctor for her mother a few times, but did not take her to a public health facility. 'My mother can still deal with the illness – she can stay home and the aches are bearable' she said. Only when the mother's situation becomes serious – when the private doctor cannot treat her properly or the fee is not affordable – the woman will have 'no alternative [but] finding a motodup to the health centre and holding my mother on it'.

Finally, a number of older respondents expressed the view that their health problems are not worth acting upon. One woman, who said she has been enduring chronically numb feet but did not seek treatment, stated that she is 'already old so it doesn't matter'. 'My children said I should stay home', she continued, 'and even if I become paralysed, I don't have to do many things except for cooking rice'. Another woman, who said she has high blood pressure and intestinal problems, stated, 'I don't want anyone to go with me to the hospital or take care of me – I'm already seventy years old and can die'.

5.3.5.3 Shame or fear of medical staff

One older woman cited her fear of doctors as the reason for not going to receive treatment. She said, 'I'm afraid of the doctor and especially of needles […] Even when I was young and the doctor came to the village, I used to hide'. Another woman stated she was ashamed of her sickness, and too shy to go to any doctor, because her health problem 'has to do with the reproductive organs'.

5.3.5.4 Home treatment and traditional remedies

For small ailments such as headaches or colds, many respondents preferred to practice the traditional treatment of 'coining' ('ghap kchal' in Khmer) at home, whereby the skin is scratched repeatedly with a smooth coin or other piece of metal. 'This is customary and passed on from my ancestors,' one man said. The use of traditional herbs was also often mentioned, for instance pandan leaves, which were boiled with water and drunk by some participants not only in cases of illness, but daily. Further home remedies people referred to included soaking swollen feet in hot water, chewing lime seeds for dizziness, and spreading a mix of salt and herbs on the skin for torso pains – 'a traditional remedy that my mother knew', as one interviewee stated.

5.3.5.5 Choice of treatment according to sickness

Rather than dealing with further specific forms of utilisation barriers, this final subsection presents data on the participants' choices of care for different kinds of health problems, as stated by them. Specifically, respondents were also asked what treatment, if any, they usually seek or would seek for certain ailments. In the replies, people linked the choice of treatment with the perceived severity of the illness.

In cases of small ailments, for which 'mild cold' and 'headache' were often given as examples, most participants stated they would either just wait for it to pass, practice coining, or buy medicine from the grocery store. Going to the health centre for such ailments was not important, and there was 'no need' and 'no reason' to do so. If the initial choice of treatment did not resolve the ailment after a few days, people move on to another kind of treatment. Those who first used coining turned to medicine from the grocery store; those who first bought drugs from the grocery store might go to a private clinic or doctor, or to the health centre. For conditions such as 'a more serious cold, with coughing', 'blood pressure problems', and 'heart problems', participants mentioned visiting a pharmacy, private clinic, or private doctor.

The only health scenarios for which the health centre or referral hospital were consistently mentioned were 'serious illness' 'critical condition,' and 'emergency'. Such health problems included: 'strong cold with fever that doesn't go away'; 'malaria or dengue fever, with shaking'; 'something severe that starts suddenly'; 'vomiting and not being able to eat or walk'; 'when the pain is no longer bearable'; and 'when you cannot move and your earnings are affected'. In practice, however, the public facility is not always the provider utilised, even in cases of more severe or urgent health problems. One woman, for instance, commented, 'My husband was suffering from swollen feet and arms, and pains in the knees. I suggested he go to the health centre, but he said it's unnecessary. In the end, the pain became unbearable and he then went to the private clinic, because it was easier to get to'.

In accordance, when people were questioned on their opinion about the insurance booklet, their replies commonly referred to the motif of severe illnesses:

- 'I know that in case of a serious sickness, the family will get treatment it could otherwise not afford'.
- 'I wouldn't give away the booklet even for 300 USD – it could help if I got seriously ill, and I wouldn't have to pay a lot of money'.
- 'I'm happy with the booklet since I know that if I became badly sick, I could depend on the scheme'.
- 'I'm satisfied [with the booklet] because I expect that if I have a serious disease, I can get care for free'.

Box 3: Summary of demand-related barriers

- Knowledge: Partial knowledge → Scheme benefits.
- Knowledge: Misinformation → Distribution and validity of the insurance booklet.
- Physical: Geographic access → Long distance and bad condition of roads to the public facility.
- Physical: Geographic access → Difficulty finding transport.
- Physical: Travelling to the public facility → Personal inability to travel (due to illness or old age).
- Financial: Opportunity cost → Loss of work time.
- Socio-cultural: Reluctance to leave home → Unwillingness to stay for longer treatment; need to take care of household members.
- Cognitive/psychological: Shame or fear → Shame or fear of medical staff (among older beneficiaries).
- Socio-cultural: Traditional remedies → Preference for using vernacular treatment methods.
- Cognitive/psychological: Carrying the insurance booklet → Forgetting the booklet in cases of perceived severe or urgent illnesses.
- Cognitive/psychological and socio-cultural: Concerns about utilising public facilities → Worries about health staff complaints regarding frequency of visits; fears about not getting treatment when using the booklet.
- Socio-cultural: Tolerance of ailments and perceptions of severity and required treatment → Lack of willingness to act upon health problems; reluctance to 'share' one's illness with others; lack of perceived need to use public services for ailments that are not 'serious'.

Table 2: Overview of perceived utilisation barriers

Barrier category	Barrier	Scheme/ supply/ demand
Physical	Distance	Demand
	Lack of available transport	Demand
	Physical inability to travel	Demand
Financial	Lack of transport reimbursement/ Insufficient transport reimbursement	Scheme
	Transport reimbursement only when the scheme operator's staff is present	Scheme
	Transport reimbursement only after paying for transport	Scheme
	Lack of food allowance for inpatient caretaker/ Insufficient food allowance	Scheme
	Loss of work time	Demand
Service	Absence of health staff	Supply
	Restricted operating hours	Supply
	Long wait times	Supply
	Improper staff behaviour/ Discrimination against scheme members	Supply
	Perceived low quality of treatment	Supply
Knowledge	Partial knowledge of scheme benefits	Demand
	Misinformation about the insurance booklet	Demand
Socio-cultural	Reluctance to undergo longer (i.e., inpatient) treatment	Demand
	Need to take care of households members	Demand
	Use of traditional treatment methods	Demand
	Tolerance of ailment	Demand
	Reluctance to 'share' illness	Demand
	Lack of perceived need for medical treatment	Demand
Psychological/ cognitive	Shame or fear of medical staff	Demand
	Forgetting the insurance booklet in perceived severe or urgent situations	Demand
	Worries about staff complaints regarding high frequency of visits	Demand
	Fears about not receiving treatment when using the booklet	Demand

III Discussion

In this section, several issues arising from both the quantitative and qualitative data are discussed and analysed, and possible explanations and relations between different results are suggested. The first subsection deals with data provided by the quantitative analysis, which is complemented and linked with findings from the qualitative data where possible. In the subsequent subsection the focus then shifts to the qualitative results.

6 Socio-demographic factors and health centre parameters

6.1 Household size

Having more household members was found to statistically increase the likelihood of using the health centre. A simple explanation for this would be that more members in the household generally mean more occurrence of illness, and thus more demand for care. As stated by the HEF members interviewed, at least some of this demand, especially in cases of perceived severe illness, is directed toward the health centres, which contributes to overall higher utilisation (see section 2.3.5.5).

Another possible reason for the effect of the household size on utilisation has to do with the cost of transportation to the health centre and reimbursement for it. The allowance for travel vouchers provided by the scheme is two vouchers per household member per year, and thus bigger households receive a larger amount of vouchers.

Lastly, in theory, having more members in the household might also translate into a larger pool of people who could take care of children and other relatives in the household requiring attention, or help with work. They could therefore provide support in overcoming the need to take care of other household members, and the loss of work time – utilisation barriers that made it difficult for some participants to leave home in order to seek treatment. However, this assumption

Focus group discussion with beneficiaries

was refuted by participants in interviews and FGDs, who depicted a lack of help and support from others in the community in illness-related situations. This is further discussed below.

6.2 Sex

The sex of the household head was identified as statistically insignificant with respect to the likelihood of health centre utilisation. In this context, a study of Cambodia's general population showed that households headed by females are likelier to be poorer than those headed by males (Sovannary 2003), and thus to belong to the socioeconomic group that is entitled to HEF coverage. The population of the quantitative analysis, however, was composed only of HEF (poor) households, which already share similar socioeconomic characteristics. This could be the reason that the household head's sex was not found to have an effect on the likelihood of utilisation.

When it came to individual HEF members, on the other hand, the quantitative analysis found that women were more likely than men to visit a health centre. This finding was also supported by an MoH report (2011b) which showed a disproportionate ratio in public health care utilisation between males and females (in favour of the latter). This result may be due to women's use of health

centres for the additional services of contraception, antenatal/postnatal care and deliveries. The qualitative analysis could not support or provide any more data on this tendency; the majority of participants were females, however this was mostly due to them being at home during daytime, and thus available for interviews and FGDs more often than men.

6.3 Age

Having a household member over the age of 60 had no effect on utilisation probability, according to the quantitative analysis. This could perhaps be understood when considering that households have different health-spending priorities, which might include focusing on the younger members in the household, such as children or infants, or on perceived severe and urgent illnesses. The latter instance is further addressed below when discussing public and non-medical providers.

The age of the household head, on the contrary, was found to be statistically significant, as households with older heads were less likely to utilise a health centre. This result may make sense when taking into account that households with younger heads are also more likely to have younger members, who might use public facilities for purposes that older persons do not, such as immunisations and pregnancy-related care.

At the individual level, the quantitative analysis found that an increase in age correlated with a decrease in the likelihood of utilisation among HEF members. This result was clearly supported by the qualitative analysis, where the elderly participants identified particular factors preventing their utilisation of health centres. First, statements about fear or shame of doctors were made only by elderly beneficiaries. Second, tolerance and acceptance of chronic ill health seemed to be especially high within this group, and the value or quality of life seemed to be low (see section 5.3.5.2). Consequently, elderly participants often showed little willingness to receive any medical care other than self-treatment (e.g., home remedies or self-purchased medicines), which could keep their health problems at a bearable level which allowed them to function temporarily.

Third, the physical condition of some elderly people did not allow them to travel the considerable distance to the public facility (see section 5.3.2.3), which meant that they experienced additional access challenges. It is here that public facilities presented an objective problem. If the elderly person wanted to receive treatment it had to be at their home, and only private doctors make house calls. Usually, however, the older person simply had others collect medicines for them, and this again was possible solely with non-public providers (i.e., private providers and stores). In order to utilise the scheme for receiving medicine free of charge, one has to go to the public facility in person. Scheme benefits are non-transferable, so that it is not possible to obtain medicine for others.

6.4 Health centre assessment score and number of staff

Lastly, in terms of supply, the quantitative analysis found that a lower health centre assessment score, as well as by a higher number of health staff, reduced the likelihood of utilisation. The latter is somewhat difficult to account for and might require further study; it may be suggested that rather than the amount of personnel, it is the actual functioning of the health centre that matters more to beneficiaries; for example, that the staff are indeed present during operating hours, which was a problem indicated interviewees (see section 5.2.1). Two supply-related factors that are not included in the assessment score, but which seemed to be of importance for the qualitative participants, are health staff attitude and quality of treatment. These are discussed in the respective sections below.

7 Access

All scheme-related barriers mentioned by participants in interviews and FGDs, with the exception of food subsidies for inpatient caretakers, involved the cost of transportation to the health facility. Transport costs remained a difficulty for the beneficiaries despite the existence of the travel vouchers, with cases of the reimbursement not being sufficient to cover the whole expense, or not being provided at all, described by respondents (see sections 5.1.3.1 and 5.1.3.2).

Such financial transportation hurdles were of course linked to the barrier of distance, which was also identified in the quantitative analysis as a factor reducing the likelihood of utilisation. The cost of transport, when the expense was either not reimbursed or not fully covered by the reimbursement, often made it more economical for beneficiaries to use a closer private provider (e.g.,

to buy medicine at a local shop). This was especially true for participants who lived further from the health facility. These geographical-financial barriers were also combined with (exogenous) physical difficulties in traveling to public facilities, which included available means of transport and the physical ability of the individual to travel. Taken together, all these barriers constituted an access problem which, in its different aspects, was central to this evaluation's HEF participants, and deterred them from seeking care at public facilities.

8 Trust by beneficiaries

8.1 Trust in the scheme

Whether in regard to the transportation reimbursement, or to the food allowance for caretakers at the referral hospital (see section 5.1.4), participants depicted incidents in which they did not receive the additional scheme benefits they were entitled to, or cases where these had been inadequate. The specific circumstances of such cases cannot always be known, and they may have to do with either the operation or design of the scheme. It could be, for example, that those participants who complained about having to pay for food while at the hospital did not receive the allowance they were supposed to as caretakers, or alternatively that this allowance was insufficient.

It could also be that participants who reported not receiving the transportation reimbursement had already used their limit of two travel vouchers per household member per year, as set by the scheme. However, as the evaluation's participants were non-users or very infrequent users of health centres, this possibility seems somewhat unlikely. In any case, even if there were justified reasons for not granting them the reimbursement, it was clear from the participants' responses that they did know what these were. All in all, the picture arising from participants' statements is of an irregularity in the distribution of the transport reimbursements.

As mentioned above, apart from making it more financially worthwhile to buy medication from non-medical providers, not being fully reimbursed for transportation might also have a more profound consequence – especially when the reasons for this remain unclear to beneficiaries. Namely, this damages HEF members' trust in the scheme, and creates uncertainty regarding the receipt and adequateness of benefits. Such uncertainty affects the beneficiaries who have a negative experience with the scheme, possibly causing them to refrain from using it again.

These beneficiaries, moreover, possibly also tell and share their experiences, so that doubts about the adequate functioning of the scheme might extend to others. Even participants who have never used the scheme, for instance, expressed worry and insecurity about receipt of the travel reimbursement, and preferred not to take the risk. Some of these participants also had to pay a lot of money for transport to the health centre prior to the scheme, and this could exacerbate their current reluctance to trust that they will now be compensated for this expense. It should be kept in mind that non-users might have experiences visiting public facilities from before the scheme, and these can play a role in shaping their attitudes toward it.

8.2 Trust in providers

Respondents reported cases of improper staff attitude, which included impolite behaviour and discrimination against HEF members as booklet owners (see section 5.2.4.1). First, such incidents may be linked to beneficiaries' reported fears that they will not receive treatment when using the booklet, or that the health staff will rebuke them for coming too frequently (see sections 5.2.4.2 and 5.3.4.1). Second, cases of inappropriate demeanour by public health staff once again bring up the issue of trust – this time not necessarily in relation to the fulfilment of the SHP scheme benefits, but to public providers more generally.

The level of trust in providers, as based on interpersonal interactions with them, has been emphasised by Ozawa & Walker (2011) as playing a central role in rural Cambodians' health care decisions. The importance of trust in the Cambodian context may be explained through the country's recent history of war and domestic strife, where 'deception and mistrust were commonplace' (Chandler, Dubois, in ibid.: i21), and through the traditional Khmer health cosmology, where health care is understood in terms of social morality, which implies a personalised relationship between patient and therapist (Ovesen & Trankel 2010). Experiences of negative interactions with public health staff are likely to weaken HEF members' trust in public facilities. This, in tandem with reported attentiveness from private providers (see, for instance, section 5.2.4), can contribute to a preference for the latter.

In this context, respondents also mentioned the fact that pharmacies and private clinics, as well as non-medical providers such as grocery stores, often allow people to defer payment for treatment or medicines (see section 5.2.5.2). Rather than simply mitigating the burden of expense by removing the need to pay immediately, the possibility to defer payment can also be seen as a significant sign of confidence, and thus a reason to trust private and non-medical providers.[9]

Furthermore, deferred payment is also an indication of morality, which is engrained in the indigenous Cambodian health worldview, as mentioned above. It implies delayed, longer-term reciprocity and tolerance of imbalance, which is, according to anthropologist Maurice Bloch (1973), a fundamental characteristic of a moral relationship. Finally, morality may also play a role in respondents' fears of an 'overuse' of public facilities with the booklet (see section 5.2.4.1). Beneficiaries might not want to abuse or take advantage of something they receive for free too often, and might worry that this could lead to the booklet being taken away from them. This could additionally imply and be related to HEF members not thinking of public health care as an entitlement, or a right that they have as 'consumers'.

9 Assistance from others

Many statements by respondents concerned, directly or indirectly, the possibility of receiving assistance from relatives, neighbours, or others in the village in illness-related situations. Participants mentioned that there is nobody to take them to the public facility when a motodup is not available (see section 5.3.2.2), nobody to look after their children or other close relatives when absent from home (see section 5.2.2.3); and nobody to accompany or take care of them at the hospital (see section 5.3.3.3). These statements identify a paucity of strong mutual social assistance.

This paucity can have different reasons. The lack of caretakers in the hospital, for example, could perhaps be attributed in part to the inconveniences that are imposed on them; the scheme-related barrier 'food at the hospital' was experienced not directly by the patient, but by the person caring for him or her while they are an inpatient. Moreover, caretakers might experience, together with the ill person, 'uncertainty about the reception one is going to get' (Ovesen & Trankel 2010: 268), in terms of staff behaviour and discrimination, and encounter the practical difficulties of having to pay for food (see section 5.1.4) and commute between home and the hospital (see section 5.3.3.3). This already calls attention to the way in which non-utilisation can result not only from the ill person themselves, but also from others in their social vicinity.

On a deeper level, however, the general lack of mutual assistance is also a result of the social structure in rural Cambodia, which is individualistic in character and in which strong social relationships and trust are not maintained (Ovesen et al. 1996). This is largely an outcome of the 'cumulative psychological trauma' inflicted by the Khmer Rouge's institutionalised betrayal system (ibid. in Matsuoka et al.). Ovesen & Trankel further argue that specifically in cases of illness, another reason that mutual assistance between neighbours and relatives seldom materialises is that 'the temporary or permanent loss of work capacity that a severe illness entails affects the household's ability to fulfil the obligations of reciprocity on which traditional mutuality between households rests' (2010: 267).

In conformance with this analysis of Cambodian rural social organisation, HEF beneficiaries generally did not ask or expect help from others, whether it was with travel to the health facility, taking care of their children or small shop, or accompaniment to the hospital. They did not even enquire about the possibility of such help, since they assumed that this would be impossible as people are busy with their own matters. There was thus a general reluctance among respondents to 'bother' others by asking for assistance or 'favours'. In fact, participants often simply did not tell family members or close associates about their health problems, either because they did not want to worry them or they did not think the ailments were serious enough to mention (see section 5.3.5.1), so that any possibility of help could not occur.

Reluctance to bother others seemed to also extend to scheme-related interactions: not wanting to bother the health staff by visiting the health centre too often (see section 5.3.4.1); not wanting to bother SKY staff with requests for clear explanations about why reimbursement for transport were not given (see section 5.1.3.1 and

9 In addition to the possibility of deferred payment, the act of payment for care might itself also have significance in creating a relationship of exchange between provider and patient, and in increasing the 'value' of the purchased product in the eyes of the healthcare seekers, as opposed to something that is received for free.

5.1.3.3); and not wanting to bother SKY staff or the village chief with enquiries about how to obtain one's own insurance booklet (see section 5.3.1.1). In these instances, people's indisposition to 'bother' appeared to be related to a certain shortage of assertiveness, and unawareness of 'consumer rights' (see also Annear 2006).

10 Public vs. private providers

10.1 Patients' treatment preferences

Treatment quality seemed to be a matter of importance to participants. They expressed opinions on diverse aspects of treatment, including the efficacy of medicine, modality of treatment, medical examination and equipment, and the variety of medicines available (see section 5.2.5). These opinions about the different dimensions of medical care provided were usually in comparison to private providers. Respondents' statements, when taken together, bring up an important point, namely the compliance of private providers with patients' requests for treatment. Operating in a competitive health care environment and, unlike public facilities, less restricted by official MoH guidelines, private providers fulfil patients' preferences in a way that public facilities cannot.

One such preference that came up (in section 5.2.5.2) is the use of injections. This is in line with the work of Ovesen & Trankel (2010), who found that injections are generally well-liked among Cambodians. They are often requested even when oral medication may be adequate, and are part of the prevalent demand for 'medication of immediate efficacy' (Ovesen & Trankel 2010: 249, 254).

The popularity of injections has also been reported from other developing countries (Reeler, Van der Geest, Wyatt, in Reeler 2000: 136). They are seen as the 'outstanding symbol of biomedicine' (ibid.), and perceived as providing quick relief and more powerful than tablets and capsules (Nichter 1996). This may be attributed to the frequent use of injections by health professionals to treat serious illness (Reeler 2000: 136), as well as the act of penetration of the body with a needle, which is associated with pain and a 'direct entry into the bloodstream' (Browner in ibid.). The view that a provider who gives injections is a provider who cares is generally widespread among patients in the developing world (ibid.), and was observed also in this evaluation.

Another form of treatment that was mentioned favourably by respondents (for example, in section 5.2.5.4) is the use of different medicines. Similarly to injections, the 'dispensing of several kinds of medicine', regardless of the condition that needs to be treated, has also been recognised as a 'consumer expectation' in the Cambodian health context (Ovesen & Trankel 2010: 237). This expectation is suggested to represent a 'popular biomedical indigenisation' (ibid.). That is, a local adaptation of a Western modality of treatment, whereby traditional knowledge about health care is grafted onto patients' understanding of biomedical medications. Indigenous herbalists in Cambodia normally 'combine medicines from a variety of different ingredients'; the more ingredients they mix together, the better their skills and knowledge are considered (ibid.). The same conception is then employed with regard to biomedical providers, and is almost always met by the private providers (ibid.)

A final treatment preference that was cited (also in section 5.2.5.4) is for specific medications. Participants wanted to have the exact same pills and tablets that they already know, and have used before, which also highlights the role of habit and familiarity in health care-seeking decisions. These specific medicines were more likely to be available from private providers, where the range of drugs, again in contrast to public facilities, is less limited by the MoH. Participants identified the specific medications they wished to receive based on their size and colour, which corresponds to the results of a study conducted in rural India (Nichter 1996). Dealing with popular perceptions of medicine, the study showed how patients scrutinise medications in terms of their colours, which have different connotations and are thought to 'signify a medicine's inherent properties' (ibid.: 231).

To sum up, HEF beneficiaries often have ideas about the kinds of treatment and medicine they wished to have, thought was adequate, or saw as efficient. While these preferences may not be medically correct, they nevertheless influenced participants' health care decisions, and were seen in certain cases as worth additional expense. The extent to which patients' requests can be complied with, then, was a factor in their choice of provider. Whether it is by providing injections, a variety of several medicines, specific requested medicines, or specific medical examinations, private providers have a greater ability to meet patients' expectations and demands, and this was one reason for HEF members to seek care from these providers instead of public facilities.

In fact, in order to stay in business, private providers have to satisfy their patients by being responsive to their medical preferences. By doing so, they also reinforce people's impressions of appropriate treatments and medicines for particular illnesses (Nichter 1996: 221). This is especially problematic when understanding that private health provision in Cambodia is often provided by public health professionals. These health centre staff members engage in dual practice (i.e., act as private doctors or run private clinics), sometimes in their homes, in addition to their work at public facilities. Thus, they administer different treatments and medicines in each one of their roles according to the setting in which they operate (namely, the need to adhere to official guidelines in the public facility and the competitive, customer-oriented and less scrutinised environment of the private clinic).

10.2 Time

Lastly, service and treatment were also related to the issue of time, which was also a consideration in participants' decisions to prefer private providers over public ones (see also Ozawa & Walker 2011). Seeking care from the public facility was generally seen as more time-consuming due to the possible need to wait for absent staff to arrive (see section 5.2.1), a long wait before receiving treatment (see section 5.2.2), and the possibility of admission to the hospital for several days (see also Ozawa & Walker 2011). Care from a private provider, on the other hand, was regarded as quicker and more instantaneous, due to service and the greater perceived effectiveness of the treatment methods and drugs used.

11 Public vs. non-medical providers

The last point pertains to HEF members' use of non-medical providers as compared to public providers. As evident from people's statements, choosing the therapeutic option for an illness was initially based on the perception of its severity (see section 5.3.5.5, as well as Khun & Manderson 2007; Ozawa & Walker 2011). For what they considered ordinary diseases and minor ailments or symptoms, the majority of participants relied on self-treatment 'either through vernacular methods or by purchasing drugs' from a nearby store (Ovesen & Trankel 2010: 233). In fact, most respondents did not regard such diseases and ailments as a health problem that requires 'professional' treatment. A common answer to why someone has never visited a public health facility was that the person had not been sick. Only when specifically asked about 'small', 'mild', or 'ordinary' illnesses did people usually mention that they actually had experienced certain maladies in the recent past.

If the ailment persisted after two of three days of care, participants resorted to treatment through the medical sector, going either to private providers or the public facility (see again Khun & Manderson 2007; Ozawa & Walker 2011). If one source of care did not work, then HEF members consequently tried other modalities of treatment, thereby displaying pragmatism (see also Khun & Manderson; White 2004). This pragmatism, however, may also have to do with the fact that as their first choice of provider, participants generally preferred the non-medical sector over the medical one, with the principal stated reason for this being convenience.

The grocery store or local shop is easily accessible (i.e. able to walk to) with no need to arrange transportation, almost always open, and involves no wait times. Buying medicine there is thus generally experienced by respondents as easy, quick, and practical. This could also further explain the statistical significance of the distance factor, this time less in relation to cost, and more in relation to the parameters of time and convenience. In fact, while perhaps not as close as non-medical providers, often the location of private providers still made them more convenient to visit than public providers. Even if located outside the village, private providers tend to be situated next to a cluster of shops and businesses, or in the commercial area of Kampot town, so that they are in the vicinity of people's other activities, and did not require them to make a special trip (see section 5.3.2.1). As also reported by Ozawa & Walker with regard to Cambodian villagers, HEF beneficiaries seemed to 'value the convenience of buying drugs at stores' (2011: i24), and were willing to spend moderate sums for it, despite the fact that medicines from health centres are free of charge. Furthermore, the 'recognition of… [village] stores as places where most villagers go to buy medicine made non-medical-sector providers well-received in the community' (2011: i24).

Going to the health centre, on the other hand, which is usually more distant and requires arranging transport, was thought of as a hassle, which people preferred to avoid unless they felt it was absolutely necessary. In line with this, public facilities – in contrast to non-medical providers, and also to a larger extent private ones – were

associated by participants with severe illnesses and medical emergencies. People postponed going to the public provider until they thought their situation was serious enough that it justified overcoming the laziness – a word often used by respondents – and incurring the effort, inconvenience, and loss of time involved in visiting a public health facility.

Accordingly, participants related the insurance booklet almost exclusively with acute sicknesses, and not with milder symptoms. Despite the complaints made about treatment at public facilities, people generally thought of these – especially the hospital – as the only places that can treat severe illnesses. The reason that most respondents were happy with the booklet was the theoretical assurance that they would be treated for free if they became seriously ill (see section 5.3.5.5). Satisfaction with the booklet thus did not translate into a more regular use of the scheme and public facilities; for most beneficiaries it seemed neither essential nor useful to go to a public facility for common diseases or mild sores, but only for more severe illnesses.

It should be kept in mind, however, that the said distinctions between levels of illness severity were based on participants' own subjective (and generally uninformed) perceptions. Minor symptoms could also be indicative of a more acute sickness (and non-medical providers do not offer consultations or examinations that would allow early diagnosis). Also, medically severe conditions may not always be perceived as such, especially with the comparatively high tolerance of illness and health disability among respondents (see sections 5.3.5.2 and 5.3.5.5).

Most participants, then, seemed to tend to wait until the last minute – when their illness would usually indeed be severe – before going to a public facility. A somewhat ironic problem, then, is that severe health conditions are also likely to bring up or exacerbate some of the reported barriers to utilising public facilities. Acute health problems might: make it harder to travel, thereby enhancing the problem of access (see section 5.3.2); be more difficult to treat, thereby possibly reinforcing perceptions about low quality of care and medicine (see above as well as section 5.2.5); require admission to the hospital for longer treatment, which people are often reluctant to undergo (see section 5.3.3.3); and, lead to urgent cases, in which there was a tendency to forget or not think about the booklet due to the situation's exigency and potential feeling of panic (see section 5.3.1.2).

Box 4: Summary of discussion points

- Elderly HEF members are a group that faces particular additional utilisation challenges.
- Access, in terms of cost, distance, means of transport, and ability to travel (especially for older beneficiaries), is a central utilisation barrier.
- Trust:
  - » Cases of inadequate functioning or fulfilment of scheme benefits – whether perceived or objective – may lead to lack of trust in the mechanism and scheme;
  - » Incidents of improper staff behaviour and discrimination may create lack of interpersonal trust in public providers. Conversely, attentiveness from private providers, as well as the possibility for deferred payment, can increase this kind of trust in them.
- Utilisation barriers are linked to a lack of assistance from others, which could be related to the inconveniences imposed on caretakers, but also to weak mutual social support in the Cambodian rural social structure. Participants generally exhibited reluctance to 'bother' others (with requests for help or questions), which encompassed people in the village as well as health centre and scheme staff, and may also have to do with a lack of assertiveness and awareness of consumer rights.
- Choice of treatment option was determined first of all according to the illness's perceived severity. Care sought for mild ailments was usually through self-treatment and non-medical providers; public facilities and the insurance booklet, on the other hand, were associated almost exclusively with severe illnesses.
- Private provider (e.g., pharmacies and private clinics) 'pull factors':
  - » Providing higher perceived quality of care, by following patients' preferences for treatment and medicine.
  - » The shorter time required to visit these providers.
- Non-medical provider (e.g., grocery stores) 'pull factors':
  - » Better accessibility
  - » Convenience

IV Conclusion

While there is ample literature on the non-utilisation of public health services among poor and rural residents in Cambodia and other developing countries, much less is known about the determinants of such non-utilisation among populations covered by an SHP scheme. This evaluation attempts to explore such determinants within the HEF population in Kampot OD, which generally utilises public health facilities more than two times less than their CBHI counterparts. The evaluation's objective was to understand the factors that result in HEF beneficiaries' non-utilisation of public health services – despite the benefits provided by the SHP scheme – while placing an emphasis on beneficiaries' perspectives and considerations when making health-related decisions.

The evaluation's quantitative section revealed that statistically, non-utilisation is associated with socio-demographic, geographical, and service-related factors. Households less likely to use the health centre are those with fewer members, older heads of household, those located farther from the facility, and those assigned to health centres with lower assessment scores and a larger amount of staff. Individuals less likely to use the public health services are males and the elderly.

The qualitative section of the evaluation used individual interviews and FGDs to identify, in detail, the perceived barriers that deter HEF members from going to public facilities, and cause them to seek treatment elsewhere. Many of these barriers have already been identified in Cambodia as well as in other developing countries (Annear 2006; Das et al. 2001; Grundy & Annear 2010; Kiwanuka et al. 2008; Matsuoka et al. 2010; Niraula 1994; O'Donnell 2007; Ozawa & Walker 2011; Shaikh & Hatcher 2005; Shaikh et al. 2008). Whereas, the current evaluation:

- first, provided a detailed description of the form that these barriers take within the frame of the SHP scheme, and thereby also an account of the scheme's impact on its poor members;
- second, provided an overview of the different types of obstacles that appear in the areas of scheme, supply, and demand, which could serve as a step forward in designing possible interventions;
- and third, offered an analysis of some context-specific issues in the Cambodian setting.

Barriers that had to do with the scheme itself were primarily financial, and concerned the indirect costs of visiting public facilities, which seemed to remain a difficulty despite the scheme's additional non-medical benefits. The cost of transportation was a main issue, even with the transport reimbursement mechanism. Information shared by respondents referred to difficulties stemming from this mechanism's design, and raised the possibility of inadequate functioning of the reimbursement procedure. Such problems, whether perceived or real, could lead to a decrease of trust in the scheme overall.

All supply-related barriers – except from the physical barrier of health centres' limited operating hours –centred on two aspects of service at public facilities. The first is negative conduct of health staff, which included both unfriendly behaviour and discrimination against insurance booklet holders, and which is likely to decrease beneficiaries' trust in public providers. The second aspect is the quality of treatment, which was central for participants. HEF beneficiaries voiced negative impressions about the relative ineffectiveness of medicine at the health centre, lack of injections, insufficient equipment and examination, and limited selection and use of medications. In was apparent that many poor scheme members have clear consumer preferences of the kind of medical care they would like to receive, and that these preferences play a central role in their decision-making regarding the choice of provider. Even though other treatments (i.e., at public facilities) are offered for free, HEF members are often willing to pay more for treatments that they see as adequate and more effective. In this context, the ability of private providers to accommodate people's wishes was a reason to choose them over public providers. This highlights the need to both improve the perceptions of care at public facilities (even giving a product for free does not guarantee its use if perceived as inefficient), and at the same time the need to address supply side bottlenecks and weaknesses.

The demand section of the evaluation encompassed diverse issues operating at the individual, household and community level, and identified the largest amount

of barriers. These included problems of knowledge and information, geographical and physical access, and difficulties leaving both work and home, as well as inclinations and reluctances, cognitive and psychological obstacles, and socio-cultural perceptions, attitudes, and norms. HEF beneficiaries clearly associated illnesses that they perceived as ordinary with self-treatment or non-medical providers, and did not think it was necessary to visit public facilities in such occurrences. One main point in this context was convenience, mostly in terms of accessibility, which was a major reason for purchasing medicine from a local shop or grocery store. Several demand-related barriers were also especially pertinent to elderly people, whom the evaluation identified as a group more prone to non-utilisation. Other obstacles were related to a paucity of mutual assistance from others in the community, which was analysed in relation to the social structure in rural Cambodia.

All in all, as was also found with regard to the health care-seeking behaviour of non-HEF populations in Cambodia (Khun & Manderson 2007; Ozawa & Walker 2011), HEF members' first step in choosing a treatment was based on the perceived severity of the illness. They turned to traditional practices and non-medical providers for minor ailments, and to private and public providers for conditions deemed to be more serious. Financial considerations were certainly one factor in deciding where to seek care. Apart from these, however, there were further factors that were equally important in HEF members' decisions. Convenience was an important motivation for frequenting non-medical providers; quality and form of treatment (as well as time) were the main grounds for choosing private providers. For these aspects of health care, many HEF members were willing to pay for treatment – minor sums with non-medical providers, and moderate ones with private providers, as long as these were affordable – despite being aware of the ability to receive free treatment at public facilities.

V Recommendations

Scheme:

- Improve data entry and management by the scheme operator, in order to avoid errors in the information.
- Consider including more types of socio-demographic data on beneficiaries in the databases, and designing these databases in such a way that they could be linked with those of IDPoor, in order to allow further and more comprehensive quantitative analysis on utilisation-related issues.
- Monitor the provision of the transport reimbursement more closely.
- Reassess the value of the transport reimbursement, while taking into account the different and sometimes scattered locations of households in villages, and reimburse transportation costs accordingly and adequately.
- Reassess the value of the food allowance for caretakers at the hospital.
- Establish an official procedure whereby beneficiaries could request to change their assigned health centre (due to problems of distance and transportation), with agreed criteria for the approval or denial of such requests.
- Establish better communication with beneficiaries in terms of informing, clarifying, and explaining to them why certain actions are taken, the exact benefits they are entitled to, and *why*.
    - » If a member's booklet needs to be taken away temporarily, for instance, the beneficiary has to be clearly informed about when the booklet will be returned, and what he/she can do in the meantime if they need to seek care at a public facility. Furthermore, if a HEF beneficiary visits the public facility and is objectively not entitled to a transport reimbursement, the scheme staff need to make sure that the reason for this is clear to the member. This can prevent a sense of irregularity or randomness in the travel vouchers system among beneficiaries, and thereby reduce problems of trust in the scheme.
- Place an emphasis on improving beneficiaries' perceptions about the quality of treatment at public health facilities. This could include a focus, in information meetings and other interactions or discussions with beneficiaries, on health education. Specifically:
    - » Explain about – rather than just inform – the treatment options at public health facilities, and raise awareness about 'correct treatment' (i.e., why medicines from non-medical or private providers are not necessarily more effective or adequate treatment). Specific issues that were brought up by the evaluation's participants could also be addressed, such as why injections are not often administered at health centres, and why the same medication might be given for different ailments.
    - » Stress positive health-seeking behaviour, through strengthening awareness to the importance of early diagnosis; how 'simple' symptoms can also be indicative of more severe situations; non-communicable diseases such as diabetes and high blood pressure; and the advantages of using the health centre also for minor illnesses, in order to encourage a habit of utilisation.
- The effort to change people's opinions on care at public facilities should be carried out jointly through both scheme and supply-side activities. In addition to the health education done by the scheme operator, health staff at facilities could spend more time explaining issues of care when interacting with beneficiaries who come for treatment. (See recommendation under 'supply' below.)
- Give particular attention to elderly beneficiaries, who due to their physical weakness face additional challenges in accessing public facilities.
    - » This could include outreach activities, such as bringing certain services closer to elderly HEF members' homes, arranging adequate transport for them, or allowing, after initial diagnosis at a public facility, for a relative to refill medicines that they have to take on a regular basis.
- Link the payment to public facilities to their performance and quality assessment, as a way of attempting to control and minimise phenomena such as the absence of staff during operating hours, and discrimination against SHP scheme members.

Supply:

- Better monitor and supervise the quality of medicines at public facilities (especially health centres), and implement further quality improvement strategies.
- Take into consideration the specific widespread demand for injections, try to provide 'tangible expressions of care without administering injections', and 'use less harmful practices that may satisfy patients' needs more' (Nichter 1996: 138).
- Instruct health staff to spend more time with patients on 'explaining and communicating about illnesses and their rational treatment' (ibid.), and specifically about the medicine being given and why. This could contribute to increasing health education among beneficiaries and building positive perceptions about treatment at public facilities, as well as strengthen the interpersonal relationship between them, and thus build beneficiaries' trust in public providers (Ozawa & Walker 2011).
- Expand or make the operating hours of health centres more flexible.

Demand:

- Consider arranging, through or in collaboration with the community:
  - » Joint transport to the public facility for beneficiaries residing in more remote villages;
  - » Motodups or other forms of transport where the drivers agree to be paid after the visit to the facility, and do not require payment before beneficiaries receive their reimbursement;
  - » A system of communal support in villages for illness-related situations, where people would mutually volunteer, for example, to help take care of the children or older household members of others, when they have to leave the house in order to visit a public facility.

Future research:

- Consider using a survey method as a follow-up to the qualitative data collection in the current evaluation, which will collect socio-demographic data and also be conducted on a larger amount of people. The survey questionnaire should be informed by the results of the present evaluation's qualitative analysis; this will allow a quantification of the qualitative data as well as its sorting and analysis according to socio-demographic characteristics and groups.
- Consider including CBHI members in the study, in order to gain knowledge on their perspectives, attitudes, and experiences with health facilities, and allow a comparison between this subgroup and HEF beneficiaries in terms of factors affecting utilisation.

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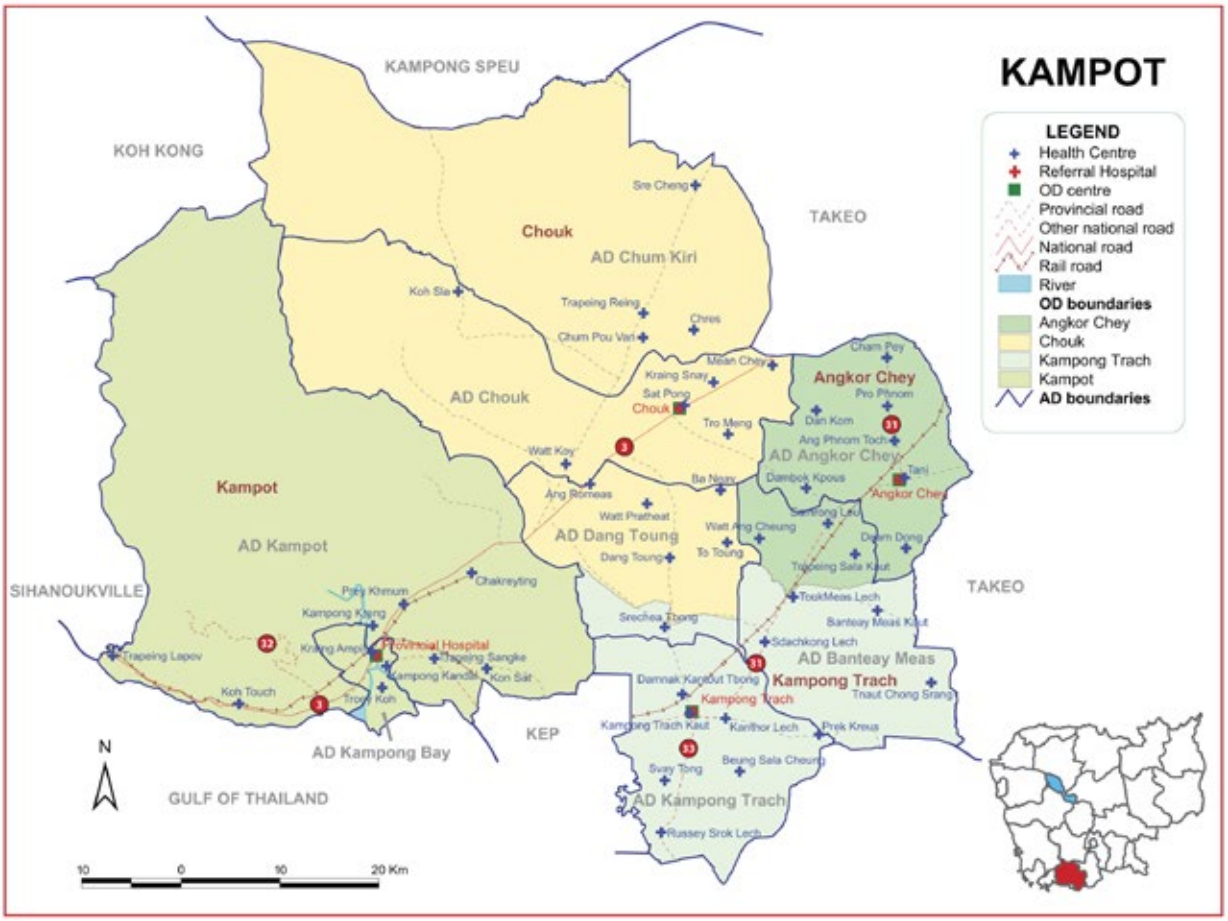
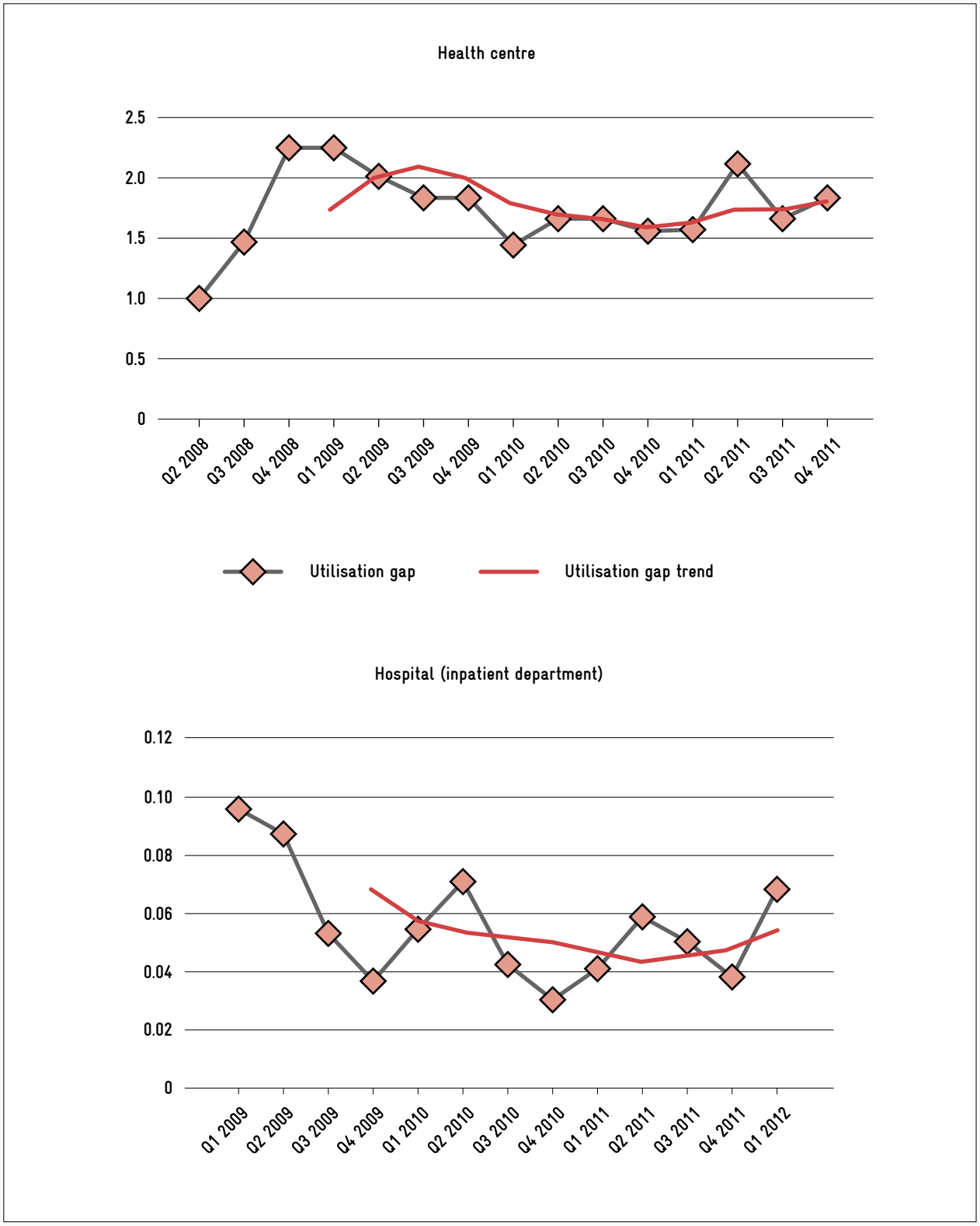
VII Annexes

1 Map of Kampot province *



* OD = operational district; AD = administrative district

2 Difference in public health facility utilisation rates between the scheme's two subgroups (CBHI-HEF utilisation gap) (in contacts per member per year by quarter)*



*Calculated as average CBHI utilisation rate minus average HEF utilisation rate.

3 Comparison of means of health centre (HC) utilisation by scheme members

Group statistics

	Household type	N	Mean	Std. deviation	Std. error mean
HC contacts	HEF	4047	12.81	20.172	.317
	CBHI	1256	26.05	36.915	1.042

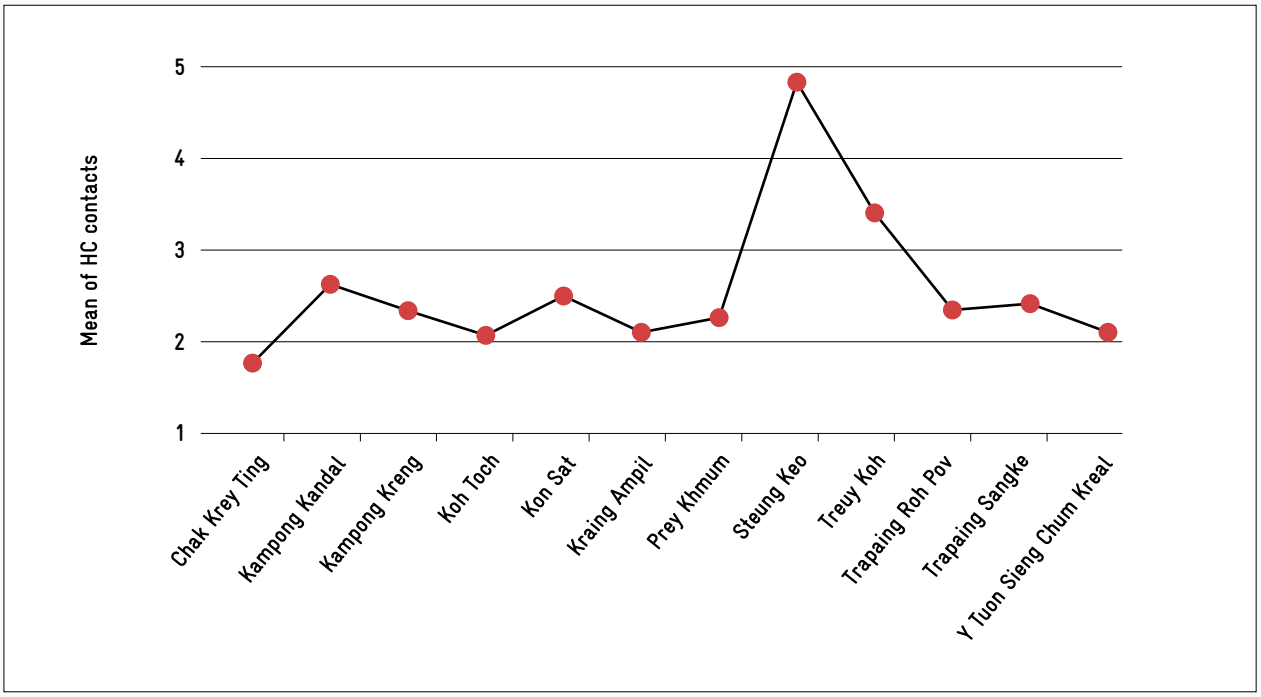
Test statistics[a]

	HC contacts
Mann-Whitney U	1.830E6
Wilcoxon W	1.002E7
Z	-15.066
Asymp. Sig. (2-tailed)	.000

[a] Grouping variable: household type

4 One-way between groups analysis of variance (ANOVA)

Means of HEF contact rates at Kampot OD's different health centres (HCs), 2008-2011



Descriptives

HC contacts		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Mini	Max	Between-Component Variance
						Lower Bound	Upper Bound			
1		3848	1.77	5.606	.090	1.60	1.95	0	182	
2		1008	2.64	6.394	.201	2.25	3.04	0	74	
3		2404	2.35	6.471	.132	2.09	2.60	0	123	
4		2148	2.06	4.241	.092	1.88	2.24	0	44	
5		1789	2.50	4.426	.105	2.30	2.71	0	44	
6		1919	2.10	4.434	.101	1.90	2.30	0	52	
7		1806	2.25	4.629	.109	2.04	2.46	0	68	
8		1022	4.84	7.693	.241	4.36	5.31	0	85	
9		3072	3.40	6.240	.113	3.18	3.63	0	93	
10		983	2.34	4.057	.129	2.09	2.60	0	34	
11		2377	2.42	4.744	.097	2.23	2.61	0	69	
12		718	2.10	4.589	.171	1.76	2.43	0	82	
Total		23094	2.47	5.461	.036	2.40	2.54	0	182	
Model	Fixed Effects			5.417	.036	2.40	2.54			
	Random Effects				.233	1.96	2.98			.523

Test of homogeneity of variances

HC contacts			
Levene Statistic	df1	df2	Sig.
40.059	11	23082	.000

ANOVA

HC contacts					
	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	11174.021	11	1015.820	34.612	.000
Within Groups	677425.464	23082	29.349		
Total	688599.486	23093			

Robust Tests of Equality of Means

HC contacts				
	Statistic[a]	df1	df2	Sig.
Welch	23.537	11	6.927E3	.000
Brown-Forsythe	34.742	11	1.382E4	.000

[a] Asymptotically F distributed

5 Non-utilisation percentages by village*

Health centre	Village	Non-utilisation percentage
ChakKrei Ting	Anglong Kokir	34.04%
	ChakKrey Ting	19.64%
	ChbarAmpov	40.00%
	DamnakLoung	21.54%
	Damnak Trach	50.57%
	Mean Ritth	27.08%
	Phnum Touch	10.81%
	Prey Thnang	23.91%
	Tuek Kraham	13.04%
	Tvear Thmei	33.33%
Koh Toch	Kandal	27.78%
	Kilou Dabpir	16.67%
	Preaek Ampil	23.76%
	Preaek Chek	12.50%
Kampong Kandal	Totoeung Thnay	42.22%
	Kep Thmey	43.06%
	Roulous	38.78%
Y Tuon Sieng Chum Kreal	Chum Krieal	12.82%
	Samrong	7.41%
	Kampong Kandal	35.56%
Trapaing RohPov	Trapeang RohPov	31.15%
	Prek Kreng	10.26%
	PrekThnot	14.81%
Kampong Kreng	Kampong Kraeng	25.00%
	Kampong Krong	37.88%
	Prey Thnaot	38.60%
	Makpraeng	27.13%
	Andong Chi Moeun	12.35%
	Sunam Prampi	29.17%
	Boat Kbal Damrey	40.00%
	Moat Peam	18.92%

Health centre	Village	Non-utilisation percentage
Trapaing Sangke	Angk	15.22%
	Bos Trabaek	10.26%
	Kampong Kes	10.53%
	Kampong Samraong Khang Cheung	12.82%
	Kampong Samraong KhangTboung	11.90%
	Trapeang Kanhchhaet	11.54%
	Trapeang Sangke	25.45%
	Trapeang Thum	52.50%
Kon Sat	Bos Nhinh	13.70%
	Kampong Thnot	7.32%
	Trapeang Prinh Cheung	36.00%
	Trapeang Prinh Tbong	16.13%
Prey Khmum	Doun Soy	17.54%
	Kou Chen Leng	14.81%
	Prey Khmum	13.04%
	Prey Tom	51.85%
	Boeung Ta Ruong	30.77%
	Vat Ang	11.90%
	Trapeang Chrap	16.33%
	Vat Por	20.83%
	Thmey	32.00%
	TraSek Kuaung	10.34%
	Trapeang Chrey	22.58%
Treuy Koh	Ta Ang	21.05%
	Daun Toak	16.00%
	Boeung Ta Pream	6.17%
	Sre	3.77%
	Ta Doeup	26.09%
	Andaung Khmer	43.44%
	Au Tauch	6.41%
Steung Keo	Anluong Mak Prang	11.63%
	Mlech Kuol	46.15%
	Dong	13.33%
	Kampong Chen	18.67%

* Calculated as the share of non-using households from the number of HEF households covered by the health centre.

6 Detailed quantitative analysis

6.1 Bivariate measures of association

First, the association was measured between the seven criterion variables and the outcome variable. The analysis here did not control the covariate effect of the criterion variables, as two multivariate analyses (binary logistic regression and cluster analysis), aimed at recognising the contribution of each criterion variable to the likelihood of visiting a health centre, were conducted additionally and are presented below.

As shown in the table below, all variables – with the exception of the number of health centre staff – had a statistically significant relationship with HEF members seeking treatment at a health centre. Of the variables, the sex of the household head and having a family member over the age of 60 displayed a very weak relationship (close to 0).

Other variables showed a statistical relationship of higher strength, despite the correlation coefficient still being rather weak (less than 0.3). These were: the age of the household head; the household size; distance to the health centre; and the health centre's quality assessment score. Older heads of households, fewer members, greater distances between the households and facilities, and lower health centre quality assessment scores all reduced the likelihood of utilisation.

Results of bivariate measures of association

Variables	Health centre utilisation		
	Chi-square	Correlation coefficient	P-value
Sex of household head	14.5	.06	<.001
Age of household head	134	.19	<.001
Distance to health centre	98	.16	<.001
Number of staff at health centre	1.3	.02	>.05
Health centre quality assessment score	48	.11	<.001
Household member over 60 years old	23	.08	<.001
Household size	202	.22	<.001

6.2 Multiple binary logistic regression

In addition to the previous analysis, multivariate analysis was applied to assess the impact of a predicted model (i.e., the group of explained variables) on the likelihood of health centre utilisation by HEF households. Prior to running this regression, which is a non-parametric statistical technique, some data considerations were applied, such as having an adequate sample size in each category of the explained variables and outcome variable.

The number of households who did visit the health centre was almost 3.5 times higher than that of the non-utilisation households (3204 households vs. 843 households); nonetheless, as the sample within each of these categories was large enough, there was no statistical problem in predicting the effect of the model. It should also be noted that the regression included only 75 percent (3,863 families) of the HEF households, as some data was either missing or its coding did not allow matching of the information at the household and individual levels. The dependent variable of whether or not a household had ever visited a health centre was categorised and coded into the dichotomous values of 0 (never visited) and 1 (visited at least once). The predicted model consisted of the seven variables used throughout the analysis: the sex of the household head was coded 1 for male and 2 for female; all the other variables were measured in ration scales.

The binary logistic regression showed that the model composed of all predictor variables was statistically significant (Chi-square [7, N=3,863] =178.7, p<.001) in explaining the likelihood of a HEF household seeking care from a health centre.

The model could also explain between 5 percent (Cox & Snell R Square) and 7 percent (Nagelkerke R Square) of the variance in 'ever visiting a health centre', and could correctly classify 79 percent of the cases.

Results of multiple binary logistic regression

Predictor variables	B	Sig.	Exp(B)
Sex of household head (1)	.107	.254	1.113
Age of household head	-.012	.006	.988
Distance to health centre	-.061	.000	.941
Number of staff at health centre	-.090	.025	.914
Health centre quality assessment score	.029	.001	1.030
Having a household member aged 60+ (1)	.122	.440	1.129
Household size	.234	.000	1.263
Constant	-.531	.430	.588

The table shows that five of the explained variables made a statistically significant contribution in the model:

- Distance (p<.001) For this variable, the value of the logistic regression coefficient (B) was negative, indicating that an increase in distance would significantly reduce the likelihood of utilisation. The odds ratio was 0.94, indicating that – while controlling for other factors in the model – for every additional one kilometre to the health centre, HEF households were 0.94 times less likely to seek treatment at the health centre.

- Household size (p<.001). According to this variable's positive correlation coefficient, with an odds ratio of 1.3, having more household members would increase the probability of seeking care at a health centre; households with more members are 1.3 times likelier to visit a health centre than those with fewer members. This finding, however, could have resulted from the categorisation procedure, in which households where no members have ever used the health centre were grouped into a value of 0, while households where any member has visited the health centre were treated as users and received the value of 1. Further analysis is thus required, which would take into account the classification of households by member age.

- The age of the household head (p<.001). With a negative relationship direction and odds ratio of 0.98, and while controlling for other explained variables, households with older heads would be 0.98 times less likely to visit a health centre than those with younger heads.

- Number of health staff (p<.05). Surprisingly, this variable had a negative correlation coefficient (Beta=-.09) – meaning that the health centre having more staff would reduce the likelihood of utilisation – with an odds ratio of 0.914.

- Quality assessment score (p<.001). With a positive correlation coefficient (Beta=0.03) and odds ratio of 1.03, a better quality assessment score would increase the probability of utilisation.

The two remaining variables – the household head's sex and having a household member over 60 years old – displayed a weak correlation coefficient, and did not make a statistically significant contribution to the model (p>.05).

In addition, logistic regression was also conducted at the individual level, in order to complement the results on the variables of sex and age, by examining their possible effects in relation to individual HEF beneficiaries (rather than household heads). Here, the odds ratio for HEF male beneficiaries was 0.60, indicating that their probability to seek treatment at a health centre was 0.6 times lower than that of HEF female beneficiaries. The age variable displayed a negative relationship with the likelihood of utilisation, meaning that the probability of a HEF member seeking care at a health centre decreases with age. As implied from the odds ratios presented in the table, in comparison with the youngest HEF age group of 0-5 years, HEF beneficiaries aged 6-13, 14-50, and 60 and above were respectively 0.6, 0.68, and 0.7 times less likely to utilise health centres for treatment.

Results of multiple logistic regression at the individual level (selected variables)

Variable	Logistic regression coefficient (B)	Odds ratios	Significance level
Gender			
Female	---	---	
Male	-.304	.738	.000
Age			
0-5 years	------	-----	
6-13 years	-.513	.599	.000
14-59 years	-.387	.679	.000
60 years +	-.351	.704	.000
Number of cases Model	18,045 280 (df=7, p<.001)		

6.3 Cluster analysis (two-step technique)

Similar to the multiple binary logistic regression, a cluster analysis was conducted in order to weigh the importance of each independent variable on the outcome variable of utilisation at the household level, this time through the use of clusters. Three such clusters were created, as can be seen in the following table. Cluster 1 was composed of the factors explaining non-utilisation among households who did not visit the health centre (717 households; 19%), and cluster 3 was composed of the factors explaining utilisation among those households that did visit the health at least once (2,766 households; 72%). Cluster 2, in this model, can be described as an 'in-between' category. In line with the objective of examining why some households seek treatment from the health centre whereas others do not, the analysis focused on clusters 1 and 3.

Cluster distribution

Cluster	Never visited health centre		Visited health centre	
	Frequency	Percent	Frequency	Percent
1	717	89.4%	0	0%
2	85	10.6%	298	9.7%
3	0	0%	2766	90.3%
Combined	802	100.0%	3064	100.0%

As the table shows, 90 per cent of the characteristics of non-utilisation can be explained through the variables in cluster 1. Cluster 3 showed a similar result in regard to the characteristics of utilisation. The cluster analysis showed that households that have never sought treatment from a health centre were those with older heads and fewer members, those that lived further away from the health centre, and those with health centres that had lower quality scores. Households that did use the health centre services, on the other hand, were those with younger heads and more members, those that lived closer to the health centre, and those with health centres that had higher quality scores.

The analysis also examined the statistical importance of each predictor variable in explaining utilisation. In cluster 1, the health centre's quality score was the most significant, followed by the household size and number of health centre staff. Distance and the age of the household head were ranked at the bottom. In cluster 3, the health centre quality score, number of health staff, and family size were of highest importance, respectively. Distance and the age of the household head were, again, not statistically significant in explaining the model.

Cluster profile

		Cluster			
		1	2	3	Combined
Age of household head	Mean	49.20	43.47	46.37	46.61
Distance to health centre	Mean	5.44	4.23	4.82	4.88
Number of staff	Mean	9.86	7.00	9.83	9.56
Quality assessment score	Mean	88.52	73.00	88.73	87.13
Household size	Mean	3.74	4.62	4.70	4.51

7 Statistical outputs

7.1 SPSS outputs of multiple binary logistic regression, household level

Case Processing Summary

Unweighted cases[a]		N	Percent
Selected cases	Included in analysis	3863	74.8
	Missing cases	1299	25.2
	Total	5162	100.0
Unselected cases		0	.0
Total		5162	100.0

[a]. If weight is in effect, see classification table for the total number of cases.

Depending variable encoders

Original value	Internal value
0	0
1	1

Categorical variables codings

		Frequency	Parameter coding
			(1)
H_Member_age_60	No member aged 60+	3035	.000
	Have at least one member aged 60+	828	1.000
H_GenderHH	Male	2245	.000
	Female	1618	1.000

Block 1: method = enter

Omnibus tests of model coefficients

		Chi-square	df	Sig.
Step 1	Step	178.673	7	.000
	Block	178.673	7	.000
	Model	178.673	7	.000

Model summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	3767.564[a]	.045	.071

[a] Estimation terminated at iteration number 5 because parameter estimates changed by less than .001.

Hosmer and Lemeshow test

Step	Chi-square	df	Sig.
1	16.321	8	.038

Classification table[a]

Observed			Predicted		
			Family_Contact		Percentage Correct
			0	1	
Step 1	Family_Contact	0	4	798	.5
		1	1	3060	100.0
	Overall Percentage				79.3

[a] The cut value is .500

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
								Lower	Upper
Step 1[a]	H_GenderHH(1)	.107	.094	1.303	1	.254	1.113	.926	1.337
	H_Age_HHH	-.012	.004	7.706	1	.006	.988	.979	.996
	H_HC_Distance	-.061	.012	24.454	1	.000	.941	.918	.964
	H_HC_Staff	-.090	.040	5.004	1	.025	.914	.844	.989
	H_HC_Score	.029	.009	10.457	1	.001	1.030	1.012	1.048
	H_Member_age_60(1)	.122	.158	.597	1	.440	1.129	.829	1.538
	H_FamilySize	.234	.023	103.679	1	.000	1.263	1.208	1.321
	Constant	-.531	.672	.623	1	.430	.588		

[a] Variable(s) entered on step 1: H_GenderHH, H_Age_HHH, H_HC_Distance, H_HC_Staff, H_HC_Score, H_Member_age_60, H_FamilySize.

7.2 SPSS outputs of multiple binary logistic regression

7.2.1 Household level

HC_contact between 2008-11

		Frequency	Percent
Valid	0	11712	50.7
	1	11382	49.3
	Total	23094	100.0

Categorical variables codings

		Frequency	Parameter coding		
			(1)	(2)	(3)
Recode_Age	<5yrs	2051	.000	.000	.000
	6-13 yrs	3802	1.000	.000	.000
	14-59 yrs	11011	.000	1.000	.000
	60+yrs	1181	.000	.000	1.000
Recode_Gender	female	9779	.000		
	Male	8266	1.000		

Logistic regression coefficients and odds ratios of predictor variable on number of HC contact

Variable	Constant	Logistic regression coefficient (B)	Odds Ratios	Significant level.
1	Distance_HC	-.035	.966	.000
2	Family_size	-.032	.968	.000
3	HC_Staff	-.003	.997	.812
4	Gender			
	Female	---	---	
	Male	-.304	.738	.000
	Age			
	0-5 yrs	------	-----	
	6-13 yrs	-.513	.599	.000
	14-59 yrs	-.387	.679	.000
	60 yrs	-.351	.704	.000
	Number of cases Model	18,045 280 (df=7, p<.001)		

7.2.2 Individual level

Case processing summary

Unweighted Cases[a]		N	Percent
Selected Cases	Included in Analysis	18045	78.1
	Missing Cases	5049	21.9
	Total	23094	100.0
Unselected Cases		0	.0
Total		23094	100.0

[a] If weight is in effect, see classification table for the total number of cases.

Dependent variable encoding

Original Value	Internal Value
never visit HC	0
At least one visited HC	1

Categorical variables codings

		Frequency	Parameter coding		
			(1)	(2)	(3)
Recode_Age	<5yrs	2051	.000	.000	.000
	6-13 yrs	3802	1.000	.000	.000
	14-59 yrs	11011	.000	1.000	.000
	60+yrs	1181	.000	.000	1.000
Recode_ Gender	female	9779	.000		
	Male	8266	1.000		

Block 0: beginning block

Classification table[a,b]

Observed			Predicted		
			Recode_HC_Contact		Percentage Correct
			never visit HC	At least one visited HC	
Step 0	Recode_HC_Contact	never visit HC	0	8260	.0
		At least one visited HC	0	9785	100.0
	Overall Percentage				54.2

[a] Constant is included in the model.

[b] The cut value is .500

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 0	Constant	.169	.015	128.571	1	.000	1.185

Variables not in the equation

			Score	df	Sig.
Step 0	Variables	Distance_HC	56.369	1	.000
		HC_Staff	.677	1	.411
		Family_size	36.403	1	.000
		Recode_Gender(1)	109.095	1	.000
		Recode_Age	93.455	3	.000
		Recode_Age(1)	38.187	1	.000
		Recode_Age(2)	1.638	1	.201
		Recode_Age(3)	5.723	1	.017
	Overall Statistics		277.927	7	.000

Block 1: method = enter

Omnibus tests of model coefficients

		Chi-square	df	Sig.
Step 1	Step	280.142	7	.000
	Block	280.142	7	.000
	Model	280.142	7	.000

Model summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	24606.507a	.015	.021

[a] Estimation terminated at iteration number 3 because parameter estimates changed by less than .001.

Hosmer and Lemeshow test

Step	Chi-square	df	Sig.
1	10.077	8	.260

Contingency table for Hosmer and Lemeshow test

		Recode_HC_Contact = never visited HC		Recode_HC_Contact = Visited HC at least once		Total
		Observed	Expected	Observed	Expected	
Step 1	1	1023	1015.768	780	787.232	1803
	2	935	942.643	864	856.357	1799
	3	922	908.203	884	897.797	1806
	4	908	877.932	903	933.068	1811
	5	841	844.000	966	963.000	1807
	6	773	807.694	1027	992.306	1800
	7	750	776.631	1056	1029.369	1806
	8	748	744.341	1057	1060.659	1805
	9	696	710.997	1113	1098.003	1809
	10	664	631.791	1135	1167.209	1799

Classification table[a]

Observed			Predicted		
			Recode_HC_Contact		Percentage Correct
			never visited HC	Visited HC at least once	
Step 1	Recode_HC_ Contact	never visit HC	2513	5747	30.4
		At least one visited HC	2151	7634	78.0
	Overall Percentage				56.2

[a] The cut value is .500

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I.for EXP(B)	
								Lower	Upper
Step 1[a]	Distance_HC	-.035	.005	57.759	1	.000	.966	.957	.974
	HC_Staff	-.003	.012	.057	1	.812	.997	.973	1.022
	Family_size	-.032	.007	22.878	1	.000	.968	.955	.981
	Recode_Gender(1)	-.304	.030	100.046	1	.000	.738	.695	.783
	Recode_Age			84.806	3	.000			
	Recode_Age(1)	-.513	.056	82.741	1	.000	.599	.536	.669
	Recode_Age(2)	-.387	.050	60.249	1	.000	.679	.616	.749
	Recode_Age(3)	-.351	.076	21.274	1	.000	.704	.607	.817
	Constant	1.059	.133	63.403	1	.000	2.885		

[a] Variable(s) entered on step 1: Distance_HC, HC_Staff, Family_size, Recode_Gender, Recode_Age.

7.3 Cluster analysis, household level

AIM TSC_4214
/CATEGORICAL Family_Contact
/CONTINUOUS H_Age_HHH H_HC_Distance H_HC_Staff H_HC_Score H_FamilySize
/PLOT ERRORBAR IMPORTANCE(X=VARIABLE Y=TEST)
/CRITERIA ADJUST=BONFERRONI CI=95 SHOWREFLINE=YES HIDENOTSIG=NO.

Two-step cluster
[DataSet1] C:\Documents and Settings\TEMP\Desktop\12June12\Data_HH_level(12June12).sav

Auto-clustering

Number of Clusters	Schwarz's Bayesian Criterion (BIC)	BIC Changea	Ratio of BIC Changesb	Ratio of Distance Measuresc
1	17434.528			
2	13731.826	-3702.702	1.000	1.398
3	11108.920	-2622.906	.708	2.577
4	10146.870	-962.050	.260	1.175
5	9341.496	-805.374	.218	1.205
6	8688.536	-652.960	.176	1.744
7	8352.990	-335.546	.091	1.223
8	8095.327	-257.664	.070	1.156
9	7884.679	-210.648	.057	1.229
10	7730.123	-154.556	.042	1.072
11	7592.089	-138.034	.037	1.033
12	7461.388	-130.701	.035	1.156
13	7360.559	-100.829	.027	1.125
14	7280.994	-79.565	.021	1.054
15	7210.085	-70.908	.019	1.091

a. The changes are from the previous number of clusters in the table.

b. The ratios of changes are relative to the change for the two cluster solution.

c. The ratios of distance measures are based on the current number of clusters against the previous number of clusters.

Cluster distribution

		N	% of Combined	% of Total
Cluster	1	717	18.5%	13.9%
	2	383	9.9%	7.4%
	3	2766	71.5%	53.6%
	Combined	3866	100.0%	74.9%
Excluded Cases		1296		25.1%
Total		5162		100.0%

Cluster Profiles

Centroids

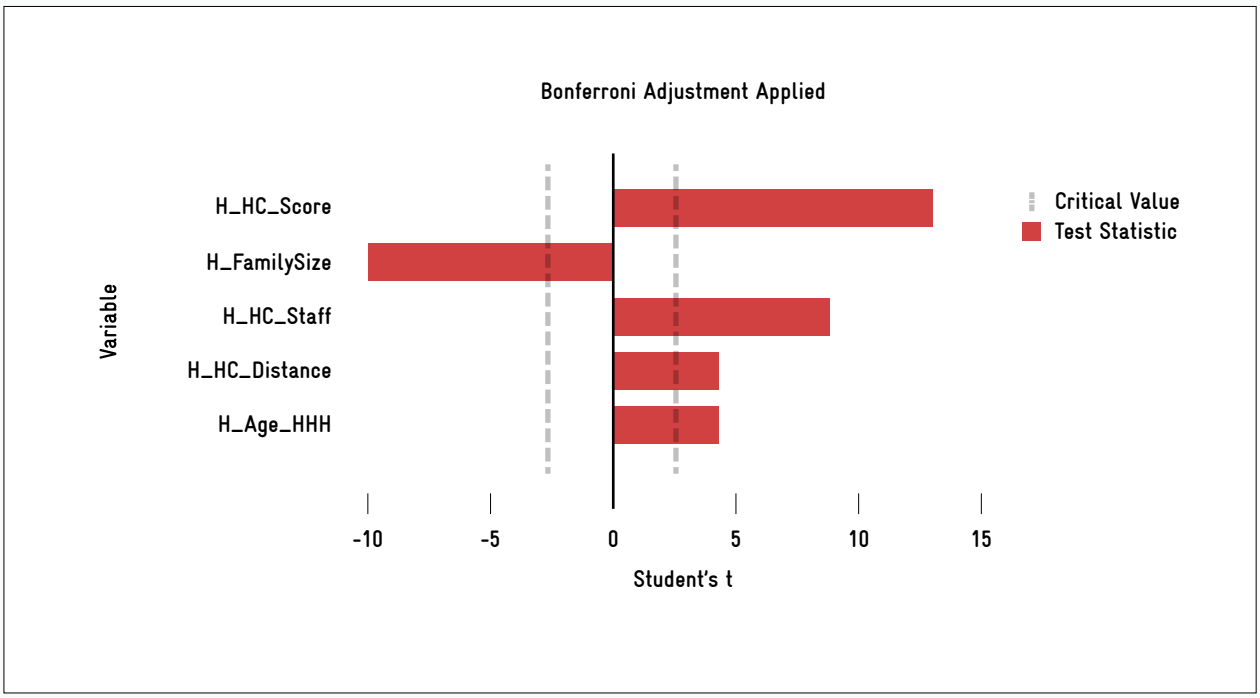
		Cluster			
		1	2	3	Combined
H_Age_HHH	Mean	49.20	43.47	46.37	46.61
	Std. Deviation	16.428	14.869	14.768	15.170
H_HC_Distance	Mean	5.44	4.23	4.82	4.88
	Std. Deviation	3.493	2.305	3.312	3.276
H_HC_Staff	Mean	9.86	7.00	9.83	9.56
	Std. Deviation	.929	.000	.927	1.222
H_HC_Score	Mean	88.52	73.00	88.73	87.13
	Std. Deviation	2.892	.000	3.065	5.499
H_FamilySize	Mean	3.74	4.62	4.70	4.51
	Std. Deviation	2.101	2.111	2.197	2.202

Frequencies

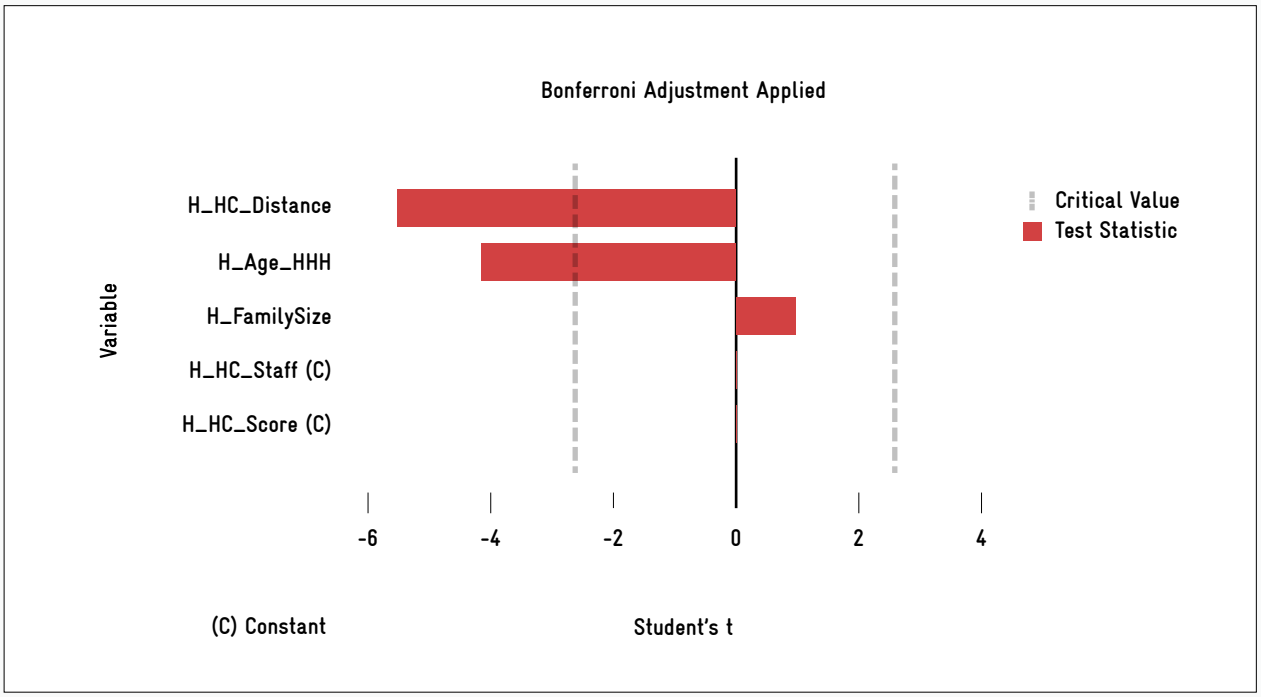
Health centre visits

		Never visit		Ever visit	
		Frequency	Percent	Frequency	Percent
Cluster	1	717	89.4%	0	.0%
	2	85	10.6%	298	9.7%
	3	0	.0%	2766	90.3%
	Combined	802	100.0%	3064	100.0%

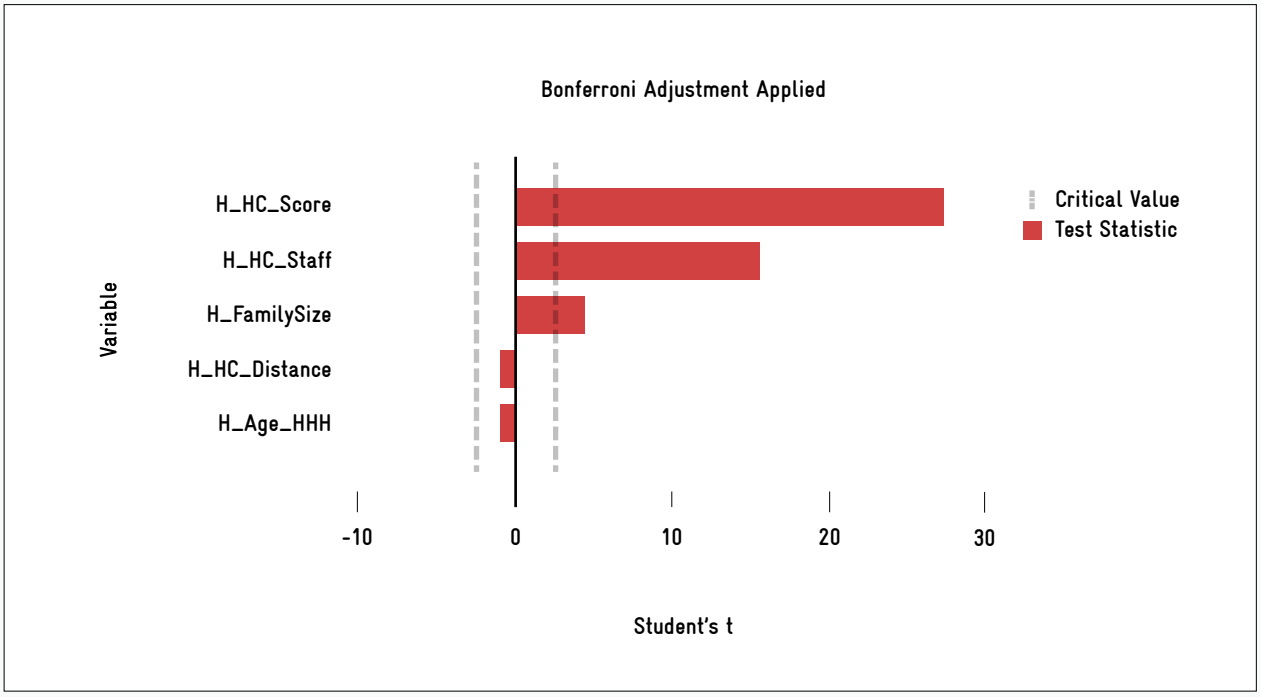
TwoStep Cluster Number = 1



TwoStep Cluster Number = 2



TwoStep Cluster Number = 3







Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH
PO Box 1238, Phnom Penh
Cambodia
T +855 23 884 476
F +855 23 884 976
E giz-kambodscha@giz.de
I www.giz.de