KINGDOM OF CAMBODIA

NATION – RELIGION - KING

ANNUAL HEALTH FINANCING REPORT 2012

BUREAU OF HEALTH ECONOMICS AND FINANCING

DEPARTMENT OF PLANNING AND HEALTH INFORMATION

MARCH 2013

FOREWORD

The Annual Health Financing Report is developed by the Bureau of Health Economics and Financing, Department of Planning and Health Information of the Ministry of Health. The-report gathers and analyses health financing information on both budget and expenditures by different sources of financing to the health sector. Those sources include the Government funding, external assistance, Out-of-Pocket spending, User Fees, Health Equity Fund, Voucher Scheme and Voluntary Health Insurance, as well as other health financing schemes that are currently available in Cambodia.

The development of this report is mainly based on a routine facility-based reporting, while other financial information is collected from other related documents.

The Ministry of Health would like to thank Provincial Health Departments, National Hospitals and Institutions as well as Health Equity Funds, Voucher and Voluntary Health Insurance Schemes (operators) and others for their technical input and contribution to the production of this report.

We much appreciate the support of the World Health Organization in the production of this report, and sincerely thank the Department of Planning and Health Information, particularly the Bureau of Health Economics and Financing for its efforts to produce this report.

We hope that the-Annual Health Financing Report 2012 will provide comprehensive updated health financing information and it will be a useful document to support the improvement and development of health sector financing in the future.

Phnom Penh, 25 March 2013

Prof. Eng Huot
Secretary of State for Health

ACKNOWLEDGEMENTS

Special thanks go to Mr. RosChhunEang, Chief of the Bureau of Health Economics and Financing, Department of Planning and Health Information, Ministry of Health, for his tireless effort in collecting data and writing this report. And sincere thanks also go to staff of the Bureau of Health Economics and Financing, the Department of Planning and Health Information for their contribution to this publication.

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Sincere appreciations also go to concerned Departments, especially Department of Budget and Financing, MoH, Provincial Heath Departments, Operational Districts, and National Hospitals, Referral Hospital and Health Centers, as well as demand-side financing operators, for their kind cooperation in providing the information.

The Department of Planning & Health Information would like to express high appreciations to World Health Organization for providing support to the development of the report.

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EXECUTIVE SUMMARY

How much was spent on health?

Financed by three main sources – development partners, Government, and household out-of-pocket spending, Total Health Expenditure (THE) has substantially increased over the last five years, from USD 564 Million in 2008 to USD 763 Million in 2012, representing more than 5% of the GDP. In 2012, THE was approximately USD 52 per capita, 24% of which comes from Government spending, 15% from development partners, and the remaining 61% from out-of-pocket spending.

Where did the money go?

Health is highly recognized by the Government of Cambodia as a priority sector for investment. National budget allocation for health has consistently increased over the last ten years, reached USD 197 Million in 2012. The current national budget allocation is 70%-30% central and provincial level allocation, respectively.

Who provided the funds?

National Health Expenditure as a percentage of the approved budget is over 95% in 2012. Total Government expenditure for health in 2012 was estimated at USD 187 Million, approximately USD 13 per capita, representing approximately 24% of THE. As a percentage of total Government recurrent spending, government health expenditure was highest in 2010 at 11.94%, with a reduction in 2010 at 10.91%, followed by an increase to 11.54% in 2012.

Development partner support to the health sector in 2012 was 141 Million USD, approximately USD 10 per capita. External spending for health was estimated at 15% of THE in 2012, at around 116 Million USD.

Household health expenditure, via OOP, contributes the greatest part of the THE. Since 2008, OOP has increased from USD 25 per capita in 2008 to USD 32 per capita in 2012 or approximately USD 459 billion, accounting for 61% of THE.

Equitable funding

Since the limited of risk pooling mechanism, irrespective of private or public health providers, fee-for-services dominate. This form of payment is highly regressive since the poor spend a higher share of their income than the non-poor to obtain the same treatment. Furthermore, since user fees are paid on an individual basis whereby each patient or caretaker spends for his/her treatment, risk sharing is not possible

Development in health financing schemes with supply and demand-side interventions

The Cambodian health system is financed by both supply and demand side financing interventions.

Supply-side schemes aim to increase access to services by the poor while improving service quality. These schemes include user charges and exemption for the poor, special operating agency and service delivery grant, midwifery incentive and government subsidy for the poor.

Demand-side schemes aim to remove financial barriers to access and increase utilization of health services. These schemes include Health Equity Funds (HEF), Voucher schemes, and Community Based Health Insurance (CBHI).

Health Financing of Schemes

Subsidy is financed by the national budget through MOH budget. Total expenditure for 2012 was USD 469,331, 50% of which was spent at national hospitals, while the remaining 49% at referral hospitals and 1% at health centers.

In 2012, the total HEF expenditure was USD 9,457,954, 85% of which was spent for direct benefit to the poor patients and other 15% for management and operation of the schemes. In 2012, the total expenditure funds for HEF reimbursed by HSSP2 was around USD 9.19 million, 84% of which was for direct benefit costs (medical and non-medical costs for the patient) and 16% for operating costs. In 2012, HEFs paid on average USD 8.40 per case to HC and USD 29.32 per case to referral hospitals. HEF reimburses on average USD 1.01 per OPD case at HC and USD 6.44 per OPD case at RH, with USD 29.24 per IPD case at referral hospital. Of note, 89% of the total HEF direct cost (USD 7,967.377) paid referral hospital services used by HEFs beneficiaries and only 11% for health center services.

Voucher project for reproductive health services is financed by KFW as a grant. Total expenditure, including direct cost and indirect cost is USD 626,360, 63% of which was spent for direct cost and 37% for indirect cost (operation).

The income of CBHI scheme is estimated around USD 656,806 in 2012. On average only 28 % came from premiums paid by members while majority of income (72%) came from other sources, mainly donor funding. The total expenditure in 2012 was USD 622,715 with 46% spent for medical fee, 34% for administrative cost, and 10% for transportation cost of patients, 4% for outreach and marketing and 2% for other cost. It is observed that only a few CBHI schemes can operate by relying solely on premiums; other schemes, especially those with high membership, must use other subsidies to support their function.

Strategic Framer work for Health Financing 2008-2012

Strategic Framework for Health Financing 2008-2015 introduced in 2008 is one of the major components of the Health Strategic Plan 2008-2015. The framework included the following strategies:

1. "Increase government budget and improve efficiency of government resource allocation for health." Budget for health has increased
2. "Align donor funding with MOH strategies, plans, and priorities and strengthen coordination of donor funding for health". Donor partners plan to continue and increase resource commitment.
3. "Develop social health protection mechanisms to reduce financial barriers". HEF scale-up continues, with 76% of the targeted poor already covered. Also, wide implementation of poverty targeting tools and social health insurance for workers supports removal of financial barriers at the point of care.
4. "Move towards managing resources near service delivery level". Government aims to devote greater resources to MCH incentives, as well as support an active role of PHDs in resource utilization design and implementation.

5. "Use evidence & information to inform health financing policy-making". Since late 2011, this has been supported by systematic reporting, studies and researches led by Department of Planning and Health Information as well as other Departments.

What were the changes in health policy?

The current status of the health care system in Cambodia is one of a publicly funded district-based health sector and a fast growing private sector primarily funded by out of pocket. Each operational health district has multiple health centers providing the first line of health services (Minimum Package of Activities) with a catchment of 10,000 and a referral hospital providing second or third line health services (Complementary Package of Activities) to a population of 100,000 – 200,000. This system faces a number of constraints to offering quality health services, ranging from insufficient funding and inadequate management capacity to low staff remuneration and limited medical clinical skills.

The Health Coverage Plan (HCP) of 1995-1996 provided guidelines for strengthening District Health Systems. During this time as well, the Ministry of Health issued a circular, No 85, supporting the development and implementation of the Health Coverage Plan for Districts and Communes. The Plan immediately resulted in the development of health service by defining criteria for the location of health facilities and their 'Catchment Area and Population', as well as the allocation of financial and human resources. However MoH needs to go along with Decentralize & De-concentration program, and other reform such as public administrative and financial management reforms of the government.

Moving Forward

Significant increases in THE over the last five years, as well as support from financial sources including the Government, development partners, and from out-of-pocket spending has brought up the THE to more than 5% of GDP, relatively higher than other neighboring countries, however the financing system is still in fragmented with limited pooling function.

Universal Health Coverage (UHC) is universal goal endorsed by the United Nation and ASEAN counties with strong commitment from member states. Cambodia has strong commitment to UHC. The new draft of health financing policy' vision is to enable active participation of all residents of Cambodians in society through a health system that provides universal access to an essential package of quality health interventions in a regulated health market based on fairness of contributions and equity in access, thereby providing protection against impoverishment due to ill health. The underlying principles of the health financing system are:

- *Universality*: equitable access to essential curative, preventive, promotive and rehabilitative health care services, irrespectively of socioeconomic status
- *Poor and vulnerable (first)*: the health financing system developments will ensure inclusion of the poor and vulnerable as a means of socioeconomic development
- *Financial protection*: access will be guaranteed irrespectively of available money
- *Health care services:* shall be effective, provided in an efficient way and acceptable
- *Good governance*: the health financing system follows the rule of law and is responsive to present and future needs of society
- *Accountability and client oriented:* health providers are accountable for the quality of their services that must be patient-centred

1. BACKGROUND

1.1 INTRODUCTION

In the context of health sector reform introduced in 1995, the Health Financing Charter 1996 allows public health facilities to implementuser charges together with exemption policy for the poor, and pilotother health financing initiatives. Since then Cambodia has become agrounds for pilot experimentation of both supply and demand side health financing initiatives. Demand side financing to leverage quality of health service through purchasing power of the third party payersincludes schemes such as health equity funding (HEF), community based health insurance (CBHI)and voucher schemes. HEF in particular has become one of the Ministry of Health (MoH)'s health financing mechanisms to improve access to health service for the poor and vulnerable people. Supply side financing to improve health service delivery includes schemes such asuser fee with exemption mechanism for the poor, subsidy scheme,autonomous hospitals and Special Operating Agency (SOA). Despite the multiple demand and supply-side initiatives, financing through budget and subsidization through the general government resources remains the main funding instrument of services.

This report provides updated information about the status and financial information of health system financing as well various health financing schemes, which are currently implemented in Cambodia.

1.2 HEALTH SYSTEM DEVELOPMENT

The country health care system is composed of a district-based public health sector mainly funded by government and a fast growing private sector mainly funded by out of pocket. For the public health sector, each operational health district has a number of health centers providing first line health services (Minimum Package of Activities) with a catchment's population of 10,000 and a referral hospital providing second or third line health services (Complementary Package of Activities) to a population of 100,000-200,000. In general, those hospitalsare fairly equipped and staffed. However, they are facing a number of constraints to offering quality health services, ranging from insufficient funding and inadequate management capacity to low staff remuneration and limited medical clinical skills to some extent. Table 1 provides a description of Health Sector Reform efforts in Cambodia and its implementation from 1995 to the present.

Table 1: Overview of Health Sector Reform

1995-1996 Health Coverage Plan (HCP) Development	• Guidelines for Strengthening District Health System 1996-2000- introduced in August 1995 • Minister of Health issued and widely disseminated "Circular" No 85 dated 24 August 95: Development & Implementation of *"Health Coverage Plan"* for District & Communes. • HCP development nationwide- central extensive support • Minister of Health issued "Prakas" on HCP in Cambodia, dated 24 July 1996 HCP of each municipality/province signed by Governor &PHD Director • Ensure that population health needs are met in an equitable way through coverage of the whole population. • Develop health services by defining *Criteria* for the location of health facilities and their *"Catchment Area and Population"* Allocate financial and human resources.

Implementation of the Reform

Institutional development	• Minister's "Prakas" No 308, 1997: Organization of PHD & OD ←Guidelines for Developing OD, 1998 • Semi-autonomous institutions sub decree • Special Operating Agency Sub-decree
Capacity building HR management	• MPA Modules, CPA training, HSMT, HMT • JD for central MoH and OD; Functional analysis linked PMG, MBPI= currently Priority Operating Cost (POC)
Financing	• National Health financing Framework1996, this provided legal framework to implement alternative Health Financing. • Strategic Framework for Health financing 2008-2015 • Draft health financing policy
Supply Side Financing	• Annual planning process 98 for PHD, revised 2003for ALL, • AoP& 3YRP for central & Province, Annual HS-AoP, 3YRP, PIP • Budget Allocation formula 96, reviewed 2005? • Introduced Accelerate District development (ADD) 96, Priority Accelerated Program, Program based Budget PBB 2007 • Special Operating Agency and service delivery grant Manual • Inter-MinisterialPrakas (MoH) and (MEF) 2007 • Guideline for the implementation of Health Financing2010
Demand Side Financing	• Monitoring and Evaluation Framework for health equity fund 2003 • Guideline for Implementation of Community Based Health Insurance • Social Health Insurance Master plan 2005

	• Guideline for Health Equity Fund Implementation 2008 • Financial Manual for Health Equity Fund 2008 • Social Health Protection Master Plan 2009 (Draft)
M & E, supervision	• Health information system web base • Integrated supervision checklist • Indicator Framework for Monitoring and evaluation GIS • Health financing quarterly report • Health equity fund quarterly report • Community based health insurance quarterly report • Joint annual review event
Logistics & supply system	• " Quota" system for drug allocation, management, distribution system (centralization)
Infrastructures	• Standard design for Health Center (HC) and Referral Hospital (RH)
Policy & strategic planning, legislating	• Health Sector Strategic Plan 2003-2007, and 2008-2015
Coordination	• Adopted SWIM, TWGH, PRO-TWG

1.3 MINISTRY OF HEALTH STRATEGIC PLAN

The Ministry of Health has successfully implemented the First Health Strategic Plan (HSP1 2003-2007) and is currently implementing the Second Health Strategic Plan (HSP2 2008-2015). HSP2 clearly states its vision, mission, and working principles as follows:

Vision:A long-term broader vision of the Ministry of Health is "to enhance sustainable development of the health sector for better health and well-being of all Cambodians, especially of the poor, women and children, thereby contributing to poverty alleviation and socio-economic development."

Mission: To provide stewardship for the entire health sector and to ensure a supportive environment for increased demand and equitable access to quality health services in order that all people of Cambodia are able to achieve the highest level of health and well-being.

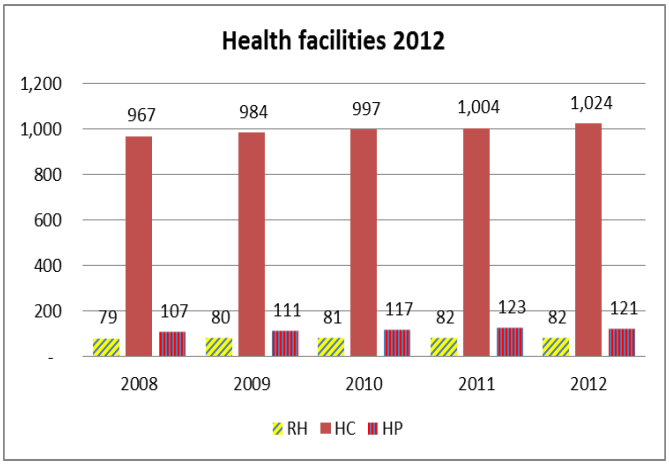
Values:A value-based commitment of the Ministry of Health is ***Equity*** and the ***Right to Health*** for all Cambodians.

Working Principles: Increased efficiency, accountability, quality and equity will be achieved only through application of morality, strong beliefs and commitment to common goals by all who are working in health care. Therefore the day-to-day activities of health managers and staff in all areas throughout the organizations at all levels should be guided by five principles.

1. Social health protection, especially for the poor and vulnerable groups	To promote pro-poor approaches, focusing on targeting resources to the poor, groups with special needs, and to areas in greatest need, especially rural and remote areas, and urban poor.
2. Client focused approach to health service delivery	To offer services with emphasis on affordability and acceptability of services, client rights, community participation and partnership with the private sector.
3. Integrated approach to high quality health service delivery and public health interventions	To provide comprehensive health care services including preventive, curative and promotive in accordance with nationally accepted principles, standards and clinical guidelines, such as MPA and CPA, and in partnership with the private sector.
4. Human resources management as the cornerstone for the health system.	To be operational and productive driven by competency, ethical behavior, team work, motivation, good working environment and learning processes.
5. Good governance and accountability	To provide stewardship for both the public and private sectors, focusing on a sector wide approach, effective planning, monitoring of performance, and coordination.

1.4 HEALTH INFRASTRUCTURE

There has been a remarkable development of health infrastructure over the last 5 years. Figure 1 indicates the number of public health facility- referral hospital, health center and health post- from 2008 to 2012. As of December 2012, the public health facility is comprised of 8 national hospitals (NH), 82 referral hospitals (RH), 1,024 healthcenters (HC) and 121 health posts(HP). Expansion of health infrastructure has increased geographical access to health services by the population, but not automatically increased the utilization of health service unless financial barriers are removed or reduced at the point of service use. It is noted that investment in infrastructure will have significant implication on human and financial resource to support health service delivery.



Source: Bureau of HIS, DPHI, MoH 2012

1.5 HUMAN RESOURCES

Although human resource remains a pressing issue, there has been a positive trend in recruitment and deployment of public health personnel. As of December 2012, the total number of health personnel employed in the public health sector is 19,721. Table 2 shows the number of health personnel by category and by year from 2008-2012. The distribution of health personnel by level is 77% at provincial (including district level) and 22% the Central levelincluding Phnom Penh (10% at national hospital, 6% at national centres and other central health institution, 4% at Phnom Penh Municipality and 3 % at the Central MoH).

Description	2008	2009	2010	2011	2012
Total number of health workforce	**18,096**	**18,113**	**18,302**	**18,814**	**19,721**
Medical Doctor, specialist docutor, professor	2,173	2,162	2,139	2,180	**2,178**
Medical Assistant	1,220	1,147	1,087	1,052	1,018
Dentist	172	177	189	212	214
Pharmacist	427	435	464	474	486
Secondary Nurses	5,084	5,098	5,155	5,366	2,432
Primary Nurses	3,407	3,404	3,359	3,381	5,662
Secondary Midwife	1,806	1,825	1,863	1,994	2,164
Primary Widwife	1,439	1,616	1,815	1,997	3,366
Secondary laborator	428	420	424	442	454
Others include dotor of pharmacy, assistant and primary, other skills.	1,940	1,829	1,807	1,716	1,747

Source: Department of Personnel, MoH 2012

1.6 HEALTH SYSTEM FINANCING

Strategic Framework for Health Financing 2008-2015introduced in 2008 is one of the major components of the Health Strategic Plan 2008-2015. The framework includedthe followingpolicy statement and strategies:

- **Policy Statement**
  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 de-concentration and decentralization, using sound planning and financialmanagement 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.

- **Strategies**
  1. Increase government budget and improve efficiency of government resource allocation for health.
  2. Align donor funding with MOH strategies, plans and priorities and strengthen coordination of donor funding for health
  3. Remove financial barriers at the point of care and develop social health protection mechanisms
  4. Efficient use of all health resources at service delivery level
  5. Improve production and use of evidence and information in health financing policy development.

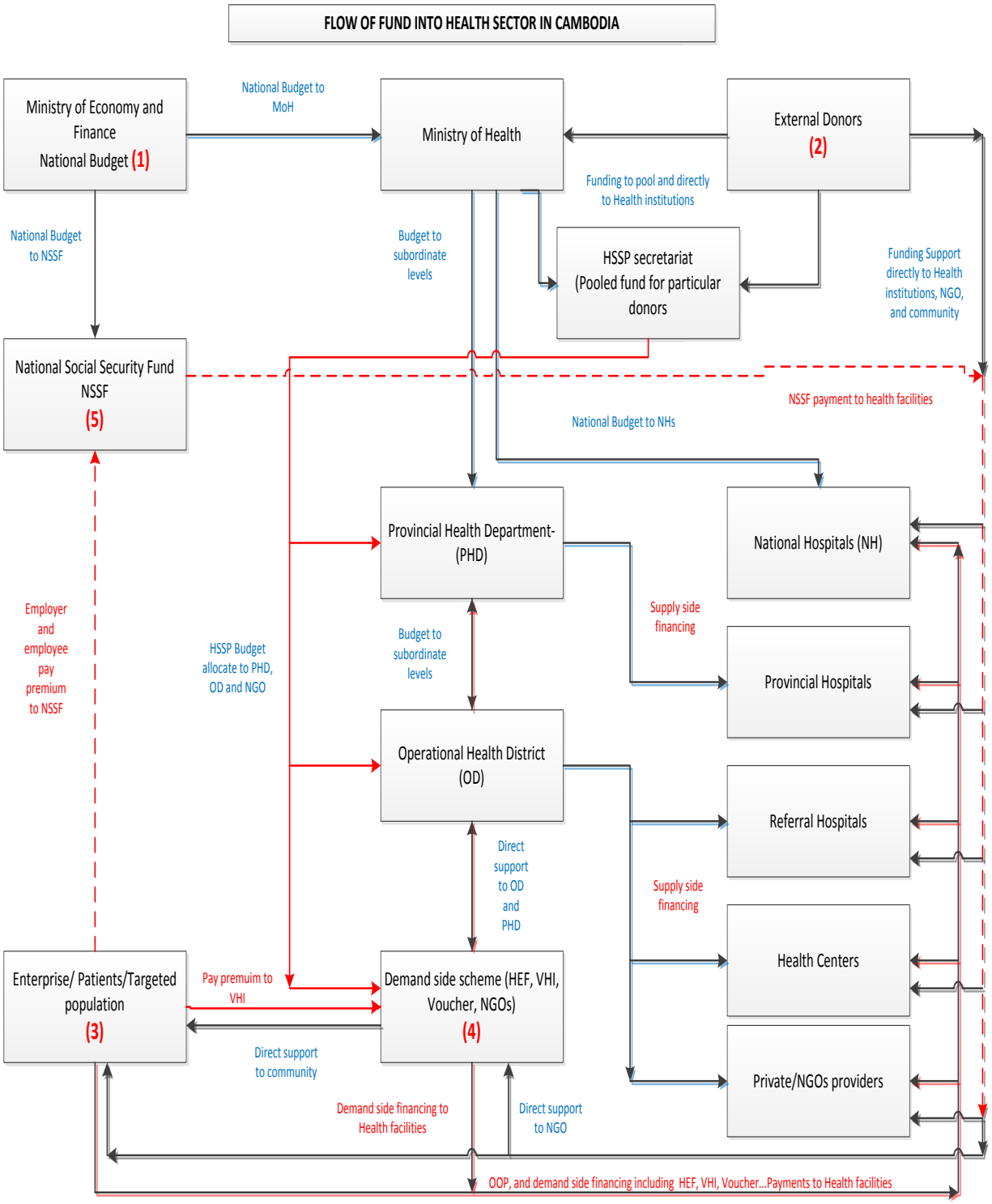
2. OVERVIEW OF HEALTH CARE FINANCING IN CAMBODIA

The table below presents an overview of **the current health financing mechanisms** in Cambodia. The individual mechanisms are described in greater detail in later sections

Financing Mechanism	Implementer/ Operator	Target population	Benefit/services	Provider Payment Method	Coverage
Tax funding via Government budget	MEF/MOH/PHD/OD/RH/HC	All population sectors	Recurrent budget, drug and material supplies	Line item budget and in kind including equipment and drug	Nationwide public health facilities
User feeexemptions	MOH/health facilities	Poor patients	MPA and CPA123	User fee exception	Nationwide
Global health initiatives and national programs	National programs	Patients with TB, malaria, AIDS, and children for vaccination	TB, Malaria, AID patients and children age under 1 year	Free of charge	Nationwide
Health Equity Fund (HEF)	NGOsfor HEFs	The eligible poor (those under the national poverty line)	MPA and CPA services , food, transport, funeral expenses	Official standardised Case base payment	In 46 Referral hospitals and 290 health centres, covering approx. 78% of the target group
Government Subsidy schemes (SUBO)	MOH/PHD/OD	The eligible poor (those under the national poverty line)	MPA and CPA services	Official Flat rate	In 6 National Hospital and 11 referral hospitals and 57 health centres
Community base health insurance (CBHI)	NGOs	Mainly informal sector, people living above poverty line	MPA and CPA services , food, transport, funeral expenses	Capitation, case base, fee for services.	19 schemes with 17 RHs and 1 NH and 231 HCs, covering 166,664 persons. . <1% of the population
Vouchers for reproductive health	NGOs	Poor women	Reproductive health services	Fee for services	In 9 ODs with 5 Hospitals and 118 HCs and 4 private clinics. Covering 107,763 women.
Occupational Risk	MOLVT/ NSSF	Formal private sector workers	Medical treatment, temporary/ permanent disable, funeral expenses and survivor benefit	Fee for service	Covered 3,921 enterprises with 745,275 workers
Maternity Benefits	MOLVT/ NSSF MOSVY/ NSSFC	Pregnant women formal sector workers and civil servants (spouses)	3 month maternity leave with 50% salary for workers. For civil servants, 3 month maternity leave with full salary and cash incentive of USD150 per newborn	Base on salary	Nationwide
Midwifery incentive	MoH, PHD, OD and HF	Midwife attending delivery	$15 per live birth at HC $10 per live birth at RH	Case reimbursement	All public health facilities
Social health insurance (SHI)	NSSF NSSFC	Formal sector workers and civil servants	Still to be defined	Study about case base payment	A formal private sector worker is transferred from HIP piloted to be managed by NSSF in Sept 2013.

Special Operating Agency (SOA) facilities	MOH/Donors/ HSSP	All population in the coverage area	Decentralize together with Performance-Based Incentives for Providers	Line item and Special Delivery Grant (SDG)	In 30 Operational Health Districts

3. HEALTH FINANCING FLOW IN HEALTH SECTOR



4. HEALTH SPENDING ANALYSIS

4.1 TOTAL HEALTH EXPENDITURE (THE)

The Cambodian health system is financedby three main sources i.e. the Government, development partner and households' out-of-pocket spending. It is observed that the Total Health Expenditure (THE) has substantially increased over the last five years, from USD564 Million in 2008 to USD 763 Million in 2012, or approximatelyrepresenting more than 5% of GDP. In other words, THE in 2012 ~~it~~is approximately USD 52 per capita. 24% of which is from Government spending, 15% from development partner and the remaining 61% from out-of-pocket spending. Figure 2 shows the trend of the proportion of THE by sources from 2008-2012.

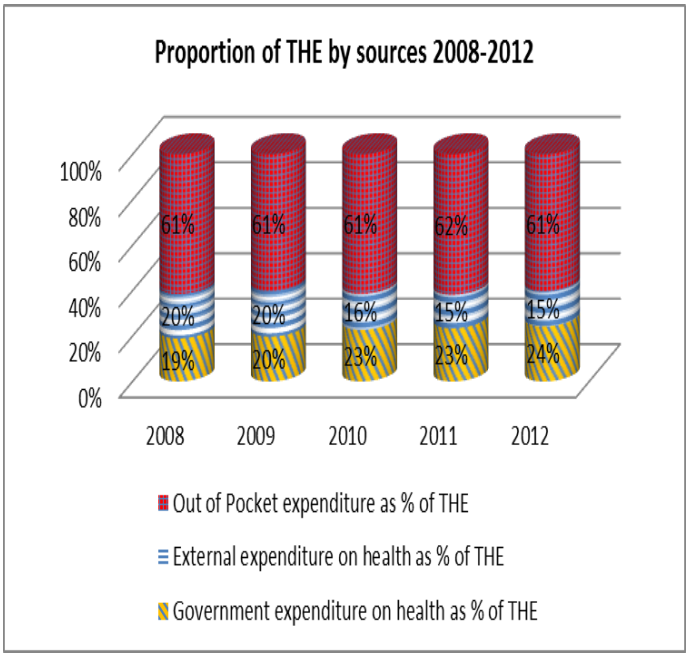


Table 3: Macro-economic Data 2008-2012

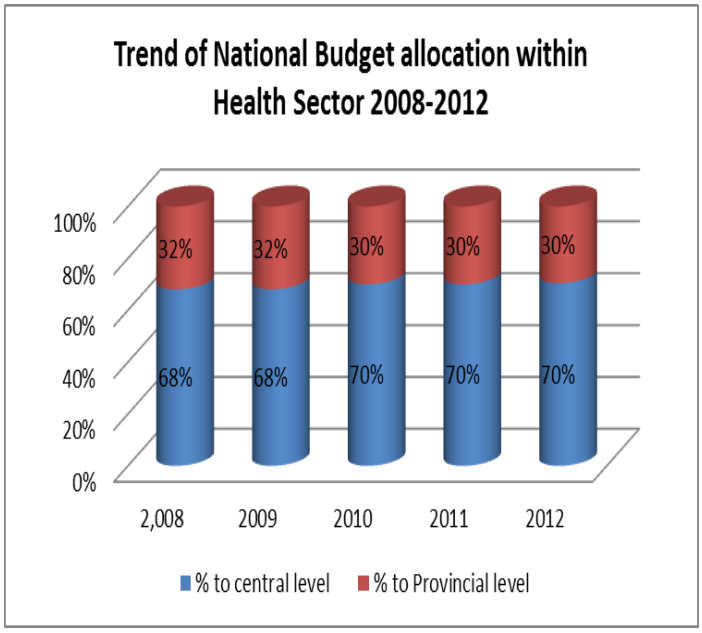
Particular	Unit	Currency	2,008	2009	2010	2011	2012
Gross Domestic Product (GDP)	Billion	Riel	41,968	43,057	47,048	52,254	57,506
Gross Domestic Product (GDP)	Million	USD	10,337	10,400	11,634	12,856	14,266
GDP, constant prices (Percent change)	%		6.69	0.09	5.96	6.09	6.25
Gross Domestic Product (GDP) per capita		USD	760	753	830	903	987
Inflation, average consumer prices(Percent change)	%		25.00	-0.66	4.00	5.48	4.03
Exchange rate		Riel	4,080	4,180	4,053	4,050	4,050
Population	Million	Person	13.87	14.09	14.30	14.52	14.74
Poor people living uder poverty line	Million	Person	4.313	4.380	4.448	2.904	2.948
Poverty rate (USD1)	%		31%	31%	31%	20%	20%
General government expenditure as percent of GDP	%		16%	21%	21%	20%	19%
Total government expenses	Billion	Riel	6,681	8,828	10,020	10,555	10,993
Current	Billion	Riel	3,953	4,912	5,154	6,002	6,578
Capital	Billion	Riel	2,728	3,915	4,866	4,225	4,415
Total government expenses	Million	USD	1,637	2,112	2,472	2,606	2,714
Current	Million	USD	969	1,175	1,272	1,482	1,624
Capital	Million	USD	669	937	1,201	1,043	1,090
Total government expenses as % of GDP	%		16%	20%	21%	20%	19%
Total health expenditure	Million	USD	564	651	678	712	763
Total health expenditure as % of GDP	%		5.46%	6.26%	5.82%	5.54%	5.35%
Total health expenditure per capita		USD	41	46	47	49	52

Source: IMF database, National Account of National Institute of Statistic2010,THE is estimated

4.1.1 Government Budget Allocation and Expenditure for Health

Budget allocation

Health is highly recognized by the Government of Cambodia as one of the priority sectors for investment. In fact, the national budget allocation for health has considerably been increased over the last ten yearsandreached USD 197 Million (approximately 794 Million Riels) in 2012.As Figure 3 suggests, the 2012 national budget allocation by level is currently70% and 30% at central and provincial level, respectively. It is noted that the central allocated budget includes the budget for procurement of drug and medical consumable that are distributed and used at service delivery level.



Budget Expenditure

The national health expenditure as percentage of the approved budget is over 95% in 2012. It is reported that the total Government expenditure for health in 2012 is estimated at USD 187 Million, approximately 52,716 Riels (USD 13) per capita. This spending represents approximately 24% of THE. It is noted that the Government health expenditures as percentage of the total Government recurrent spending was at the highest level in 2010 (11.94%), followed by a slight reductionto 10.91% in 2011, but began toincrease again to 11.54% in 2012.

Table 4: Government Budget and Expenditure for Health 2008-2012

Particular	Unit	Currency	2,008	2009	2010	2011	2012
Total Government budget for health		USD	110,992,522	132,737,718	159,529,728	172,740,346	197,253,816
Total Government budget for health	Million	Riel	404,804	503,847	600,056	694,331	794,214
Government budget for health CENTRAL Level	Million	Riel	275,257	342,820	419,716	485,571	559,039
Government budget for health PROVINCIAL Level	Million	Riel	129,547	161,027	180,340	208,760	235,175
Government expenditure on health	Million	Riel	426,790	524,146	615,375	655,099	759,207
Government expenditure on health CENTRAL Level	Million	Riel	302,383	368,083	445,469	460,695	563,579
Government expenditure on health PROVINCIAL Level	Million	Riel	124,407	156,063	169,906	194,404	195,628
Government expenditure on health USD		USD	104,605,441	125,393,660	151,832,026	161,752,840	187,458,420
Government expenditure on health as % of total current govt expenditure	%		10.80%	10.67%	11.94%	10.91%	11.54%
Government expenditure on health as % of GDP	%		1.05	1.11	1.31%	1.26%	1.31%
Government expenditure on health per capita		Riel	30,775	37,213	43,027	45,114	51,503
Government expenditure on health per capita		USD	8	9	11	12	13
Government expenditure on health as % of THE	%		18.95%	19.77%	22.76%	23.64%	24.57%

4.1.2 Health Partner Expenditure

Financial contributions to the health sector by development partners are generally committed based on multilateral and bilateral agreements. Such funds are channeled into the health sector through different funding modalities.According to the Council for Development of Cambodia (CDC) database (accessed on the 2nd January 2013), the external spending is around 116 Million US dollars, orapproximatelyUSD 8 per capita, while health partners' planned expenditure reported in the Health Sector Annual Operational Plan for 2012 is 141 Million US dollars, approximately USD10 per capita. The external spending for health is estimated at15% of THE in2012.

Table 5: External Expenditure for Health 2008-2012

Particular	Unit	Currency	2,008	2009	2010	2011	2012
External expenditure on health based on CDC database		USD	110,731,129	128,290,512	107,983,969	106,811,827	116,601,457
External expenditure on health per capita based on CDC database		USD	8	9	8	7	8
External Planned expenditure on health based on HS AOP		USD	55,998,745	85,200,498	88,196,043	114,481,024	141,188,876
External Planned expenditure on health per capita based on AOP		USD	4	6	6	8	10
External expenditure on health as % of THE	%		20%	20%	16%	15%	15%

4.1.3 Household Health Expenditure

Out-Of-Pocket health expenditure (OOP) by households constitutes thelarger part of the total health expenditure. According to the latest Cambodian Social-Economic Survey (CSES), OOP expenditure on health per capita was 28 USD in 2009, excluding transportation cost for seeking care. As Figure 4 suggests, OOP has increased from USD 25 per capita in 2008 to USD 32 per capita in 2012 or approximately USD 459 billion, accounting for 61% of THE.

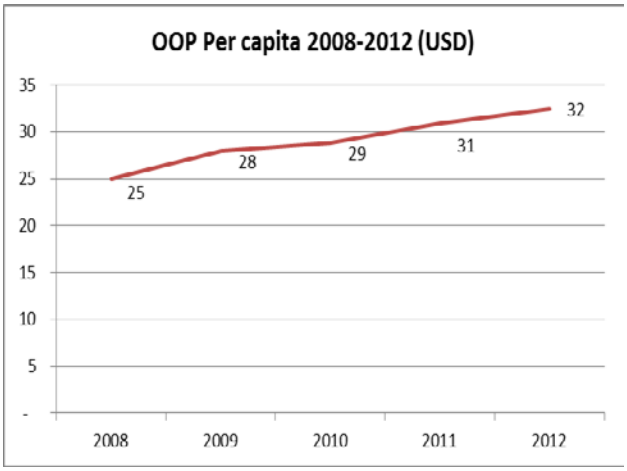


Table 6: Household Health Expenditure 2008-2012

Particular	Unit	Currency	2,008	2009	2010	2011	2012
Total out of pocket expenditure	Billion	USD	347	394	416	444	469
Total out of pocket expenditure	Billion	Riel	1,415	1,649	1,688	1,798	1,899
Out of Pocket expenditure on health per capita		USD	25	28	29	31	32
Out of Pocket expenditure on health per capita		Riel	102,000	117,040	118,023	123,833	128,823
Out of Pocket expenditure as % of THE	%		61%	61%	61%	62%	61%

5. ANALYSIS OF THE HEALTH FINANCING SCHEMES

Currently, Cambodian health system is financedby both supply and demand side financing interventionsthe former include user charges with exemption for the poor, Special Operating Agency(SOA is transformed from contracting model), and subsidy. The latter includesHealth Equity Fund (HEF), Community-Based Health Insurance (CBHI), and Voucher schemes.

5.1 SUPPLY SIDE FINANCING SCHEMES

5.1.1 User Charges and Exemption for the Poor

User charges together with exemption for the poor have been introduced officially at public facilities since 1996. An overall purpose of this scheme is to mobilize additional financial resources for public health facility, with its specific objectives to increase access to services by the poor, eliminate under-the-table payments, improve service quality, and increase staff motivation.

Fee levels are to be set in consultation with community representatives and local authorities by taking the capacity-to-pay by a majority of the population into account. These fees are usually set below cost recovery level, thereby accommodating the community members' ability to pay. Therefore, user charges in Cambodia are not a full cost recovery mechanism.

The implementation of user fees are subject to approval of MoH, and management and use of revenue collected are subject to the Inter-Ministerial *Prakas* between MoEF and MoH, which states that 60% of the total fee incomes is used for staff incentives, 39% for operating costs and the remaining 1% transferred to the National Treasury.

Although feeincome is a minor proportion of the total facility income, it plays a significant role for reducedunder-table payment, improved service quality and management practice, and increased financial incentives for providers. However, user charges remain a major financial barrier for access to hospital services. To date a majority of public health facilities formally implementuser charges. ~~.~~ The total fee income collected in 2012 is approximately at USD 19 million, excluding USD12 million generated byCalmette hospital.

Exemptionfor the poor

Exemption for the poor is strongly imposed with the implementation of user charges at public health facilities. By the Government policy,Tuberculosis services – from disease detection to treatment and careare free of charges for the general population.The other freely provided services include immunization for all targeted children, deworming, the provision of micronutrient (Vitamin A and Folic Acid) and ART and ARV for people living with HIV.

In 2012, health services used with fee exemption totalled2,112,973 cases (38% used by male and 62% by female patients), and the cost of those fee-exempted cases is approximately USD 9.4 million. Loss of income due to exemption for the poor is compensated to health facilities where pro-poor health financing schemes are implemented. These schemes include subsidy, HEFs and Vouchers.

5.1.2 Special Operating Agency and Service Delivery Grant

Special Operating Agency (SOAs) is laid out in the Royal Government's Policy on Public Services Delivery and is describe as a cornerstone of the National Program for Administrative Reform. The policy provides direction to ministries on how best to improve quality and delivery of services. It calls for enhanced performance and accountability in the provision of public services through streamlining of delivery processes and making them more transparent and responsive to people's needs. In effect, it calls for a change of paradigm within the Civil Service from that of an administrator of rules to that of a provider of public services.The purpose of SOA is to improve the quality and delivery of public services including health services.Special Operating Agency status provides public facility with a degree of autonomy in managing, and using its human and financial resources to deliver the highest possible services with improved quality in an effective way.

The MoH has developed an SOA manual, which sets out the guidance on how SOAs will be implemented and managed in the public health sectors. The development of this Manual was informed bythe guidance of the Council of Administrative Reform (CAR) as set out in the "Special Operating Agencies: Implementation Guide, Performance and Accountability" document. It aims to set practical standards for the organization of SOAs, their administration, management, financial and accounting processes, reporting, monitoring and evaluation.

The objectives of SOAs in the health sector are to:

1. Improve the quality and delivery of government health services in response to health needs;
2. Change the behavior of health sector staff gradually towards the principles of motivation, loyalty, service and professionalism;
3. Promote prudent, effective and transparent performance based management; and
4. Develop sustainable service delivery capacity within the available resources

In health sector, SOAs is intended to deliver health care of a good quality to Cambodians especially thepoor. To date, there are 30 SOAsestablished under the Royal Government's Sub-degree, located in 9 provinces covering 8 provincial hospitals and 22 Operational Districts that further cover 16 referral hospitals, 291 health centers and 63 health posts. SOAs receive funds for recurrent cost from the national budget in addition to Service Delivery Grant (SDG) via Health Sector Support Project phase 2 (HSSP2). SDG is released directly from HSSP2 account to individual SOAs' account via banking system.

5.1.3 Government Subsidy for the Poor

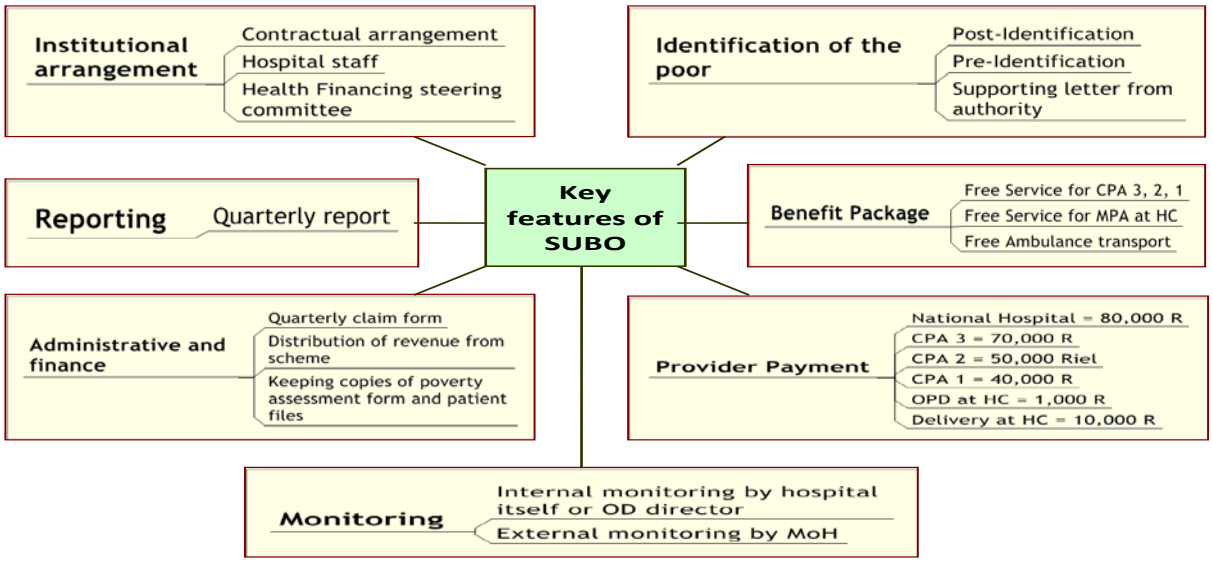
Key Features

Subsidy scheme (SUB) has been established by the Inter-ministerial *Prakas* of the MoEF and MoH (No. 809, dated 13th October 2006). A main purpose of the scheme is to encourage the poor to use health services free of charges at public health facilities by providing compensation for cost of health services provided to them. MoH is responsible fordefining mechanism to identify the poor based on clear criteria and by taking equity, fairness, and transparency into account. Furthermore, MOH and other implementing institutions have to work out practical details, including tools and methods for identification of the poor patients, as well as a monitoring mechanism. Key features of SUB are illustrated in the Figure 5.

Benefit packages defined by the*Prakas*include OPD and IPD at health center level, and IPD only at national hospitals, national centers and referral hospital level.

Provider-payment method is basically a fixed case-based payment. Fee level (flat rate) is set according to types of services and of health facility. For instance, health center is entitled to get reimbursement of 1,000 Riel and 10,000 Riel for a consultation and hospitalization, respectively. National hospital and national health centers receive reimbursement of 80,000 Riel for a hospitalized patient regardless of disease conditions and length of stay, while 40,000 Riel, 50,000 Riel and 70,000 Riel will be reimbursed to referral hospital CPA1, CPA2 and CPA3, respectively, for a hospitalization.

SUB is managed by public health facilities, namely Subsidy Operators (SUBOs) thatare entitled to receive subsidy from the Government. Practically, SUBOs are national hospitals (categorized as Group I)and operational districts (group II).



Coverage

Currently, the subsidy schemes are implemented in 6 national hospitals, 12 referral hospitals and 152 health centers in 12 operational districts in 8 provinces. However, according to reports provided to DPHI, there are 6 National hospitals, 11 RH and 57 HCs implementing subsidy scheme.SUBOS incorporate Health Equity Fund implementers and operators to address the specific needs of communities. Table 7 shows how SUBOs, present in 8 provinces including Phnom Penh, address community health needs through the number and spectrum of national hospitals (including CPA1, CPA2, and CPA3), referral hospitals, and health centers covered by the scheme.

Table 7: Coverage of SUBO schemes 2012

Province	No.	Operational District(s)	Model	Source of Fuding	HEFI	HEFO	Level Hospital	No. RHs with HF	No.HCs with HEF
Kampot	1	Kampong Trach	Subo	Government Funding	Kampong Trach	Kampong Trach	CPA2	1	12
	2	Angkor Chey	Subo	Government Funding	Angkor Chey	Angkor Chey	CPA2	1	10
	3	Chouk	Subo	Government Funding	Chouk	Chouk	CPA2	1	16
Prey Veng	4	Kampong Trabek	Subo	Government Funding	Kampong Trabek	Kampong Trabek	CPA2	1	8
Svay Rieng	5	Romeas Hek	Subo	Government Funding	Romeas Hek	Romeas Hek	CAP2	1	
	6	Chi Pou	Subo	Government Funding	Chi Pou	Chi Pou	CAP1	1	
Kampong Speu	7	Kampong Speu	Subo	Government Funding	Kampong Speu	Kampong Speu	CPA3	1	
Kampong Chhang	8	Kampong Chhang	Subo	Government Funding	Kampong Chhang	Kampong Chhang	CPA3	1	
Kandal	9	Takmao	Subo	Government Funding	Takmao	Takmao	CPA3	1	
	10	Ksach Kandal	Subo	Government Funding	Ksach Kandal	Ksach Kandal	CPA1	1	11
Pailin	11	Pailin	Subo	Government Funding	Pailin	Pailin	CPA2	1	0
Total 7 Provinces		**11 Ods**						***11***	***57***
Phnom Penh	1	National Pediatric Hospital	Subo	Government Fudning	National Pediatric Hospital	National Pediatric Hospital	CPA3		
	2	Ang Doung Hospital	Subo	Government Fudning	Ang Doung Hospital	Ang Doung Hospital	CPA3		
	3	Khmer Soviet Hospital	Subo	Government Fudning	Khmer Soviet Hospital	Khmer Soviet Hospital	CPA3		
	4	Kossamak Hospital	Subo	Government Fudning	Kossamak Hospital	Kossamak Hospital	CPA3		
	5	Calmette Hospital	Subo	Government Fudning	Calmette Hospital	Calmette Hospital	CPA3		
	6	MCH	Subo	Government Fudning	MCH	MCH	CPA3		
Total		**6 National Hospital**							

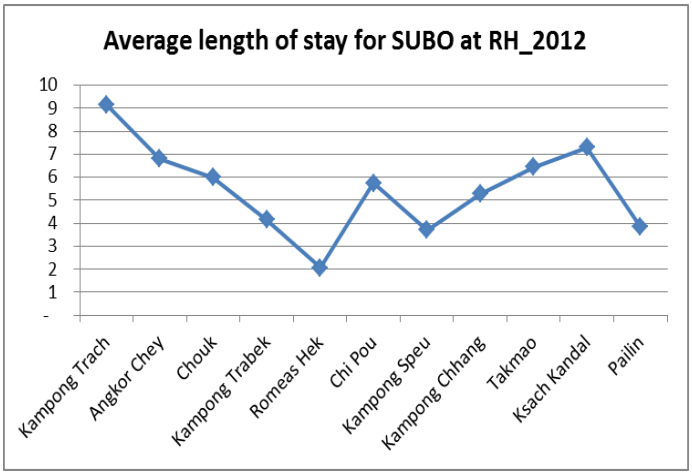
Utilization of Health Services

Table 8 indicates total utilization among referral and national hospitals, as well as among health centers throughout SUBOs 8 districts, including Phnom Penh.Health service utilization supported by SUBO is 42,792 cases in 2012. 74% of which is at referral hospitals, 22% at national hospitals, and 12% at health centers.

Table 8: Health Service Utilization Supported by Subsidy schemes 2012

No.	Provinces	No.	Operational District	Operator	Total utilization				Total utilization at RH/NH				Total utilization HC			
					OPD	IPD	ALS	Total	OPD	IPD include delivery	ALS	Total	OPD Include Delivery	IPD	ALS	Total
1	Kampot	1	Kampong Trach	Kampong Trach	1,015	1,827	9	2,842	-	1,827	9	1,827	1,015	-	-	1,015
		2	Angkor Chey	Angkor Chey	3,088	1,683	7	4,771	1,910	1,354	7	3,264	1,178	329	-	1,507
		3	Chouk	Chouk	2,753	960	6	3,713	1,304	960	6	2,264	1,449	-	-	1,449
2	Prey Veng	4	Kampong Trabek	Kampong Trabek	1,500	1,060	4	2,560	1,500	1,060	4	2,560	-	-	-	-
3	Svay Rieng	5	Romeas Hek	Romeas Hek	828	544	2	1,372	828	544	2	1,372	-	-	-	-
		6	Chi Pou	Chi Pou	20	1,503	6	1,523	20	1,503	6	1,523	-	-	-	-
4	Kampong Speu	7	Kampong Speu	Kampong Speu	8,829	941	4	9,770	8,829	941	4	9,770	-	-	-	-
5	Kampong Chhang	8	Kampong Chhang	Kampong Chhang	-	1,653	5	1,653	-	1,653	5	1,653	-	-	-	-
6	Kandal	9	Takmao	Takmao	-	2,110	6	2,110	-	2,110	6	2,110	-	-	-	-
		10	Ksach Kandal	Ksach Kandal	-	1,999	7	1,999	-	973	7	973	-	1,026	-	1,026
7	Pailin	11	Pailin	Pailin	14	652	4	666	14	652	4	666	-	-	-	-
Total for OD					**18,047**	**14,932**	**5.50**	**32,979**	**14,405**	**13,577**	**5.50**	**27,982**	**3,642**	**1,355**	**-**	**4,997**
1	Phnom Penh	1	National Pediatric Hos	National Pediatric	-	2,057	4	2,057	-	2,057	4	2,057				-
2	Phnom Penh	2	Ang Doung Hospital	Ang Doung Hospita	-	312	-	312	-	312	-	312				-
3	Phnom Penh	3	Khmer Soviet Hospital	Khmer Soviet Hosp	-	505	10	505	-	505	10	505				-
4	Phnom Penh	4	Kossamak Hospital	Kossamak Hospita	-	447	-	447	-	447	-	447				-
5	Phnom Penh	5	Calmette Hospital	Calmette Hospital	-	6,245	7	6,245	-	6,245	7	6,245				-
6	Phnom Penh	6	MCH	MCH	-	247	4	247	-	247	4	247				-
Total for NH					**-**	**9,813**	**6.30**	**9,813**	**-**	**9,813**	**6.30**	**9,813**	**-**			**-**
Grand total					**18,047**	**24,745**	**6**	**42,792**	**14,405**	**23,390**	**6**	**37,795**	**3,642**	**1,355**	**-**	**4,997**

As Figure 6shows, the average length of stay for hospitalization under SUB variesfrom 4 days to 9 days. The highest ALS isreported in Kampong Trach OD, followed by KsachKandal OD andChipou OD.



Financing of Subsidy

SUB is exclusively financed by the national budget through MOH budget. The total expenditure for 2012 is USD 469,33150% of which is spent at national hospitals, while the other49% at referral hospitals and the remaining 1% at health centers. Details can be seen in Table 9.

Table 8: Financial Information of Subsidy scheme 2012

No.	Provinces	No.	Operational District	Operator	Total cost (USD)			Total cost_RH			Total cost_HC		
					OPD	IPD including Delivery	Total Direct	OPD	IPD including Delivery	Total Direct	OPD	IPD including delivery	Total Direct
1	Kamport	1	Kampong Trach	Kampong Trach	-	23,500	23,500	-	23,500	23,500	-	-	-
		2	Angkor Chey	Angkor Chey	213	16,925	17,138	213	16,925	17,138	-	-	-
		3	Chouk	Chouk	67	10,728	10,794	67	10,728	10,794	-	-	-
2	Prey Veng	4	Kampong Trabek	Kampong Trabek	-	14,118	14,118	-	14,118	14,118	-	-	-
3	Svay Rieng	5	Romeas Hek	Romeas Hek	-	6,800	6,800	-	6,800	6,800	-	-	-
		6	Chi Pou	Chi Pou	-	15,030	15,030	-	15,030	15,030	-	-	-
4	Kampong Speu	7	Kampong Speu	Kampong Speu	-	16,468	16,468	-	16,468	16,468	-	-	-
5	Kampong Chhang	8	Kampong Chhang	Kampong Chhang	-	28,928	28,928	-	28,928	28,928	-	-	-
6	Kandal	9	Takmao	Takmao	-	36,943	36,943	-	36,943	36,943	-	-	-
		10	Ksach Kandal	Ksach Kandal	-	12,297	12,297	-	9,730	9,730	-	2,567	2,567
7	Pailin	11	Pailin	Pailin	4	8,150	8,154	4	8,150	8,154	-	-	-
Total for OD		**11**			**283**	**189,884**	**190,167**	**283**	**187,318**	**187,601**	**-**	**2,567**	**2,567**
1	Phnom Penh	1	National Pediatric Hospit	National Pediatric Hospital	-	41,140	41,140	-	41,140	41,140			-
2	Phnom Penh	2	Ang Doung Hospital	Ang Doung Hospital	-	6,240	6,240	-	6,240	6,240			-
3	Phnom Penh	3	Khmer Soviet Hospital	Khmer Soviet Hospital	-	10,100	10,100	-	10,100	10,100			-
4	Phnom Penh	4	Kossamak Hospital	Kossamak Hospital	-	8,940	8,940	-	8,940	8,940			-
5	Phnom Penh	5	Calmette Hospital	Calmette Hospital	-	207,804	207,804	-	207,804	207,804			-
6	Phnom Penh	6	MCH	MCH	-	4,940	4,940	-	4,940	4,940			-
Total for NH		**6**			**-**	**279,164**	**279,164**	**-**	**279,164**	**279,164**	**-**	**-**	**-**
Grand total					**283**	**469,048**	**469,331**	**283**	**466,481**	**466,764**	**-**	**2,567**	**2,567**

5.2 DEMAND SIDE FINANCING SCHEMES

Removing financial barrier in access to and utilization of health services by the poor and near poor remains a major issue of concern in Cambodia. In this regard, the MoH has implemented ~~to~~ various demand side financing schemes; namely Health Equity Funds (HEF) and Voucher scheme, and supported Community Based Health Insurance (CBHI). The coverage of theseschemes has gradually been expanded within financial resources and technical assistance made available by both the Government and health partners.

5.2.1 Health Equity Funds

Key Features

Health Equity Funds is a pro-poor health financing mechanism and widely recognized as asocial-transfer mechanism. HEFs aredesigned to reimburse a full or partial cost of health services provided to the poor at public health facilities. This involves the poor swhoare entitled as HEFs beneficiaries,using health services as they need free of charge. Usually, HEFs' beneficiaries are entitled by the process of pre-identification of the poor (community-based assessment), but post identification or health facility-based assessment remains conducted for those who access health facilities and claim themselves without identification of this status, usually through ID poor.

Benefit packages covered by HEFs include reimbursement for medical services and other associated costssuch as transportation cost, allowances for a patient's care-taker, funeral cost and referral cost.

Provider payment method is based on standardized rate as approved by MoH letter No.10-12HSSP2, dated 12th December 2012.

Contractual arrangements are a basis for HEF management and implementation. HEFs aremanaged by HEFs Implementers (HEFI) and operationalized by HEF Operators (HEFO). Selection of HEFIsand HEFOs is a competitive and open bidding process that is handled by MOH (HSSP2 Secretariat and DPHI). HEFIs and HEFO are currently not-for-profit NGOs.

Geographical Coverage

To date, 45HEF schemeshave beenimplemented in 45 ODs in 23 provinces through contract arrangements with 47 RHsout of 89 RHs in total, and with 313 HCsout of 1,024 HCs in total. 44 RHs and 281 HCs are financed by pooled funds, which include RGC counterpart fund, under HSSP2, and other 3 RHs and 32 HCs are financially supported by UNICEF, URC and Swiss Red Cross. The Table 10 provides more information about the current geographical coverage of HEFs, HEFI and HEFO, as well as funding sources and facilities where HEFs are implemented.

Population Coverage

HEFs currently protect an estimated 2.45 million identified poor. In other words, the proportion of the poor living under the national poverty line (national average 31% in 2007) supported by HEFs has increased significantly from 11% in 2008 to 21% in 2009 and reached 35% in 2010. To date poverty rate is estimated at 20% (draft by Ministry of Planning), HEF coverage was therefore estimated around 71% of target population in 2011, and up to 76% in 2012. The Ministry of Health has planned to expand HEFs program to reach its full coverage in 2015.

Utilization of Health Services

It is noted that HEFs have increased the utilization of health services in both OPD and IPD by the poor over the period from 2008 to 2012. In fact, the total number of OPD cases has increased from 8,972 in 2008 to 68,183 cases in 2011 and up to 1,176,116 cases in 2012. The

level of health services utilization is higher at HC up to 72% against 28% at referral hospitals. Table 11 illustrates the level of health service utilization by health facility with HEFs' support.

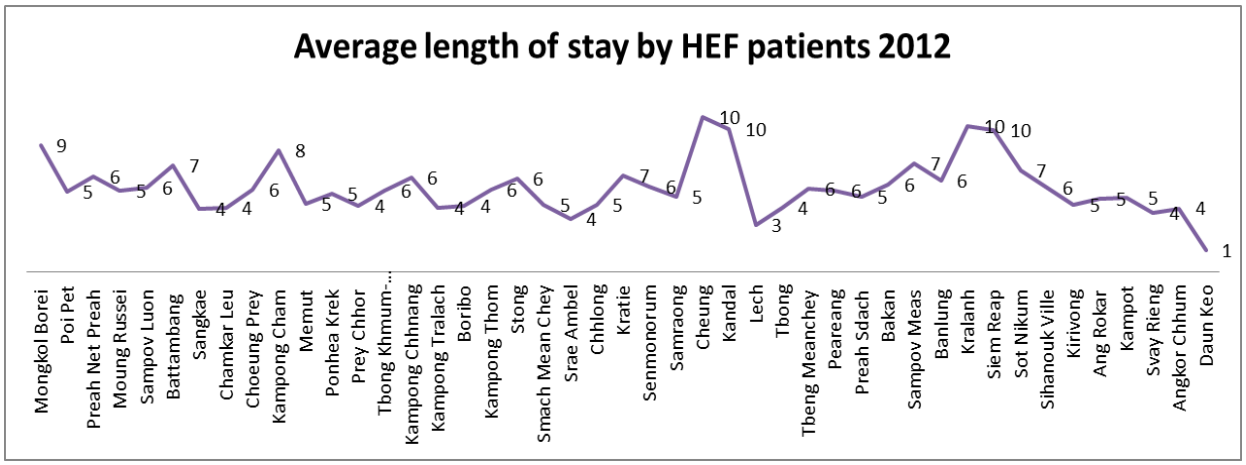
Table 10:HEFs Coverage, Funding Sources and HEFI/HEF

Province	No.	Operational District(s)	Model	Source of Fuding	HEFI	HEFO	Level Hospital	No. RHs with HF	No.HCs with
Banteay Meanchey	1	Mongkol Borei	HEF	HSSP2	URC-CHS	PFD	CPA3	2	19
	2	O'Chrov	HEF	HSSP2	URC-CHS	PFD	CPA2	1	11
	3	Preah Net Preah	HEF	HSSP2	URC-CHS	PFD	CPA1	1	13
Battambang	4	Battambang	HEF	HSSP2	URC-CHS	PFD	CPA3	1	23
	5	Sangke	HEF	HSSP2	URC-CHS	PFD		0	15
	6	Mong Russey	HEF	HSSP2	URC-CHS	PFD	CPA2	1	13
	7	Sampov Luon	HEF	HSSP2	URC-CHS	PFD	CPA1	1	0
Koh Kong	8	Smach Meanchey	HEF	HSSP2	URC-CHS	RHAC	CPA3	1	4
	9	Sre Ambel	HEF	HSSP2	URC-CHS	RHAC	CPA1	1	5
Rattanakiri	10	Banlung	HEF	HSSP2	URC-CHS	AFH	CPA2	1	0
Mondolkiri	11	Senmonorom	HEF	HSSP2	URC-CHS	AFH	CPA2	1	0
Kampong Thom	12	Kampong Thom	Linkage HEF& CBHI	HSSP2	URC-CHS	AFH	CPA3	1	21
	13	Stong	HEF	HSSP2	URC-CHS	AFH	CPA2	1	0
Kampong Cham	14	Tbong Kmum	RPH	HSSP2	URC-CHS	RHAC	CPA2	1	13
	15	Ponhea Krek	HEF	HSSP2	URC-CHS	RHAC	CPA1	1	0
	16	Memut	HEF	HSSP2	URC-CHS	RHAC	CPA2	1	0
	17	Prey Chhor/Kang Meas	HEF	HSSP2	URC-CHS	AFH	CPA1	1	3
	18	Chamkar Leu /Stung Trang	HEF	HSSP2	URC-CHS	AFH	CPA1	1	3
	19	Choeung Prey - Batheay	HEF	HSSP2	URC-CHS	AFH	CPA1	1	3
	20	Kampong Cham - Kampong Siem	HEF	HSSP2	URC-CHS	AFH	CPA3	1	0
Siem Reap	21	Siem Reap	HEF	HSSP2	URC-CHS	AFH	CPA3	1	0
	22	Sotnikum	HEF	HSSP2	URC-CHS	AFH	CPA2	1	0
	23	Kralanh	HEF	HSSP2	URC-CHS	CHC	CPA2	1	0
Oddar Meanchey	24	Samroang	HEF	HSSP2	URC-CHS	CHC	CPA2	2	0
PP. Municipal	25	Kandal	HEF	HSSP2	URC-CHS	FHD	CPA3	3	1
	26	Choeung	HEF	HSSP2	URC-CHS	FHD	CPA1	0	2
	27	Lech	HEF	HSSP2	URC-CHS	FHD	CPA1	1	1
	28	Tbong	HEF	HSSP2/ USA	URC-CHS	CBO	CPA1	1	4
Kampong Chhnang	29	Kampong Chhnang	HEF	HSSP2	URC-CHS	RHAC/OD	CPA3	1	15
	30	Kampong Tralach	RPH	HSSP2	URC-CHS	RHAC	CPA1	1	11
	31	Boribo	RPH	HSSP2	URC-CHS	RHAC	CPA1	1	11
Takeo	32	Kirivong	HEF	HSSP2	URC-CHS	BFH	CPA2	1	20
	33	Ang Roka	HEF	HSSP2	URC-CHS	BFH	CPA1	1	10
Preah Vihear	34	Thbeng Meanchey	HEF	HSSP2	URC-CHS	AFH	CPA3	1	0
Prey Veng	35	Pearaing	HEF	HSSP2	URC-CHS	AFH	CPA2	1	0
	36	Preah Sdach	HEF	HSSP2	URC-CHS	AFH	CPA1	1	0
Sihanouk	37	Sihanouk	HEF	HSSP2	URC-CHS	BFH	CPA3	1	12
Kratie	38	Kratie	HEF	HSSP2	URC-CHS	AFH	CPA3	1	0
	39	Chhlong	HEF	HSSP2	URC-CHS	AFH	CPA2	1	4
Pursat	40	Sampov Meas	HEF	HSSP2/ USA	URC-CHS	PFD	CPA3	1	22
	41	Bakan	HEF	HSSP2	URC-CHS	PFD	CPA2	1	10
Kampot	42	Kampot	Linkage HEF& CBHI	HSSP2-GIZ & AusAID		SKY (Jan-Jun 12) AFH (Jul-Dec 12)	CPA3	1	12
Total of HEF HSSP								***44***	***281***
Svay Rieng	1	Svay Rieng	HEF	Unicef	Unicef	Svay Rieng	CPA3	1	0
Siem Reap	2	Angkor Chhum	HEF	URC	URC-CHS	STSA	CPA1	1	17
Takeo	3	Daun Keo	HEF	SRC	SRC	BFH	CPA3	1	15
Total of HEF UNICEF and SRC								***3***	***32***
Grand Total								**47**	**313**

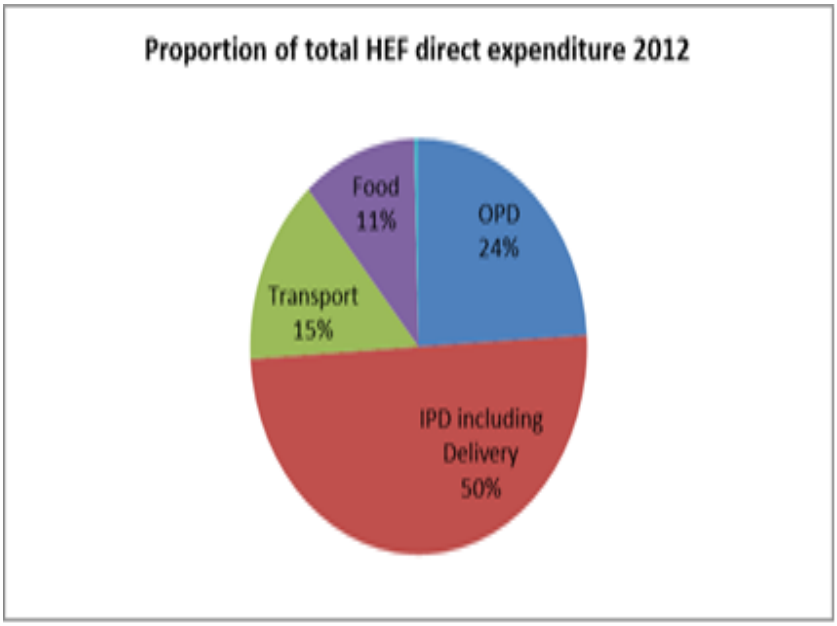
Table 11:Health Services Utilization Supported by HEFs in 2012

No.	Provinces	No.	Operational District	Operator	Total utilization					Total utilization at RH					Total utilization HC			
					OPD	IPD	Delivery	ALS	Total	OPD	IPD include delivery	Delivery	ALS	Total	OPD Include Delivery	IPD	Delivery	Total
1	Banteay Meanchey	1	Mongkol Borei	PFD	48,502	6,325	1,139	9	54,827	2,818	6,325	633	9	9,143	45,684		506	45,684
		2	Poi Pet	PFD	27,792	3,735	598	5	31,527	8,959	3,735	420	5	12,694	18,833		178	18,833
		3	Preah Net Preah	PFD	31,762	1,764	569	6	33,526	4,545	1,764	150	6	6,309	27,217		419	27,217
2	Battembang	4	Moung Russei	AFH	74,739	3,680	1,614	5	78,419	2,873	3,680	780	5	6,553	71,866		834	71,866
		5	Sampov Luon	PFD	16,193	3,114	840	6	19,307	1,524	3,114	396	6	4,638	14,669		444	14,669
		6	Battambang	AFH	89,683	8,237	1,962	7	97,920	12,121	8,237	1,008	7	20,358	77,562		954	77,562
		7	Sangkae	AFH	64,414	575	767	4	64,989	9,364	575	11	4	9,939	55,050		756	55,050
3	Kampong Cham	8	Chamkar Leu	AFH	5,543	3,527	463	4	9,070	55	3,527	366	4	3,582	5,488		97	5,488
		9	Choeung Prey	AFH	14,361	2,811	438	6	17,172	231	2,811	266	6	3,042	14,130		172	14,130
		10	Kampong Cham	AFH	1,517	6,899	667	8	8,416	1,517	6,899	667	8	8,416	0		0	0
		11	Memut	RHAC	6,856	3,350	428	5	10,206	123	3,350	360	5	3,473	6,733		68	6,733
		12	Ponhea Krek	RHAC	6,176	3,732	343	5	9,908	2,095	3,732	208	5	5,827	4,081		135	4,081
		13	Prey Chhor	AFH	6,112	2,343	271	4	8,455	5	2,343	140	4	2,348	6,107		131	6,107
		14	Tbong Khmum-Kroch Chhmar	RHAC	32,317	4,034	518	6	36,351	28	4,034	319	6	4,062	32,289		199	32,289
4	Kampong Chhnang	15	Kampong Chhnang	RHAC	29,107	4,935	1,485	6	34,042	5,772	4,935	796	6	10,707	23,335		689	23,335
		16	Kampong Tralach	RHAC	32,184	1,601	952	4	33,785	119	1,601	278	4	1,720	32,065		674	32,065
		17	Boribo	RHAC	33,314	813	724	4	34,127	66	813	166	4	879	33,248		558	33,248
5	Kampong Thom	18	Kampong Thom	AFH	35,945	3,423	418	6	39,368	10,898	3,423	377	6	14,321	25,047		41	25,047
		19	Stong	AFH	1,618	1,686	415	6	3,304	1,618	1,686	415	6	3,304	0		0	0
6	Koh Kong	20	Smach Mean Chey	RHAC	8,181	1,938	323	5	10,119	5,934	1,938	323	5	7,872	2,247		0	2,247
		21	Srae Ambel	RHAC	11,069	1,915	469	4	12,984	2,477	1,915	408	4	4,392	8,592		61	8,592
7	Kratie	22	Chhlong	AFH	11,855	2,827	380	5	14,682	3,961	2,827	342	5	6,788	7,894		38	7,894
		23	Kratie	AFH	81	4,317	647	7	4,398	81	4,317	647	7	4,398	0		0	0
8	Mondulkiri	24	Senmonorum	AFH	0	2,683	72	6	2,683	0	2,683	72	6	2,683	0		0	0
9	Oddar Meanchey	25	Samraong	CHC	2,491	4,018	264	5	6,509	2,491	4,018	264	5	6,509	0		0	0
10	Phnom Penh	26	Cheung	FHD	14,915	280	204	10	15,195	278	280	0	10	558	14,637		204	14,637
		27	Kandal	FHD	23,445	5,332	650	10	28,777	20,542	5,332	650	10	25,874	2,903		0	2,903
		28	Lech	FHD	5,424	431	96	3	5,855	5,424	431	96	3	5,855	0		0	0
		29	Tbong	FHD/KCHP	12,068	1,108	180	4	13,176	6,349	1,108	146	4	7,457	5,719		34	5,719
11	Preah Vihear	30	Tbeng Meanchey	AFH	2,037	4,946	181	6	6,983	2,037	4,946	181	6	6,983	0		0	0
12	Prey Veng	31	Peareang	AFH	394	2,383	190	6	2,777	394	2,383	190	6	2,777	0		0	0
		32	Preah Sdach	AFH	1	2,558	178	5	2,559	1	2,558	178	5	2,559	0		0	0
13	Pursat	33	Bakan	PFD	27,577	1,249	609	6	28,826	920	1,249	122	6	2,169	26,657		487	26,657
		34	Sampov Meas	PFD	62,326	2,886	1,652	7	65,212	14,421	2,886	766	7	17,307	47,905		886	47,905
14	Ratanakiri	35	Banlung	AFH	72	2,100	68	6	2,172	72	2,100	68	6	2,172	0		0	0
15	Siemreap	36	Kralanh	CHC	602	1,036	103	10	1,638	602	1,036	103	10	1,638	0		0	0
		37	Siem Reap	AFH	9,343	3,783	78	10	13,126	9,343	3,783	78	10	13,126	0		0	0
		38	Sot Nikum	AFH	6,767	2,397	149	7	9,164	6,767	2,397	149	7	9,164	0		0	0
16	Sihanouk Ville	39	Sihanouk Ville	BFH	31,992	4,541	1,137	6	36,533	1,142	4,541	769	6	5,683	30,850		368	30,850
17	Takeo	40	Kirivong	BFH	46,587	2,783	576	5	49,370	3,772	2,783	31	5	6,555	42,815		545	42,815
		41	Ang Rokar	BFH	44,899	4,399	834	5	49,298	6,469	4,399	379	5	10,868	38,430		455	38,430
18	Kampot	42	Kampot	SKY & AFH	16,217	547	82	5	16,764	1,685	547	37	5	2,232	14,532		45	14,532
	Total				**896,478**	**127,041**	**23,733**	**6**	**1,023,519**	**159,893**	**127,041**	**13,755**	**6**	**286,934**	**736,585**	**0**	**9,978**	**736,585**
Utilization supported by others																		
1	Svay Rieng	1	Svay Rieng	Svay Rieng	2119	1104	215	4	3223	2119	1104	215	3.97	3223	0	0		0
2	Siem Reap	2	Angkor Chhum	STSA	84032	153	1088	4	84185	541	153	11	4.30	694	83491		1077	83491
3	Takeo	3	Daun Keo	BFH	7895	7339	746	1	15234	7895	7339	746	1.47	15234	0	0		0
	Total				**94046**	**8596**	**2049**	**3**	**102,642**	**10555**	**8596**	**972**	**3.25**	**19151**	**83491**	**0**		**83491**
	Grand total				**990,524**	**135,637**	**25,782**	**5**	**1,126,161**	**170,448**	**135,637**	**14,727**	**5**	**306,085**	**820,076**	**0**	**9,978**	**820,076**

Average Length of Stay (ALS) of HEF patients was around 5 days similar to an overall ALS at public hospitals. However a large variation in ALS was observed between schemes; the longest ALS was 10 days in 4 ODs followed by 9 days in one OD (see below Figure 7).



Financing HEFs



In 2012, the total HEF expenditure is USD 9,457,954. 85% of which is spent for direct benefit to the poor patients and other 15% for management and operational of the schemes. Spending for direct benefits is mostly for IPD (50%), followed by 24% for OPD, then 15% for transportation and 10% for food allowance (see Figure 8)

It is noted that 42 HEFs schemes out of 45 schemes in total are funded by HSSP2 pooled funds, in which the Government shared 30% of the total cost reimbursed for direct benefit and HSSP2 partners financially contributed the remaining 70%. In 2012, the total expenditure funds for HEF reimbursed by HSSP2 was around USD 9.19 million, USD7.72 Million (84%) of which was spent for direct benefit (medical cost and non-medical benefits such as transportation, food, cash), and USD 1.45 (16%) for operating cost.Figure 9 shows share of HEFs expenditure for direct benefit and management cost, and Figure 10 indicates HEFs expenditure by cost category.

According to cost analysis, HEFs co-financed by RGC and HSSP2 partners paid on average USD 8.40 per caseto HC and USD 29.32 per caseto referral hospital. These costsincludedirect benefit cost (medical cost and non-medical cost) and management cost. In term of medical benefit, HEF reimburses on average USD1.01 per OPD case at HC and USD 6.44 per OPD case

at RH, and USD29.24 per IPD case at referral hospital. HEFs also paid for non-medical benefit (transportation cost, referral, foods, allowances for a caretaker, and funeral) around USD6.57 per case at RH and USD0.07 per case at HC. More information is provided in Table 12.

Table 12: HEF's expenditure by levels of health facilities 2012

Particular	RH	HC	Total
Expenditure for medical benefit OPD	1,096,872	825,523	1,922,395
Expenditure for medical benefit IPD	3,977,202		3,977,202
Expenditure for non-medical benefit	2,010,045	57,735	2,067,780
Total expenditure for direct cost	**7,084,120**	**883,258**	**7,967,377**
Total expenditure for administration			1,490,577
Grand total	***7,084,120***	***883,258***	***9,457,954***
Utilization_OPD	170,448	820,076	990,524
Utilization_IPD	135,637	-	135,637
Total utilization	***306,085***	***820,076***	***1,126,161***
Medical cost per OPD cases	6.44	1.01	1.94
Medical cost per IPD cases	29.32		29.32
Non-medical cost per case	6.57	0.07	1.84
Total direct cost per case	23.14	1.08	7.07
Total cost per case	23.14	1.08	8.40

It is noted that 89% of the total HEF direct cost (USD 7,967.377) was paid for, referral hospital services used by HEFs beneficiaries and only 11% for health center services.

5.2.2 Voucher Scheme for Reproductive Health Services

Key Features

To reduce maternal mortality in Cambodia, the Ministry of Health has introduced a set policy and strategic interventions including the National Strategy for Reproductive and Sexual Health and Road map for Accelerating Maternal and Child Mortality. A voucher for Reproductive Health project has been designed to support the country efforts in reducing maternal mortality and the implementation of the above-mentioned interventions. Theproject is a financial component of Social Health Protection Program (SHP) in Cambodia under Cambodian-German cooperation.

Identified poor women (by pre-ID poor) are beneficiaries of the voucher project. "Vouchers" are distributed to those poor women by voucher promoters. The vouchers entitle them to use reproductive health service at contracted public and private health facilities.

Benefit packages covered by the voucher include ANC, delivery, PNC, family planning and safe abortion (for all women). The voucher also reimburses transportation cost and hospital services at referral hospitals, where HEFs are not available.

The vouchers are managed by Voucher Management Agency (VMA) and operated by voucher operator via contractual schemes arrangements with MOH.

Geographical Coverage

The voucher schemes have been implemented since 2011. To date the schemes have contracted with 5 referral hospitals and 118 HCs in 9 ODs in 3 provinces and with 4 private clinics for providing safe abortion services (Table 13 below).

Table 13: Geographical coverage voucher scheme 2012

No.	Provinces	Operational Districts	Implementing Agency		Budget (USD)	Year		Facility covered		
No.	Provincial Name	OD Name	Int. NGO	Local NGO	Sources	Start	End	RH	HC	Clinic
1	Kampong Thom	Kampong Thom (MSI clinic)	EPOS	AFH	KFW	Jan-12		0	20	1
		Staung	EPOS	AFH	KFW	Jan-12		0	8	
		Baray and Santuk (Ms Sim clinic)	EPOS	AFH	KFW	Jan-12		1	19	1
2	Kampot	Angkor Chey	EPOS	AFH	KFW	Jan-12		1	10	
		Chhouk	EPOS	AFH	KFW	Jan-12		1	16	
		Kampong Trach	EPOS	AFH	KFW	Jan-12		1	12	
		OD Kampot	EPOS	AFH	KFW	Jan-12				1
3	Prey Veng	Kampong Trabek	EPOS	AFH	KFW	Jan-12		1	8	
		Pearaing	EPOS	AFH	KFW	Jan-12		0	16	
		Preah Sdach	EPOS	AFH	KFW	Jan-12		0	9	
	Svay Rieng	Chipou (Clinic MSI)	EPOS	AFH	KFW	Jan-12				1
TOTAL								5	118	4

Population Coverage

Currently, voucher scheme covers an estimated 107,763 women of reproductive age from 15-49 years-oldin those 9 ODs (Table 14).

Table 14: Population coverage by voucher schemes 2012

No	Province	OD	targeted population
1	Kampong Thom	Kampong Thom	21,650
		Baray Santok	20,254
		Stong	11,043
1	Kampot	Angko Chey	5,724
		Chhouk	8,465
		Kampong Trach	8,179
1	Prey Veng	Pearaing	13,928
		Preah Sdach	9,106
		Kampong Trabek	9,413
Total			107,762

Utilization of Health Services

Total utilization of reproductive health services supported by the voucher project in 2012 was 36,299 cases, mostly at health centers (85%), followed by 10% at private clinics and4% at referral hospitals. Table 15 provides detailed information about utilization of reproductive services in 2012 by location, including funding sources and voucher operator.

Table 15: UTILIZATION SUPPORTED BY VOUCHER_2012																							
No.	Province	No.	Operational District	Funding Source	HEFI	Operator	Utilization at RH					MSI, RHAC and Chheng Sim			Utilization at HC					Total Utilization				
							FP	SA	Delivery	Other	Total	FP	SA	Total	FP	SA	Delivery	Other	Total	FP	SA	Delivery	Other	Total
1	Kg Thom	1	Baray Santouk	KFW	EPOS	AFH	45	52	82	1	180	255	86	341	460	213	563	2,619	3,855	760	351	645	2,620	4,376
		2	Kg Thom	KFW	EPOS	AFH	0	0	0	0	0	993	1,924	2,917	460	0	175	1,445	2,080	1,453	1,924	175	1,445	4,997
		3	Stong	KFW	EPOS	AFH	0	0	0	0	0	0	0	0	588	0	297	2,304	3,189	588	0	297	2,304	3,189
2	Kampot	4	Angkor Chey	KFW	EPOS	AFH	0	171	66	0	237	0	0	0	1,184	507	384	2,393	4,468	1,184	678	450	2,393	4,705
		5	Chhouk	KFW	EPOS	AFH	0	96	114	1	211	0	0	0	941	120	496	2,274	3,831	941	216	610	2,275	4,042
		6	Kampong Trach	KFW	EPOS	AFH	0	51	81	0	132	0	0	0	988	262	381	2,092	3,723	988	313	462	2,092	3,855
		7	Kampot OD (RH Kampo	KFW	EPOS	AFH	0	168	93	0	261	200	227	427	0	0	0	0	0	200	395	93	0	688
3	Prey Veng	8	Kampong Trabek	KFW	EPOS	AFH	27	14	182	4	227	0	0	0	686	0	456	2,357	3,499	713	14	638	2,361	3,726
		9	Peareang	KFW	EPOS	AFH	0	0	0	0	0	0	0	0	529	22	390	1,423	2,364	529	22	390	1,423	2,364
		10	Preash Sdach	KFW	EPOS	AFH	0	0	0	0	0	0	0	0	831	0	523	2,841	4,195	831	0	523	2,841	4,195
4	Svay Rieng	11	Chipou	KFW	EPOS	AFH	0	0	0	0	0	136	26	162	0	0	0	0	0	136	26	0	0	162

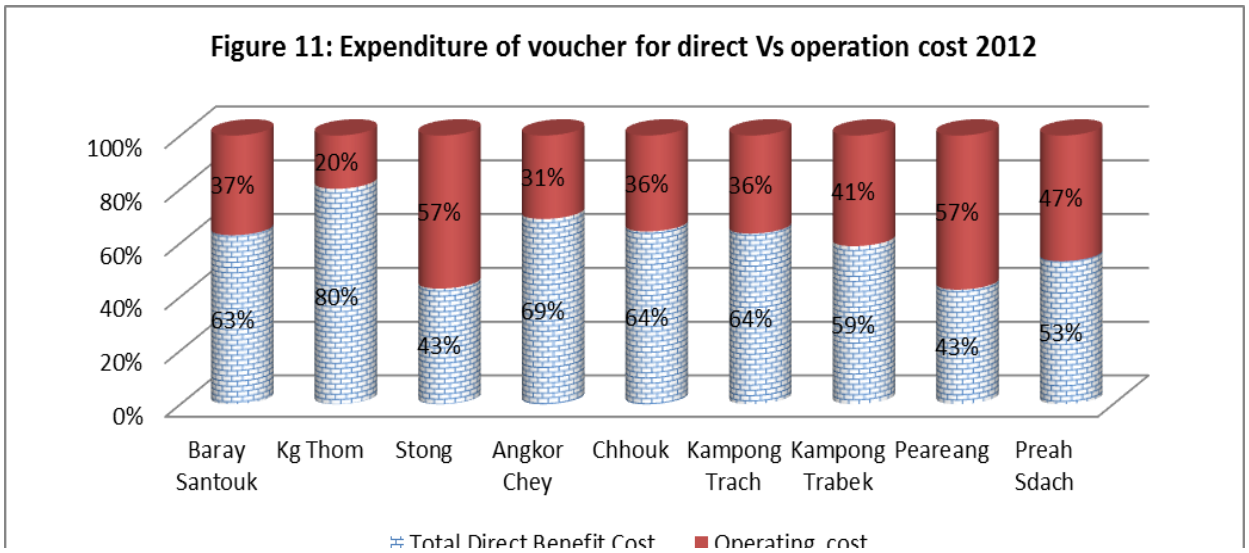
Financing of Voucher Schemes

The voucher project is financed by KFW as a grant. Total expenditure, including direct cost and indirect cost is USD 626,360,63% of which was spent for direct cost and 37% for indirect cost. Table 16 provides detailed information about expenditure in 2012.

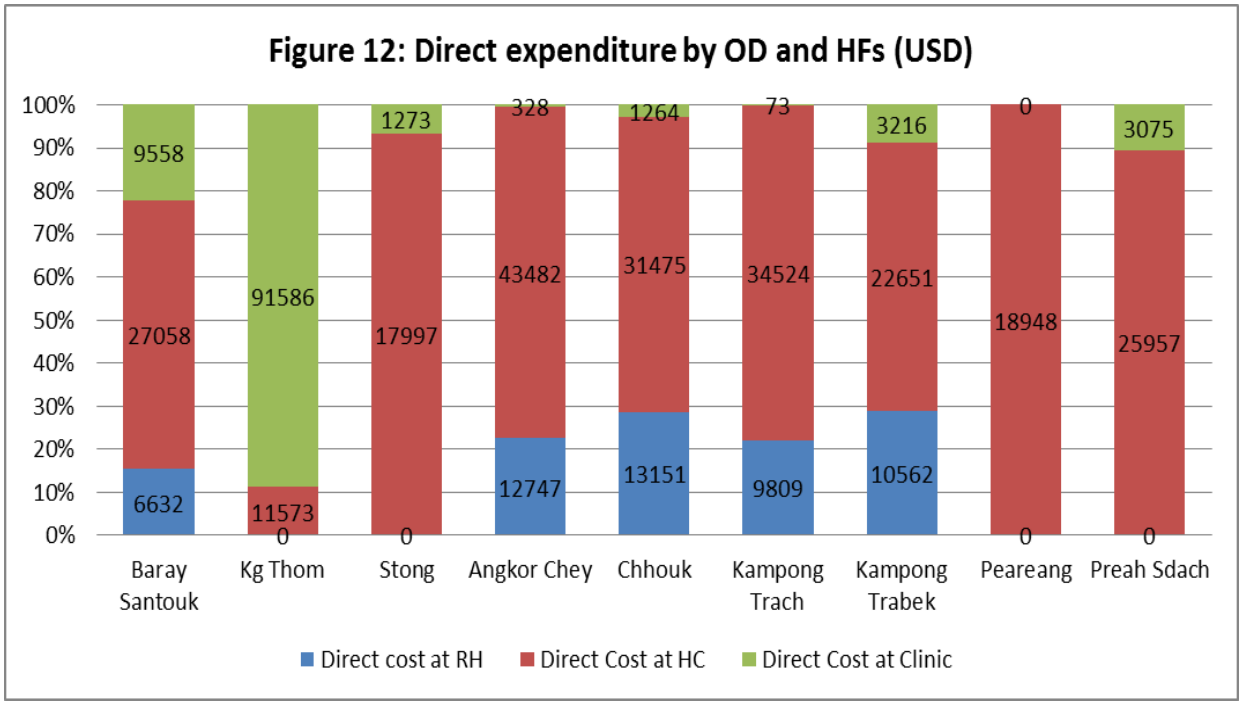
Table 16: Total expenditure of voucher scheme by OD_2012

No.	Operational District	Operator	Total Direct benefit Cost (USD)								Indirect Cost (USD)						Total Cost (USD)
			FP	SA	Delivery	ANC1-4, PNC1-2 and Miscarriage (SMH)	Transport	Food	Other costs (SMH)	Total Direct Benefit Cost	Admin.	Equipment	TA	Program development	Pre ID	Total indirect cost	
1	Baray Santouk	AFH	7,621.25	8,335.00	9,940.00	3,802.00	6,034.50	3,192.63	4,321.75	43,247.13	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	68,738.75
2	Kg Thom	AFH	20,995.75	43,065.00	2,525.00	2,093.50	31,739.25	1,542.73	1,198.40	103,159.63	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	128,651.25
3	Stong	AFH	1,864.75	350.00	4,140.00	3,209.50	5,163.75	2,004.15	2,538.30	19,270.45	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	44,762.07
4	Angkor Chey	AFH	10,418.75	16,843.33	8,675.00	3,522.50	9,962.92	3,922.73	3,211.13	56,556.36	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	82,047.98
5	Chhouk	AFH	5,080.00	7,073.33	10,860.00	3,140.00	11,252.92	4,166.93	4,316.08	45,889.26	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	71,380.88
6	Kampong Trach	AFH	9,025.00	8,508.33	8,815.00	2,996.50	8,008.54	3,697.91	3,354.00	44,405.28	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	69,896.91
7	Kampong Trabek	AFH	5,967.88	532.50	10,480.00	3,203.00	6,884.13	4,800.00	4,561.48	36,428.98	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	61,920.60
8	Peareang	AFH	3,145.25	500.00	5,200.00	1,990.50	3,192.63	1,934.43	2,984.78	18,947.58	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	44,439.20
9	Preah Sdach	AFH	3,645.38	232.50	7,015.00	3,999.00	6,582.13	3,595.40	3,962.15	29,031.55	16,980.13	109.07	0.00	6,100.97	2,301.45	25,491.62	54,523.17
Total			67,764.00	85,440.00	67,650.00	27,956.50	88,820.75	28,856.90	30,448.05	396,936.20	152,821.21	981.62	0.00	54,908.72	20,713.08	229,424.62	626,360.82

The operating costs of these schemes are extremely high and range between 20% and 57%- The highest operating cost (indirect cost) were the schemes operating in OD Stong and OD Pearaing (both 57%), followed by Preah sdech (47%), whereas the lowest operating cost was the scheme in Kg. Thom and Angkor Chey ODs (20% and 31%, respectively) (Figure 11). Similarly, total direct benefit costs range from 43% (Stong and Peareang, respectively) to 80% (Kampong Thom).



The figure 12 below shows that vouchers were most spent at HCs, corresponding to high level of utilization of HC services (75%). It is interesting to note that the voucher project provided close to 90% of the total amount of reimbursements for safe abortion services used at private clinics in Kompong Thom.



5.2.3 HealthInsurance

Moving toward universal health coverage is a long journey for Cambodia. Social health insurance is at a very early stage of development. In the Cambodian context,a pathway to universal health coverage will reachthrough multiple approaches. Such approaches include:

- **Social assistance** schemes for the poor and vulnerable - such as health equity funds, conditional cash transferetc.
- **Compulsory** health insurance for formal sector, covering civil servants and salaried workers in private sector;
- **Voluntary**health insurance for informal sector through the development of community-based health insurance schemes.

5.2.4 Social Health Insurance

Two types of Compulsory Health Insurance scheme have been developed and implemented: National Social Security Funds (NSSF) and National Social Security Funds for Civil Servant (NSSFC).

(1) Ministry of Labor and Vocational Training (MOLVT) is responsible for the development of compulsory social security and health insurance for private-sector salaried workers as stipulated under the Social Security Law (2002). The law articulates, among the others, the establishment of the Social Security Organization and the provision of a work injury program and old age pensions.

NSSF was established by the Government's Sub-decree No. 16, dated 2nd March 2007, pursuing the following objectives:

- To manage and administer the social security schemes;
- To ensure provision of all benefits to members to support income security in case of any contingency such as old age, invalidity, death, occupational risks, and others;
- To collect contributions from its members and employers;
- To facilitate and organize provision of health and social services for the members;
- To cooperate with organizations concerned to educate and promote methods of occupational risk prevention, take measures on health and safety at work places, and study and investigate occupational diseases; and
- To manage the investment of social security funds.

NSSF is overseen by a Governing Board, comprising of representatives of MoLVT, MoEF, Council of Administrative Reform, MoH, Unions and Employers associations, and executed by Director.

Employment Injury scheme has been implemented since 2008. According to Social Security Law,private enterprises employing 8 workers and more have to register with NSSF. The premium is 0.8% of gross salary, 0.5% and 0.3% of which was contributed byemployers and the Government, respectively. Since 2011, the contribution of 0.8% has been made by employers only. It is reported that the premium varies from a minimum level of 1,600 riels to a maximum level of 8,000 riels per month. Up to 2012, 4,583 enterprises were registered with NSSF, and

86.7% of those enterprises (3,921 enterprises)paid contribution for 745,275 employees.The expansion was made from three provinces in 2008 to 20 provinces included Phnom Penh Municipality.A health insurance scheme is planning to be implemented in 2013.

Work Injuries Scheme	2008-2009	2010	2011	2012
No. of province and PP	3	8	13	20
Coverage of enterprises	884	1,564	2,429	3,921
Coverage of membership (enterprise/employees)	340,840	530,599	594,458	745,275

(2) Ministry of Social Affairs, Veterans and Youth (MOSVY), which is responsible for the development of social security for civil servants, has recently drafted a sub-decree on the provision of pensions, occupational injury and other benefits including maternity and sick leave. The RGC Sub-Decree on *the Establishment of National Civil Servant Social Security Fund (NCSSF)* adopted in February 2008 paves the way for *the "Creation of an Institution of Public Administration with the Mission to provide Social Security Services to the Public, and manage Social Security Benefits to Civil Servants and their Dependents"*.

The NSSFC was officially established in February 2009.

5.2.5 Voluntary Health Insurance Schemes

Voluntary health insurance refers to community based health insurance (CBHI),which is designedbased onthe principlesof risk pooling and pre-payment and arenon-for-profit schemes and run by NGOs. Premiums are sold at a low-costto community members, who are willing to register with the schemes. Insured personsandtheir family are entitled to use the defined health servicesat contracted public health facilities i.e.health centers and referral hospitals. The CBHI operator reimbursesthose facilities for the cost of services consumed by its members.

Geographical coverage

To date, 19 CBHI schemes have been implemented in 19 ODs in 11 provinces via contracts with231 Health Centers, 18 RHs (5 CPA1, 4 CPA2, and 8 CPA3) and 1 National Hospital. Provider payment methods are mixed according to design of each individual scheme. Those include fee-for-service, case base payment and capitation. Table 17provides key information about CBHI schemes.

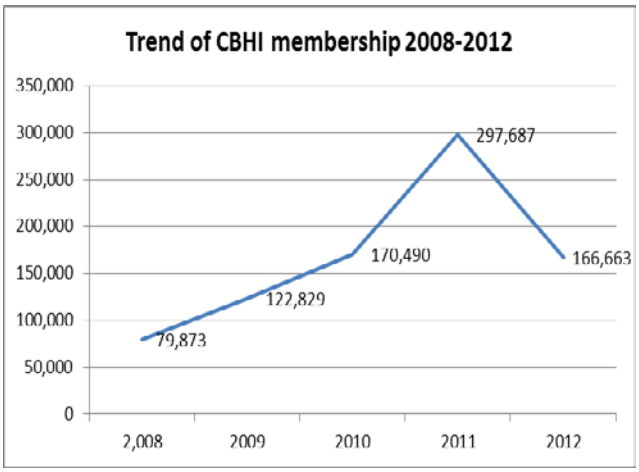
Table 17: Coverage of CBHI 2012

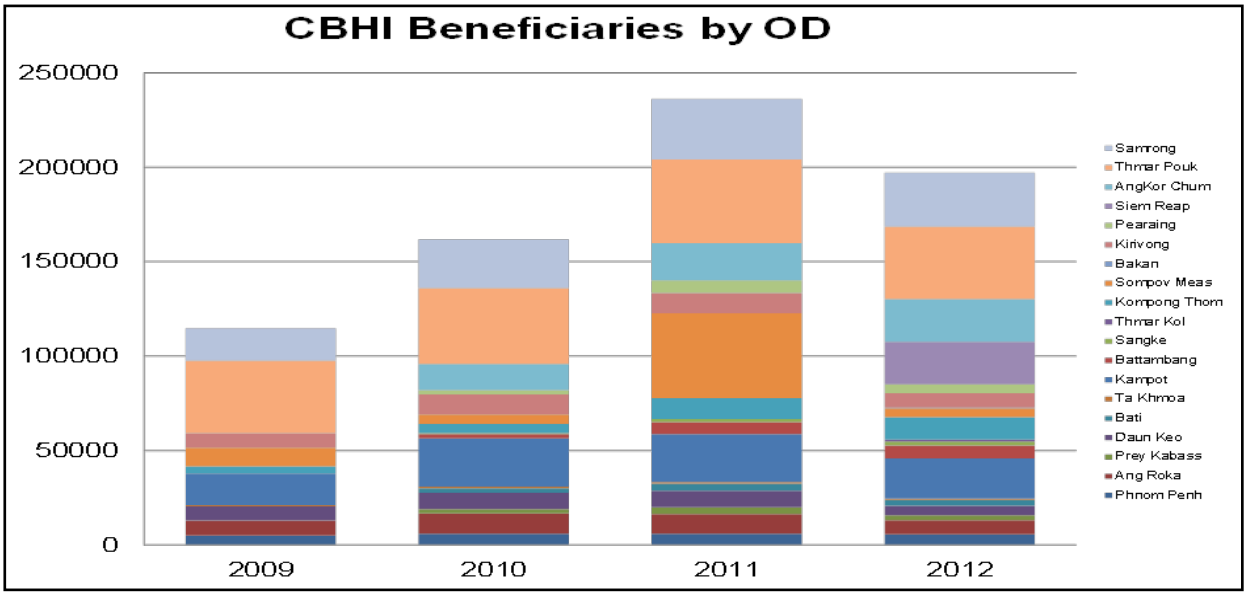
No	Province	No.	Scheme	Start date	No.	Operational District(s)	No. HC with CBHI	Payment Model to HC	Primary Referal Hospital	Payment Model to RHs	Secondary Referal
1	Banteay Meanchey	1	CAAFW	Feb, 2005	1	Thmar Pouk	10	Case	Thmor Pouk RH	Case	Monkol Borey Hospital
2	Oddar Meanchey	2	CAAFW	January, 2009	2	Samrong	19	case	Anlong Veng	Case	Samrong
3	Kampong Thom	3	AFH	January, 2010	3	Kampong Thom	21	Formular linkage	Privincial hospital	Case based + User Fees	
4	Siem Reap	4	CHC	Januray, 2011	4	Siem Reap	22	Case	Provincial Hospital	Case	
	Siem Reap	5	STSA	August, 2010	5	Angkor Chum	17	Case	Angkor Chhum and Puok RH	Case	Siem Reap RH and Khmer Soviet
5	PP. Municipal	6	SKY	Dec, 2006	6	Phnom Penh	2	Fee	Chamkar Morn, Pochentong, Tuo Scay Prey, Samdach Ov, Khmer Soviet Hospital	Fee Lumpsum	Kosamak
6	Takeo	7	SKY	2001	7	Ang Roka	10	Capitation	Ang Roka RH	Capitation	Takeo Hospital
	Takeo	8	SKY	2008	8	Daun Keo	15	Capitation	Takeo RH	Case	
	Takeo	9	SKY	2010	9	Bati	13	Capitation	Takeo RH	Case	
	Takeo	10	SKY	2010	10	Prey Kabass	14	Capitation	Takeo RH	Case	
	Takeo	11	BFH	January, 2006	11	Kirivong	21	Capitation	Kirivong RH	Capitation	Takeo RH
7	Kandal	12	SKY	1998	12	Ta Khmoa		Capitation	Chey Chum Neah Hospital	Fee Lumpsum	Kosamak
8	Kampot	13	SKY	2008	13	Kampot	12	Capitation	Kampot Hospital	Capitation	
9	Prey Veng	14	RACHA/HN	July, 2010	14	Pearaing	10	Capitation	Pearaing RH	Case based	khmer Soviet
10	Pursat	15	PCHSFA	January, 2012	15	Bakan	10	Flat Rate	Bakan RH	Flat Rate	
	Pursat	16	PCHSFA	August, 2011	16	Sampov Meas	22	Flat Rate	Pursat RH	Flat Rate	
11	Battambang	17	CHO	October, 2009	17	Battambang	9	Case	Battambang	Case	
	Battambang	18	CHO	Januray, 2010	18	Sangke	3	Case	Battambang		
	Battambang	19	CHO	March, 2012	19	Thma Kol	1	Case	Thmar Koul		
	Total				**18**		**231**				

Appreciations:
(SKY) SokhapeapKrousaYeung, (BfH) Buddhism for Health, (CAAFW) Cambodian Organization for Assistance to families and Widows, (PFD) Poor Family Development , (CHHRA): Cambodia Health and Human Rights Alliance, (CHO) Cambodian Health Organization, (RACHA) Reproductive and Child Health Alliance, (HNI) Health Net International, (URC) University Research co llc., (STSA) SamakumTheanearabrongSokhapheap (The scheme being managed by the commune council).

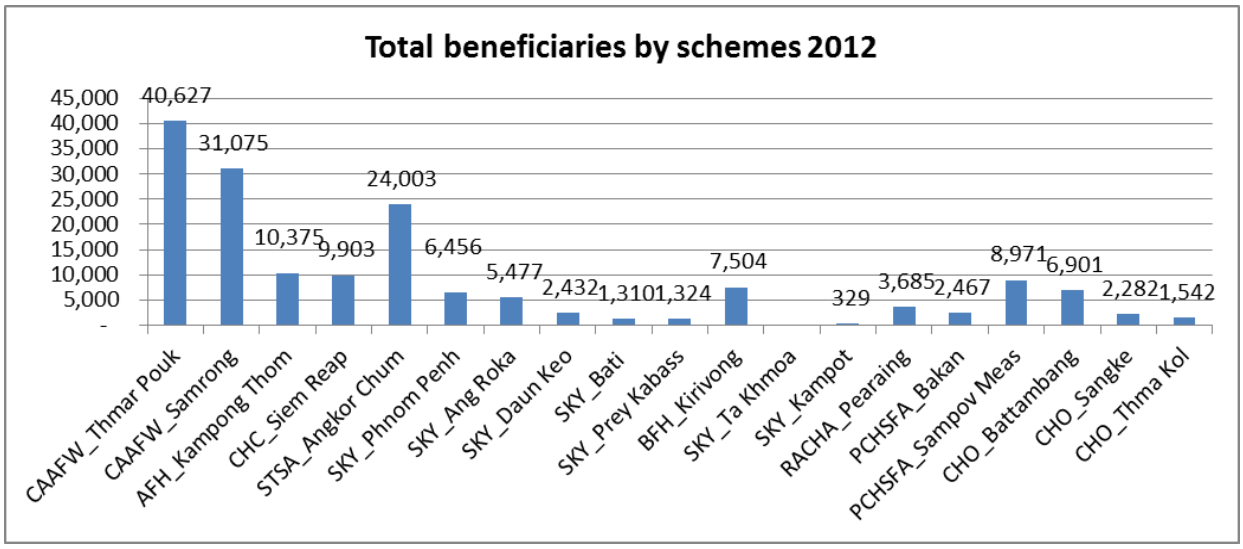
Population coverage

It is noted that the number of schemes has increased from 18 in 2011 to 19 in 2012. In contrast, the total members, who enrolled with those schemes, have decreased from 297,687 in 2011 to around 166,663 in 2012. Following a steady increase between 2008 and 2011, this means that the average dropout rate is high 5% (see figure 13 and 14 below).





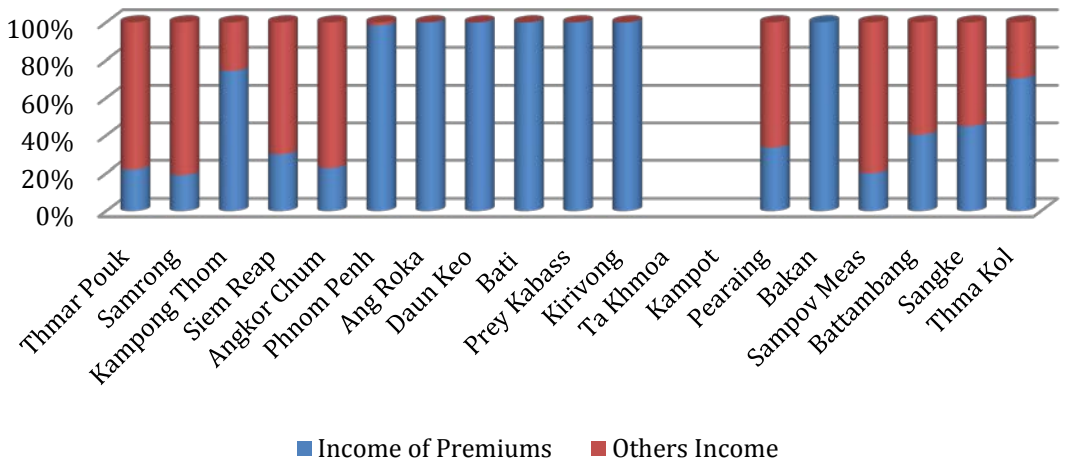
From Figure 15below, it is noted that CAAFW in ThmorPouk OD, Banteay Mean Chey province and Samrong OD in Ordor Mean Chey province have highest memberships (40,627 and 31,075 persons, respectively), and account for almost half of CBHI membership in the country.



CBHI Revenue

The income of CBHI scheme is estimated around USD 656,806 in 2012. On average only 28 % came from premiums paid by members while majority of income (72%) came from other sources, mainly donor funding. It is observed that only a few CBHI schemes can operate by relying solely on premiums; other schemes, especially those with high membership, must use other subsidies to support their function. Figure 16 below identifies the importance of premiums as a significant funding source for CBHI scheme's viability.

Figure 16: income of CBHI by sources 2012



CBHIExpenditure

As Figure 17 indicates, the total expenditure in 2012 was USD 622,715 with 46% spent for medical fee, 34% for administrative cost, and 10% for transportation cost of patients, 4% for outreach and marketing and 2% for other cost.

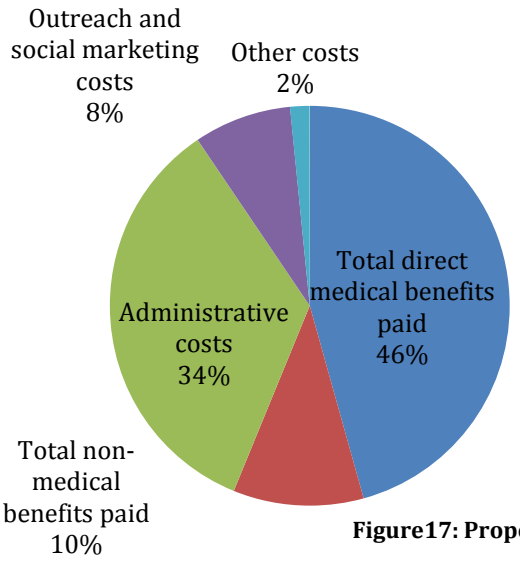
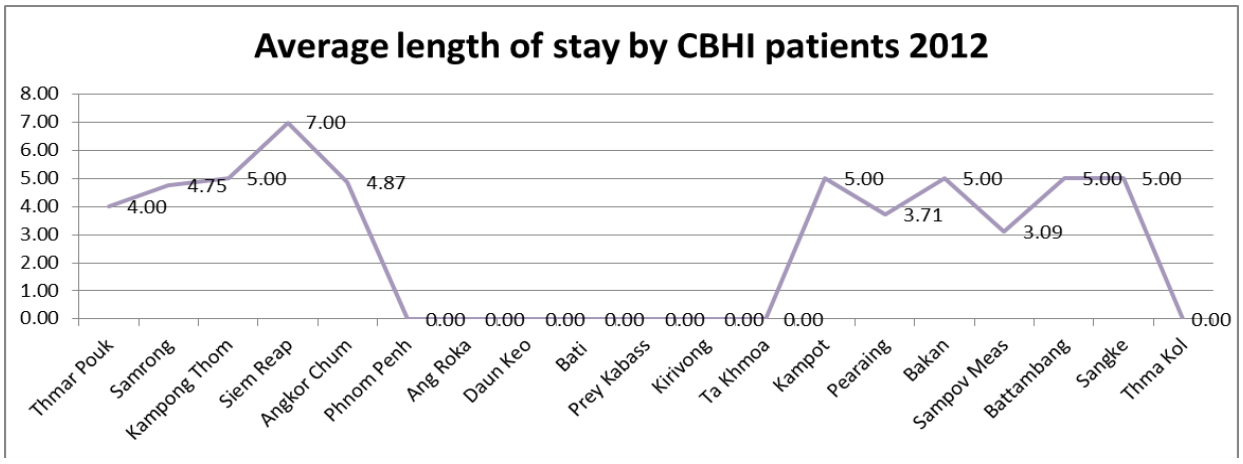


Figure17: Proportion of expenditure 2012

Table 18: Total income and expenditure of CBHI in 2012 (US)

Scheme	No.	OD	Income (USD)			Expenditures (USD)					
			Total Premiums Collected	Others Income	Total Income(USD)	Total direct medical benefits paid	Total non-medical benefits paid	Administrative costs	Outreach and social marketing costs	Other costs	Total Expenditure
CAAFW	1	Thmar Pouk	49,269	174,223	223,492	78,558	13,446	61,908	19,744	6,604	180,260
	2	Samrong	46,963	198,506	245,469	86,570	22,610	68,497	20,829	-	198,506
AFH	3	Kampong Thom	9,666	3,321	12,987	6,577	2,149	20,159	2,683	3,192	34,761
CHC	4	Siem Reap	7,272	16,969	24,242	12,067	331	3,942	257	25	16,622
STSA	5	Angkor Chum	12,112	41,334	53,446	39,188	14,119	6,459	2,133	18	61,917
SKY	6	Phnom Penh	21,469	351	21,820	10,676	3,224	37,056		30	50,985
	7	Ang Roka	6,332	3	6,335	4,698	950	-	-	-	5,648
	8	Daun Keo	2,162	2	2,164	4,612	403	-	-	-	5,015
	9	Bati	2,353	1	2,354	1,551	31	-	-	-	1,582
	10	Prey Kabass	2,186	0	2,187	1,596	218	-	-	-	1,814
BFH	11	Kirivong	4,835	3	4,838	4,798	295	-	-	-	5,093
SKY	12	Ta Khmoa			-						-
	13	Kampot	-	-	-	397	425	14,279	1,816	-	16,917
RACHA/HN	14	Pearaing	2,510	4,978	7,488	3,708	1,057				4,765
PCHSFA	15	Bakan	4,216	-	4,216	7,701	1,266	-	-	-	8,967
	16	Sampov Meas	8,256	32,697	40,953	18,513	4,613	1,267	750	-	25,143
CHO	17	Battambang	475	700	1,175	1,271	261	79	391		2,002
	18	Sangke	572	700	1,272	1,047	128	79	297		1,551
	19	Thma Kol	1,670	700	2,370	726	231	79	132	-	1,168
			182,317	**474,489**	**656,806**	**284,252**	**65,758**	**213,804**	**49,031**	**9,869**	**622,715**

Figure 18 bellow shows variability between ODs in CBHI patients' average length of stay. The average length of stay (ALS) of CBHI patients was estimated to around 4.77 days. However, it is observed that ALS among CBHI patients was longest in Siem Reap OD (7days) compared to other ODs, which were around 4 and 5 days. Zero days means not shown in report.



6. Progress towards Health Financing Strategies included in the HSP2

HF Strategies in the HSP2	Objectives in the Strategic framework for health financing	Progress reported till end of 2011	Areas for consideration
Increase public spending & improving its efficiency	SO 1: Increase government budget and improve efficiency of government resource allocation for health.	• Public spending above 7% of total Government expenditure • Budget fully disbursed • Bottom-up AOP process well established	• Move forward MEF PFM reforms, including: • Revision of programmatic classification • Integrating AOP process into Budget Strategic Plan and revised MEF budget classification • More (flexible) resources at service delivery level needed
Align donors to MoH strategies & plans	SO 2: Align donor funding with MOH strategies, plans and priorities and strengthen coordination of donor funding for health	• Increasing DPs resources are 'on-planning' through AOP • Partners pledge (& fulfill) their resources every year	• Donors to align resources with RGC budget classification to bring on-budget and increasingly use government financial management systems • Need to reduce multiple management & reporting channels • HF issues overseeing body might be needed
Develop social health protection mechanisms to reduce financial barriers	SO 3: Remove financial barriers at the point of care and develop social health protection mechanisms	• Expansion of HEF, covering 76% of targeted poor (goal was 80% by 2010); 24% HC • Wide implementation of poverty targeting tools • Establishment of insurance for	• OOP high but most still use unregulated private sector • CBHI expansion requires further study HEF further development: • Cover all country • Standardized benefit package • Enhance provider payment mechanism

		workers, including design with SHI like packages	• Develop institutional arrangement
Move towards managing resources near service delivery level	SO 4: Efficient use of all health resources at service delivery level	• Government resources devoted to MCH • Midwifery incentives • Move towards a more active role of PHDs in programmed resources	• Bringing more resources under program based budgeting • Institutionalize financial monitoring tools including consideration of NHA • Double burden of diseases: NCDs seem to be underfunded
Use evidence & information to inform health financing policy-making	SO 5: Improve production and use of evidence and information in health financing policy development	• Systematic reporting on health financing reforms • DPHI playing a leading role in HF related research	• Further need for nationally led research agenda, coordination of research and planning

Source: HSP2 Mid-Term Review 2011

7. GLOSSARY

User fees Refers to decentralized and affordable user chargesat public health facilities, as stipulated in Cambodia Health Financing Charter 1996. The Charter certifies the imposition of official fees according to an agreed schedule at affordable rates following consultation with the community. Public hospitals and Health Centers are allowedto implementthis scheme after approval of the MoH.

Exemption A system that allows poor people to receive health care services free of charge at public health facilities. In practice, the exemption system does not work effectively and cannot achieve its desired results, becauseless than half areconsidered too poor to pay for services.

Health Equity Fund A social-transfer mechanism designed to remove financial access to public health facilities by the poor by paying fees for services viaa third-party payer, mainly local NGOs. Pre-identification and post-identification are commonly used to identify the poor, who are entitled to get health services free of charge at the point of use.The third party then reimbursesdirectly the cost of such services usedat facilities on a monthly basis.

Health Equity Fund Implementer (HEFI) An agency whichmanages health equity fund Operator(s).

Health Equity Fund Operator (HEFO) An agency (NGO or any other type of Civil SocietyOrganization) responsible for implementing HEFs,with oversight HEFOs,and representing the voice of and acting in the interest of the poor in coverage areas of HEFs schemes bypurchasing health services from public health providers.

Subsidy (SUB) Subsidy Government fundedscheme(s)wherebypublic health facilities provide services free of charge to the poor patients and their caretakers, but receives by financialcompensationfrom the national budget. The schemes are managed directly by ODs and Hospitals.

Subsidy operator(SUBO)is Any Public Health Authority that is authorized by the Government to receive and manageSUB scheme(s).

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

Voluntary Health Insurance Scheme: 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 operated at community level. These schemes are funded by voluntary premium payments by beneficiaries and commonly require subsidies from other donors. Services are provided by contracted health providers usually in the public sector but may also include qualified private providers.

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