KINGDOM OF CAMBODIA

Nation- Religion- King

STRATEGIC FRAMEWORK

FOR

HEALTH FINANCING

2008-2015

Bureau of Health Economics and Financing
Department of Planning & Health Information

April 2008

Abbreviations

ADB - Asian Development Bank
AOP - Annual Operational Plan
CAR - Council for Administrative Reform
CBHI - Community Based Health Insurance
CDHS - Cambodia Demographic and Health Survey
CPA - Complementary Package of Activities
DFID - Department for International Development (UK)
DPHI - Department of Planning and Health Information
GAVI - Global Alliance for Vaccines and Immunization
GDP - Gross Domestic Product
GFATM - Global Fund for AIDS, Tuberculosis and Malaria
GTZ - German Technical Cooperation
HC - Health Centre
HCP - Health Coverage Plan
HEF - Health Equity Funds
HFC - Health Financing Charter
HSP - Health Sector Strategic Plan
HSSP - Health Sector Support Project
ILO - International Labour Organization
IMR - Infant Mortality Rate
MDG - Millennium Development Goal
MOEF - Ministry of Economics and Finance
MOP - Ministry of Planning
MOLVT - Ministry of Labour and Vocational Training
MOH - Ministry of Health
MOSVY - Ministry of Social Affairs, Veterans and Youth Rehabilitation
MPA - Minimum Package of Activities
MTEF - Medium Term Expenditure Framework
NCD - Non-communicable diseases
NGO - Non-government organization
OD - Operational District
OECD - Organization for Economic Cooperation and Development
OOP - Out-of-pocket
PHD - Provincial Health Department
PIP - Public Investment Program
PMG - Priority Mission Groups
RH - Referral Hospital
SFHF - Strategic Framework for Health Financing
SHI - Social health insurance
SWAp - Sector Wide Approach
SWiM - Sector Wide Management
TWGH - Technical Working Group for Health
U5M - Under 5 Mortality
UNFPA - United Nations Population Fund
USAID - United States Agency for International Development
WHO - World Health Organization
WB - World Bank
3YRP - Three-Year Rolling Plan

FOREWORD

The Ministry of Health's Health Sector Strategic Plan advocates for the "Allocation of financial resources to improve the accessibility of health services for the poor through alternative health financing schemes". In a context of under-funded health sector, with population suffering from poor access to health services, the strategy for financing health care advocates for increase and mobilization of resources as well as allocation of funds in a transparent, equitable, efficient and effective way.

Since the introduction of the Health Financing Charter for Cambodia in 1996, various financing schemes have been implemented in the public health sector by the Ministry of Health and our health partners. Those schemes consist in user charges with exemption policy, contacting, health equity fund and community based health insurance etc.

Given the diversity of health financing mechanisms in Cambodia, the Ministry of Health has decided to develop this framework to capture, analyze and streamline all sources of funds and their uses in the health sector. The framework aims at improving access to health services and guides the development and implementation of a social health protection mechanism.

The Ministry of Health hopes that the introduction of the Strategic Framework for Health Financing in Cambodia can contribute to prevent poverty linked to ill-health, improve the level of funding and quality of health care, and pave the way towards universal health insurance coverage. To reach that goal will take time and there will be many challenges ahead. It will require political and social support, adequate financial resources, appropriate human capacity, and effective coordination. We are confident that the Royal Government of Cambodia, other line ministries and our partners in health will support the MoH in implementing this Strategic Framework for Health Financing.

April , 2008

Acknowledgments

Formulation of the Strategic Framework for Health Financing 2008-2015 was led by the Bureau of Health Economics and Financing of the Department of Planning and Health Information (DPHI) of the Ministry of Health (MOH) with support from WHO Cambodia and the Western Pacific Regional Office.

The development was done through a series of consultative process with technical advisory group (TAG) for macro economics and health which consists of representative from Ministry of Health (MoH), Ministry of Economy and Finance (MEF), and Ministry of Planning (MoP). Also the consultation was done with the technical working group for health TWGH and national consultative workshop which participated from all level in the health sector, MEF, MoP, Council Minister, CDC and Health Development Partners, we would like to extend our sincerely thanks to those whom participated.

We appreciate the hard work of Dr. Aviva Ron, Dr. Peter Annear and Ms Maryam Bigdeli for their technical support though out the development process that this framework will provide a guide principle for effective and sustainable health financing development in CAMBODIA.

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1. Background

This document provides a Strategic Framework for the development of health financing during the years 2008 –2015. Health financing deals with the mechanisms for providing the funding required for the delivery of health services to the population, both in terms of sources of funding for the delivery of health care (input) and the way in which these funds are spent (output).

The purpose of the Strategic Framework for Health Financing 2008-2015 (SFHF) is to put the various existing forms of health financing in Cambodia under a single coherent plan.

The Strategic Framework builds on past achievements in the health sector and supports current planning activities. These include:

- The development of health administration and infrastructure through the 1995 Health Coverage Plan (HCP)
- The achievements of the 1996 Health Financing Charter (HFC)
- The health-care targets proposed by the National Strategic Development Plan 2006-10 (NSDP)
- The implementation of the Health Sector Strategic Plan 2003-2007 (HSP)
- Achievement of the targets set by the Cambodian Millennium Development Goals (MDG) for health by 2015.
- The Second Health Sector Strategic Plan 2008-2015

1.1- Funding sources and utilization of funds in the Cambodian health sector

The issues of health financing may be considered both from the perspective of the sources and uses of funding for health care and from the perspective of the supply of and demand for health care services.

The three principal sources of health financing in Cambodia are from (i) the government health budget, (ii) from donors and other health partners and (iii) from households. These funds can be used in various ways to acquire health services through public health service delivery and through the private sector.

On the supply side, financing may come from government, donor agencies or non-governmental organizations. Out-of-pocket expenditures go to either user fees in public facilities or the private sector. Demand-side financing schemes are characterized by health insurance systems of various types or social transfers including health equity funding

The fundamental need in the health financing process is to achieve the best outcomes in terms of both the allocation of resources and their efficient use, based on the need for equitable access to health services.

As detailed in the situation analysis presented in Annex 1, the financing of health care in Cambodia is characterized by:

1. A high level of poverty (35%) and inadequate access to health services for the most vulnerable populations, with substantial impact on equity in health as reported in the Cambodian Demographic and Health Survey 2005.

2. A reasonable level of national health expenditures per capita compared to other developing countries reaching about US$27-37 per capita per year, depending on source of data and estimates of out-of-pocket spending

3. An increasing level of recurrent government spending for health, reaching 12% of national budget, although remaining a low share of GDP at little more than 1% in 2007 (or approximately US$6 per capita per year in 2007

4. A very high level of private, out-of-pocket (OOP) household spending that accounts for approximately two-thirds of all health expenditure (or approximately US$25 per capita per year).

5. High Dependence on donor funding for health care, reaching US$ 103 million or US$7 per capita per year in 2007 .

6. A chronic misalignment of public funding with the priorities of the health sector

7. A low level of salaries and incentives for staff working in the public health sector, preventing effective delivery of health services;

8. A low level of public funding (less than 40%) reaching the service delivery level, with significant impact on service delivery.

9. A high utilization of unregulated private providers.

Within this health financing context, the MOH is committed to providing equitable, quality health care for all Cambodians. The MOH aims to deliver full Minimum Package of Activities (MPA) at all Health Centers and Complementary Package of Activities (CPA) at all Referral hospitals in all health Operational Districts, and to provide access to health services for the poor

The long-term aim of health financing in Cambodia is to achieve universal coverage of the population with funded pre-payment mechanisms. This, however, is still many years away. Already, beside government budget for health and direct out-of-pocket spending, a number of different health financing mechanisms have emerged independently: donor funding, donor funded pools (Health Sector support Project and SwiM), , user fees at public facilities, fee-exemptions for the poor, contracting of public service delivery, health equity funding (HEF), community-based health insurance (CBHI) and proposals for different social health insurance schemes (SHI).

The purpose of the Strategic Framework is to bring various forms of health financing into a single plan. This plan constitutes a 'mixed model' of health care financing that will provide the basis for moving to universal coverage in the longer term.

1.2 Issues and concerns

1. **Poverty and Equity**: With about one-third of the population too poor to pay for health care in the public or the private sector, any plan for national health financing must provide appropriate and satisfactory social-protection measures and other safety nets. Currently, this protection is provided through various fee-exemption systems and through health equity funding; the need is to institutionalize and scale-up these mechanisms in the national framework and to develop new means to protect the poor.
2. **Health transition**: Cambodia is developing rapidly and the population is ageing. The consequence of this is a change in the illness profile away from the complete domination of communicable diseases and towards increasing prevalence of non-communicable diseases. The prevalence of both hypertension and diabetes mellitus has increased faster than would be expected from the increase in life expectancy. The age of onset of chronic disease is relatively low. The number of deaths and injuries from traffic accidents increased by 50% between 2000 and 2005. Consequently, emerging health issues in the areas of prevention, acute care and rehabilitation will require additional resource allocations, especially chronic diseases and traffic accidents
3. **Resource allocation**: The level of total national health expenditure and the resources available to achieve the health MDGs are both adequate. However, the economic allocation of these resources is skewed, with excessive dependence on private sources and services and too little contribution by the public sector. There are many different reasons for this. However, there is a fundamental need to redirect resources from the private to the public sector, especially with regard to current levels of household health spending. And there is a fundamental need to protect the poor and to move from direct OOP expenditures towards pre-payment and social-transfer mechanisms.
4. **Harmonization:** Donors will continue to provide substantial support to the health sector in the foreseeable future. There is therefore an underlying need to increase the harmonization of donor funding in support of national health goals. Some donors have already shown support for a shared sector policy and strategy known as Sector Wide Management (SWiM) that has focused on broad coordination issues such as formulating plans and targets and reviewing progress. This has mainly been achieved through the Health Sector Support Project involving a group of donors (World Bank, DfID, ADB and UNFPA). A Review of SWiM was conducted in 2007 and provides interesting recommendations for moving the process forward. A number of national and international mechanisms are now in place that will improve donor harmonization in the near future[1]

[1] Such as the Harmonization and Alignment Working Group and the International Health Partnership, for which Cambodia is a pilot country.

1.3- Policy statement

Derived from issues and challenges in the health financing situation in Cambodia, the following policy statements form the foundation of this strategic Framework for Health financing:

1. Allocate existing resources and ensure their efficient use at service delivery level
2. Advocate for stronger government taxation and revenue collection
3. Mobilize and allocate resources to under-funded health priorities
4. Implement deconcentration and decentralization, using sound planning and financial management tools, provincial block grants and internal contracting
5. Move aggregate resources from inefficient private health care provision to an efficient health care system through enhanced quality and improved access to public health services
6. Implement social health protection measures and advocate for development of a social health insurance system
7. Use health financing mechanisms as a leverage for quality of health services
8. Support harmonization and alignment for results
9. Empower communities to participate in local policies and decisions that affect their financial access to health services

2- Strategic framework

The Strategic Framework for Health Financing marks the first step in the development of a national health financing strategy. In the broader sense, the pre-requisites for the development of a health financing strategy are: (1) The priorities of the health sector must be clearly defined, (2) the strategies to address sector priorities must be developed and documented, (3) the cost of implementing these strategies must be calculated, and (4) the allocation of resources within the sector must be adjusted for optimum results

The Strategic Framework provides a broad analysis of the sources and uses of funds in the health sector by responding to the situation of excessive OOP spending and the low level of public health spending at service delivery level. It is built on initiatives to improve supply of and access to services and provides direction in the implementation of social health protection mechanisms.

2.1- Aims and objectives

The ultimate goal of national health financing is to provide **universal coverage** of the population with appropriate and affordable pre-payment and social-transfer mechanisms that effectively pool the risks of individual health care expenditures and provide social health protection to the entire population. This long-term aim cannot be achieved during the period proposed by this Strategic Framework. However, the objective of the Framework is to create the path and outline the steps towards the achievement of universal coverage in the longer term (beyond 2015).

The underlying principles of the Strategic Framework are to increase the equity and improve the efficiency of health resources allocation and use. It aims to produce a more appropriate balance in the distribution of resources between the private and public sectors and in the proportion of financing provided by government, donors and households. The implementation of the Strategic Framework aims to remove financial and other barriers to access to health services for the poor and to protect the poor and the non-poor from the effects of catastrophic expenditures on health care. Furthermore, the strategic framework wishes to emphasize the use of health financing as leverage for quality of health services. These aims may be expressed as a vision statement for health financing strategy during 2008-2015:

Vision Statement

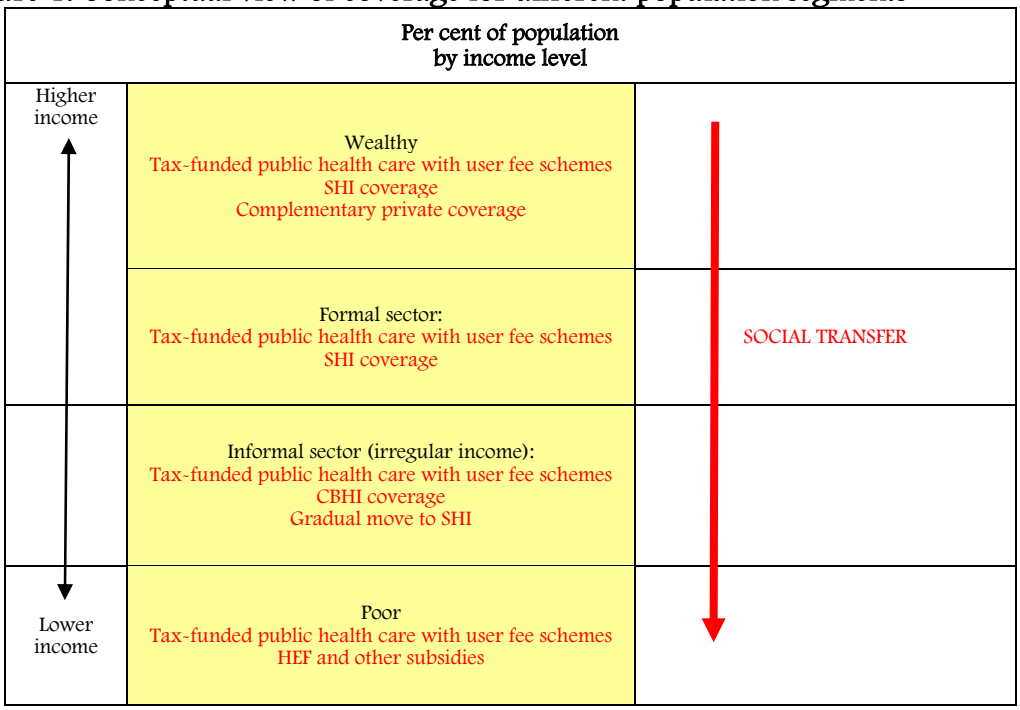
By 2015 the different elements and institutions of the health financing system will be combined under a single strategy guided by national health priorities; social health insurance mechanisms will be in place; the poor will be protected by suitable social-transfer mechanisms; government funding for health will be at a level appropriate for the adequate provision of quality services to the population; donor support will be harmonized and aligned with national priorities; health financing policies will be based on sound evidence from both public and private sectors.

2.2- Strategic approach

For the year 2008-15, the health financing strategy in Cambodia will be based on a mixed model, combining funding from taxation with pre-payment schemes, social health insurance and sustained donor funding for social protection funds.

2.2.1-Population coverage

Figure 1: Conceptual view of coverage for different population segments



All Cambodian citizens are entitled to tax-funded public health care, currently subsidized through government fixed budgets, donor funds and user fees. The aim here is to strengthen public funding for service delivery as well as incentives for efficiency and quality. This may be achieved through implementation of deconcentration and decentralizatin, and expansion of contracting arrangements.

The wealthiest section of the population must participate in the future Social Health Insurance scheme in order to allow appropriate social transfers to take place. This population segment is also considered to have the resources needed to finance their specific needs in the private health sector and by purchasing complementary private health insurance if needed.

The formal employment sector of civil servants and private-sector employees are to be covered by Social Health Insurance schemes with employer and employee funding. While these schemes are yet to begin and may start independently, the aim is to build them in a way that will eventually cover all paid employees under a common system.

The largest part of the population has no formal employment and little disposable income. The not-so-poor (those living just above the poverty line) can afford small premium payments for community-based health insurance as a means to protect themselves against catastrophic expenditures that cause impoverishment. The task is to expand the coverage of CBHI and other pre-payment schemes into those areas with informal-sector workers. However, as a voluntary scheme CBHI cannot provide 'universal coverage' in this segment, which will continue to include fee-for-service and OOP expenditures. The aims here are to strengthen public service

delivery and to keep OOP payments at affordable levels. Eventually, a gradual move of CBHI scheme under SHI umbrella is desirable in order to expand universal coverage to this segment of the population and allow appropriate social transfers.

The poorest part of the population will be protected through a range of social protection measures including fee exemptions, HEF and other subsidies for health care costs, such as voucher schemes. The aim is to provide access to free health care to all those living below the poverty line.

Much work still has to be done to 'scale-up' the identified schemes and to extend their coverage nationally. This work will be carried out within the context of this Strategic Framework. When this is achieved, a pattern of universal coverage may begin to emerge.

2.2.2- Financing mechanisms

Financing mechanisms in place and to be designed shall cover all three healths financing functions of an effective health system:

2.2.2.1-*Revenue collection and resource mobilization*

Increase in government's share of total health spending through overall improvements in national taxation and other revenue collections

Improve financial management, allowing increased availability of government funding at decentralized level and for health service delivery, including linkage with performance of the system

Sustainable, harmonized and aligned donor funding, especially for HEF and contracting arrangements

Implementation of existing government policy on Social Health Insurance and enabling policy environment for scaling-up CBHI schemes

Resource mobilization for under-funded priorities and neglected health problems

2.2.2.2-*Pooling*

Piloting and policy on linkages between HEF and CBHI schemes in a way that increases the efficiency in their implementation, combines administrative resources using a common database of beneficiaries, allows for portability between HEF and CBHI as population status and poverty levels change, promotes progressive subsidization and avoids unwanted transfers.

MOH policy on scaling-up HEF at national level, including policy on pooling of government and donor funds to finance service delivery for the poor and vulnerable population

Implementation of existing government policy on Social Health Insurance, migration of beneficiaries from HEF to other pre-payment schemes and from informal schemes to social health insurance

Implementation of Decentralization and Deconcentration in the health sector through strengthened planning and financial management processes at PHD level

Implementation of provincial and District block grant mechanisms, allowing decentralized pooling of funds

2.2.2.3- *Purchasing*

Enhance local governance and community participation in user fee and demand-side financing schemes and in local health planning processes

MOH policy on quality of health service provision and use of purchasing arrangements as leverage for achievement of quality standards

Definition and funding of MPA and CPA packages and treatment protocols, as well as continuums of care to support achievement of health sector priorities (e.g. Reproductive, Mother, Newborn and Child health services)

MOH policy on contracting arrangements and scaling-up at national scale

MOH policy on HEF and CBHI, and use of those demand-side schemes as leverage for quality health service delivery

Human resources strategy and staff management policy

Integration of provider payment mechanisms at facility level (budget, fees, capitation or staff incentives) to avoid duplication and overlaps at HC and RH level, and to allow a coherent funding of health facilities recurrent costs and staff

Introduce private practice regulations, including licensing and accreditation of private providers, alongside enforcement measures.

2.2.3- Stakeholders

The role of the **Government** is to provide the infrastructure, human resources and operational costs of the public health system, to exercise stewardship over the whole health system, define priorities, increase the delivery of public health services as a proportion of total service delivery, ensure efficiency and quality. **Contracting arrangements** are an essential tool for fulfilling government's role.

The role of **Donors** is to provide technical assistance, to support national health priorities and to fill the gap in funding between resources currently available and those needed to achieve health goals. **Harmonization and alignment**, in particular along defined **contracting arrangements** will be needed for an effective donor support.

Official, regulated **User Fees** will continue to be an important supplementary source of revenue for health facilities to finance staff incentives and running costs, with fee exemptions for the poor and defined packages of interventions. The role of **HEF schemes** is to provide access to health services and to protect the poor from catastrophic health expenditures. The role of **CBHI** is to provide a risk-pooling mechanism for informal-sector workers who live above the poverty line. **SHI** provides universal coverage to wage earners employed in the formal sector. The ultimate objective is to bring all pre-payment schemes under a common Social Health Insurance umbrella.

Through a well-regulated the **private sector**, services may be provided to those who can afford the costs of health care and private health insurance premiums

3-Strategic objectives and interventions

3.1-Government Health Expenditures

Strategic objective 1: Increase government budget and improve efficiency of government resource allocation for health.

This area will focus on increasing the share of government expenditures for health over the total health expenditures, meaning a gradual shift from donor funding towards a sustainable national health budget. Effective yearly and medium term planning tools exist in the health sector: the Strategic Framework recommends their efficient implementation at sub-sector and decentralized level and their use in strategic budgeting at all levels. At the same time, sound financial management tools need to be implemented at all levels of the health sector to allow efficient implementation of government resources for both recurrent and capital expenditures.

Component 1: Allocation of National Resources for Health

Desired Outcomes	Strategic Interventions
• Increased health budget as a proportion of GDP • Decreased dependence on external aid for recurrent costs • Resources allocated efficiently to maximize health outcomes • Increased funding for under-covered areas	• Advocate with MoEF to increase the share of government expenditures for health • Use 3YRP and AOPs in strategic and yearly budget formulation • Identify resources for 3YRP and AOP and perform gap analysis • Monitor allocation of increased funding to health priorities • Mobilize additional resources to cover health care costs of traffic accidents victims and NCD prevention and promotion.

Component 2: Credible government budget for health

Desired Outcomes	Strategic Interventions
• Full commitment to approved national health budget • Full commitment to the approved budget for central, PHD, OD, RH and facilities.	• Strengthen MOH capacity for strategic budgeting and PFM reform implementation • Use 3YRPs and AOPs for budget negotiations and implementation.

Component 3: Efficient implementation of government resources

Desired Outcomes	Strategic Interventions
• Efficient disbursement of approved budgets, particularly provincial budget to OD and facilities level.	• Implement D&D in the health sector, with relevant capacity building in PFM at PHD, OD and facility levels • PFM reform implementation especially Programme-based budgeting, with relevant output indicators

Component 4: Coherent infrastructure development

Desired Outcomes	Strategic Interventions
• Balanced allocations for capital costs with coherent funding for maintenance and recurrent expenditures • Comprehensive budget formulation	• Design a coherent PIP for health including recurrent costs for maintenance and training needs • Integrate PIP for health into AOP and 3YRP • Health Sector budget includes capital funding, recurrent costs for maintenance and training

3.2- External Funding for health

Strategic objective 2: Align donor funding with MOH strategies, plans and priorities and strengthen coordination of donor funding for health

RGC has adopted the Paris Declaration and supports implementation of harmonization and alignment in all sectors. In line with this government policy, donor coordination is already very strong in the health sector but would need to be strengthened for financial and pooling arrangement. At the same time, alignment of donor funding with health sector priorities 2008-15 place in the health sector. The same yearly and medium term planning and budgeting tools as well as financial management tools should be used to plan and monitor donor funding. This harmonization and alignment process should be applied to NGOs working in the health sector, although the important role of the civil society in supporting marginalized populations and engaging in policy dialogue should be recognized and supported.

Component 1: Alignment of external assistance with MOH priorities

Desired Outcomes	Strategic Interventions
• Donor support aligned with priority issues defined in the HSP 2008-15 • Donor support fully coordinated through MOH processes • Predictable donor support in the medium term	• Identify areas of duplication and gaps through AOP and 3YRP gap analysis at all level. • Integrate a core segment of donor funding into the national health budget • Implement financial pooling arrangements at all level. • Strengthen medium and long term forward projection of donor resources for health • Mobilize additional resources for identified under-funded priorities

Component 2: Harmonization of donor funding

Desired Outcomes	Strategic Interventions
• Donor funds coordinated through the SWiM/SWAP process and reflecting the Paris Declaration	• Implement SWiM Review recommendations, especially recommendations on funding arrangements and pooling • Agreement on financing expansion of successful initiatives to national scale.

Component 3: NGO assistance for health service delivery

Desired Outcomes	Strategic Interventions
• NGO assistance in line with HSP 2008-15 • Support NGO assistance for under-funded areas and health needs, and marginalized populations	• Implement contractual arrangements with NGOs for provision of defined services as needed, including medium and long-term sustainability plans • Sustain policy dialogue between NGOs, civil society and health policy makers • Support NGOs in implementation of pilots and innovative interventions

3.3- Household expenditures on health

Strategic objective 3: Remove financial barriers at the point of care and develop social health protection mechanisms

Reducing financial barriers to access depends on coordinated intervention on regulation of user fee schemes, scaling-up HEF arrangements in a sustainable manner and expansion of CBHI as an intermediate measure before an effective implementation of compulsory health insurance. Social Health Protection schemes need to be designed to achieve health sector goals and priorities in terms of financing of services, delivery of priority interventions and avoidance of catastrophic health expenditures.

Component 1: Health seeking behaviour

Desired Outcomes	Strategic Interventions
• Enhanced trust in public health services • Spending from the private/informal sector redirected to the public health sector	• BCC/IEC activities on health seeking behaviour, household health financing methods and all available exemption mechanisms • Develop financial incentives for rational health seeking behaviours (e.g. maternity grants) • Implement financial incentives for delivery of client-oriented services at public health facilities • Support community participation in local decision making and policies that will affect their access to health services, and in monitoring and evaluation of demand-side financing schemes

Component 2: Financial barriers to access public health services

Desired Outcomes	Strategic Interventions
• Increased Access to public health services for all, especially for the poor • Reduced catastrophic expenditures for health	• Regulate user fees at public facilities • Ensure compliance with the exemption regulations at all provider levels • Implement nationwide poverty identification • Scale-up sustainable HEF arrangements • Expand CBHI coverage • Initiate linkage between HEF and CBHI • Encourage pilots of other demand side financing schemes and streamline with HEF and CBHI (e.g. voucher schemes) • Extend availability of social health protection schemes to all households nationally • Explore other financing mechanisms to remove debt for health care such as cash transfers, microfinance initiatives

Component 3: Social Health Insurance

Desired Outcomes	Strategic Interventions
• Social Health Insurance coverage of employees in the private and public sectors	• Establish compulsory health insurance for civil servants and for private sector employed workers • Ensure appropriate design for compulsory insurance schemes to achieve health sector goals and priorities: benefit package, premium levels, provider payment methods • Streamline CBHI, HEF and other forms of subsidized care with formal sector health insurance schemes

3.4- Financing of service delivery at public health facilities

Strategic objective 4: Efficient use of all health resources at service delivery level

Appropriate allocation of credible budgets to service delivery units can be achieved through decentralized budget control and appropriate planning, budgeting and accounting capacities and tools. National health accounts or other types of comprehensive financial flow and expenditure tracking surveys need to be in place and provide a baseline for the implementation of the strategy. Scaling-up contractual arrangements will ensure adequate coverage of health priorities, with

appropriate funding for recurrent budget and staff incentives. All sources of funding, especially demand-side financing schemes should be effectively used as leverage for quality of health services.

Component 1: Effective financing of health priorities

Desired outcomes	Strategic Interventions
• Funding from all sources allocated to meet health care needs at service delivery level	• Perform burden of disease assessment • Cost MPA and CPA delivery, including referral system, and defined continuums of care, including reproductive and women and children health services. • Target public funding to priority health interventions based on health needs

Component 2: Allocation of health resources at service delivery level and effective financial accountability at service delivery level

Desired outcomes	Strategic Interventions
• Effective implementation of funds at health service delivery level	• Use AOPs ans 3YRP for provincial budget negotiations, including facility-level budgets • Decentralize budget and expenditures control • Build financial management capacity at facility, OD and PHD levels and implement accounting procedures at facility level • Implement use of banking system for cash transfers

Component 3: Account for sources and uses of funding at health service delivery level

Desired outcomes	Strategic Interventions
• Effective financial tracking and monitoring at service delivery level	• Perform regular financial flow analysis and expenditures tracking at health service delivery level • Strengthen and integrate monitoring and supervision role of ODs and PHDs in financial management

Component 4: Financing to support quality health service delivery

Desired Outcomes	Strategic Interventions
• Improved health service delivery • Increased quality of health services	• Conduct assessment of service delivery contracting options • Scale-up contracting arrangements • Consolidate annual planning, budgeting and funding for public facilities with provincial and provincial block grants • Arrange pooling of funds at adequate level and use them to leverage quality of services

3.5- Evidence and information for health financing policy

Strategic objective 5: Improve production and use of evidence and information in health financing policy development

Adequate health financing policy making requires production and analysis of evidence, as well as capacity in health systems and health economics research. .This should include the analysis of the health financing situation with the equity and gender perspective, taking in special account the needs of marginalized and vulnerable populations.

Component 1: Health financing monitoring and evaluation

Desired Outcomes	Strategic Interventions
• Comprehensive health financing data on all sources and uses of funding for health • Information on costs of health interventions • Leverage quality of service delivery through health financing monitoring and evaluation • Health financing policy formulation based on sound evidence	• Perform burden of disease and costing studies as needed • Develop and implement National Health Accounts or other forms of expenditure tracking tools • Strengthen reporting of donor and NGO spending in health • Strengthen health financing report system (user fee, HEF, CBHI etc) • Strengthen data collection on OOP expenses • Include private sector spending in expenditure tracking tools • Link health financing monitoring and evaluation to quality assurance • Develop policy makers capacity for using health financing information and evidence in policy making

Component 2: Health economics research capacity

Desired Outcomes	Strategic Interventions
• Health economics research capacity	• Involve research teams in all step of research and study including financial data collection design, analysis and reporting • Build capacity to conduct health economics research • Build capacity for policy research

Component 3: Equity and gender perspectives in health financing

Desired Outcomes	Strategic Interventions
• Equity and Gender perspectives included in health financing data, analysis and policies	• Develop inter-sectoral collaboration for equity and gender analysis • Ensure health financing data collection is designed with appropriate indicators for equity and gender analysis • Build capacity for equity and gender analysis • Perform policy analysis from equity and gender perspectives

4-Implementation, Monitoring and Evaluation

Implementation of the Strategic Framework for Health Financing (SFHF) is a complex process involving a range of different plans, programs and agencies. To implement activities in a timely manner, a comprehensive implementation plan will need to be formulated with short, medium and long-term targets and timelines.

In line with HSP2 implementation, the strategic Framework will adopt a consolidation and a scaling-up phase, that will be further detailed in the full implementation plan. These two phases include:

1. Consolidation phase 2008-2010

- ✓ SFHF implementation and roadmap
- ✓ Institutional arrangements allowing SFHF implementation
- ✓ Perform burden of disease assessment
- ✓ Perform costing studies of MPA and CPA
- ✓ Costing of health programs (RMNCH, CDC, NCD)
- ✓ MOH policy on implementation of Decentralization and Deconcentration
- ✓ Policy on contracting
- ✓ Policy on health equity funds and targeting interventions to the poor and vulnerable
- ✓ CBHI regulations and CBHI network
- ✓ PFM reform implementation, including PBB
- ✓ Strengthen 3YRP and AOP formulation and use in strategic and annual budget formulation
- ✓ Capacity building at central, provincial, district, commune and facility level on health financing, including supervision and monitoring of health financing schemes
- ✓ Strengthen User fees, CBHI, HEF and other demand-side schemes reporting
- ✓ Strengthen health expenditure data collection from all sources – initiate NHA
- ✓ Advocate for equity and gender analysis
- ✓ Initiate health economics research capacity building
- ✓ Prepare for mid-term review

2. Scaling-up phase 2010-2015

- ✓ National implementation of:
  - Contracting arrangements
  - Health equity funds and targeted interventions for the poor and vulnerable populations
- ✓ Routine production and analysis of health financing information
- ✓ Long-term cross-sectoral collaboration including:
  - Phasing-in social health insurance for the formal sector
  - Gradual move to consolidation of all schemes and universal coverage
- ✓ Ongoing capacity building in financial management
- ✓ Ongoing capacity building in health economics research
- ✓ Equity and gender analysis
- ✓ Perform mid-term review
- ✓ Prepare for final review

The SFHF will adopt a **monitoring framework** with

1. An annual health financing report, presenting comprehensive health financing data and analysis, particularly the defined indicator bellow.
2. A mid-term review in 2011, with a thorough situation analysis and amendment of the strategic framework as needed.
3. A final review prior to formulation of the next strategic plan

Indicators for Monitoring and Evaluation

Indicator	Target			Definition/sources
	2007	2011	2015	
Government funding for health				
1- Share of Government as % of GDP	1.08			Health budget/ GDP
2- Government health expenditure per capita	USD 5.94			Health budget/population
3- % of expenditure over approved budget	98%			Health expenditure /approved budget
4- % of budget allocated to PHD	27%			Budget allocated to PHD/ total health budget
Donor funding for health				
5-% of health partner submitted financial report to MoH				Number of submitted health partners/ total number
6- Donor contribution to public health per capita	USD 7			Total donor fund/ population
7- Share of donor funding channeled through budget support				Donor spending in cash to health sector/ total donor funds
Household expenditures for health				
8- # of patient visits exempted at health facilities with user fees systems	1.3 Millions			Number of cases exempted
9- Per capita expend to public health sector	USD 0.8			OOP to public facilities via user fee, HEF, CBHI.
10- Annual household expenditure in public sector and private	USD 37			CDHS2005
11- OOP per capital on health	USD 25			CDHS 2005
Financing health service delivery				
12-Government health funding reaching province, OD and facilities				NHA or PETS
PHD Office	45%			
OD Office	7%			
Referral Hospital	26%			
Health Center	32%			
13- Health financing schemes register at MoH				
HEF scheme coverage cases	246,598			
CBHI members and cases	45,882 and 1Million cases			
Other schemes				
14-Coverage of contracting arrangement (ODs)	19			Monitoring and Evaluation of Contracting
Evidence and information for health financing policy				
15-NHA or other expenditure tracking tool in place and regularly updated				Report
16-Equity and gender analysis of health financing policies performed				Survey
17-Number of research or study or new health financing scheme initiatives introducing for implementation.	1			Case study on financial access to health services

Terminology

Social health protection is an umbrella term used to describe all schemes and procedures that provide an element of protection against health care expenditures for the poor and for other users. This includes fee exemptions, health equity funding, community health insurance and social health insurance.

Social health insurance refers to various compulsory pre-payment schemes within the formal employment sector supported by legislation and usually funded either by the government (for civil servants) or by employers (for formal private-sector employees), often with part-contributions also from the employees.

Community-based health insurance refers to private, non-profit, voluntary pre-payment schemes targeted on the informal employment sector of small scale and self-employed urban and rural workers. Such schemes are usually sponsored by an NGO and operate at community level. These schemes are funded by voluntary

Health Equity Fund is a social-transfer mechanism designed to provide targeted income transfers to the poor for the purpose of paying for health care in the public health system through providers contracted by the equity fund. It is a third-party payer scheme for indigent patients in which a fund is managed at district level by a local agent (usually NGO), supervised by an international NGO, and funded by government and mainly donors (or in some cases through community collections).

Annex 1 Situation Analysis

1.1 Population and health

Cambodia has a population of more than 14 million and a per capita GDP of US$409 (2005). Approximately 85% of the population live in rural areas and are engaged mainly in subsistence agriculture. Approximately 35% of the population lives below the poverty line. Economic growth has averaged 7% per annum in recent years, and the structure of the economy is changing. Commercial agriculture, fishing and forestry account for a third of national income, and strong growth has been evident in industrial sectors including the garment and footwear industries and in tourism. This industrial growth has led to an increase in the number of formal-salaried and informal-sector workers in urban areas. Wages remain low, however, and the income tax system remains under-developed. The anticipated commencement of oil production and other mining activities may expand formal employment opportunities. It is a hope that anticipated revenues from oil production may provide resources for investment in the social sectors including health care.

The National Strategic Development Plan 2006-2010 (NSDP) sets the main priorities for Cambodian strategic development, while the Cambodian MDGs set the indicators and targets to achieve by 2015.

The aims of the HSP 2003-2007 was to strengthen health service delivery, improve access to health services for the poor, improve attitudes of health providers, improve the quality of services, ensure a regular and adequate flow of funds to facilities, strengthen staff skills and capacities, improve the drug supply and expand health information.

While key health indicators have improved in recent years major concerns remain and key health indicators are weaker in Cambodia than in many neighboring countries. As Figure 1 indicates, results from the CDHS 2005 show a considerable improvement in life expectancy and infant and under-5 mortality rates. The maternal mortality rate remains unacceptably high, and child mortality rates are still high compared to other countries in the region. As noted in the CDHS 2005, 37% of children under 5 are stunted and 36% of children are underweight.

NSDP 2006-2010 Priorities in health and connected sectors	CMDG's target by 2015
Poverty reduction	Halve the number of people living below the poverty line
Access to basic education	All children complete nine year basic schooling, gender disparities in primary education eliminated
Gender equality	Reduce gender disparities in secondary and tertiary education, eliminate gender disparities in wage distribution and public institutions
Access to safe drinking water	Halve by 2015 proportion of people without access to safe drinking water and sanitation
	Halve under-five mortality rates, improve DPT3 and measles immunization rates
Reduction of maternal mortality	Reduce maternal mortality to 1/3 of baseline rate, improve access to deliveries assisted by trained birth attendants
Combat HIV/AIDS, malaria and other diseases	Decrease the spread of HIV/AIDS, malaria, dengue fever and TB: Reduce HIV/AIDS prevalence, TB and malaria case fatality rates, improve malaria treatment at facility and TB detection rates

Figure 1. Key health indicators in Cambodia

Only 21.6% of reported episodes of illness are treated in the public sector, where the quality of service delivery remains poor. The constraints on the delivery of quality public health services include inadequate management capacity, low salary levels that in turn create an incentive for different forms of private practice and inadequate skill levels at most health centers and some hospitals. The private health care sector is largely unregulated and of unknown quality; it accounts for 48.2% of treatment episodes. The non-medical sector, with a variety of providers such as drug vendors, traditional and religious healers and birth attendants attract 20.8% of patients.

1.2 Achievements to date

Indicator	CDHS 2000	CDHS 2005
Life Expectancy (years) Female Male	 57 50	 65 60
Infant mortality (per 100 live births)	95	66
Under 5 Mortality (per 1000 live births)	124	83
Maternal Mortality (per 1000 live births)	437	472

Cambodia has made significant progress in the reconstruction of the health sector and the improved delivery of health services to the population in the last two decades. By the mid-1990s Cambodia had already achieved much in developing national health policy and program priorities, re-establishing functioning primary health services through a district-based health system, strengthening national programs aimed at the principal communicable and preventable diseases, and raising the capacity of the health system overall to manage resources and perform basic functions efficiently. Now, under the HCP, a public health infrastructure has been provided across most of the country, a minimum drug supply to public facilities guaranteed through the Central Medical Store and health staff placed in most facilities. The quality of service delivery, however, remains low.

Progress has been made towards the establishment of national health financing systems. The first truly national budget for health care was adopted in 1994 (until then health services were financed through allocations made to provincial governments). In 1995 the Health Coverage Plan was adopted, and in 1996 the Health Financing Charter authorized the collection of user fees at public facilities and helped to reduce the cost of services (by replacing more expensive under-the-table charges) and increasing utilization.

The low utilization of public health services has been a chronic problem. In effect, the inability to provide good quality and affordable public health services created a vacuum that has been filled in different ways by private service delivery. Despite many supply-side reforms, the demand for public health services has often not responded: access to services has been restricted by financial and other barriers and levels of utilization of public services have remained low.

In the past decade, Cambodia has been the site for experimentation with a range of new and interesting initiatives in health systems development. On the supply side, new initiatives have been piloted in health service coverage and in contracting to non-government providers. On the demand side, initiatives have been piloted in community co-financing, health equity funding and community based health insurance.

The different levels of success of these schemes have been well documented in terms of improved service-delivery management, increased quality of service and increased access to services. Most of the schemes have been local initiatives, often supported by NGOs, or have been implemented locally in selected health districts, but have not achieved national coverage (with the exception of the HCP). In terms of health financing, it is significant that demand-side initiatives to relieve the burden of OOP expenditures began with HEF (which is now available in almost half of all health districts) and CBHI (with

more limited coverage) initiatives and only more recently have plans to implement SHI arrangements been developed. The burden of social protection measures has therefore fallen on localized and independent schemes. As in most countries of similar socio-economic status, it is likely that a national coverage of social health insurance and social health protection will be difficult to organize and fund, because of the weak taxation system, constraints on government funding and the dependence on donor resources.

While considerable improvements have been made in health indicators and access to services (including for the poor) in the past five years, these results have largely been achieved with the support of substantial donor input and technical assistance. In the future, this fragmented approach is likely to be both ineffective and unsustainable. There is therefore an over-riding need for a national framework for health financing.

1.3 Health financing

Government budget, donor funding and household spending are the principal sources of financing for health care, but the allocation of resources between these is not optimal. A comprehensive discussion of health financing issues in the period to 2015 is contained in *Scaling* Up for Better Health in Cambodia: A Country Case Study for the Royal Government of Cambodia / World Health Organization / Post-High Level Forum on Health Millennium Development Goals, April 2007, by Christopher Lane.

1.3.1 National health budget

The national health budget is increasing. Following a sharp drop in 2004 the budget has since recovered, and the 2007 budget targeted health spending equivalent to 12% of government recurrent spending and 1.2% of GDP. In nominal terms, budget spending increased from US$2.10 per capita in 2000 to US$5.70 per capita in the 2007 budget. These increases are broadly in line with NSDP objectives.

Budget disbursement has also improved. As a proportion of budget, actual expenditure rose to 95% for the central health budget (including national hospitals, national programs and national drug fund) and to 80-90% for provincial budgets during 2005-06.

However, a large proportion of transfers to provincial health departments are still paid in-kind, and the back-loading of spending remains a significant problem. Disbursements tend to be low in the early months of the year, particularly at the provincial level.

The proportion of public funding reaching the service delivery level is relatively low, and only about one third of the government health budget reaches the primary service delivery level according to 2004 estimates.[1] The low level of public resources reaching the primary health care service delivery level explains both the high level of out-of-pocket payments and the widespread prevalence of private providers.

The budget mainly finances salaries and recurrent costs, including part of essential drugs and medical supplies. In 2007, US$19.5 million of the budget was allocated to the health Public Investment Plan for capital costs, although it is not clear if this is own financed or donor on-budget financed expenditures. Consequently, making health services work effectively to meet MOH goals may require substantial increase in health expenditures on service delivery.

The Public Financial Management Reform Program (PFM) which has been implementing by MEF, will ensure higher standards of management and accountability of public resources for health, starting with government current and capital budget in priority social areas such as health and education sectors.

[1] It is estimated that district hospitals and health centers receive about 18% of the gross health budget and 36% of resources when donor transfers are included.

GOVERNMENT HEALTH EXPEDITURE

YEAR 2003

Chapter	Approved Budget	Mandate	%	Expenditure	%
GRAND TOTAL	202,389,668,000	167,856,706,919	82.94%	157,065,968,415	93.57%
Sub Central	*132,100,000,000*	*109,292,384,664*	*405.52%*	*101,188,104,964*	*92.58%*
10	5,280,000,000	4,437,605,941	84.05%	4,437,605,941	100.00%
11	87,415,000,000	73,095,272,970	83.62%	73,095,272,970	100.00%
31	350,000,000	25,022,800	7.15%	25,022,800	100.00%
32	25,000,000	20,448,600	81.79%	20,448,600	100.00%
12	7,080,000,000	4,516,228,030	63.79%	4,516,228,030	100.00%
PAP13	31,950,000,000	27,197,806,323	85.13%	19,093,526,623	70.20%
Sub Province	*70,289,668,000*	*58,564,322,255*	*83.32%*	*55,877,863,451*	*95.41%*
10	21,769,668,000	17,733,901,026	81.46%	17,733,901,026	100.00%
11	24,090,000,000	19,411,317,743	80.58%	17,201,858,939	88.62%
31	1,230,000,000	401,950,540	32.68%	401,950,540	100.00%
Add13	6,000,000,000	5,974,000,000	99.57%	5,497,000,000	92.02%
PAP13	17,200,000,000	15,043,152,946	87.46%	15,043,152,946	100.00%

YEAR 2004

Chapter	Approved Budget	Mandate	%	Expenditure	%
GRAND TOTAL	226,900,000,000	191,196,122,287	84.26%	185,009,437,239	96.76%
Sub Central	*153,610,000,000*	*132,388,628,336*	*424.92%*	*126,130,182,288*	*95.27%*
10	7,420,000,000	5,370,084,472	72.37%	5,370,084,472	100.00%
11	103,475,000,000	88,747,081,194	85.77%	88,747,081,194	100.00%
31	200,000,000	34,090,700	17.05%	34,090,700	100.00%
32	50,000,000	37,554,650	75.11%	37,554,650	100.00%
12	7,575,000,000	6,302,498,663	83.20%	6,302,498,663	100.00%
PAP13	34,890,000,000	31,897,318,657	91.42%	25,638,872,609	80.38%
Sub Province	*73,290,000,000*	*58,807,493,951*	*80.24%*	*58,879,254,951*	*100.12%*
10	23,860,000,000	18,324,817,330	76.80%	18,358,113,730	100.18%
11	23,785,000,000	19,106,198,461	80.33%	19,206,198,461	100.52%
31	1,245,000,000	397,752,060	31.95%	397,752,060	100.00%
Add13	6,960,000,000	5,671,564,000	81.49%	5,671,564,000	100.00%
PAP13	17,440,000,000	15,307,162,100	87.77%	15,245,626,700	99.60%

YEAR 2005

Chapter	Approved Budget	Mandate	%	Expenditure	%
GRAND TOTAL	240,446,930,000	230,575,855,225	94.06%	224,672,237,312	97.44%
Sub Central	*160,859,990,000*	159,136,038,983	94.06%	*158,307,633,676*	99.48%
10	6,928,000,000	6,390,397,748	92.24%	6,390,397,748	100.00%
11	108,507,000,000	103,398,098,788	95.29%	103,398,098,788	100.00%
31	240,000,000	35,825,565	14.93%	35,825,565	100.00%
32	50,000,000	38,604,340	77.21%	38,604,340	100.00%
12	7,575,000,000	7,283,403,458	96.15%	7,283,403,458	100.00%
PAP13	37,000,000,000	36,016,890,700	97.34%	35,188,485,393	97.70%
Sub Province	*78,510,000,000*	*71,471,174,966*	*91.03%*	*71,366,994,166*	*99.85%*
10	25,044,000,000	21,368,398,792	85.32%	21,368,398,792	100.00%
11	25,466,000,000	23,332,045,745	91.62%	23,332,045,745	100.00%

31	1,000,000,000	517,752,222	51.78%	517,752,222	100.00%
Add13	5,578,000,000	5,413,264,000	97.05%	5,413,264,000	100.00%
PAP13	21,422,000,000	20,839,714,207	97.28%	20,735,533,407	99.50%

YEAR 2006

Chapter	Approved Budget	Mandate	%	Expenditure	%	Chapter	Approved Budget
GRAND TOTAL	261,013,000,000	276,032,840,000	105.75%	261,742,457,013	94.82%	256,391,894,592	97.96%
Sub Central	*176,657,000,000*	*186,043,000,000*	*105.31%*	*179,713,996,948*	*96.60%*	*179,713,996,948*	*100.00%*
10	8,426,000,000	9,812,000,000	116.45%	8,960,727,001	91.32%	8,960,727,001	100.00%
11	88,912,000,000	96,912,000,000	109.00%	93,317,875,563	96.29%	93,317,875,563	100.00%
31	100,000,000	100,000,000	100.00%	39,059,845	39.06%	7,747,805,803	100.00%
32	50,000,000	50,000,000	100.00%	41,563,222	83.13%	69,606,965,514	100.00%
12	7,791,000,000	7,791,000,000	100.00%	7,747,805,803	99.45%	39,059,845	100.00%
PAP13	71,378,000,000	71,378,000,000	100.00%	69,606,965,514	97.52%	41,563,222	100.00%
Sub Province	*84,356,000,000*	*89,989,840,000*	*106.68%*	*82,028,460,065*	*91.15%*	*76,677,897,644*	*93.48%*
10	26,806,000,000	31,456,240,000	117.35%	28,102,433,793	89.34%	27,558,804,813	98.07%
11	48,133,000,000	49,054,600,000	101.91%	44,914,075,282	91.56%	40,228,261,631	89.57%
31	8,210,000,000	8,210,000,000	100.00%	8,209,842,800	100.00%	8,209,842,800	100.00%
Add13	1,207,000,000	1,269,000,000	105.14%	802,108,190	63.21%	680,988,400	84.90%

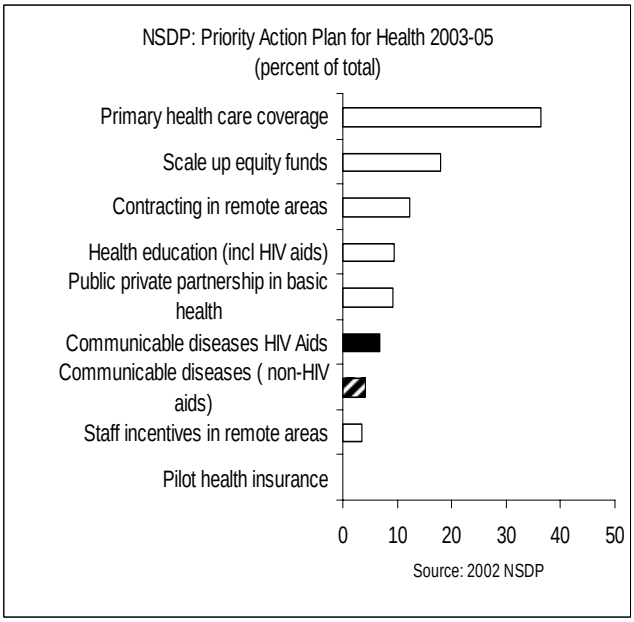
Government health budget Vs Expenditure 2007

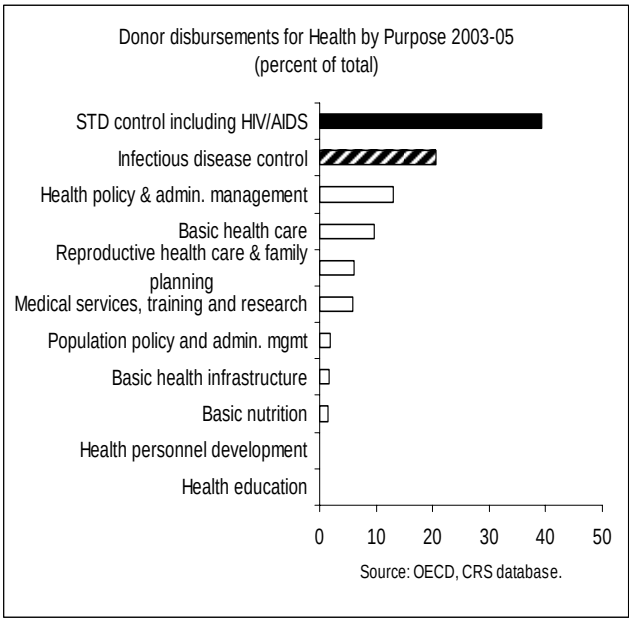
Charpter	Approved Budget by Assembly	Adjusted budget	Requested for commitmen		Committed budget		Requested mandate			Mandated budget			Cash disbursed		
			Amount	%	Amount	%	Amount	%	%	Amount	%	%	Amount	%	%
1	2	3	4	5=4/3	6	7=6/3	8	9=8/3	10=8/4	11	12=11/3	13=11/6	14	15=14/3	6=14/1
Grand total	**336,926,000,000**	**361,079,021,000**	**349,506,893,358**	**96.8%**	**347,639,527,990**	**96.3%**	**341,165,557,492**	**94.5%**	**97.6%**	**341,165,557,492**	**94.5%**	**98.1%**	**338,107,786,630**	**93.6%**	**99.1%**
Sub Central	**238,576,000,000**	**262,729,021,000**	**255,135,658,733**	**97.1%**	**253,497,291,783**	**96.5%**	**247,060,338,468**	**94.0%**	**96.8%**	**247,060,338,468**	**94.0%**	**97.5%**	**247,060,338,468**	94.0%	100.0%
None- Program Budget															
sum	**218,231,000,000**	**242,384,021,000**	**236,473,869,311**	**97.6%**	**234,975,451,311**	**96.9%**	**228,721,478,405**	**94.4%**	**96.7%**	**228,721,478,405**	**94.4%**	**97.3%**	**228,721,478,405**	94.4%	100.0%
60	56,303,000,000	59,017,800,000	58,403,120,414	99.0%	58,327,961,136	98.8%	58,167,081,033	98.6%	99.6%	58,167,081,033	98.6%	99.7%	58,167,081,033	98.6%	100.0%
61	9,493,000,000	8,189,600,000	7,638,130,463	93.3%	7,600,881,103	92.8%	7,453,375,888	91.0%	97.6%	7,453,375,888	91.0%	98.1%	7,453,375,888	91.0%	100.0%
62	15,983,000,000	12,879,400,000	10,745,635,688	83.4%	10,715,421,556	83.2%	10,633,862,794	82.6%	99.0%	10,633,862,794	82.6%	99.2%	10,633,862,794	82.6%	100.0%
63	86,000,000	86,000,000	83,307,000	96.9%	83,307,000	96.9%	83,307,000	96.9%	100.0%	83,307,000	96.9%	100.0%	83,307,000	96.9%	100.0%
64	13,100,000,000	13,369,040,000	11,956,973,861	89.4%	11,953,223,661	89.4%	11,953,223,661	89.4%	100.0%	11,953,223,661	89.4%	100.0%	11,953,223,661	89.4%	100.0%
65	123,266,000,000	148,842,181,000	147,646,701,885	99.2%	146,294,656,855	98.3%	140,430,628,029	94.3%	95.1%	140,430,628,029	94.3%	96.0%	140,430,628,029	94.3%	100.0%
Program Budget															
sum	**20,345,000,000**	**20,345,000,000**	**18,661,789,422**	**91.7%**	**18,521,840,472**	**91.0%**	**18,338,860,063**	**90.1%**	**98.3%**	**18,338,860,063**	**90.1%**	**99.0%**	**18,338,860,063**	90.1%	100.0%
60	2,317,000,000	2,317,000,000	2,154,822,000	93.0%	2,143,612,000	92.5%	2,130,330,000	91.9%	98.9%	2,130,330,000	91.9%	99.4%	2,130,330,000	91.9%	100.0%
61	581,000,000	581,000,000	568,709,400	97.9%	540,320,000	93.0%	451,048,963	77.6%	79.3%	451,048,963	77.6%	83.5%	451,048,963	77.6%	100.0%
62	6,152,000,000	6,152,000,000	4,663,554,022	75.8%	4,564,190,472	74.2%	4,483,963,100	72.9%	96.1%	4,483,963,100	72.9%	98.2%	4,483,963,100	72.9%	100.0%
65	11,295,000,000	11,295,000,000	11,274,704,000	99.8%	11,273,718,000	99.8%	11,273,518,000	99.8%	100.0%	11,273,518,000	99.8%	100.0%	11,273,518,000	99.8%	100.0%
Sub Province	**98,350,000,000**	**98,350,000,000**	**94,371,034,625**	96.0%	**94,142,236,207**	95.7%	**94,105,219,024**	95.7%	99.7%	**94,105,219,024**	95.7%	100.0%	**91,047,448,162**	92.6%	96.8%
60	28,275,000,000	28,275,000,000	26,895,289,146	95.1%	26,815,221,166	94.8%	26,786,958,733	94.7%	99.6%	26,786,958,733	94.7%	99.9%	26,558,980,719	93.9%	99.1%
61	16,410,000,000	16,410,000,000	15,229,527,764	92.8%	15,191,276,776	92.6%	15,183,954,776	92.5%	99.7%	15,183,954,776	92.5%	100.0%	14,005,834,676	85.3%	92.2%
62	11,476,000,000	11,476,000,000	9,177,907,144	80.0%	9,141,909,344	79.7%	9,141,909,344	79.7%	99.6%	9,141,909,344	79.7%	100.0%	8,775,247,544	76.5%	96.0%
64	38,318,000,000	38,318,000,000	39,274,040,271	102.5%	39,240,002,051	102.4%	39,240,002,051	102.4%	99.9%	39,240,002,051	102.4%	100.0%	37,992,113,103	99.1%	96.8%
65	3,850,000,000	3,850,000,000	3,788,610,300	98.4%	3,748,166,870	97.4%	3,746,734,120	97.3%	98.9%	3,746,734,120	97.3%	100.0%	3,709,612,120	96.4%	99.0%
63	21,000,000	21,000,000	5,660,000	27.0%	5,660,000	27.0%	5,660,000	27.0%	100.0%	5,660,000	27.0%	100.0%	5,660,000	27.0%	100.0%

1.3.2 Donor funding

Donor finance exceeds the government budget for health (a total of $114 million in 2005, equivalent to about $8 per capita compared to public current health spending of $4 per capita). In recent years the financial level of donor funding for health has been increasing (partly due to the depreciating value of the US dollar). There was a sharp increase in donor funds in 2002-04 from the US, Japan, UK and the Global Fund; there was a further increase in 2005 particularly from the Global Fund.

Donor coordination, harmonization and alignment are critical issues. Donor funding comes from a diverse range of multi-lateral and bi-lateral sources and a large number of international NGOs and is delivered mainly through a project approach. There has so far been only limited alignment of donor programs with Cambodian institutions and procedures, according to the 2006 OECD harmonization and alignment baseline survey, which identified at least nine different 'project implementation units' in the health sector.





Donor financing is not closely aligned with national priorities as set out in the HSP, but a number of donors have supported a program-based approach in health sector through SWiM and in the implementation of HIV/Aids assistance.

By devolving budget control and management closer to service delivery public-sector reforms supporting deconcentration and public finance management reform will address transparency and accountability issues. Better tracking and accountability, as envisaged in the second Platform of the PFM reform (2007-09) will in turn set the stage for channeling donor finance through the budget and addressing harmonization and alignment problems with donor finance.

Estimated Donor Disbursements for Health, 2003 and 2005 (US$ millions)

Donors		2003*	2005**
Multilateral		**25.4**	**23**
UN		16.9	15.7
UNFPA		3.1	1.8
UNICEF		4.1	6.6
WFP support to MCH		1.1	1.8
WHO		4.3	2.7
UNDP		0.7	2.7
UNAIDS			0.1
ADB		1.5	3.6
WB		3.1	1.2
EC		3.8	2.4
Global Health Partnerships		**7.7**	**21**
GAVI		1.2	2.2
GFATM		6.5	18.8

Donors		2003*	2005**
Bilateral		**46.9**	**65.3**
Australia		1.3	0.6
Belgium		1.4	1.7
Canada		1	
UK		6	12.8
France		1	5
Germany		1.2	3.6
Japan		7.6	11.1
Korea		0.1	1.2
Netherlands			0
Norway		0.3	0
Switzerland			2.2
US		26.9	27.1
NGO		**3.6**	**4.9**

	2003*	2005**
Total	**83.5**	**114.2**

* Source Michaud (2005),
** Source: Cambodia Center for Development Cooperation,
OECD DAC Creditor Reporting System and GAVI and Global Fund websites

1.3.3 Household health spending

It is estimated that 67% of total health spending in 2005 came from households in the form of OOP payments. Out-of-pocket payments are made as user fees to public and private providers, payments to government staff working privately and the direct purchase of medicines from pharmacies and drug sellers. Approximately three-quarters of this OOP health expenditure is financed by cash in hand and savings and one-quarter by gifts, borrowing and asset sales.

In 2006, a study by Catherine Michaud (for the Macroeconomics and Health initiative) estimated that little more than 40% of total health expenditure flowed into the public sector with almost 60% to private providers. It was also estimated that, out of the total household OOP expenditure on health care, about 30% went to public health services and about 70% to private providers. To some extent, this dependence on private services reflects distrust in the public health system. But expenditure figures must be disaggregated against income levels to reveal a truer picture. Much of the private spending on health care comes from higher-income groups while poorer households either rely on government services or are excluded from care because of cost.

The introduction of official user fees at public facilities in 1996 was an attempt to regulate unofficial charges in a situation where under-the-table payments were common and expensive and to provide additional revenue to facilities to supplement low government salaries. Official fees were set at a level considered affordable to most people, and the introduction of official fees effectively lowered the costs of access to health services and increased utilization at most government health centers and some referral hospitals. However, the distribution of these gains was not uniform across income groups.

While the official user fees system also introduced a process of exemptions for the very poor, in practice the proportion of patients receiving exemptions remained very low. This occurred mainly because the cost-recovery policy did not foresee that the absence of any mechanism to fund the exemptions would lead to a

situation in which few exemptions were actually granted. Consequently, user fees remained a major barrier for the poor.

Private spending on health care exhibits very limited risk pooling, making the poor particularly vulnerable to the expenses incurred during ill health. A consequence of high OOP expenditures and limited risk-pooling is considerable inequality in health outcomes by income level. For example, the under-five mortality rate for the bottom two wealth quintiles is three times the rate for the highest quintile. In fact, the Cambodian MDG for U5M (65 deaths per 1,000 live births) has already been achieved by the richest quintile while the remainder of the population remain far away from it.

The effects of OOP on impoverishment of households are demonstrated in several studies on debt for health and landlessness[2]. Consequently, there is a crucial need for social health protection measures, particularly for the poor. Health equity funding emerged in 2000 in response to this situation as a means to fund fee exemptions at public facilities for the identified poor. Similarly, community-based health insurance emerged at the same time as a pre-payment mechanism designed to protect the not so poor from impoverishment due to health costs, particularly catastrophic health expenditures.

1.4 Institutional framework

1.4.1 Public Financial Management Reform Program

The Public Financial Management Reform Program (PFM) implemented by MEF aims "to install much higher standards of management and accountability in the mobilization of all government current and capital resources and effectiveness and efficiency in the use of resources in their application […]". The PFM reform is sequenced in 4 platforms: (i) A more credible budget; (ii) effective financial accountability; (iii) Affordable and prioritized policy agenda; (iv) Managers fully accountable for program performance.

Platform 1 is being currently implemented with the following activities:

- Improve comprehensiveness of and integration of budget formulation and execution
- Improve realism and sustainability of budget
- Streamline ability of budget holders to spend in line with budget
- Avoid re-accumulation of payment arrears
- Improve process for post-budget supplementary expenditure credit approval
- Develop revised procurement procedures
- Capacity development measures
- Motivational measures within MEF and line ministries
- Integration of functions within MEF

1.4.2 Policy on Public Service Delivery

The Policy on Public Service Delivery applies to services of social affairs that include health and sanitation. The policy prescribes that public administration has to (i) Ensure accessibility to services; (ii) Focus on the real needs of consumers; (iii) Provide services where needed; (iv) Be transparent and accountable; (v) Ensure quality, efficiency and effectiveness of services.

[2] An Oxfam study in 2000 showed that 60% of households who sold productive land did so to cover for health care costs. A case study among urban poor population (Center for Advanced Studies 2006) analyze indebtness as a result of health care costs. A survey among garment factory workers (GRET 2007) also shows health care as a cause of debt.

Implementation mechanisms for the policy rely on One-Window Office, and deconcentration and decentralization of public services, in line with the strategic framework on decentralization and deconcentration reform adopted in 2005.

1.4.3 Health Coverage Plan

According to the 1996 HCP, there are 76 ODs, 69 Referral Hospitals and 966 HCs across Cambodia. Referral hospital are classified into three categories in providing CPA services (CPA1, CPA2 and CPA3) while HCs are mandated to provide MPA service. Until now there are 77 ODs, 22 CPA1, 32 CPA2 and 18 CPA3 and 877 MPA HCs are functioning and also 95 Health Posts have been established to provide basic health care in remote areas. However, most public health facilities remain underutilized by a public that often prefers the formal and informal private sector where quality of services is perceived as being higher than in public facilities.[3]

1.4.4 Health Financing Charter

Since 1996 the HFC has authorized the collection of user fees for services provided through public health facilities. User fees are implemented and administered by the health facilities themselves following approval by the MOH. Regulations provide that user fees will be implemented in consultation with the community and local authorities by taking into account consumer needs and affordability, drug, supplies and equipment costs, and allowances to staff, and once a user-fee scheme is approved and put into operation all other forms of user fees previously implemented shall be stopped, in particular 'under-the - table payment'.

Following a 2005 the MOH and the MOEF's Inter-Ministerial Prakas, income from user fees at facilities has been allocated 60% to the facility for staff incentives, 39% for operating costs and 1% paid as tax to the treasury. User fees remain a minor proportion of facility revenues but play a significant role in financing additional incentives for staff and non-salary operational costs of health facilities. In 2004, user fees accounted for 13% of HC and 22% RH operational expenses. According to the AOP 2007, user fees will finance up to US$5 million out of planned MOH recurrent spending (including loan funds and NGO contributions) of US$80 million.

An Inter-Ministerial Prakas in 2006 allows government funds to be used within the framework of MOH credit budgets for paying user fees on behalf of poor patients, but fee-exemption schemes at health facilities have not worked adequately to protect the poor or provide sufficient access to services, mainly because these fee-exemptions have not been funded. Until now there are 67 Referral Hospitals, 793 HCs, 6 Natinoal Hospitals and 3 Health Institutes are officially implementing user fee.

1.4.5 Contracting

The contracting of public health service delivery to non-government providers (generally international NGOs) began with pilot schemes in 1999. In 2004 the MOH introduced a second phase of Contracting in 11 ODs under the Health Sector Support Project (HSSP). Contracting is not strictly a form of health financing but aims at better management of services.

Contracting has strengthened facility management in these districts and helped to increase facility utilization. Contracting contributes to better staff remuneration and incentives and works to improve access to services and key service delivery indicators (like immunization levels). Contracting is commonly associated with user fees for service and often with health equity funding schemes. Contracting arrangements have recently been reviewed under the HSP Review process.

Among other forms of contracting of services used in Cambodia are performance-based contracts used by bilateral and multilateral donors and other donors with various health units (such as a Provincial Health Department or OD Office).

[3] In fact the quality of private health providers has never been assessed and is not monitored. Health seeking behavior is determined by a lack of trust in public facilities and perceived higher quality of private providers, The situation is aggravated by health workers dual public and private practice.

Recent positions of the MOH indicate phasing out of contracting in its current form and shifting to internal contracting.

Contracting ODs by Provinces

No	Province	Effective date contract	End date contract	Source of fund	Contract amount	National Budget extimate per year
1	**Kampong Cham**			HSSP/ADB/DFID	$2,239,262.00	
	OD Memut	April 1, 2004	December 31, 2007			$208,569.10
	OD Ponhea Krek-Dambe					$325,456.00
2	**Prey Veng**			HSSP/ADB/DFID	$2,066,400.00	
	OD Pearaing	April 1, 2004	December 31, 2007			$346,958.40
	OD Preah Sdach					$204,539.20
3	**Mondulkiri**			HSSP/ADB/DFID	$947,600.00	
	OD Sen Monorom	April 1, 2004	December 31, 2007			$82,506.60
4	**Takeo**			HSSP/ADB/DFID	$2,543,780.00	
	OD Kirivong	May 1, 2004	December 31, 2007			$401,848.00
	OD Ang Rokar					$208,360.00
5	**Rattanakiri**			HSSP/ADB/DFID	$1,468,500.00	$215,046.00
	OD Banlong	October 1, 2004	December 31, 2007			
6	**Koh Kong**			HSSP/ADB/DFID	$1,392,757.00	
	OD Smach Meanchey	January 1, 2005	December 31, 2007			$120,061.80
	OD Sre Ambel					$157,440.60
	Sub Total				**$10,658,299.00**	**$2,270,785.70**
7	Preah Vihear					
	OD Thbeng Meanchey	April 1, 2005	December 31, 2007	HSSP/WB/DFID	$1,337,551	$302,263.20
	Grand Total				**$11,995,850.00**	**$2,573,048.90**

1.4.6 HEF national framework

Health Equity Funds are an informal social-transfer mechanism designed to subsidize health facilities for the costs of user-fee exemptions provided to the poor. Poor patients receive free or discounted care at public facilities. The poor are identified according to eligibility criteria and the HEF reimburses the public health care providers for the cost of services provided, and it reimburses poor patients for the costs of transport and food during hospitalization.

Currently, HEFs are decentralized schemes commonly based in a single OD; they are donor-funded and mostly implemented through international and local NGOs (in a few cases the HEF is implemented through local community organizations, Pagodas or Hospital-based committees). Since their beginning in Cambodia in 2000, the number of HEF schemes has grown rapidly to cover now almost half of all health ODs. While conditions vary widely between ODs, HEFs on average fund exemptions for approximately a third of referral-hospital patients where a scheme is available, roughly the same level as the proportion living below the poverty line on average.

The 2006 Study of Financial Access to Health Services for the Poor in Cambodia Phase 1 (for the Ministry of Health, WHO, AusAID and RMIT University) found that HEF significantly increased utilization of facilities, successfully targeted the poor, provided access for the poor who previously could not attend due to cost, reduced debt and interest payments for health care, reduced the impact of health costs on impoverishment, and provided a needed subsidy to facilities.

In 2005, the MOH adopted the National Equity Fund Implementation and Monitoring Framework to coordinate the work of the various independent HEFs. The MOH regards HEF as a primary initiative to help the poor population with access to quality public health services. The Implementation and Monitoring Framework offers a partnership with donors and NGOs to establish a uniform monitoring and reporting process, with guidelines for pre-identification of beneficiaries and a common schedule of benefits. The Framework was supplemented with an HEF reporting and monitoring system developed in 2007 by the Bureau of Health Economics and Financing of the DPHI.

The MOH intends to accept greater responsibility for the funding, implementation and management of HEF schemes. The JAPR 2006 proposed that the number of HEF schemes be increased from 16 to 35 in non-Contracting ODs and continue in all 11 Contracting ODs through the HSSP (reaching a total of 46 out of all 77 ODs). It proposed to increase HEF coverage of the poor, increase the proportion of health

facilities offering HEF and improve HEF information systems. Expansion of HEF coverage was endorsed by the 2006 HSSP Mid-Term Review

The actual impact of HEF on overall out of pocket spending may however be limited for the following reasons: 1) many HEF cover only referral hospital care, 2) post-identification mechanism in place in many ODs is not very effective in informing the population about their entitlements and 3) a large proportion of the population still prefers private health services not covered by HEF.

Health Equity Fund Schemes by Operational District

# of OD and Hosp.	Province	Health Operational District	Facility	Donor	INGO	LNGO	HEF began	At RH	IPD y/n	OPD y/n	At HC
	HEF schemes supported by NGOs										
1	Banteay Meanchey	Mongkul Borei	Provincial Hospital	USAID	URC	CFDS	6/2003	Yes	Yes	Yes	No
2	Banteay Meanchey	Thmar Pouk	Referral Hospital	CIDA	MSF/HNI	CAAFW	5/2000	Yes	Yes	No	No
3	Battambang	Mung Russei	Referral Hospital	USAID	URC	AFH	7/2004	Yes	Yes	No	No
4	Battambang	Sampov Luon	Referral Hospital	USAID	URC	AFH	8/2006				
5	Kampong Cham	Chamkar Leu-S.Treng	Referral Hospital	BTC	BTC	AHRDHE	12/2005	Yes	Yes	Yes	No
6	Kampong Cham	Cheung Prey-Batheay	Referral Hospital	BTC	BTC	AFH	11/2005	Yes	Yes	Yes	No
7	Kampong Cham	K. Cham-K. Siem	Provincial Hospital	BTC	BTC	AFH	9/2005	Yes	Yes	Yes	No
8	Kampong Cham	Prey Chhour-Kong Meas	Referral Hospital	BTC	BTC	AFH	1/2006	Yes	Yes	Yes	No
9	Kampong Thom	Kampong Thom	Referral Hospital	HSSP	GTZ	AFH	10/2005	Yes	Yes	No	No
10	Kratie	Chhlong	Referral Hospital	USAID	URC	AFH	6/2004	Yes	Yes	No	No
11	Kratie	Kratie	Referral Hospital	USAID	URC	AFH	8/2006				
12	Mondulkiri	Sen Monorom	Provincial Hospital	HSSP	HNI	CFDS	10/2002	Yes	Yes	No	Yes
13	Odar Meanchey	Samrong/Anlong Veng	PH and HC	BTC	BTC	CHHRA	1/2005	Yes	Yes	Yes	Yes
14	Phnom Penh	Municipality (4 ODs)	Municipal RH	USAID	URC	USG	8/2000	Yes	Yes	Yes	Yes
15	Preah Vihear	Thbeng Meanchey	Referral Hospital	HSSP	HU		2006.08	Yes	Yes	Yes	No
16	Prey Veng	Peareang	Referral Hospital	HSSP	HNI	AFH	7/2002	Yes	Yes	No	Yes
17	Prey Veng	Preah Sdach	Referral Hospital	HSSP	HNI	AFH/RHAC	7/2002	Yes	Yes	No	No
18	Pursat	Sampeov Meas	Provincial Hospital	USAID	URC	CFDS	7/2003	Yes	Yes	Yes	No
19	Rattanakiri	Rattanakiri-Banlong	Provincial Hospital	HSSP	HNI	AFH	12/2004	Yes	Yes	No	No
20	Siem Reap	Siem Reap PH	Provincial Hospital	BTC	BTC	CHHRA	2/2005	Yes	Yes	Yes	No
21	Siem Reap	Sotnikum	RH and HC	BTC	BTC	CFDS/CHHRA	9/2000	Yes	Yes	Yes	Yes
22	Siem Reap	Kralanh	RH	BTC	BTC	CHHRA	4/2006	Yes	Yes	Yes	No
23	Sihanoukville	Sihanouk	Referral Hospital	USAID	URC	RHAC	7/2006	Yes	Yes	Yes	No
24	Stung Treng	Stung Treng	Provincial Hospital	VSO	VSO	Hospital	1/2005	Yes	Yes	Yes	No
25	Svay Rieng	Svay Rieng PH	Provincial Hospital	UNICEF	UNICEF	EFS Cttee	7/2002	Yes	Yes	Yes	No
26	Takeo	Ang Roka	Referral Hospital	EU	SRC/HNI	AFH	4/2005	Yes	Yes	No	No
27	Takeo	Kirivong	Referral Hospital	EU	SRC/HNI	BFH	1/2005	Yes	Yes	No	No
28	Takeo	Kirivong	Health Centers	CIDA	EED/SRC	Pagodas	5/2003	No	No	No	Yes
29	Takeo	Takeo PH (Daun Keo)	Provincial Hospital	SRC	SRC	CFDS	5/2005	Yes	Yes	Yes	No
	Districts supported by MOH										
30	Kampong Chhnang	Kampong Chhnang		RGOC	MOH	ODO	6/2007				
31	Kampong Speu	Kampong Speu		RGOC	MOH	ODO	6/2007				
32	Kampot	Angkor Chey		RGOC	MOH	ODO	6/2007				
33	Kampot	Kampong Trach		RGOC	MOH	ODO	11/2006				
34	Kandal	Ksach Kandal		RGOC	MOH	ODO	6/2007				
35	Kandal	Takhmao		RGOC	MOH	ODO	6/2007				
36	Prey Veng	Kampong Trabek		RGOC	MOH	ODO	6/2007				
37	Svay Rieng	Romeas Hek		RGOC	MOH	ODO	6/2007				
38	Takeo	Daun Keo		RGOC	MOH	ODO	6/2007				
39	Pailin	Pailin		RGOC	MOH	ODO	6/2007				

	National hospitals supported by MOH										
40	National Hospital	Ang Doung		RGOC	MOH	Hospital	2007				
41	National Hospital	MCH		RGOC	MOH	Hospital	2007				
42	National Hospital	Calmette		RGOC	MOH	Hospital	2007				
43	National Hospital	Preah Kossamak		RGOC	MOH	Hospital	2007				
44	National Hospital	National Paediatric		RGOC	MOH	Hospital	2007				
45	National Hospital	Kampuchea-Soviet		RGOC	MOH	Hospital	2007				

1.4.7 CBHI guidelines

A number of community-based health insurance schemes have been introduced in various parts of the country by a range of international and local NGOs. Following the formulation and launch of the Social Health Insurance Master Plan in 2005 (see next section), the MOH produced guidelines for CBHI implementers.

CBHI is based on the principle of risk pooling and pre-payment for health care. CBHI is a private, non-profit, voluntary insurance mechanism based on the sale of low-cost insurance premiums that provide the purchaser and their family with coverage for health charges for a stated list of medical benefits delivered at contracted public health facilities (generally health centers and referral hospitals). The CBHI scheme pays the contracted facility for the cost of services delivered to its members.

CBHI coverage is currently offered through six schemes by five international and local NGOs working in seven ODs nationally, with a total of approximately 30,000 beneficiaries. All the schemes are supported by external premium subsidies or funding for administration provided by the sponsoring NGOs and other donors. The JAPR 2006 proposes to expand the number of CBHI schemes and to increase the membership of existing schemes.

The MOH has adopted Guidelines for Implementing CBHI prepared by the DPHI in 2006. The Guidelines provide for a common approach to the administrative and technical requirements, basic benefit package, and portability between different CBHI schemes. Formal regulations for CBHI implementation are to be introduced through the Draft Sub-Decree on Micro Insurance prepared by the MOEF. All companies and NGOs who want to implement CBHI must register with MOEF by submitting a financial plan they have obtained a Certificate of Recognition for the CBHI scheme from the MOH.

Operational District with Community Based Health Insurance (CBHI)

PHD_Code	PHD_Name	OD_Name	OD population	Pupulation Covered	Type	Starting	Source	Implementers	Health Facility Types	Benefit	Payment Mechnism
1	Banteay MeanCheay	Thma Puok	130,621	25,341	CBHI	Feb-05		CAAFW	1 RH & 8HCs	OPD & IPD	Case based payment
2	Kampong Thom	Kampong Thom	290,443	565	CBHI	2007	GTZ/GRET	GRET/SKY	RH	IPD	Capitation
3	Kandal	Koh Thom	153,694	565	CBHI	1998		GRET/SKY	HC Rolous	OPD	Capitation
4	Phnom Penh	Municiplity		2,417	CBHI	2005		GRET/SKY	RH	IPD	Capitation
5	Pursat	Sampov Meas	296,792	1,257	CBHI	Aug-06		RACHA	1RH and 1 HC	OPD & IPD	Capitation
6	Takeo	Ang Rokar	129,466	5,774	CBHI	2001	AFD/GRET	GRET/SKY	2 RHs & 9HCs	OPD & IPD	Capitation
7	Takeo	Kirivong	221,942	1,335	CBHI	Apr-06	SRC/GRET	BFH	2 RH and 8HCs	OPD & IPD	Capitation
8	Takeo	Kirivong		1,166	CBHI	2003		GRET/SKY	RH &HC	OPD & IPD	Capitation
9	Ordor Mean Cheay	Samraong	102,835	1,386	CBHI	Aug-05		CHHRA	2 HCs	OPD	Case based payment
	Total			39,806							

Abbreviations:

Con	Contracting
HEF	Health Equity Fund
CBHI	Community Based Health Insurance
CAAFW	Cambodian Association for Assistance to Families and Widows
CFDS	Cambodian Family Development Services
CHHRA	Cambodian Health and Human Rights Alliance
CIDA	Canadian International Development Agency
EFS	Equity Fund Steering committee
EU	European Union
GRET	Groupe de Recherche et d'Echanges Technologiques
HSSP	Health Sector Support Project, funded by the ADB, WB and DFID
SKY	Soka Pheap Kruosa Yeung
BTC	Belgian Technical Cooperation
GTZ	German Technical Cooperation
HNI	Health Net International
URC	University Research Company
SRC	Swiss Red Cross
UNICEF	United Nation
VSO	Volunteer Services Overseas
HU	Health Unlimited

Source: Based on MOH, Bureau of Health Economics; Annear et al. 2006. *Study of Financial Access to Health Services for the Poor in Cambodia – Phase 1: Scope, Design and Data Analysis*. Phnom Penh: MOH, WHO, AusAID, RMIT University (Melbourne).

1.4.8 SHI Master plan

In 2005, the MOH adopted the Master Plan for Development of Social Health Insurance and an inter-ministerial Social Health Insurance Committee was established between the MOH, MOLVT, MOSVY, MOP, MOEF and the Council of Ministers.

The Master Plan covers compulsory social health insurance through the social security framework for public and private sector salaried workers and their dependents, voluntary insurance through the development of CBHI schemes sponsored by different development partners, local NGOs and health care providers for the informal employment sector and social assistance schemes including health equity funds and other funds proposed by government for the poor.

The MOLVT is responsible for the development of compulsory social security and health insurance for private-sector salaried workers under the Social Security Law of 2002 (which authorized the establishment of the Social Security Organization), including the provision of a work injury program and old age pensions; health care will be added in the next phase (after 2009), following the establishment of the National Social Security Fund.

The MOSVY is responsible for the development of social security for civil servants and is developing a sub-decree on the provision of pensions, occupational injury and other benefits including maternity and sick leave. MOSVY is also looking into development of a sub-decree on medical benefits to provide a legal basis for a pilot scheme in social health insurance for Ministry employees in Phnom Penh.

1.5 Lessons learned and challenges

From the situation analysis a number of lessons can be drawn:

- While the health status of the population is improving key health indicators are weaker than in neighboring countries.
- Because per capita total national health expenditure is very high compared to all other developing countries **the total quantity of health financing does not appear to be the central impediment to achieving improved health outcomes**.
- Important issues relating to the economic allocation of existing resources and their efficient use remain unresolved.
- While government funding for health care is a significant proportion of the national budget the health budget remains low in absolute terms; **strengthening government taxation and revenue collection is essential.**
- The relatively low proportion of public funding reaching the service delivery level largely explains the high level of out-of-pocket payments which in turn leads to considerable inequality in access to services and health outcomes. **Strengthening the efficient allocation of appropriate levels of resources to the service delivery level is a priority**.
- Because service quality is poor only one in five illness episodes are treated in the public sector. **There is a need to move aggregate resources from inefficient and ineffective private providers to an efficient public health system**.
- The provision of health care mainly through the private sector funded through private out-of-pocket payments by households will continue until 2015 even though the quality of care obtained through private providers is generally low. The dependence on OOP spending for health care means that **the implementation of social health protection measures is crucial**.
- Different health financing schemes are in place but they are not consistent and not integrated into a single plan. **Strengthening Contracting, HEF, CBHI and integrating them in a coherent plan are an immediate need**.

While it is substantial, external aid for health is highly fragmented and not closely aligned with national health priorities. **Better donor-government coordination, harmonization and alignment are crucial.**

Annex 2: References

The following documents were consulted in the preparation of the Strategic Framework:

- Annual Operational Plan 2007 (MOH)
- Cambodia Demographic and Health Survey (MOH, MOP, December 2006)
- Cambodia Health PETS (World Bank)
- Cambodia Millennium Development Goals Report 2003, Department of Planning
- Declaration by the RGC and Development Partners on Enhancing Aid Effectiveness (October 2006, Phnom Penh)
- Draft Sub-decree on Micro Insurance Business (Version 1)
- External Resource Flows to the Health Sector in Cambodia (May 2005, Catherine M. Michaud, WHO)
- Guidelines for Implementing CBHI (DPHI/MOH in collaboration with WHO and GTZ, June 2006)
- Guidelines for Managing Central Level Health Financing (DPHI, MOH 2006, disseminated on 7 February 2007)
- Guidelines for Managing Provincial Health Financing (DPHI, MOH 2006, disseminated on 7 February 2007)
- Guidelines for the Preparation of a Pilot Program Budgeting (Budget Department, MEF, 31 May 2006)
- Health Financing Charter (May 2006, MOH in collaboration with WHO)
- Health Financing Revisited – A Practitioner's Guide, World Bank, 2006
- Health Sector Strategic Plan 2003-2007 (Volume 1, August 2002)
- HEF Reporting and Monitoring System (developed the Bureau of Health Economics and Financing of the DPHI/MOH 2007)
- HSSP Mid-Term Review Report (2003 – June 2006, October 1, 2006, MOH)
- Inter-Ministerial Prakas on Permission for Health Facilities to Provide Consultation and Treatment Services for Patients with Some Charges (signed by ministers of Health and Economy and Finance on October 11, 2005)
- Inter-ministerial Prakas on the Principle of Paying for Poor Patients (MOH, MEF, 13 October 2006)
- Joint Annual Performance Review
- Law on Social Security Schemes for Persons Defined by the Provisions of the Labour Law

- Master Plan for Social Health Insurance in Cambodia (Prepared in collaboration with WHO, December 2003)
- Merit Based Pay Initiative - Institutional Development and Incentives for Better Healthcare - Proposal for MOH Merit Based Pay Initiative
- National Equity Fund Implementation and Monitoring Framework (September 2005)
- National Strategic Development Plan 2006-2010 (Draft 8 November 2005)
- Papers on Macroeconomics and Health (Prepared by Technical Advisory Group on Macroeconomics and Health, Ministry of Health, Ministry of Economy and Finance, Ministry of Planning in collaboration with WHO and Columbia University, New York, September 2006)
- Paris Declaration on Aid Effectiveness – Ownership, Harmonization, Alignment, Results and Mutual Accountability, Joint Progress Toward Enhanced Aid Effectiveness, High Level Forum (Paris February 28 to March 3 2005)
- Procedures for Identification of Poor Households in Cambodia (Version 1, for 2007 Rounds 1a and 1b, Last update: 12 September 2006)
- Public Financial Management Reform Program - Strengthening Governance through Enhanced Public Financial Management (MEF, Volume 1, December 2004)
- Scaling Up for Better Health in Cambodia - A Country Case Study for the Royal Government of Cambodia, World Health Organization, Post-High Level Forum on Health Millennium Development Goals (Chris Lane, April 2007)
- Strategic Framework for Decentralization and Deconcentration Reforms (Royal Government of Cambodia, 17 June 2005)
- Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions 2006-2010 (WHO Western Pacific Region, South-East Asia Region)
- Study of Financial Access to Health Services for the Poor in Cambodia (for the Ministry of Health, WHO, AusAID and RMIT University, 30 April 2006, Phnom Penh).