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ANNUAL HEALTH FINANCING
REPORT 2015

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Foreword

Cambodia has a mixed public-private health financing system, mostly financed by household out-of-pocket (OOP) payments, government general taxation revenues and the remainder from international donors. It has been noted that the health budget has risen rapidly in recent years.

The Government of Cambodia is committed to universal health coverage, which means that all people can access the health care they need at an affordable cost. Health financing arrangements also drive sustainability and efficiency of resource allocation and use. Information and data on health financing can help government and development partners to make decisions on policy, planning and resource allocation. Efforts are being made to strengthen systematic reporting of financial data.

The Annual Health Financing Report is annually developed by the Bureau of Health Economics and Financing, Department of Planning and Health Information of the Ministry of Health. The objective of this report is to consolidate health financing information including government budget and disbursement for health, Official Development Assistance, Out of Pocket, User Fee, Health Equity fund, Government subsidy scheme, Voucher scheme and Voluntary Health Insurance. The development of this report is mainly based on the existing information through regular reporting from health facilities and schemes to the MoH and other related documents.

We would like to express our sincere thanks to the Department of Planning and Health Information, particular the Bureau of Health Economics and Financing for its effort to the development of this report.

We hope that this health financing report 2014 provides a comprehensive updated health financing information.

May 12, 2015 



Prof. Eng Huot

Secretary of State for Health

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Contact Address

***Bureau of Health Economics and Financing
Department of Planning and Health Information
Ministry of Health
#80 Samdah Penn Nouth Blvd (289), Sangkat Boeungkak 2, Khan Tuol Kok,
Phnom Penh
Email: chhuneangmoh@gmail.com***

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Executive Summary

The objective of the report is to present health financing information by different sources of financing to the health sector, including government funding, external assistance and out-of-pocket expenditure. The report also provides an overview of health financing schemes currently in place in Cambodia, such as Health Equity Funds, voucher schemes and voluntary health insurance.

How much was spent on health?

Total health expenditure is financed by three main sources – Government, development partners, 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 approximately 1 billion USD in 2014, representing more than 6% of GDP and about 70 USD per capita. Out-of-pocket spending accounts for more than 60% of THE, followed by 20% each from the Government and donors.

Where did the money go?

The Government of Cambodia recognizes health as a priority sector for investment. National budget allocation for health has consistently increased over the last ten years. Of the current national budget allocation, 70% is managed by the central level (including equipment, supplies and drugs to be distributed to health facilities) and 30% by the provincial level. Development partners provide technical and financial support to particular health institutions, health facilities or pooled funds through the Second Health Sector Support Program (HSSP2). NGOs support both supply and demand sides financing. Out of pocket expenditure for health is individually paid by people or households to public and private health facilities when using health services.

Who provided the funds?

The national health budget has been increased annually, particularly in 2014, the Government budget was about USD 240 Million, around 1.3% of GDP, 13% of Government current spending, and USD 16 per capita, which representing around 19% of THE.

Development partner support to the health sector in 2013 was USD 199.6 million, approximately USD 10 per capita, while in 2014 it was USD 191.1 million (approximately 18% of THE) according to reporting to the database. The National Health Accounts (NHA) found that expenditure by development partners was USD 209.0 million in 2012; this data was collected through survey questionnaires. The NHA donor support survey 2013 and 2014 is underway and NHA findings are anticipated to be released in the third quarter of 2015.

Household health expenditure, via out-of-pocket expenditure, contributes the greatest part of THE (about 63% of total health spending). In 2014, out-of-pocket expenditure amounted to USD 658 million.

Equitable funding

While Health Equity Funds cover the poor population, since there is no pre-payment schemes or social health insurance and limited risk pooling, the majority of household pay fee-for-services to private and public health providers when they use health services. 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. (1) Supply-side schemes aim to increase access to services by the poor while improving service quality. These schemes include regular budget, user charges with exemption for the poor, special operating agency and service delivery grant, midwifery incentive and government subsidy for the poor. (2) 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).

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. The introduction of user charge with exemption policy as well as other financing scheme initiatives including midwifery incentive and demand sides financing which result in emerging concept of social health protection to universal health coverage (UHC). MOH will implement the Decentralization and De-concentration program in the health sector, and other reforms such as public administrative and financial management reforms of the government. Draft health financing which mainly focus on UHC is under consultations and the Third Health Strategic Plan 2016-2020 (HSP3) is under development.

Moving Forward to UHC

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 increased THE to more than 6% of GDP, relatively higher than other neighbouring countries, however the financing system is still fragmented with limited pooling function.

UHC is a universal goal endorsed by the United Nation and ASEAN counties with strong commitment from member states. Cambodia has strong commitment to UHC. The vision of the new draft national health financing policy 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. Introduction

Health financing issues have been at the centre of Cambodia's efforts to rebuild the health system and have been a crucial part of the health reform process that began after 1993. Particularly from 1996, there has been a series of health sector reform including health system financing. Beginning with the adoption of the Health Financing Charter, the government permitted public health facilities to introduce modest and regulated user fees to supplement facility revenues; however user fee is not cost recovery. Government tax financing through supply side remain the major source of funding for publicly provided health services. Since then, different health financing options on both the supply side and the demand side have been implemented. In particular, the implementation of numerous schemes has made the governance of the health financing system more complex, through: (a) the proliferation of different types of schemes introduced at the initiative of development partners, (b) the limited capacity of the Government to control and regulate multiple initiatives including the private sector.

Cambodia has a mixed public-private health financing system, mostly financed by household out-of-pocket (OOP) payments, government general taxation revenues and the remainder from international donors. It has been noted that the health budget has risen rapidly in recent years.

The Government of Cambodia is committed to universal health coverage, which means that all people can access the health care they need at an affordable cost. Health financing arrangements also drive sustainability and efficiency of resource allocation and use. Information and data on health financing can help government and development partners to make decisions on policy, planning and resource allocation. Efforts are being made to strengthen systematic reporting of financial data. Cambodia produced its first ever National Health Accounts (NHA) in 2014 (with 2012 data).

The Annual Health Financing Report, which has been produced by the Bureau of Health Economics and Financing, Department of Planning and Health Information, Ministry of Health, since 2007, attempts to further increase available data on health system financing. This year's report provides updated data on health expenditure and social health protection coverage, and reviews progress on the key health financing functions: revenue-raising, pooling, purchasing and stewardship.

2. Country context

2.1 Macroeconomic context

Cambodia is a low-income country with an estimated gross domestic product (GDP) per capita of US\$ 1,043 in 2013, US\$ 1,130 in 2014 and US\$ 1,225 in 2015 (Ministry of Economy and Finance booklet, 2015 budget brief). Except during the financial crisis in 2009, the economy has grown by at least 6% annually since 2005 (in 2005-2007 it was at least 10%) and is projected to increase by 7.5% in 2015. The economy is driven by the garment, construction, and services sectors, especially tourism. The inflation is rather stable with the variation around 3% so as the exchange rate is around 4,050 per one US dollar.

2.2 Poverty reduction

Cambodia has made impressive progress on reducing poverty. A recent assessment by the World Bank found that the poverty rate decreased from 53% in 2004 to around 20% in 2011, primarily due to strong (pro-poor) economic growth (World Bank, 2014).

2.3 Health status

The health status of the Cambodian population has been steadily improving during the past decades and Cambodia is on track to achieve the health-related Millennium Development Goals as indicated by preliminary findings of the 2014 Cambodia Demographic and Health Survey (CDHS). The maternal mortality ratio decreased from 472 per 100,000 live births in 2005 to 206 in 2010 and 170 in 2014. Under-five mortality decreased from 83 per 1,000 live births in 2005 to 54 in 2010 and 35 in 2014. Remaining challenges include neonatal mortality, poor nutrition outcomes (40% of children were stunted in 2010, a measure of chronic malnourishment), a double disease burden of communicable and non-communicable diseases (NCDs), and high rates of adolescent pregnancy. There are also significant inequalities in health status by socio-economic status and between urban and rural populations.

3. The health system and its financing

3.1. Health System Organization

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 expenditure. For the public health sector, each operational health district (OD) has a number of health centres providing first line health services (Minimum Package of Activities) with a catchment 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. The organization of the health system comprises Ministry of Health, 12 Departments, 4 National Programs and 8 National Hospitals, 25 Provincial health departments, 88 Operational Districts, 98 Referral Hospitals, 1105 Health Centres and 106 Health Posts (Table 1).

Table 1: Number of health facilities, 2008-2014

Description	2008	2009	2010	2011	2012	2013	2014
No of Operational district	77	77	77	77	79	81	88
Total hospital	87	88	89	90	91	94	106
Number of National Hospital including MCH and TB	8	8	8	8	8	8	8
Number of Referral Hospital	79	80	81	82	83	86	98
Number of Referral Hospital with CPA1		34	34	33	36	39	51
Number of Referral Hospital with CPA2		28	30	31	29	29	29
Number of Referral Hospital with CPA3		17	17	18	18	18	18
Number of Health Center	967	984	997	1,004	1,024	1,088	1105
Number of Health Post	107	111	117	123	124	86	106
Number of Bed	8,968	9,545	11,587	12,051	12,651	12,513	12,249

3.2 Policies, strategies and legal frameworks on health financing

The Charter on Health Financing was introduced in 1996 along with major health sector reforms, including the health coverage plan and realignment of administrative districts with the concept of ODs. The Charter provided a policy framework to introduce and pilot a series of health financing schemes, including user fees and contracting.

The Strategic Framework for Health Financing 2008-15, which fed into the Second Health Strategic Plan 2008-15 (HSP2), is currently the overarching health financing strategy. The strategy calls for:

- increasing the government budget for health while spending it more efficiently
- aligning external funding with government priorities and improve coordination
- developing social health protection mechanisms to improve financial access to care
- improving efficiency of resource use at the service delivery level
- Increasing use of evidence to inform decision-making.

A draft National Health Financing Policy has been developed in consultation with government and development partners. The draft policy is currently under consideration by the Ministry of Economics and Finance prior to submission to the Council of Ministers. The vision of this policy is to enable active participation of all residents of Cambodia 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 principle of the Health Financing Policy is guided by Constitution, which stipulates that the health of each citizen is to be guaranteed and that the poor should receive free medical care. The importance of improving health services and ensuring access to them for the poor was reiterated in the Rectangular Strategy Phase III for Growth, Employment, Equity and Efficiencies in Cambodia.

The underlying principles 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.

The policy suggests actions in six strategic areas (population coverage, benefit package, purchasing services, and source of funds, institutions and regulation) and outlines institutional arrangements to strengthen social health protection to achieve universal health coverage in Cambodia.

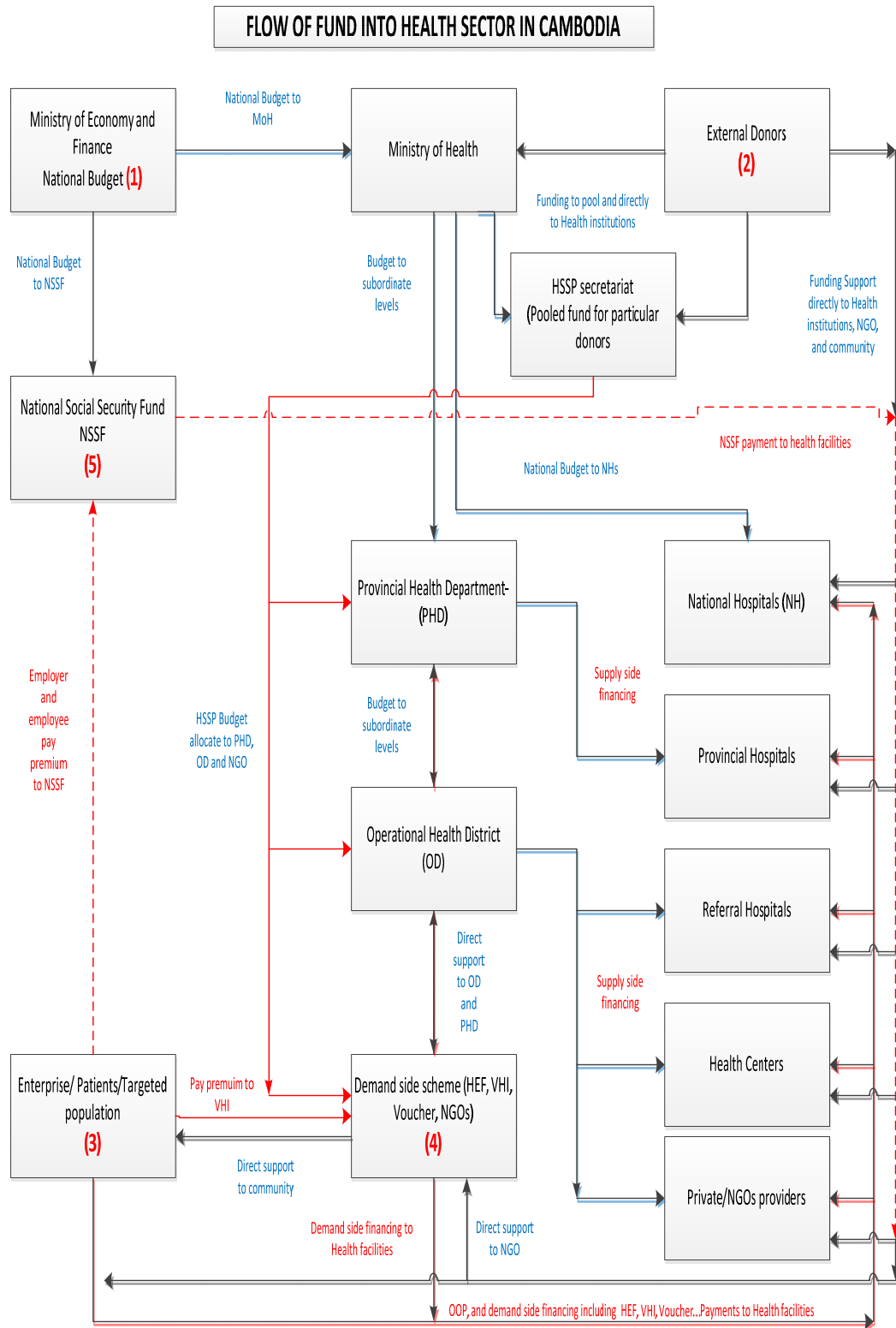
Cambodia is an official member of the ASEAN + 3 (China, Japan and Korea) UHC Network that provides a “platform to support and accelerate progress towards well-functioning and sustainable UHC in developing countries and advancing the regional and global UHC agenda.” Cambodia is also a signatory to UN Resolution A/67/L.36 on Universal Health Coverage adopted on 12 December 2012, which urges governments to ensure all people access to affordable quality health services and “calls upon Member States to ensure that health financing systems evolve to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care as well as a mechanism to pool risks among the population”. The Ministry of Health has nominated officials to be member of ASEAN’s Universal Health Coverage Network.

3.3 Description of how funds flow through the system

As illustrated in Figure 1, the main sources of funding in the Cambodian health system are the government (the national budget through the Ministry of Economy and Finance), external donors and household expenditure through out-of-pocket (OOP) expenditure. Companies also finance some health care through the work injury scheme operated by the NSSF. There are several mechanisms through which these funds are channelled through the health system. Out-of-pocket expenditure is primarily channelled through user fees at health facilities (a considerable amount of OOP expenditure is accounted for by public and private providers, including pharmacies and drug-sellers). A large part of Government budget channelled through annual regularly budget and partially of Government budget with donor funding for health is combined under the joint Second Health Sector Support Program (HSSP2).¹ Some donor funds also pass directly to health organizations, health facilities and to NGOs. MOH provides funding to national hospitals. The provincial Health Department (PHD) and MOH channel funding to the ODs, which in turn transfer funds to referral hospitals and health centres for provision of primary and secondary health care. There are also funding channelled through vouchers, community based health insurance (CBHI) and the NSSF’s work injury scheme mentioned above.

¹ The successor of HSSP2 is currently being designed to support and align with the Third Health Strategic Plan 2016-2020 (HSP3).

Figure 1: Overview of financial flows in the public health sector of Cambodia



By ROS CHHUN EANG 2012 HSSP: Health Sector Support Program, NGO: None Government Organization, NSSF: National Social Security Fund, HEF: Health Equity Fund, VHI: Voluntary Health Insurance,

3.4 Health financing and social health protection schemes

Table 2 provides an overview of health financing and social health protection schemes operating in Cambodia. Further details about these schemes are provided below.

Table 2: Overview of health financing and social health protection schemes

Scheme	Implementer Operator	Target population	Benefit/ services	PPM	Funding	Coverage/ remark
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	Govt.	Nationwide public health facilities
User fee	Health facilities	All affordable population	All available services by health facilities level	Fee for service Lump sum or case base	OOP	It is partially cost recovery as most of supports already provides by the government.
User fee* exemptions	MOH/health facilities	Poor patients	MPA and CPA123	User fee exception	Health facility	Nationwide
Global health initiatives and national programs	National program	Patients with TB, malaria, AIDS, and children for vaccination,	TB, Malaria, AID patients and children age under 1 year	Free of charge	Govt. and DPs	Nationwide
Health Equity Fund (HEF)	NGOs for HEFs	The eligible poor (those under the national poverty line)	MPA and CPA services , food, transport, funeral expenses	Official standardised Case base payment	Govt. and DPs	In 63 RHs , 1 NH and 602 health centres, covering approx. Almost 90% covered of targeted population.
Government Subsidy schemes (SUBO)	MOH/PHD/OD	The eligible poor (those under the national poverty line)	MPA and CPA services	Official Flat rate	Govt.	In 6 National Hospital and 11 referral hospitals and 57 health centres
Voluntary Private Health insurance	Private company	All affordable population		Fee for services	OOP	
Voluntary 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.	OOP and DPs	20 ODs with 21 RHs and 1 NH and 157 HCs. Coverage far less than 1% of the population
Vouchers for reproductive	NGOs	Poor women	Reproductive health	Fee for	Govt. and	In 20 ODs with 21 Hospitals and 183 HCs and

Scheme	Implementer Operator	Target population	Benefit/ services	PPM	Funding	Coverage/ remark
health			services	services	DPs	6 private clinics.
Occupational Risk	MOLVT/ NSSF	Formal private sector workers	Medical treatment, temporary/ permanent disable, funeral expenses and survivor benefit	Fee for service	Employers	Covered 5,255 enterprises with 964,988 workers
Maternity Benefits	MOLVT/ NSSF MOSVY/ NSSF	Pregnant women formal sector workers and civil servants	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	Govt. and others	Nationwide
Social health insurance (SHI)	NSSF NSSF	Formal sector workers and civil servants	Still to be defined	Study about case base payment	Employers and Employees	A formal private sector worker is being piloted by NSSF.
Special Operating Agency (SOA) facilities	MOH/Dons/ HSSP	All population in the coverage area	Decentralize together with Performance-Based Incentives for Providers	Line item and Special Delivery Grant (SDG)	Govt. and DPs	In 36 Operational Health Districts
Midwifery incentive	HC and Hospitals	Midwives working in public facilities	15 US dollar at RH, and 10 US dollars at HC per a live birth	Case base	Govt.	National wide

Govt.= Government; **DPs**= Development Partners; **CPA** = Complementary Package of Activities; **HC** = Health centre; **HSSP2** = Second Health Sector Support Programme **MOH** = Ministry of Health; **MOLVT** = Ministry of Labour and Vocational Training; **MPA** = Minimum Package of Activities; **NGO** = Non-governmental organization; **NSSF** = National Social Security Fund; **OD** = Operational health district; **PHD** = Provincial Health Department; **RH** = Referral hospital

3.4.1 Government budget

The health sector is one of the prioritized sectors in Cambodia; the government investment has been increased notably from year to year. The government provides support in terms of inputs into health sector as line item budget through annual operation plan annually. In 2014, the government budgeted around 977 billion Riels (approximately 241 million US dollars) for the health sector, which is more than double the amount (US\$ 104 million) in 2008. Of this budget, around 30% was allocated to provincial level, while the rest was managed by central MOH. Even though it was seen as high spending by central MOH, the spending included procurement of drug, equipment and other supplies to be distributed to health facilities. The actual expenditure has been around 95% compared to the approved budget. Section 5 contains additional information on government health expenditure.

3.4.2 User fee, exemption and free health programs

As part of the health sector reforms initiated in 1996, nominal user fees were introduced with the objective of generating additional revenue to improve quality of services and increase staff motivation. Fees levels were to be set in consultation with community representatives, taking into account the capacity-to-pay by the population; ideally it is not a full cost recovery of service provided. User fees revenues are managed locally by respective health facilities in accordance with the inter-ministerial Prakas No. 657 MoEF dated 11 October 2005, which states that 60% of the revenue can be used for staff incentives, 39% for operating costs while 1% is transferred to the National Treasury. User fees can constitute a considerable proportion of facility funding. Contrary to international experience, the introduction of user fees was associated with an increase in utilisation, an issue which is ascribed to reduced under-the-table payments and display of incentive-induced improved interpersonal skills.

In compliance with the Charter on Health Financing, user fee exemptions for the poor are strongly imposed at public health facilities. By the Government policy, Tuberculosis services – from disease detection to treatment and care are 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.

3.4.3 Midwifery incentive

To boost the delivery at public health facility with trained staff and contribute for reduction of MMR and IMR, the government of Cambodia has initiated midwifery incentive for a live birth delivery. Government midwifery incentive scheme (GMIS) is a government initiated and funded supply-side and output-based health financing mechanism aimed at motivating skilled birth attendants (or trained health personnel) to promote deliveries in public health facilities. It became operational nationwide in late 2007, following a joint Prakas (directive) by MOH and the Ministry of Economy and Finance to allocate government budget to the payment of an incentive for midwives of 60,000 Riels (USD15) for each live birth attended in health centres and 40,000 Riels (USD10) in hospitals. The number of deliveries is reported monthly by health facilities through the routine health information system. The report must be signed by the director of the health facility and, for health centres, also by the commune chief. Based on the number of reported deliveries, health facilities submit their reimbursement claim on a quarterly basis through public administrative and financial channels.

3.4.4 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 described 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. SOA status provides public facilities

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.

MOH has developed an SOA manual, which sets out the guidance on how SOAs will be implemented and managed in the public health sector. The development of this Manual was informed by the 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 behaviour 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 the poor. Up to 2013, there are 30 SOAs established under the Royal Government’s Sub-decree, located in 9 provinces covering 8 provincial hospitals and 22 Operational Districts that further cover 16 referral hospitals, 291 health centres 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 SOA accounts via the banking system. SOA health facilities are also allowed to charge user fees and contracted payment from demand side financing schemes. From January 2014, there are 6 additional SOAs, so total SOA will be 36 made of 26 ODs and 10 Hospitals, 387 HCs and 84 HPs. It is observed that because there are multiple funds and injected mechanism to SOA, purchasing power still remains low. Therefore it would better if the fund is pooled.

3.4.5 Health Equity Funds

Health Equity Funds is a pro-poor health financing mechanism and widely recognized as a social-transfer mechanism. HEFs are designed to reimburse the full or partial cost of health services provided to the poor at public health facilities. This involves the poor who are entitled as HEFs beneficiaries, using health services as they need free of charge. Usually, HEF beneficiaries become entitled through the process of pre-identification of the poor (community-based assessment), but post identification or health facility-based assessment is an option for the poor who access health facilities haven’t been identified and registered already.

The HEFs are implemented through a third party implementer (HEFI) and third party operator (HEFO) according to standard benefit package and payment mechanism. A health equity fund operator (HEFO) is an agency (NGO or other type of organization in the civil society) that acts in the interest of poor people in an operational district to facilitate access and purchase of health care services from a health care provide from which it is independent. A health equity fund implementer (HEFI) is an agency identified by MOH which supervises the activities of a cluster of HEFOs through field level output monitoring certification of direct benefit invoices, and technical assistance to ensure validity of expenditure and harmonization of HEF operators.

Contractual arrangements are a basis for HEF management and implementation. Selection of HEFIs and HEFOs is a competitive and open bidding process that is handled by MOH (HSSP2 Secretariat).

Benefit packages covered by HEFs include reimbursement for medical services available at public health facility (MPA service at health centre and CPA services at hospital) and other associated costs such as transportation cost, food cost, allowances for a patient’s care-taker, and funeral cost.

Provider payment method is based on standardized rate as approved by MOH letter No.10-12 HSSP2, dated 15th June 2012. Payment is case based payment mechanism for OPD, IPD, delivery, average surgery cost by level of health facility such as CPA1, CPA2, CPA3, National Hospitals, Former District Hospital, MPA, ambulance services, transportation reimbursement, maximum emergency vehicle transportation, caretaker food allowance, funeral.

HEF is funded by Development Partners through pooled funding and government counterpart fund coordinated by HSSP2 secretariat within the Ministry of Health. As of 2014, HEF benefits were provided in 61 ODs, including, 602 health centres, 63 referral hospitals, and one national hospital (Figure 2). Table 3 provides additional data on the implementation of HEFs. Concomitant with the expansion of HEFs in the recent past, the proportion of the poor living under the national poverty line (31%) protected supported by HEFs has risen significantly from 11% in 2008 to 21% in 2009 and 35% in 2010, and with current poverty rate (20%), the HEF coverage is around 71% in 2011, and 76% in 2012, more than 85% in 2013 and almost 90% in 2014. The Ministry of Health has planned to expand HEFs program to reach its full coverage in 2015, meaning that all the poor living under the national poverty line will be protected by HEFs.

Figure 2: Health Care facilities covered by Health Equity Funds, 2000-2014

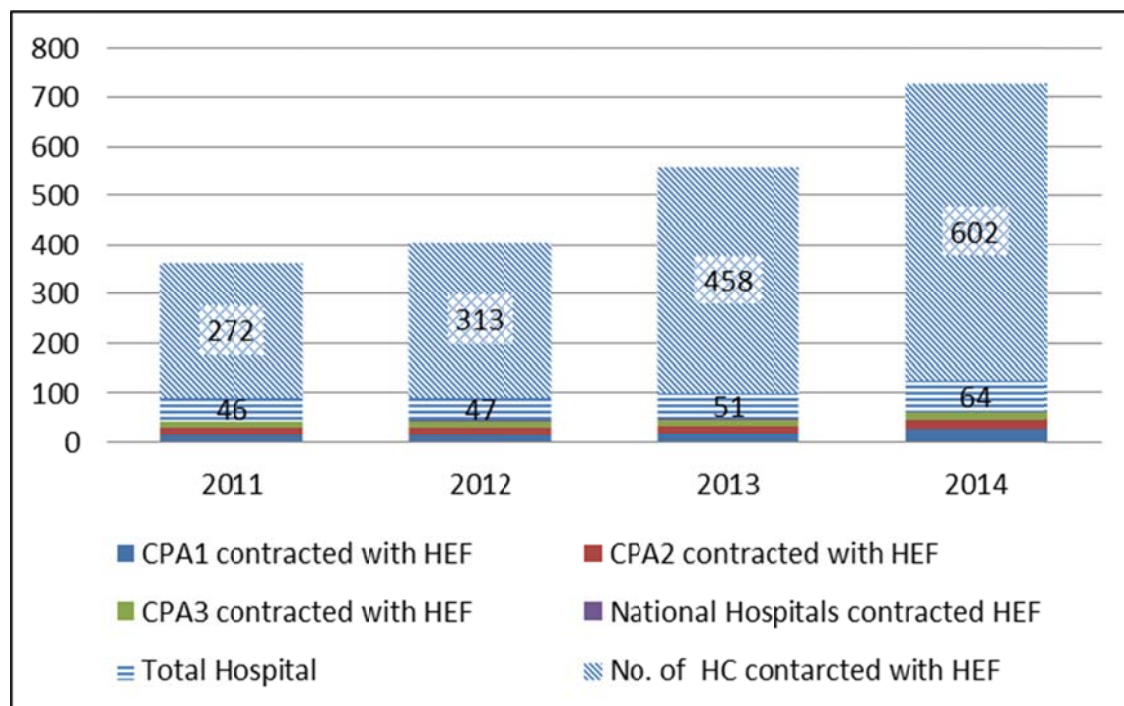


Table 3: Overview of Health Equity Funds

Health Equity Fund Schemes_HEF	Currency	2,008	2009	2010	2011	2012	2013	2014
Health Equity Fund Schemes_OD		42	42	44	44	45	49	61
Total Hospitals		44	44	45	46	47	51	64
CPA1 contracted with HEF					18	18	19	28
CPA2 contracted with HEF					14	14	17	21
CPA3 contracted with HEF					13	14	14	14
National Hospitals contracted HEF				1	1	1	1	1
No. of HC contracted with HEF		110	141	235	272	313	458	602
Total utilization cases supported by HEF		58,110	425,705	125,209	890,568	1,128,161	1,299,046	1,575,466
OPD cases		19,101	321,713	106,018	791,819	990,524	1,171,969	1,423,245
IPD cases		39,009	103,992	19,191	98,749	137,637	127,077	152,221
Total health equity fund expenditure	USD	0	4,820,215	4,652,391	6,429,228	10,045,676	9,959,458	11,559,134
HEFO expenditure	USD	0	4,820,215	4,652,391	6,429,228	9,457,954	9,384,585	10,938,053
HEF Direct Expenditure	USD		3,634,603	4,099,096	5,178,589	7,967,377	7,690,737	8,966,852
HEF Direct Expenditure for OPD	USD				829,932	1,922,395	1,471,346	1,799,250
HEF Direct Expenditure for IPD	USD				2,906,346	3,977,202	4,232,529	4,932,208
HEF Direct Expenditure for transportation, food, funeral..	USD				1,442,311	2,067,780	1,986,862	2,235,394
HEF Indirect Expenditure (Management)	USD		1,185,612	553,295	1,250,639	1,490,577	1,693,848	1,971,201
HEF Implementer expenditure	USD					587,722	574,873	621,081
Coverage of population (poor and near poor)	Person	469,038	909,606	1,535,478	2,028,739	2,244,852	2,693,373	2,620,759

3.4.6 Government subsidy scheme

The government-funded subsidy scheme (SUBO) aims at removing financial barrier in access to and utilization of public health facility for the poor by providing compensation for cost of health services used by the poor through the issue of the inter-Ministerial Prakas 809 in October 2006, which has eight articles provides guidance and key principles for the implementation of this scheme and refers to the MOH and other implementing institutions to work out the practical details, including tools and methods for identification of poor patients and monitoring.

Provider payment method is based on a fixed case based payment as stipulated in the joint Prakas 809, dated 2006 of the Ministry of Health and the Ministry of Economy and Finance.

So far, the subsidy scheme are implemented in 6 national hospitals, 12 referral hospitals and 152 health centres in 12 operational districts in 8 provinces. However, according reports to DPHI there are 6 National hospitals, 11 RH and 57 HCs implementing subsidy schemes (Table 4).

Table 4: Overview of Government subsidy scheme

SUBO	2,008	2009	2010	2011	2012	2013	2014
SOBO schemes				12	12	12	12
Total Hospitals				11	11	11	11
CPA1 implementing SUBO							
CPA2 implementing SUBO				8	8	8	8
CPA3 implementing SUBO				3	3	3	3
National Hospitals implementing SUBO				6	6	6	6
No. of HC implementing SUBO				47	57	57	57
SUBO utilization		-	-	71,018	75,771	55,928	48,827
OPD cases				50730	8,917	31,337	33671
IPD cases				20288	16,705	24,591	15156
Total SUBO expenditure (USD)				351,606	284,955	424,561	214,940
SUBO Expenditure for OPD				18,124	150,777	4,588	
SUBO Expenditure at IPD				333,482	134,178	419,972	214,940

3.4.7 Vouchers for reproductive health

Vouchers allow targeting poor and underserved populations, increasing their access to specific health services that tend to be underutilised, including maternal, neonatal, child and reproductive health services. A voucher scheme for reproductive health services is relevant to the Cambodia context where the poor and vulnerable in general and women and children in particular face numerous barriers to accessing these services. Coverage and utilization data is provided in Table 5. The voucher scheme was seen as another fragmentation but will increasingly be linked with the health equity funds, employing the same operators and applying similar operational aspects, including accounting systems, provider payment methods and amounts and provision of social benefits. The introduction of the voucher scheme was found to have boosted an increase in facility-based deliveries, uptake of family planning and especially safe abortion. During 2014 the voucher scheme targeted poor women with specific benefit package consisting mainly of reproductive health services including delivery, family planning and safe abortion. The voucher scheme is currently operated by a local NGO (AFH) and implemented by EPOS Company. The scheme is financially support by KFW Germany.

Table 5: Overview of voucher scheme

Voucher Scheme_ Voucher for Reproductive Health	2,008	2009	2010	2011	2012	2,013	2014
Voucher_Coverage of ODs				9	9	9	21
Total Hospitals				5	5	5	20
Voucher_Coverage of CPA3				1	1	1	
Voucher_Coverage of CPA2				4	4	4	
Voucher_Coverage of CPA1							
Voucher_Coverage of National Hospital				-	-		1
Voucher_Coverage of HC				78	118	121	297
Voucher_Coverage of clinics				2	4	4	6
Total utilization cases				13,712	36,299	53,772	68,276
Utilization at HC				11,432	31,204	46,693	59036
Utilization at RH				178	1,248	1,981	4243
Utilization at Private-None profit				2,102	3,847	5,098	4997
Total expenditure				307,606	1,119,632	1,229,255	1,804,337
Expenditure for Direct and associated cost				124,467	614,391	614,391	1128017
Expenditure for Operating cost				183,139	505,241	614,864	676320

3.4.8 Social health insurance

There is no social health insurance in Cambodia so far. In 2005, the MOH developed the Master Plan for Development of Social Health Insurance and Inter-Ministerial Committee for Social Health Insurance was established, comprising of the MOH, MOLVT, MOSAVY, MOP, MOEF and the Council of Ministers. Since then a number of policy and guidelines have been developed in order to support the development and implementation of various forms of social health protection mechanism, moving towards the ultimate goal of universal coverage under unified social health protection measures.

Then the draft of Social Health Protection Master Plan revised from the first Social Health Insurance's Master Plan has stated two strategic approaches to universal coverage: (1) consolidate the exist schemes thoroughly, and (2) develop a unified national system for social health protection. The plan has also elaborated clearly the role of concerned institutions involving in the development of social health insurance. Such as, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) takes an oversight role for the development of social health insurance for civil servant, which will be executed by the National Social Security Funds for Civil servant, while the Ministry of Labour and Vocational Training (MoLVT) is responsible for the development of Social health insurance for the private salaried sector, which is currently operated by the National Social Security Funds. The Ministry of Health is responsible for the development of social health protection for the informal sector, which includes CBHI, HEF and other schemes. And the Ministry of Economics and Finance will have a regulatory function. This plan was not approved.

To facilitate implementation of so called CBHI, the Ministry of Health has developed Guidelines on Community Based Health Insurance to provide guidance for (i) the design, arrangements and operation of CBHI schemes, which are subject to MOH's approval, and (2) facilitation CBHI schemes to be operated in the context of "the same purpose and the same core principles". It is interesting to note that a sound legislative framework for CBHI schemes is currently included in the temporary circular of micro insurance of the MoEF. An overall purpose of this temporary circular is to provide a legal tool for regulation, including licensing, of Micro insurance providers. Micro-insurance services specified by the circular include micro-health insurance, micro-life insurance, micro insurance for property and loan insurance. This regulatory tool also identifies two types of organization that can operate micro insurance schemes. The first one is "Micro-insurer- a company" and the second is "CBHI operators".

Mandatory health insurance

Two types of Compulsory Health Insurance scheme are envisioned in the draft National Health Policy, to be implemented and managed by two different institutions according to the target population.

First, the Ministry of Labour and Vocational Training (MOLVT) is responsible for the development of compulsory social security for private-sector salaried workers under the Social Security Law (2002). The law articulates, among other provisions, the establishment of the Social Security Organization and the provision of a work injury program and old age pensions.

The National Social Security Fund for the private sector (NSSF) was established by Sub-decree No. 16 dated 02 March 2007, in order to pursue the following objectives:

- To manage and administer the social security schemes
- To ensure provision of all benefits to members to support security of income in case of any contingencies 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 about methods of occupational risk prevention, take measures on health and safety at work places; and study and investigate occupational diseases.
- To manage the investment of social security funds

The Employment Injury scheme started its implementation in 2008, and covers private enterprises employing 8 or more workers, the contribution of employer is 0.8% of average wage of employees. Up to 2014, 7,041 enterprises with 1,021,588 employees (725,327 women) were registered with NSSF and 5,255 enterprises had paid the contribution for work injury scheme for a total of 964,988 employees.

The social health insurance under NSSF did not start yet, but preparations have been made, such as draft Prakas on the benefit package and the provider payment system. Currently, NSSF is managing a voluntary health insurance scheme targeting private garment industry workers in Phnom Penh. The project is called the Health Insurance Project (HIP) and was initiated by the French NGO Groupe de Recherche et d'Echanges Technologiques (GRET). HIP covered 8,249 employees in 11 enterprises in 2014. The premium is 1.6 US dollars per month, which splits to be paid by employer 50% and employee 50%. The scheme contracted two health centres (Tuol Kork and Stung Mean Chey) and three public hospitals (Khmer Soviet, Preah Kossamak and Pochentong) to provide health services to its beneficiaries. Expenditure for medical health was 71,282 US dollars in 2014.

Second, the 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 NSSF was officially established in February 2009.

3.4.9 Voluntary health insurance

Voluntary health insurance referred to (1) community base health insurance and (2) private health insurance.

Community-based health insurance

In Cambodia, voluntary health insurance refers to community based health insurance (CBHI) which is designed on the basis of the principles of risk pooling and pre-payment for health care. The CBHI is non-for-profit, voluntary insurance scheme whereby the premiums are sold at low-cost to

community members who have willing to register as members of the schemes. The insured persons and their family are entitled to use the defined health services at contracted public health facilities i.e. health centres and referral hospitals. The CBHI reimburses the cost of services consumed by its members. The first CBHI scheme has been implemented since 1998.

So far there are 7 CBHI schemes being implementing by mostly NGOs in 11 provinces, 20 ODs, contracted to 183 Health Centres, 20 RHs and 1 National Hospitals. The modes of payment are mixed according to their individual scheme design.

Total membership of CBHI schemes was 139,971 persons (Figure 3). It is noted that number of scheme and sites have almost remained the same, but total membership has decreased. Utilization and expenditure data are presented in Table 6. From a financial perspective, it is observed that there is no trend towards sustainability of the CBHI schemes based only on their premium.

Figure 3: Community Based Health Insurance membership

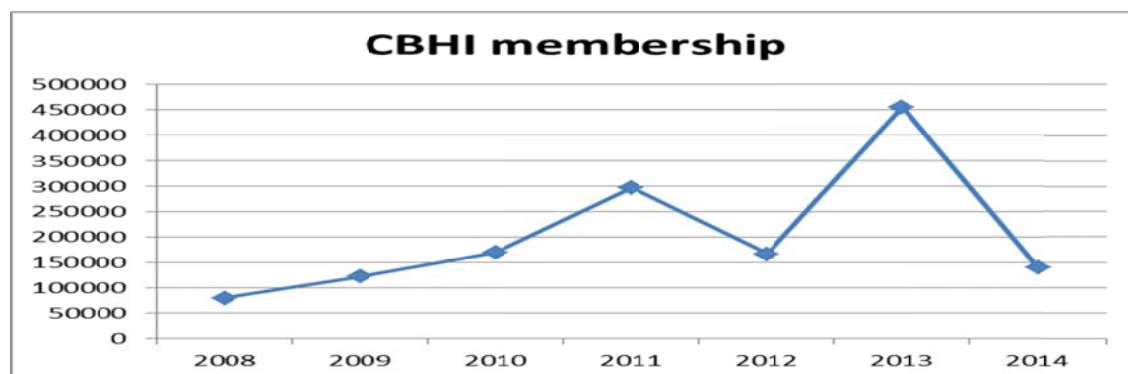


Table 6: Data on CBHI implementation, 2008-2014

Community Based Health Insurance Schemes CBHI	2,008	2009	2010	2011	2012	2,013	2014
Community Based Health Insurance Schemes CBHI	12	13	18	18	19	19	20 OD
CBHI membership	79,873	122,829	170,490	297,687	166,663	455,648	139,971
Total Hospitals	11	12	22	22	20	26	21
CPA1 contracted with CBHI			5	5	5	10	11
CPA2 contracted with CBHI			6	6	5	7	5
CPA3 contracted with CBHI			9	9	8	7	4
National Hospitals contracted CBHI			2	2	2	2	1
No. of HC contacted with CBHI	81	81	164	182	231	240	183
Total utilization cases supported by CBHI	466,705	249,439	333,914	491,185	533,098	266,909	273,311
OPD cases	4,559	242,305	324,067	477,378	515,126	256,707	263,991
IPD cases	462,146	7,134	9,847	13,807	17,972	10,202	9,320
Total expenditure (USD)	448,944	697,089	855,604	901,361	622,715	1,213,722	284,883
CBHI Expenditure for direct cost for Medical fee	302,462	287,518	433,085	435,960	284,252	543,721	108,198
CBHI Expenditure for direct cost for non medical cost.			64,695	70,978	65,758	85,288	1,674
CBHI Expenditure for Admin and others operating	146,482	409,571	357,824	394,423	272,705	584,713	175,011

Voluntary private health insurance

The insurance business started in Cambodia in 1956. On 31 December 1963, the government bought back all insurance companies in the private sector. On 9 January 1964 the national assembly adopted a law of insurance, which gave the government control over all insurance business in the country. The national insurer was established namely Societe National d'Assurance (SNA) as a monopoly to serve the insurance needs of Cambodians from 1964 to 1975. All insurance business did not exist since 1975, particularly during Khmer rouge regime, businesses were demolished.

On 30 October 1992, the national assembly adopted a new law on insurance business. The law aimed to contribute to economic development, and compensates the victim against loses caused by natural catastrophic, accident and other mishaps.

Since 2000, Cambodia made a transition from planned economy to a free market economy with growth in the insurance market. The government has updated law and regulation which were promulgated during 1990-1999 including insurance business law to a new law on insurance that was approved by parliament on 20 June 2000 and followed by sub decree on insurance on 22 October 2001. Insurance business is regulated by Department of Financial Industry of the Ministry of Economy and Finance by issued Prakas and circulars regarding insurance.

With the absence of compulsory health insurance, private insurance companies offer any kind of health benefits to members who can afford to pay premium and contract with any health facilities and with any kind of provider payment mechanisms. It is seen that members of private health insurance are people working with UN, bilateral organization, banks, micro finance institutions, micro credit, NGOs, projects and individual. Data of private health insurance is very limited.

4. Progress on universal health coverage

4.1 Population coverage

According to the draft National Health Financing Policy, coverage of the population is to be achieved through three social health protection schemes: NSSF for formal private sector employees, NSSFC for civil servants and NSHPF for the poor and non-poor informal sector population. To date only one major scheme is operational, which is the HEFs for poor people. In 2014, 2,620,759 people of the total population were beneficiaries of HEFs.

A very small number of poor women are protected by the Voucher schemes so as there is a small proportion of better off people who voluntarily join private health insurance and CBHI.

To date, NSSF provides compensation for health care costs related to work injuries, so far covers 964,988 persons. A side from this scheme NSSF also is piloting health insurance for garment factories, which so far has 8,246 memberships. Social health is scheduled to start social health insurance in 2015. It is difficult to estimate population covered by social health protection schemes since they are implemented through fragmented approaches.

4.2 Service coverage

On the supply side, basic service coverage of the population has been largely achieved geographically through implementation of the 1995 Health Coverage Plan, which provides national coverage of government health centres and referral hospitals that deliver a Minimum Package of Activities (MPA) and a Complementary Package of Activities (CPA), respectively. These standard service packages are not legislated but established through MOH operational guidelines. The MPA guidelines were formulated in 2008. The CPA guidelines were revised in 2014. There appears to be a need to widen the standard package of services as new needs arise based on changing demographic and epidemiologic context, and as additional services are provided, mainly due to the increased budget for health care and an attempt to meet unsatisfied demand.

In principle, the MPA and CPA packages include diagnosis, treatment, prevention, health promotion, rehabilitation, long-term nursing care, long-term care for older people and people with mental health problems, palliative care, occupational health care and prevention, accident related care, transport, patient information, alternative therapy or complementary medicine, optical care and glasses, pharmaceuticals (outpatient and inpatient), dental care, renal dialysis, cosmetic surgery, antenatal care, care during childbirth and postpartum, termination of pregnancy, contraception, in vitro fertilization, organ transplantations and treatment abroad. In addition, services are provided free of charge for immunization, HIV/AIDS treatment, malaria control and tuberculosis care through MOH/donor-funded vertical and national programs. However, in practice actual coverage and availability of all these services is much lower and NCDs are not well covered except in acute cases where facilities are equipped to handle them (such as amputation of limbs). Expansion of the basic service packages is under consideration.

Each of the demand-side financing schemes has a standard package of benefits. For the HEF, benefit package is paid according to the standardised payment mechanism and rate so as SUBO, while CBHI schemes, the benefits package is paid up to their respective scheme designed. HEF and some CBHI schemes also provide support for transport, food, funeral and other patient costs. The benefit package for vouchers explicitly includes access only to those services covered by the voucher (antenatal care, facility-based deliveries, emergency obstetrics, postnatal care, family planning and safe abortion). Voucher schemes provide additional support for transport for the pregnant woman and an accompanying person, food costs and a cash payment to acquire care items for the new baby. In all schemes (outside the private insurance sector), the benefits package is uniform across the whole target population.

4.3 Financial protection

There is no national data on the proportion of patient costs covered per case for services delivered through the demand-side social health protection schemes. Out-of-pocket payment for health care (even among beneficiaries) remains high (see next section), while catastrophic and impoverishing expenditures, and going into debt due to health care spending, have been reduced but not eliminated. In principle, HEF and CBHI schemes cover 100% of health care fee for MPA and CPA services and voucher schemes cover 100% of the costs of the reproductive health services package. National vertical disease programmes are provided free to the patient. However, patients still face

additional out-of-pocket costs for informal charges at government facilities, drug purchases in the private market and to attend ancillary private providers.

It has been demonstrated that the HEF schemes reduce household OOP payments by 29% on average (larger for poorer households that mainly use public providers and live closer to a district hospital; HEFs also reduce households' health-related debt by around 25% on average (Flores et al., 2013). On average, members of CBHI schemes, where they operate, experience a reduction in health-care costs and health shocks by more than 40%, have 75% less health-related debt, and increase the use of (covered) public health facilities (Levine et al., 2012).

5. Health Expenditure

There multiple source of fund spent for health such as government, Donors and Out of Pocket expenditure. The first ever NHA report 2012, provide detailed data on health expenditure from all sources using standardized methods to facilitate international comparisons. The first NHA used data from 2012. Data collection for NHA 2013-2014 is currently underway and results are expected in mid-2015. Key findings of NHA 2012 are presented in Box 1.

Box 1: 10 Key Findings of 2012 National Health Accounts

1. Cambodia spent more than one billion US dollars on health care in 2012, which is considerably higher than previous estimates.
2. Total health expenditure as a share of Gross Domestic Product (GDP) was the highest among low- and middle income countries in the region.
3. Government health expenditure as a share of GDP was lower than in most low- and middle income countries in the region.
4. 60% of total spending came from out-of-pocket expenditure by households.
5. The government and donor shares of health expenditure were almost equal (about 20% each).
6. 60% of total spending occurred at private providers, particularly private clinics and practitioners.
7. Pharmaceuticals accounted for 40% of total health spending (and almost 50% of government spending).
8. 20% of health expenditure was spent on salaries and incentives of health workers.
9. Communicable and non-communicable diseases accounted for 33% and 6% of total spending, respectively.
10. Only 6% was spent on prevention and only 0.4% was spent on nutrition.

5.1 Total health expenditure

Total health expenditure has almost doubled between 2008 (USD 550 million) and 2014 (USD 1042 million). Preliminary estimates suggest that spending on health accounted for 5.8% of GDP in 2014 and USD 69 per capita (Table 7). Not all donors have submitted their 2013-2014 NHA questionnaires. The donor estimates in Table 7 are therefore based on the reporting to the ODA database managed by the Council for the Development of Cambodia (CDC). The results of the NHA 2013 and 2014 are anticipated in the third quarter of 2015.

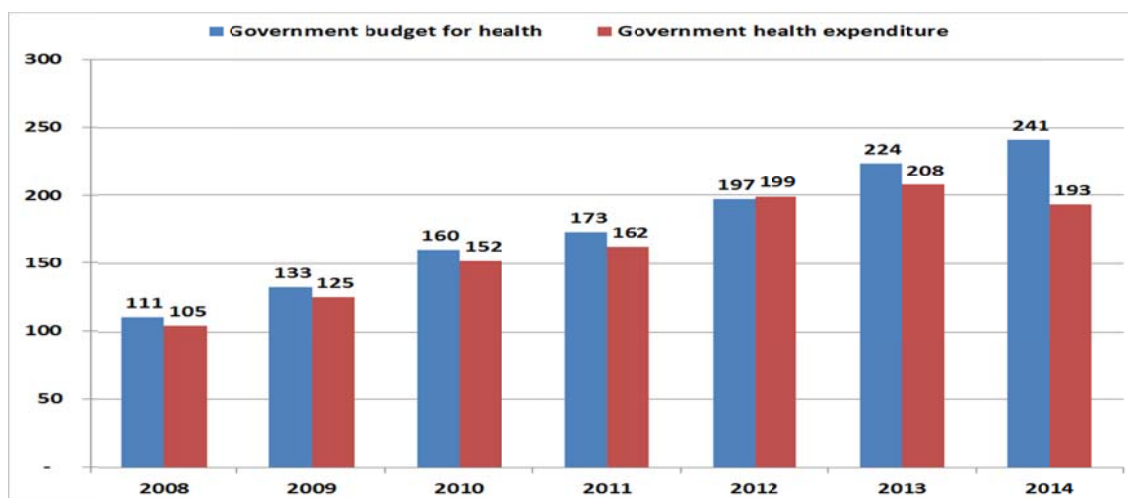
Table 7: Summary of health budget and expenditure by source of financing, 2008-2014

	2008	2009	2010	2011	2012	2013	2014
Macroeconomic indicators							
GDP (million USD)	10,337	10,400	11,634	12,856	14,266	15,191	18,040
Population (million)	13.4	14.1	14.3	14.5	14.6	14.7	15.2
GDP per capita (USD)	772	738	813	885	974	1,033	1,188
Total government budget							
Total government budget (million USD)	1,638	2,112	2,472	2,525	2,714	2,957	3,187
Current (million USD)	969	1,175	1,272	1,482	1,624	1,693	1,790
Capital (million USD)	669	937	1,201	1,043	1,090	1,264	1,398
Total government budget as % of GDP	15.8%	20.3%	19.9%	19.6%	19.0%	19.5%	17.7%
Total govt current budget as % of GDP	9.4%	11.3%	10.9%	11.5%	11.4%	11.1%	9.9%
Government budget for health							
Govt budget for health (million USD)	111	133	160	173	197	224	241
Govt health budget as % of GDP	1.1%	1.3%	1.4%	1.3%	1.4%	1.5%	1.3%
% of total government budget	6.8%	6.3%	6.5%	6.8%	7.3%	7.6%	7.6%
% of total government current budget	11.5%	11.3%	12.5%	11.7%	12.1%	13.2%	13.5%
Govt health budget per capita (USD)	8.29	9.42	11.15	11.90	13.47	15.22	15.90
Annual increase of govt health budget		19.6%	20.2%	8.3%	14.2%	13.4%	7.9%
Government expenditure on health							
Govt health exp (GHE) (million USD)	105	125	152	162	199	208	193
GHE as % of approved health budget	94.2%	94.5%	95.2%	93.6%	100.9%	92.9%	80.0%
GHE as % of total govt expenditure	6.4%	5.9%	6.1%	6.4%	7.3%	7.0%	6.1%
GHE as % of total govt current exp	10.8%	10.7%	11.9%	10.9%	12.3%	12.3%	10.8%
Annual increase of GHE		19.9%	21.1%	6.5%	23.1%	4.5%	-7.1%
Total health expenditure							
Total health exp (THE) (million USD)	550	648	676	713	1,033	1,070	1,042
THE as % of GDP	5.3%	6.2%	5.8%	5.5%	7.2%	7.0%	5.8%
Distribution of THE (million USD)							
Government	105	125	152	162	199	208	193
External donors	111	128	108	107	209	200	191
Out-of-pocket expenditure	335	394	416	444	622	662	658
Health insurance	N/a	N/a	N/a	N/a	3	N/a	N/a
Share of THE by source of funding							
Government	19.0%	19.3%	22.5%	22.7%	19.3%	19.4%	18.5%
External donors	20.1%	19.8%	16.0%	15.0%	20.2%	18.7%	18.3%
Out-of-pocket expenditure	60.9%	60.9%	61.6%	62.3%	60.2%	61.9%	63.2%
Exp per capita by source (USD)							
Government	7.81	8.90	10.62	11.14	13.59	14.14	12.71
External donors	8.27	9.11	7.55	7.36	14.27	13.58	12.59
Out-of-pocket expenditure	25.00	28.00	29.12	30.58	42.50	45.06	43.37
THE	41.08	46.01	47.29	49.07	70.37	72.78	68.67

5.3 Government health expenditure

The government budget for health has increased every year, but the budget has not always been fully implemented. In 2014, expenditure amounted to only USD 193 million of the budget of around USD 241 million (equivalent to USD 16 per capita, 1.3% of GDP and around 8% of total government expenditure, and 13% of total government recurrent spending), see Table 7. Figure 4 shows how much of the government health budget was been spent in 2008-2014.

Figure 4: Government health budget and expenditure, 2008-2014 (USD million)



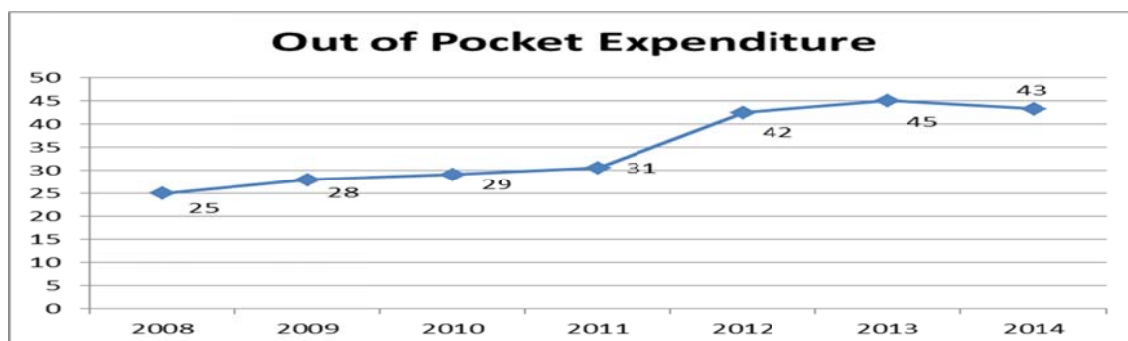
5.3 Donor health expenditure

According to NHA, donor health expenditure amounted to 209.0 million USD in 2012. According to reporting to CDC, donors accounted for 199.6 million USD in 2013 and 191.1 million USD in 2014. The survey for donor expenditure 2013 and 2014 is underway; the results will be released in next NHA report.

5.4 Out-of-pocket expenditure

Out-of-pocket expenditure accounted for US\$ 622 million in 2012 (60.3% of total health expenditure), US\$ 662 million in 2013 and US\$ 658 million in 2014. Figure 5 shows that out-of-pocket expenditure has increased significantly between 2004 and 2014. Several factors may explain the increase, including increased costs of health care, increasing disposable incomes of households, and low coverage of social health protection schemes.

Figure 5: OOP expenditure on health per person (total population), 2008-2014 (USD)

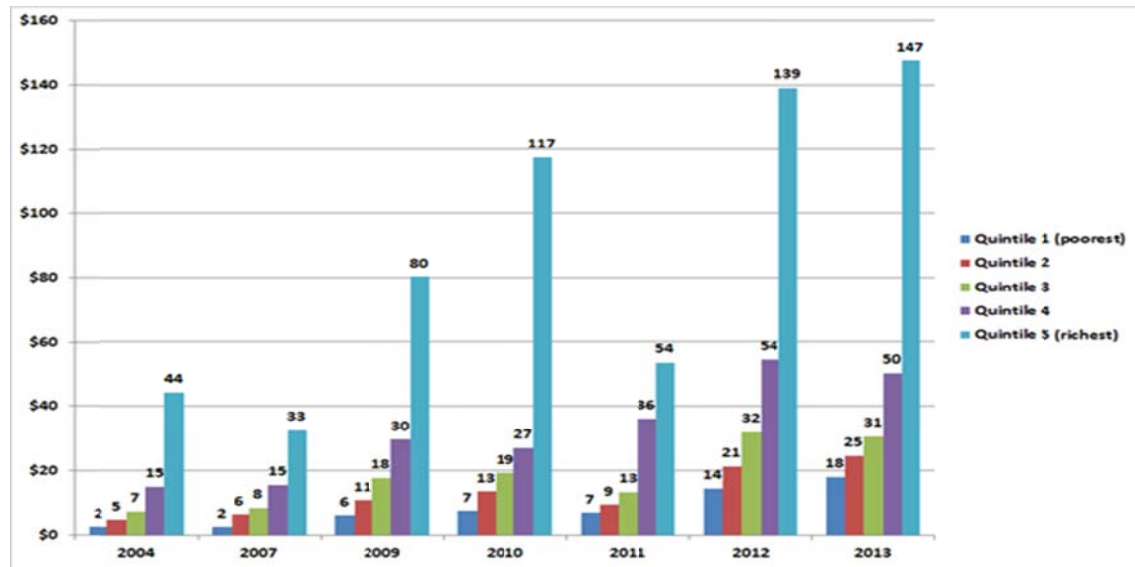


Source: analysis of out-of-pocket expenditure by MOH, GIZ and WHO using data from the Cambodia Socioeconomic Survey.

In 2004 the richest 20% spent 18 times more on OOP compared to the poorest 20%; in 2013 they spent 8 times more (Figure 6). However, the absolute rich/poor gap increased: in 2004 the richest

quintile spent US\$ 42 more than the poorest quintile; in 2013 this figure had increased to US\$ 130. This is likely to be a reflection of a widening income gap.

Figure 6: OOP expenditure on health by wealth quintile, 2004-2013



Source: analysis of out-of-pocket expenditure by MOH, GIZ and WHO using data from the Cambodia Socioeconomic Survey.

While people 60 and above account for only 6% of the population, they accounted for about 50% of OOP on health in 2013. This share is likely to increase over time as the population ages and as the NCD share of the burden of disease continues to increase. Another analysis of CSES data found that people 60 and above spend three times more than younger people, people with disabilities (PWDs) spend five times more than those without disabilities, and people with NCDs spend 16 times more than people without NCDs (GIZ, WHO and MOH, 2015).

The proportion of households incurring catastrophic expenditure² was about 6% in both 2004 and 2013. Somewhat counterintuitive, catastrophic expenditure increased from the poorest to richest quintiles in most years. However, catastrophic expenditure is a relative measure and the absolute amount left after OOP spending on health also matters. Nevertheless, the rate of catastrophic expenditure is relatively low by international standards. The rate of impoverishing expenditure is also low (less than 2% of households in 2013). This is likely due to the increase social health protection coverage provided through the HEFs, which cover almost all of Cambodia’s poor population (about 3 million), as well as the general decrease in poverty.

² Catastrophic expenditure occurs when a household’s spending on OOP on health care is more than 40% of income net of subsistence spending (food, shelter, clothing, etc.). The methodology is described in Ke, 2005.

6. Health financing functions

6.1 Resource mobilization

6.1.1 Existing sources of financing

There are three major categories of sources of finance for health care: [1] general revenues of the government; [2] development assistance by donors and; [3] out-of-pocket payments by individuals of households through payment while receiving services.

6.2 Pooling

The pooling function refers to the accumulation and management of revenues so that members of the pool share collective health risks to protect them from large, unpredictable health expenditures. Important associated factors relate thus to population coverage as well as composition of the risk pool while the major objective concerns financial risk protection.

The greatest risk pool is established through the public health system that operates through government subsidies (supply side financing). Since the public health facilities charge user fees, financial risk protection through pooling is not guaranteed. Population coverage therefore refers to the population covered by social health protection schemes, which is currently limited to those having an ID-Poor card entitling them free care at public health facilities. As seen earlier a small proportion of the population is enrolled with voluntary insurance schemes. No social health protection schemes are yet operational for the formal sector population, apart from the injury scheme under the National Social Security Fund. The latter is scheduled to start operating the social health insurance arm in 2015. Thus to date 2.6 million people, or about 17% of the population, are covered. This does not include those under private health insurance.

Attention should be paid to the issue of fragmentation. This implies the concurrent operations of various, often small, risk pools. The smaller the risk pool, the less likely it will be able to cover health care costs, especially large and unpredictable amounts. The voluntary insurance schemes clearly run such risks.

Financial protection should result from the risk pooling whereby the better-off contribute for the poor and the healthy for the sick and out-of-pocket expenses for health are minimal. Due to insufficient risk pooling, out-of-pocket spending for health remains high in Cambodia. Indicators for such unhealthy expenses include catastrophic health expenditure and indebtedness due to paying for health. Catastrophic expenditures imply that people spend such a high amount for health care that they are forced to cut down on other basic necessities such as food and clothing or are forced to take their children from school. Indebtedness due to health care results from people taking a loan when lacking cash money to pay for health services. Table 8 indicates the incidence of catastrophic health expenses as well as the proportion of families in debt because of health expenses in the year 2013. As can be seen, families with members who are disabled, aged more than 60 years or suffer NCDs are at elevated risk for high out-of-pocket expenses.

Table 8: Catastrophic expenditures and indebtedness due to health care, 2013

	General population	People with disability	Older people	People with non-communicable diseases
Catastrophic expenditure	6.3%	13.4%	8.6%	20.5%
Indebted due to health care costs	3.1%	8.8%	3.5%	8.0%

Source: Cambodia Socioeconomic Survey, 2013

6.3 Purchasing and provider payment

The way providers are reimbursed sets incentives that influence provider and patient behaviour. Provider payment mechanisms (PPMs) can serve as a powerful tool for policy-makers to achieve policy objectives such as access, efficiency, equity, quality and sustainability of health systems financing. Table 9 describes different PPMs, their advantages and disadvantages, and potential measures to address those disadvantages. No mechanism is perfect and most countries use a mix of mechanisms depending on their policy objectives and specific context. The mix usually involves trade-offs between policy objectives, but also between stakeholders as some mechanisms are more beneficial to some stakeholders.

Strategic purchasing of health services aims to improve quality and efficiency by leveraging the purchasing power of a health insurance agency or other purchasing agency. Strategic purchasing should be informed by an assessment of the burden of disease and population health needs, including how they vary across the country and between different groups. Interventions and services should be identified that best meet the population's needs within the available resource envelope and that constitute an optimum mix of promotion, prevention, treatment and rehabilitation services. Finally, strategic purchasing involves assessing how these interventions and services should be purchased or provided, including contractual arrangement and PPMs, and from whom they should be purchased, taking into account the availability of providers and their levels of quality and efficiency (WHO, 2010).

Table 9: Summary of provider payment methods

Payment method	Definition	Advantages	Disadvantages	Measures to address disadvantages
Budget	Providers are allocated of a fixed amount of funds to cover specific input costs or to provide a set of services.	Relatively low administrative costs Predictable expenditure	Limited attention to quality Limited incentives for efficiencies Shifting costs to other providers Under-provision of services Imposes mostly pre-defined use of resources, not allowing timely responses	Monitoring providers Allocated budget based on population needs or according to performance
Salary	Salary is a form of periodic, often fixed, amount of payment from employer to employee.	Administratively simple Allows for central control Predictable expenditure Cost containment	Covers only cost of personnel Underperformance is likely Potential dual practices Little incentive for efficiencies	Include performance-related aspects in the payment Peer review of practices
Fee-for-service	Providers are paid for each health service or single item used in provision of a health service.	Promotes the delivery of (underprovided) services (to underserved population groups) Incentives for efficiencies	Overprovision of services and thus increased costs High administrative costs for monitoring and billing Potentially less time spent per service, reducing quality	Periodically adjusting fees Capping the amount payable
Capitation	Providers are paid a fixed amount of money per person or per patient for a certain time period.	Administratively relative simple Incentives to apply efficiencies	Under-provision of services likely Selection of low-risk cases, potentially transferring cases to higher level of care Unnecessary cost containments, impairing quality of care	Monitor provider practices Peer review of practices Adjust payments to risk Group individual providers together Promote competition whereby patients choose the provider
Case-based	An agreed amount of money is paid for each category of patient or episode of care	Increases efficiency of care	Relatively high administrative costs Selection of low-risk patients and transfer more complicated cases to others Incentive to over-diagnose severity of condition	Monitoring diagnosis of patients Group patients according to their use of resources

Cambodia has been experiencing with a wide range of purchasing mechanisms, including contracting, performance-based budgeting and vouchers, amongst others. It is currently using the following PPMs:

- Budget line-items from the government budget
- User charges (fee-for-service)
- Performance-based payments from the HSSP2 budget
- Case-based payments from the HEFs
- Capitation, case-based, and fee-for-service payments from various voluntary health insurance (CBHI) schemes

- Output-based payments to midwives for facility deliveries;
- Subsidization of user fees and provision of other operational support from national programs, donors and NGOs

These varied provider payment mechanisms and performance-based contracting arrangements have contributed to fragmented and poorly coordinated financial management. The government is planning to reform the current provider payment system.

The main PPM used by government is budget line items to pay for infrastructure and health worker salaries, and in-kind distribution of pharmaceuticals and commodities. The allocation of the budget to public health facilities is based on historical allocations originally informed by the number of health workers, the number of hospital beds per population and similar indicators rather than based on population health needs. Public health services are well defined according to level of provider, with the MPA for health centres and CPA level 1 to 3 for referral (district and provincial) hospitals. However, health services are insufficiently available to appropriately deal with the needs of people living with disabilities and emerging conditions such as chronic NCDs. Specialised services are provided by national hospitals and some private not-for-profit hospitals. There is no direct link between the MPA and CPA 1-3 delivered in health facilities and the resources allocated/spent there. The costs of the MPA and CPA have been estimated, but those estimates need to be updated (Collins et al, 2009a, 2009b). Budgets are easy to administer, but this type of PPM tend to be insufficiently linked to output or quality of services. There is no agreed volume or price for specific type of health services such as outpatient or inpatient. There is in general a very weak relationship between what is being paid for and what is delivered to the population.

In addition to the government budgets, health facilities are also paid through fee-for-service comprised by official user fees approved by MOH.

Some health facilities receive additional payments if they have gained status as an autonomous agency. Autonomous hospitals are managed by a board of directors with representatives from Ministry of Economy and Finance, MOH, hospitals and clients. Most of these hospitals receive fund from government through a regular one line-item budget to cover recurrent costs. These hospitals also receive support financially and technically from development partners including capital investment and from other sources through contractual arrangement such as the small work injury scheme operated by the National Social Security Fund. Special Operating Agencies (SOAs) were introduced in the health sector in 2009. The purpose of the SOA is to improve quality of services by conferring the public health facility with a degree of autonomy in managing its human and financial resources. SOAs receive regular government funds through budget line-items and also Service Delivery Grants (SDGs) based on population size, geographical situation, number and level of health facilities, staff availability, etc., and are governed by internal contracts with performance indicators and SOA also allowed to charge user fee and reimbursement from other demand side financing schemes.

Historically HEFs paid health facilities through fee-for-service according to a fee schedule approved by MOH. In 2012, the PPM was changed by MOH to a fixed case-based payment system, generally on a quarterly basis. The CBHI schemes use a mix of PPMs: capitation for health centres and fee-for-

service or case-based payment at referral hospitals. The voucher scheme reimburses providers on a fee-for-service according to agreed contract.

Development partners use a range of PPMs with different degrees of complexity. The pooling funds of HSSP2 use a contracting arrangement with performance payments, mixing budget allocation resulting from a formula that combines different criteria with bonus payment related to meeting defined targets. A bottom-up planning (preparation of Annual Operational Plan) is conducted every year, but this is not fully driving budget allocations.

6.4 Stewardship

Overall governance of the health financing system in Cambodia has been constrained by (a) the limited ability of the government to manage and coordinate multiple initiatives, (b) the proliferation of several types of schemes, tried, implemented or funded by development partners and (c) ineffective regulation public and of private providers.

Government policy-making has been compromised by weak systematic reporting and structured analysis to make use of the available data. However, recent studies have attempted to fill this gap, such as the Health in Transition review (WHO, 2015) and a health sector analysis to inform the development of the Third Health Strategic Plan (HSP3) 2016-2020 (Annear, 2015).

Mechanisms of coordination between government and development partners seem more effective in influencing how donor resources are spent than government ones. For instance, the Annual Operational Plan, which should be used as basis to allocate both government and donor resources, is mostly used for donor resources only. Multiple joint coordination groups exist and joint monitoring is also promoted.

Overall accountability of the system towards Cambodian citizens is at an early stage of development. The process of decentralization is on-going. Sub-national levels manage part of government resources (about 30%) through the provincial treasuries, but larger items remain centrally managed (about 70%) which include procurement of medical commodities for national wide use. Some delegation from provinces to OD can be observed. The presence of community leaders in health facilities decision-makers committees, as described in the Health Financing Charter, could play a role in bringing community voices to relevant decision-making on health financing. However, lack of expertise of representatives and non-rotational selection is not helping to secure this role.

International and local NGOs have played an active role as financing agents (in HEFs and CBHIs), which has strengthened public awareness about the importance of health services and communities involvement. Their role is to secure access and reimburse the services of the poor (HEF).

7. Conclusions

The health system financing in Cambodia mostly relies on supply side financing through regular budget provided by the Government and support from Development partners. Even though there are some fund through demand side financing, purchasing power is still limited.

Better services could be obtained when pooling the money through pre-payment mechanisms or improved tax revenues. This would imply channelling the money through the demand side, such as a health insurance scheme, which would enable an increased purchasing power by the financial intermediate. Because of this purchasing power demands concerning quality of care could be made.

Total health expenditure is comprised of Government, Donors and out-of-pocket expenditure. THE is relatively high compared to neighbouring countries, however the share of out-of-pocket expenditure remains high (more than 60% of total health spending) due to the lack of financial risk protection mechanism beyond the Health Equity Funds for the poor.

Currently the biggest pool is the public health system but the money is channelled as budget by the government, limiting intended effectiveness. The only demand-side mechanism is the health equity funds that are limited to the poor only who comprise a fifth of the population. The social health insurance schemes for the salaried private sector workers or civil servants are not yet operational. As a result, the population living above the poverty line can either enrol with voluntary insurance or private insurance.

Cambodia is committed to universal health coverage; the draft health financing policy has laid out the principles and strategies to achieve UHC. The future, however, may witness a series of initiatives that could remedy many of the current weaknesses. The foundations for these cures have been laid or are being developed. We look forward to report on these developments in the forthcoming annual reports.

8. Challenges in producing this report

- ✓ Availability of systematic tracking health expenditure by program and non-program according to the planned expenditure in the AOP or budget allocation.
- ✓ Systematic report of health expenditure by level throughout the system
- ✓ Financial information from development partners
- ✓ Emerging capacity to conduct secondary analysis of out-of-pocket expenditure using data from the Cambodia Socioeconomic Survey CSES

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