Kingdom of Cambodia
Nation – Religion - King

Ministry of Health

ANNUAL HEALTH FINANCING REPORT 2010

Bureau of Health Economics and Financing
Department of Planning and Health information
April 2011

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 objective of this report is to consolidate information on all mechanisms of funding to the health sector such as government budget and disbursement for health, external assistance, User Fee, Health Equity fund 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 thank Provincial Health Departments (PHDs), National Hospitals and Institutions as well as Health Equity Fund (HEF), Voluntary Health Insurance schemes (VHI) and others for their contribution to this report by submitting their regular reports and documents to the Bureau of Health Economics and Financing, Department of Planning and Health Information, MoH.

We take this opportunity to acknowledge the contribution, both technical and financial, made by our health development partners in support to improving the health status of Cambodian people. In particular, we greatly appreciate the support of the World Health Organization in the production of this report.

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 2010 provides an updated comprehensive health financing information and will be useful for our future work in addressing financial constraints in the health sector in more equitable manner.

April , 2011

ACKNOWLEDGEMENTS

Special thanks go to Mr. Ros Chhun Eang, 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 BHEF, DPHI, for their contribution to this production.

Appreciations go to Dr. Lo Veasnakiry, Director, Department of Planning & Health Information, for his technical input and editing work.

Sincere appreciations 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 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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Table of content

1. INTRODUCTION

In the context of the health sector reform introduced in 1995, the Health Financing Charter 1996 allows public health facilities to implement user charges together with exemption policy for the poor, and pilot-other health financing initiatives. Since then Cambodia has become site for pilot experimentation of both supply and demand side health financing initiative. Demand side financing such as health equity funding, Community based health insurance and voucher schemes are designed and put in place for implementation. While supply side financing mechanisms to improve health service delivery, known as contracting health services have been implemented for years. This model has recently been institutionalized through Special Operating Agency (SOA).

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

2. CAMBODIA AT A GLANCE

Territory	181 035 Km^2
Number of Municipality	1
Number of provinces	23
Number Districts	159
Number of Khans	8
Number of Cities	26
Number of communes	1,417
Number of Sangkats	204
Number of Villages	14,073
Fiscal year	January-December
Currency	Riel

Demography

Population in total	14.1 Millions
Annual population growth rate	1.35
Density population	83
Life expectancy at birth (male)	61.35
Life expectancy at birth (Female)	67.68
Distribution of population by age group (1)	
0-14 years	34.34%
15-64 years	61.82%
The elderly population (65+)	3.84%

Macro Economics

Gross Domestic Product (GDP)	USD 7,268 Million
GDP per capita	USD 792
Inflation	6.0

Health

Indicator	2008	2010
Total Fertility Rate	3.11	3*
Infant Mortality Rate per 1,000 live births	66 (2006)	45*
Under 5 Mortality Rate per 1,000 live births	83 (2006)	54*
Maternal Mortality Ratio per 100,000 live births	461 (2006)	350
Delivery by trained staff	58 %	71%*
Malaria mortality rate among 100,000 persons	2.10	1.2
Prevalence TB among 100,000 persons	617	564
HIV/AIDS prevalence among adult age 15-49 years	0.7%	0.7%

**CDHS 2010. Preliminary Report*

Education

Adult literacy age 15 and over (total)	77%
- Male	85.1%
- Female	70.9%
- Urban (both sexes)	90.4%
- Rural (both sexes)	74%

Sources:

Summary of NSDP 2009-2013

National Institute of Statistics, Ministry of Planning , General Population Census of Cambodia 2008

3. HEALTH SYSTEM DEVELOPMENT

The country health care system is composed of a district-based public health sector and a fast growing private sector. For the public health sector, each operational health district has a number of health centres providing first line health services (Minimum Package of Activities) with 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. As of December 2010, there were 997 health centres and 81 referral hospitals located in 77 operational health districts. In addition, there are 8 national hospitals in Phnom Penh. In general, those hospitals–are 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 extend.

OVERVIEW OF HEALTH SECTOR REFORM

1992-1994 **Strategic planning for the reform** **1995-1996** **HCP Development** **Implementation '96**	● Health Policy & Strategy Guidelines 94-96 ● Health Development Plan 94-96 introduced in Jan 1994 ● 3-day national consultation workshop to discuss on implementing strategy for health system reform in May 1994 ● 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 based on 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
Capacity building HR management	15 MPA Modules, CPA training, HSMT, HMT JD for central MoH and OD; Functional analysis linked PMG, MBPI
Financing	*NHFC 96 provided legal framework to implement alternative Health Financing,Strategic Framework for Health financing 2008-2015*
Planning & Budgeting & Financial management	Annual planning process 98 for PHD, revised 2003 for ALL, AoP & 3YRP for central & Province, Annual HS-AoP, 3YRP Allocation formula 96, reviewed 2005 Introduced ADD 96, PAP, PBB 2007
M & E, supervision	HIS 93, revised twice, integrated supervision, Indicator Framework for ME, GIS
Logistics & supply system	" Quota" system for drug allocation, management, distribution system
Infrastructures	Standard design for HC and RH
Policy & strategic planning, legislating	Health sector Strategic Plan 2003-2007, and 2008-2015
Coordination	Adopted SWIM, TWGH, PRO-TWGH

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 the following:

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 Cambodian, especially of the poor, women and children, thereby contributing to poverty alleviation and socio-economic development."*

MISSION

The Statement underlies the Ministry of Health, Royal Government of Cambodia commitment. The statement emphasizes exercising "stewardship" for the provision of services in all areas across the health sector. It highlights also the population's "highest level of health and well-being" of which a health system strives to promote – the system that places "increased demand, improved quality and promoted access" at the heart of health care delivery.

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

VALUES

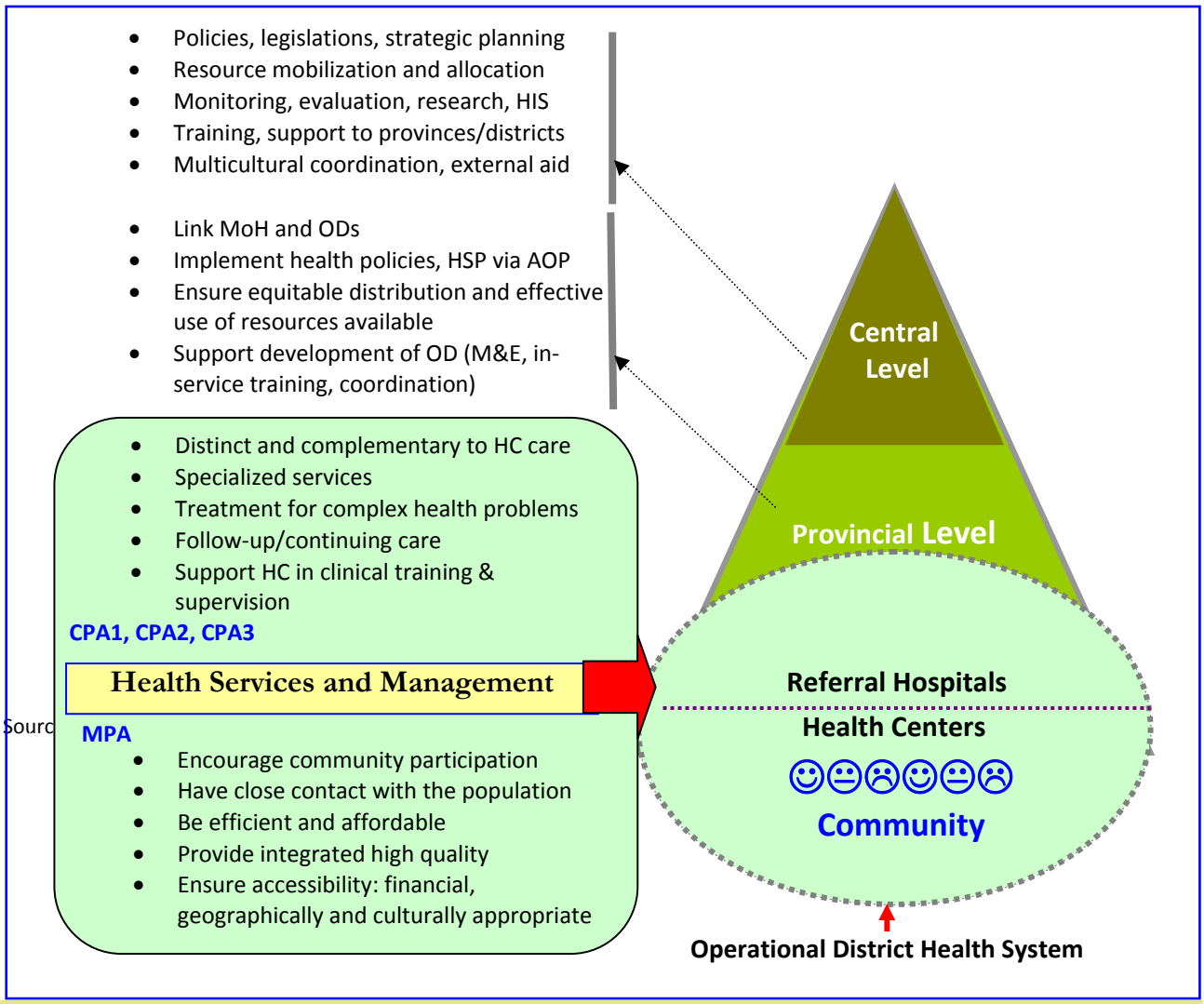
A value-based commitment of the Ministry of Health is ***Equity*** and the ***Right to Health*** for all Cambodians.

WORKING PRINCIPLES

Increased efficiency, accountability, quality and equity throughout the health system 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 and 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 promotion 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 process.
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.

HEALTH SYSTEM ORGANIZATION



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HEALTH FACILITIES ESTABLISHMENT CRITERIA

Criteria	(1) Population	(2) Accessibility
Health Center (HC) MPA	Optimal: 10,000 Vary: 8,000-12,000	Radius: 10 km or Max. 2 hrs walk
Referral Hospital (RH) CPA	Optimal: 100,000-200,000 Vary: 60,000-200,000+	20-30 Km between 2 RHs or Max. 3 hrs by car/boat

SUMMARY OF THE HEALTH COVERAGE PLAN

Code	Provinces	Operational Dostrict	Referral Hospital	Health Centere in Plan	Functioning Health Centere	New built Health Centere	Health Post
1	BANTEAY MEANCHEY	4	5	69	55	2	8
2	BATTAMBANG	5	4	76	76	0	3
3	KAMPONG CHAM	10	12	136	136	0	0
4	KAMPONG CHHNANG	3	3	34	34	0	4
5	KAMPONG SPEU	3	3	50	50	2	4
6	KAMPONG THOM	3	3	50	50	0	2
7	KAMPOT	4	4	51	51	0	0
8	KANDAL :	8	7	86	86	2	3
9	KOH KONG	2	2	11	11	0	2
10	KRATIE	2	3	27	24	1	11
11	MONDULKIRI	1	1	7	7	1	18
12	PHNOM PENH	4	5	27	27	0	11
13	PREAH VIHEAR	1	1	22	18	8	12
14	PREY VENG	7	7	90	90	1	4
15	PURSAT	2	2	32	32	0	3
16	RATTANAKIRI	1	1	11	11	0	19
17	SIEM REAP	4	4	79	79	3	0
18	SIHANOUK PROVINCE	1	1	12	12	0	2
19	STUNG TRENG	1	1	12	9	0	2
20	SVAY RIENG	3	3	38	38	1	0
21	TAKEO	5	5	73	72	0	5
22	ODOR MEANCHEY	1	2	20	19	2	3
23	KEP PROVINCE	1	1	4	4	0	1
24	PAILIN VILLE	1	1	6	6	0	0
	TOTAL	**77**	**81**	**1,023**	**997**	**23**	**117**

Source: Bureau of planning, policy and health sector reform, DPHI, MoH 2010

4. HEALTH SYSTEM FINANCING

As an attachment to the health sector strategic plan 2008-2015, the Strategic Framework for Health financing 2008-2015 introduced in 2008 states that "By 2015 the different elements and institutions of the current health financing system will be combined under a single strategy guided by national health priorities; social health insurance mechanisms will be in place; the poor will be protected by suitable social-transfer mechanisms; government funding for health will be at a level appropriate for the adequate provision of services to the population; donor support will be harmonized and aligned with national priorities and support effective service delivery".

Health Financing Policy Statement

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

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

There are three principal sources of health system financing: (1) the national budget (2) external funding from development partners and (3) household expenditures known as out of pocket spending. The government finances the public health facilities through salary payment for health workers, supplies of medicines and medical materials, and budget for recurrent costs.

OVERVIEW OF HEALTH FINANCING IN CAMBODIA

Scheme	Implementer/ Operator	Target group	Benefit/Service	Coverage/Location
Tax funding via Government budget	MEF/MoH/PHD /OD/RH/HC	All population sectors	Recurrent budget, drug and material supplies	Nationwide public health facilities
User fee exemptions	MOH/health facilities	Affordable population with exemption for poor patients	User fees	Nationwide
Global health initiatives and national programs	National programs	Patients with TB, malaria, AIDS, and children for vaccination,	Free of charge	Nationwide
HEF schemes	NGOs for HEF schemes	The eligible poor (those under the national poverty line)	User fees, food, transport Limited funeral expenses and other basic items	In 46 Referral hospitals and 318 health centres, covering approx. 78% of the target group
Government Subsidy schemes	MoH/PHD/OD	The eligible poor (those under the national poverty line)	User fees	In 6 National Hospital and 10 referral hospitals and 89 health centres
CBHI	Mainly NGOs	Mainly informal sector people living above poverty line	User fees Limited food and transport, funeral cost	In 16 hospitals and 164 health centres, covering approx. <1% of the population
Occupational Risk	MOLVT/NSSF	Formal sector workers	User fees (medical care), transportation, temporary/ permanent disable, funeral expenses and survivor benefit	In 3 national hospitals and 12 referral hospitals in 7 provinces, covering approx. 40% of the formal sector workers
SHI	NSSF NCSSF	Formal sector workers and civil servants	Still to be defined	Being developed A pilot for formal sector workers is being tested in Phnom Penh
SOA facilities	MOH/Donors/ HSSP	All population in the coverage area	Decentralize together with Performance-Based Incentives for Providers	In 30 Operational Health Districts

4-1. NATIONAL HEALTH BUDGET

The national budgeting process requires line ministries to prepare their annual budget then submit to the Ministry of Economy and Finance for a review and comment. Afterwards, the budget negotiation takes place at the MoEF. It provides opportunity to line ministries to defend their individual proposed budget. The MoEF consolidates the whole national budget and submits to the Council of Ministers and afterwards to the legislative bodies for final approval.

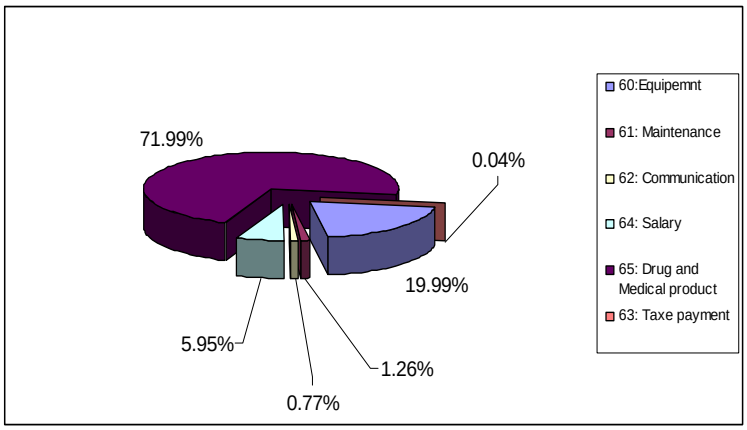
It is noted that the annual national budget for health has increased from year to year; particularly the adjusted budget has increased by 23% between 2008 and 2009 and continues to increase by 16.41% in 2010, reaching the total amount of Riel 645,138,220,000 or USD 161, 284,555. 71% of which was allocated to central level, while the remaining 28% was allocated to provincial level. The percentage of disbursement by the central and provincial level is generally improved, reaching 94.8% and 99.5%, respectively by comparing the total adjusted budget with the total mandated budget. The Ministry of Health is one of the ministries piloting Program Based Budgeting (PBB) since 2007. The PBB requires allocation of budget to identified program and is applied in budgeting process for the Central level only. It notes that only 9.11% of the total adjusted budget for the Central level is allocated to and characterized as the program budget. While the remaining is allocated through line item budget.

Allocation and Disbursement of the National Budget for Health for 2010

Chapter	Budget Plan	Adjusted budget	Requested budget		Commitment		Mandated request			Mandated			Disbursment		
			Amount	%	Amount	%	Amount	%	%	Amount	%	%	Amount	%	%
1	2	3	4	5=4/3	6	7=6/3	8	9=8/3	10=8/4	11	12=11/3	13=11/6	14	15=14/3	16=14/11
Grand Total	**600,056,000,000**	**645,138,220,000**	**619,637,912,420**	**96.0%**	**616,512,225,965**	**95.6%**	**615,335,688,198**	**95.4%**	**99.3%**	**614,410,029,416**	**95.2%**	**99.7%**	**611,357,559,206**	**94.8%**	**99.5%**
1- Central level	**419,716,000,000**	**460,694,480,000**	**449,564,460,661**	**97.6%**	**446,520,828,895**	**96.9%**	**445,429,717,473**	**96.7%**	**99.1%**	**445,429,717,473**	**96.7%**	**99.8%**	**445,429,717,473**	**96.7%**	**100.0%**
1.1- None Program Budget															
Total	**377,727,000,000**	**418,705,480,000**	**409,384,418,354**	**97.8%**	**407,428,803,378**	**97.3%**	**406,478,697,752**	**97.1%**	**99.3%**	**406,478,697,752**	**97.1%**	**99.8%**	**406,478,697,752**	**97.1%**	**100%**
60	68,704,000,000	82,704,000,000	81,389,022,222	98.4%	81,288,953,878	98.3%	81,244,580,528	98.2%	99.8%	81,244,580,528	98.2%	118.3%	81,244,580,528	98.2%	100.0%
61	5,893,000,000	5,726,000,000	5,223,871,898	91.2%	5,221,821,998	91.2%	5,115,644,265	89.3%	97.9%	5,115,644,265	89.3%	98.0%	5,115,644,265	89.3%	100.0%
62	5,792,000,000	5,959,000,000	3,219,182,205	54.0%	3,272,579,665	54.9%	3,147,598,653	52.8%	97.8%	3,147,598,653	52.8%	96.2%	3,147,598,653	52.8%	100.0%
64	26,208,000,000	27,186,480,000	24,193,029,124	89.0%	24,182,085,124	88.9%	24,170,641,124	88.9%	99.9%	24,170,641,124	88.9%	100.0%	24,170,641,124	88.9%	100.0%
65	270,959,000,000	296,959,000,000	295,197,856,405	99.4%	293,301,906,213	98.8%	292,638,776,682	98.5%	99.1%	292,638,776,682	98.5%	99.8%	292,638,776,682	98.5%	100.0%
63	171,000,000	171,000,000	161,456,500	94.4%	161,456,500	94.4%	161,456,500	94.4%	100.0%	161,456,500	94.4%	100.0%	161,456,500	94.4%	100.0%
1.1- Budget by Program															
Total	**41,989,000,000**	**41,989,000,000**	**40,180,042,307**	**95.7%**	**39,092,025,517**	**93.1%**	**38,951,019,721**	**92.8%**	**96.9%**	**38,951,019,721**	**92.8%**	**99.6%**	**38,951,019,721**	**92.8%**	**100%**
60	2,961,000,000	2,961,000,000	2,958,860,824	99.9%	2,958,238,704	99.9%	2,955,863,704	99.8%	99.9%	2,955,863,704	99.8%	99.9%	2,955,863,704	99.8%	100.0%
61	1,755,000,000	1,755,000,000	1,664,574,600	94.8%	1,664,574,600	94.8%	1,656,841,231	94.4%	99.5%	1,656,841,231	94.4%	99.5%	1,656,841,231	94.4%	100.0%
62	11,708,000,000	11,708,000,000	10,254,028,600	87.6%	9,985,431,500	85.3%	9,905,796,600	84.6%	96.6%	9,905,796,600	84.6%	99.2%	9,905,796,600	84.6%	100.0%
65	25,565,000,000	25,565,000,000	25,302,578,283	99.0%	24,483,780,713	95.8%	24,432,518,186	95.6%	96.6%	24,432,518,186	95.6%	99.8%	24,432,518,186	95.6%	100.0%
63	0	0	0	0.0%	0	0.0%	0	0.0%	0.0%	0	0.0%	0.0%	0	0.0%	0.0%
2- Provincial leve	**180,340,000,000**	**184,443,740,000**	**170,073,451,759**	**92.2%**	**169,991,397,070**	**92.2%**	**169,905,970,725**	**92.1%**	**99.9%**	**168,980,311,943**	**91.6%**	**99.4%**	**165,927,841,733**	**90.0%**	**98.2%**
60	34,035,000,000	34,035,000,000	33,760,474,779	99.2%	33,739,233,029	99.1%	33,698,893,939	99.0%	99.8%	33,448,270,757	98.3%	99.1%	33,100,363,147	97.3%	99.0%
61	24,541,000,000	24,541,000,000	24,266,196,500	98.9%	24,239,500,561	98.8%	24,179,961,206	98.5%	99.6%	24,136,143,706	98.4%	99.6%	23,947,816,362	97.6%	99.2%
62	15,962,000,000	15,962,000,000	14,767,590,409	92.5%	14,766,258,209	92.5%	14,766,258,209	92.5%	100.0%	14,741,143,209	92.4%	99.8%	14,591,244,159	91.4%	99.0%
64	93,292,000,000	97,395,740,000	85,392,769,471	87.7%	85,392,715,171	87.7%	85,417,811,171	87.7%	100.0%	84,985,651,071	87.3%	99.5%	82,927,417,365	85.1%	97.6%
65	12,290,000,000	12,290,000,000	11,828,816,900	96.2%	11,796,086,400	96.0%	11,785,442,500	95.9%	99.6%	11,611,499,500	94.5%	98.4%	11,304,147,000	92.0%	97.4%
63	220,000,000	220,000,000	57,603,700	26.2%	57,603,700	26.2%	57,603,700	26.2%	100.0%	57,603,700	26.2%	100.0%	56,853,700	25.8%	98.7%

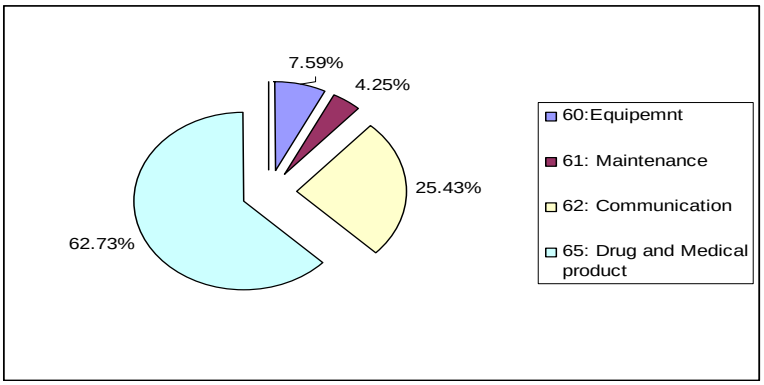
4.1.1 Disbursement of Non-Program Budget by Chapter at the Central Level

The pie chart below shows the disbursement of national non- program budget by chapter, the total national non-program budget was around 90% of total national health budget. It is shown that the highest spending was on Chapter 65 for drugs and medical products, accounting for 71.99%, followed by Chapter 60 for equipment 19.99%, Chapter 64 for salary 5.95%, Chapter 61 for maintenance 1.26% Chapter 62 for communications 0.77% and Chapter 63 for paying taxes 0.04%.

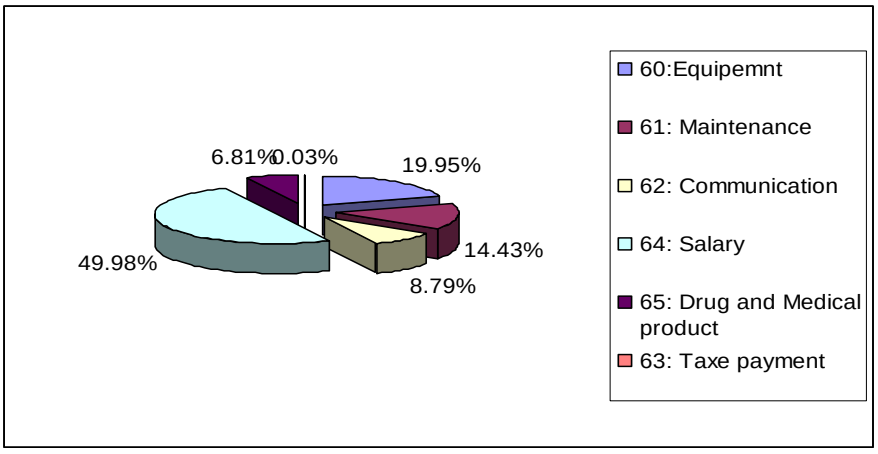


4.1.2 Disbursement of Program Budget by Chapter at the Central Level

A majority of spending was for chapter 65; accounting for 63%, followed by 25%, 8% and 4% for Chapter 62, Chapter 60 and maintenance, respectively.



4.1.3 Disbursement by Chapter at Provincial Level



Drugs are distributed through the Central Medical Store to public health facilities at all levels of the health system. According to the CMS report, drugs, medical supplies and vaccines are purchased through the national budget and funding from health partners. . In 2010, 88 % (or USD106, 422,237) of total expenditure for drugs, medical supplies and vaccines was covered by the national budget and the remaining 12% was funded by various health partners.

4-2 External Funding

It is noted that there has been constraints for collecting financial information from health partners supporting the health sector. However, the Council for Development of Cambodian (CDC)'s database on (http://cdc.khmer.biz/index.asp) is considered as a potential source of such information. This report, therefore, can provide financial information about two external funded projects, which are managed directly by the Ministry of Health: (1) Health Sector Support Program Phase 2 (HSSP) under management and coordination of HSSP2 secretariat and (2) Global Fund Fighting HIS/AIDS, Tuberculosis and Malaria under management and coordination of Principle Recipient (PR).

4-2-1 Health Sector Support Program Phase 2 (HSSP2)

The total 2010 budget planned of HSSP2 was USD33, 292,790. This total amount includes USD26, 090,968 allocated for year 2010 plus "carry-over" of committed budget from the previous years. According to HSSP2 senior Financial Officer, the total disbursement in 2010 was around 84% of approved budget.

HSSP2 disbursement by Sources of funding

CATEGORY	Cat. No.	POOLED FUNDS		COUNTERPART FUND		UNICEF		UNFPA	
		Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Service Delivery Grants	1	4,512,782	3,082,434	501,420	342,492				
HEF Grants	2	2,125,422	2,806,033	394,000	701,133	100,000	83,930	200,000	240,909
MBPI & related payment	3								
Others									
- Goods	4A	5,503,689	881,933						
- Civil Works	4B	92,000							
- Consultant Services	4C	3,906,851	1,487,490					213,350	201,032
- Operating Costs	4D	7,091,700	4,781,650			195,000	44,166	603,431	538,037
- Training	4E	5,532,191	3,974,663			195,000	290,444	354,438	311,684
Total		28,764,635	17,014,203	895,420	1,043,625	490,000	418,540	1,371,219	1,291,661

CATEGORY	Cat. No.	BTC		AFD		Total Pool and Disrecte fund	
		Budget	Actual	Budget	Actual	Budget	Actual
Service Delivery Grants	1			803,407	709,576	5,817,609	4,134,502
HEF Grants	2				300,397	2,819,422	4,132,401
MBPI & related payment	3					-	-
Others						-	-
- Goods	4A	10,000	10,817	1,500		5,515,189	892,750
- Works	4B				278,521	92,000	278,521
- Services	4C	95,000	101,078	486,417	422,787	4,701,618	2,212,386
- Operating Costs	4D	48,217	55,926	109,125	40,680	8,047,473	5,460,458
- Training	4E	141,649	93,288	76,201	109,034	6,299,479	4,779,113
Total		294,866	261,109	1,476,650	1,860,995	33,292,790	21,890,132

HSSP2 Disbursement by Program

CATEGORY	Program No.	POOLED FUNDS		COUNTERPART FUND		UNICEF		UNFPA	
		Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Reduce maternal, new born and child morbidity and mortality with improved reproductive health	P1	5,257,369	3,120,719			781,100	334,610	1,151,664	853,281
Reduce morbidity and mortality of HIV/AIDS, Malaria, TB and other communicable diseases	P2	2,127,445	2,013,272						
Reduce risk behavior leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental..	P3	984,984	513,077						
Health system strengthening	P4	11,531,272	11,367,136	895,420	1,043,625	100,800	83,930	400,000	438,380
Non program	P5	2,557,164							
Total . . . . . :		22,458,234	17,014,204	895,420	1,043,625	881,900	418,540	1,551,664	1,291,661

CATEGORY	Program No.	BTC		AFD		TOTAL (2010)	
		Budget	Actual	Budget	Actual	Budget	Actual
Reduce maternal, new born and child morbidity and mortality with improved reproductive health	P1			47,130	44,845	7,237,263	4,353,455
Reduce morbidity and mortality of HIV/AIDS, Malaria, TB and other communicable diseases	P2			20,900	39,638	2,148,345	2,052,910
Reduce risk behavior leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental..	P3			19,837	7,873	1,004,821	520,950
Health system strengthening	P4	128,366	261,109	900,366	1,768,640	13,956,224	14,962,820
Non program		140,000		488,417		3,185,581	-
Total . . . . . :		268,366	261,109	1,476,650	1,860,996	27,532,234	21,890,135

4.2.2 Global Funds

Global Fund for Fighting against HIV/AIDS, Tuberculoses and Malaria is one of the main funding sources for health sector. The funds are channeled through MoH's Principle Recipient, whose main role is to coordinate the funds Global Fund in the health sector. The total disbursement for 2010 was 88% of the total planned expenditure or USD 21,869,022, in shich 67%, 24%, 5% and 4% was disbursed for AIDS, Malaria, Strengthening Health System, and Tuberculoses, respectively. The total budget planned for 2011 is estimated at USD14, 937,089.

4.3 Household Health Spending

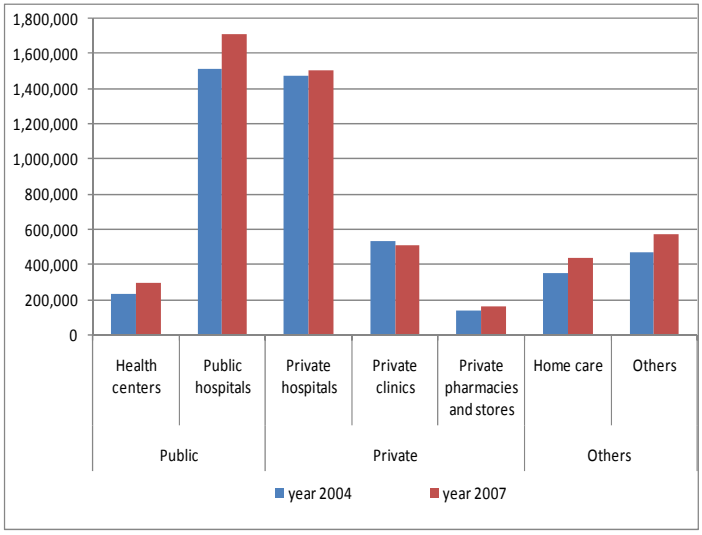
Out-of-pocket health spending by households is made of a major share of the total health expenditure. Households pay to public and private providers when using services through user charges. This spending includes fees ranging from cost of services used to medication, as well as cost of medicines directly purchased from pharmacies and drug outlets.

CDHS 2005 report indicated an ***average OOP*** per capita per year was 81,048 Riel (US$19.4) in 2005. Noting that transportation cost was a significant proportion of the total health expenditure , and may be excluded from out of pocket health spending assement. The transportation cost

accounted for about 9% of the total health related costs or 10% of the OOP expenditure. The CDHS 2005 data also provided information on the average out-of-pocket expenditure per visit by type of providers. The average spending per visit at public-run health centers was much cheaper than that of at private clinics (7,628 Riel (US$1.8) vs 59,849 Riel (US$14.3) for 1st visit). The expenditure at private hospitals was two times higher than that of at public hospitals. The transportation costs to seek care by type of health care providers is varied. The travel cost to seek care at public hospitals is higher than that of at private hospitals. It is estimated that an average health spending at public sector was lower, at about 60% of health spending level at private providers.

Secondary data analysis of Cambodian Social Economics Survey 2004 and 2007 (CSES) revealed that the annual average of OOP per capita, excluding transportation cost, decreased from 64,788 Riel (US$15.9) to 60,434 Riel (US$14.7) in 2004 and 2007, respectively.

Annual Average Out-Of-Pocket expenditure (in Riel) per capita among those who sought care by provider type – Source: CSES 2004 and 2007



It is noted that the average OOP expenditure for individuals who sought care was over 1.7 millions Riel (US$415.7) per capita at public hospitals and 1.5 million Riel (US$373.0) at private hospitals in 2007. The average health spending at private sector accounted for about half of OOP spending in both years 2004 and 2007. The share of health spending at public sector increased from 30% in 2004 to 35% in 2007, while the share of spending at non-medical providers almost doubled; from 8% in 2004 to 15% in 2007. Spending at public hospitals and private hospital and clinics together accounted for more than 50% of cumulative household health spending. The share of OOP from the richest quintile decreased from 62% in 2004 to 50% in 2007.

It is observed that the average amount of spending per capita also varies across population group. Women had higher average spending than male. Elderly also had higher average OOP per capita

than children and other age groups. It is interesting to note that both richest quintile and poorest one has spend more in 2007 if compared with the average health spending in 2004.

5. ALTERNATIVE HEALTH FINANCING SCHEMES

In order to promote access to and utilization of health services by population, in particular by the poor, different health financing schemes for both supply and demand side interventions have been implemented. The schemes include user charges with exemptions, subsidy, Special Operating Agency (SOA) transformed from performance-based contracting, Health Equity Fund (HEF), Community-Based Health Insurance (CBHI), and Vouchers. Social Health Insurance (SHI) for the formal sectors and for civil servant are under the process of development and implementation. All the above mentioned schemes are considered as an integral part of Social Health Protection mechanism.

5.1 Supply Side Financing Schemes

5.1.1 User fee

User charges together with exemption policy has been introduced officially at public facilities since 1996, aiming at generating additional incomes to improve quality of services, promote access to services by the poor, and eliminate under-the-table payments and increase motivation for staff. Fees level was set in consultation with community representatives and local authorities by taking the affordability to pay by majority of the population into account.

User fees implemented at public health facilities are subject to the MoH's approval. Revenues collected from user fees are managed locally by collecting facility in accordance with the MoEF and MoH Inter-Ministerial Prakas, which clearly states that 60% of the total fee incomes is used for staff incentives, the other 39% for operating costs and the remaining 1% is transferred to the National Treasury. User fees remain a minor proportion for facility revenues but play a significant role in reducing the-under-table payment and increasing financial incentives for staff, as well as bringing additional resource to cover non-salary operational costs of health facilities. The implementation of exemption policy for the poor who cannot afford to pay is strongly recommended. In practice this exemption policy is not consistently implemented across health facilities, and likely ineffective at referral hospitals. To date, there are 6 national hospitals, 3 national health institutions, 23 provincial hospitals and 1 Municipality hospital, 55 referral hospitals, and 852 health centers are officially implemented user charges.

5.1.2 Exemption Cases at National Hospitals

There are 6 national hospitals have gained status of *administrative public enterprises*. These facilities still receives funding from the national budget in term of recurrent cost together with subsidy for reimbursement for exempted cases used by the poor. Health financing information is not reported on regular basis from theses facilities.

5.1.3 Exemption Cases at Referral Hospitals and Health Centers

As indicated in the table below, the total of exempted cases used by the poor at referral hospitals and health centers was 1,769,249 cases, including 1,608,770 cases for OPD, 4,9731 cases for IPD, 37,073 deliveries, and the rest are for paramedical clinic services and others. It is noted that 92% of the total exempted cases occurred at health center levels.

Province	Exemption case					Total
	OPD	IPD	Para clinic	Delivery	Other	
Battambang	160,711	4,123	2,287	1,166	1,247	169,534
HCs	156,816	1,867	1,021	860	1,148	161,712
RHs	3,895	2,256	1,266	306	99	7,822
Banteay Meanchey	73,915	1,421	2,903	934	323	79,496
HCs	72,873	634	2,129	844	217	76,697
RHs	1,042	787	774	90	106	2,799
Kratie	16,571	651	338	168	7	17,735
HCs	14,668	295	337	101		15,401
RHs	1,903	356	1	67	7	2,334
Kg. Cham	354,427	5,157	1,411	2,842	2,362	366,199
HCs	350,315	760	154	2,441	1,917	355,587
RHs	4,112	4,397	1,257	401	445	10,612
Kg Thom	82,731	13,014	2,112	1,404	60	99,321
HCs	80,399	11,555	1,887	1,332	36	95,209
RHs	2,332	1,459	225	72	24	4,112
kg Chhnang	64,629	2,109	4,507	2,858	1,429	75,532
HCs	64,528	1,025	2,315	2,814	1,297	71,979
RHs	101	1,084	2,192	44	132	3,553
Kg Speu	46,948	772	1,020	639	100	49,479
HCs	46,424	448	52	569	46	47,539
RHs	524	324	968	70	54	1,940
Krong Kep	4,930	332	236	113	30	5,641
HCs	1,311		78	29		1,418
RHs	3,619	332	158	84	30	4,223
Kampot	84,481	1,700	585	1,108	417	88,291
HCs	76,524	671	287	651	347	78,480
RHs	7,957	1,029	298	457	70	9,811
Kok Kong	3,679	353	496	64	26	4,618
HCs	3,550	278	55	62	21	3,966
RHs	129	75	441	2	5	652
Kandal	112,173	2,416	1,814	3,161	80	119,644
HCs	111,309	1,823	1,132	2,945	59	117,268
RHs	864	593	682	216	21	2,376
Mondukiri	5,872	336	509	155	125	6,997
HCs	5,872	336	509	155	125	6,997
RHs						
Odor Meanchey	18,550	175	705	592	189	20,211
HCs	17,857		685	592	189	19,323
RHs	693	175	20			888
PP Municipality	41,620	2,889	351	1,757		46,617
HCs	32,847	1,608		1,201		35,656
RHs	8,773	1,281	351	556		10,961
Pursat	15,739	584	216	210	336	17,085
HCs	15,301	71	186	182	314	16,054
RHs	438	513	30	28	22	1,031
Prey Veng	116,546	2,614	6,243	5,681	332	131,416
HCs	106,117	1,191	5,097	4,831	282	117,518
RHs	10,429	1,423	1,146	850	50	13,898
Pailin Ville				2		2
HCs						
RHs				2		2
Prea Vihear	57,518	4,408	7,292	2,547	2,064	73,829
HCs	56,274	4,224	6,803	2,539	2,040	71,880
RHs	1,244	184	489	8	24	1,949
Rattanakiri	7,572					7,572
HCs	6,999					6,999
RHs	573					573
Seam Reap	148,101	2,749	23,492	4,818	1,114	180,274
HCs	141,626	728	792	3,996	1,081	148,223
RHs	6,475	2,021	22,700	822	33	32,051
Stung Treng	14,840	356	986	5	12	16,199
HCs	14,183	129	348			14,660
RHs	657	227	638	5	12	1,539
Svay Rieng	59,339	2,688	3,156	4,263	174	69,620
HCs	51,197		1,644	3,246	57	56,144
RHs	8,142	2,688	1,512	1,017	117	13,476
Sihanouk vill	65,620	497	201	355		66,673
HCs	63,406			310		63,716
RHs	2,214	497	201	45		2,957
Takeo	52,258	387	1,381	2,231	1,007	57,264
HCs	44,847	58	595	2,108	488	48,096
RHs	7,411	329	786	123	519	9,168
Total	***1,608,770***	***49,731***	***62,241***	***37,073***	***11,434***	***1,769,249***
HCs	*1,535,243*	*27,701*	*26,106*	*31,808*	*9,664*	*1,630,522*
RHs	*73,527*	*22,030*	*36,135*	*5,265*	*1,770*	*138,727*
Total	***1,608,770***	***49,731***	***62,241***	***37,073***	***11,434***	***1,769,249***

5.1.4 Revenue from User Fees, HEF and CBHI at Referral Hospitals and Health Centers

The total revenue collected from various health financing schemes at all referral hospitals and health centers in 2010 was 33.5 million riel or approximately USD 8.7million. 66% of which is generated by referral hospitals. It noted that 65%, 32% and 3% of the total revenue is collected through user fee, HEF and CBHI, respectively.

5.1.5 Special Operating Agency (SOA)

Special Operating Agency (SOAs) is laid out in the Royal Government's Policy on Public Services Delivery [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.

In health sector, SOAs is intended to delivering health care of a good quality to Cambodians especially the poor . To date, there are 30 SOAs established 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 HSSP2. SDG is released directly from HSSP2 account to individual SOAs' account via banking system. 15 ODs receive the national funding directly from the MoH, whereas the other 15 SOAs receives its funds though PHDs and ODs.

The MoH has developed SOA manual, which sets out the guidance on how SOAs will be implemented and managed. The development of this Manual is informed by the guidance of CAR as set out in document, namely "Special Operating Agencies: Implementation Guide, Performance and Accountability" (General Secretariat, Council for Administrative Reform, June 2008). 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

Coverage of SOAs

Province	No.	SOA-OD/RH	Performance Agreement MOH-PHD	Service Delivery Management Contract PHD with PRH or OD	SDG Implemented (SDG start date)	Number of Provincial Hospital	Number of Referral Hospital	Number of HC	Number of HP
1.Kampong Cham	1	Kg. Cham PRH	1-Apr-09	4-Aug-09	Jan 1 2010	1			
	2	Memut OD		24-Jul-09	1-Jul-09		1	10	-
	3	Punhea Krek OD		24-Jul-09	1-Jul-09		1	16	-
	4	Cheung Prey OD		28-Jul-09	Jan 1 2010		2	14	-
	5	Chamkar Leu OD		28-Jul-09	Jan 1 2010		1	13	-
	6	Prey Chhor OD		31-Dec-09	Jan 1 2010		1	15	-
2.Takeo	7	Ta Keo PRH	1-Apr-09	30-Apr-10	Jun 1 2010	1			
	8	Daun Keo OD		30-Apr-10	Jun 1 2010			15	-
	9	Prey Kabas OD		30-Apr-10	Jun 1 2010		1	14	1
	10	Baty OD		30-Apr-10	Jun 1 2010		1	13	-
	11	Kirivong OD		16-Jul-09	1-Jul-09		1	19	2
	12	Ang Rokar OD		16-Jul-09	1-Jul-09		1	10	1
3. Koh Kong	13	Koh Kong PRH	1-Apr-09	24-Jul-09	1-Aug-09	1			
	14	Smach Meanchey OD		24-Jul-09	1-Aug-09			6	3
	15	Sre Ambel OD		24-Jul-09	1-Aug-09		1	5	-
4. Ratanak Kiri	16	Ratanakiri PRH	1-Apr-09	28-Jul-09	1-Aug-10	1			
	17	Ban Lung OD		28-Jul-09	1-Aug-10			11	18
5. Mondul Kiri	18	Mondulkiri PRH	1-Apr-09	24-Jul-09	1-Oct-09	1			
	19	Sen Mnorum OD		24-Jul-09	1-Oct-09			7	18
6. Preah Vihear	20	Preah Vihear PRH	1-Apr-09	17-Jul-09	1-Oct-09	1			
	21	Tbeng Meanchey OD		17-Jul-09	1-Oct-09			14	11
7. Oddar Meanchey	22	Odamean Chey PRH	21-Oct-09	21-Apr-10	Jan 1 2010	1			
	23	Samrong OD		23-Oct-09	Jan 1 2010			17	3
8. Siemreap	24	Siem Reap PRH	1-Oct-09	9-Apr-10	Jan 1 2010	1			
	25	Siem Reap OD		9-Apr-10	Jan 1 2010			18	3
	26	Sotnikum OD		20-Apr-10	Jan 1 2010		1	23	-
	27	Angkor Chum OD		20-Apr-10	Jan 1 2010		1	17	-
	28	Krolanh OD		9-Apr-10	Jan 1 2010		1	10	-
9. Prey Veng	29	Preah Sdach OD	1-Apr-09	14-Jul-09	1-Jul-09		1	9	-
	30	Pearaing OD		14-Jul-09	1-Jul-09		1	15	3
Total		**30 SOAs**	**9 contracts singed**	**30 Contracts signed**	**30 SOAs**	**8**	**16**	**291**	**63**

5.2 Demand Side Financing Schemes

Like many other low-income countries, Cambodia is facing a great challenge in developing financial protection. Absence of such financial protection is one of the main barriers for access to health services, in particular the poor. Financial barriers in access to health services include fees of health services and other associated cost such as transportation, food, and opportunity costs, in addition to ineffective exemption practices.

To minimize this issue, a various demand side financing schemes has been introduced; namely Health Equity Funds, Government subsidy scheme, Voucher scheme and Community Based Health Insurance. Since its inception, all these schemes have been expanded gradually within resources available including technical and financial support of the Government and health partners.

5.2.1 Health Equity Fund

Health Equity Funds is pro-poor health financing mechanism. In other words, it is widely recognized as a social transfer mechanism, and designed to subsidize costs of user-fee exemptions provided to the poor when they use public health services. Generally speaking, poor patients are entitled to use health services they need free of charges at the point of use. The poor are identified according to eligibility criteria, and HEF reimburses to health facility a full or partial cost of services used by the poor, depending on the ability to pay or not pay by the poor. It also reimburses the costs of transportation and food for the patients during hospitalization, as well as other benefits.

HEF Coverage

Currently, HEF are mainly funded by external funds and mostly implemented through international and local NGOs. To date there are 44 HEF schemes operated in 44 ODs in 23 provinces and Phnom Penh municipality, covering 42 referral hospitals and 323 health centers. 30 schemes are funded by various health partners via HSSP2, 8 of which are directly funded by BTC, 4 by USAID and the rest by other health partners. Generally, all HEFs subsidize for a common benefit package cost of health services, transportation, foods, other) but applies different provider payment methods.

Number of HEF Scheme and Contracted Health Facilities in 2010

No	Province and Population 2008	No.	Operational District	Funding Source	HEFI	Operator	Contracted RH		Contracted HC	
							No.	Payment type	No.	Payment type
1	Banteay Meanchey	1	Mongkol Borei	HSSP/WB/USAID	URC-CHS	PFD	2	FFS	23	FFS
		2	Ou Chrov	HSSP/WB/USAID	URC-CHS	PFD	1	CS	11	FFS
		3	Preah Net Preah	HSSP/WB/USAID	URC-CHS	PFD	1	CS	12	FFS
		4	Thma Puok	ICCO	No	CAAFW	1	FFS	10	FFS
2	Battambang	5	*Thma Koul*	*No*	*No*	*No*				
		6	Mong Russei	HSSP/WB/USAID	URC-CHS	AFH	1	CS	13	FFS
		7	*Sampov Luon*	*No*	*No*	*No*				
		8	Battambang	HSSP/WB/USAID	URC-CHS	AFH	1	CS	23	FFS
		9	Sangkae	HSSP/WB/USAID	URC-CHS	AFH	0		15	FFS
3	Kampong Cham	10	Chamkar Leu - Stueng Trang	BTC	BTC	AHRDHE	1		8	FFS
		11	Choeung Prey - Batheay	BTC	BTC	AFH	0		14	FFS
		12	Kampong Cham - Kampong Siem	BTC	BTC	AFH	1		22	FFS
		13	*Kroch Chhmar - Stueng Trang*							
		14	Memut	HSSP/ADB	URC-CHS	RHAC	1	CB	1	CB
		15	*O Reang Ov - Koh Soutin*							
		16	Ponhea Krek - Dambae	HSSP/ADB	URC-CHS	RHAC	1	CB		
		17	Prey Chhor - Kang Meas	BTC	BTC	AHRDHE	1		8	FFS
		18	*Srei Santhor - Kang Meas*	*No*	*No*	*No*				
		19	Tbong Khmum - Kroch Chhmar	HSSP/UNFPA	RHAC	RHAC	1	CB	13	CB
4	Kampong Chhnang	20	Kampong Chhnang	MoH/UNFPA	UNFPA	RHAC/ODO	1	CB	12	CB
		21	Kampong Tralach	HSSP/UNFPA	RHAC	RHAC	1	CB	11	CB
		22	Boribo	HSSP/UNFPA	RHAC	RHAC	1	CB	8	CB
5	Kampong Speu	23	*Kg Speu (Including PRH)*	*MoH*	*PHD*	*ODO*				
		24	*Kong Pisey*	*No*	*No*	*No*				
		25	*Ou Dong*	*No*	*No*	*No*				
6	Kg Thom	26	*Baray Santouk*	*No*	*No*	*No*				
		27	Kg Thom	HSSP/WB		AFH	1	FFS	10	
		28	Stong	HSSP/WB		AFH	1	FFS	0	
7	Kampot	29	*Angkor Chey*	*MoH*	*PHD*	*ODO*				
		30	*Chhouk*	*No*						
		31	*Kampong Trach*	*MoH*	*PHD*	*ODO*				
		32	*Kampot*	*HSSP/WB/AusAID*	*GTZ*	*GRET*				
8	Kandal	33	*Ang Snuol*	*No*	*No*	*No*				
		34	*Kean Svay*	*No*	*No*	*No*				
		35	*Koh Thom*	*No*	*No*	*No*				
		36	*Ksach Kandal*	*MoH*	*PHD*	*ODO*				
		37	*Muk Kam Poul*	*No*	*No*	*No*				
		38	*Ponhea Leu*	*No*	*No*	*No*				
		39	*Saang*	*No*	*No*	*No*				
		40	*Takhmau*	*MoH*	*PHD*	*ODO*				
9	Kep	41	*Kep*	*No*	*No*	*No*				
10	Koh Kong	42	Smach Mean Chey	HSSP/ADB	URC-CHS	RHAC	1	CB	0	
		43	Srae Ambel	HSSP/ADB	URC-CHS	RHAC	1	CB	0	
11	Kratie	44	Chhlong	HSSP/WB	URC-CHS	AFH	1	CB	4	
		45	Kratie	HSSP/WB	URC-CHS	AFH	1	CB	0	
12	Mondulkiri	46	Senmonorum	HSSP/ADB	URC-CHS	AFH	1	FFS	0	
13	Oddar Meanchey	47	Samraong	BTC	BTC	CHHRA	1	FFS	0	
14	Pailin	48	*Pailin*	*MoH*	*PHD*	*ODO*				
15	Phnom Penh	49	Cheung	USAID	URC-CHS	FHD	0		1	FFS
		50	Kandal	USAID	URC-CHS	FHD	2	FFS	1	FFS
		51	Lech	USAID	URC-CHS	FHD	1	CB	2	FFS
		52	Tbong	USAID	URC-CHS	FHD	0	CB	2	FFS
	Preah Vihear	53	Tbeng Meanchey	HSSP/WB	URC-CHS	AFH	1	FFS	0	No
17	Prey Veng	54	*Kamchay Mear*	*No*	*No*	*No*				
		55	Kampong Trabek	MoH	PHD	ODO				
		56	*Mesang*	*No*	*No*	*No*				
		57	*Neak Loeung*	*No*	*No*	*No*				
		58	Peareang	HSSP/ADB	URC-CHS	AFH	1	FFS	0	
		59	Preah Sdach	HSSP/ADB	URC-CHS	AFH	1	FFS	0	
		60	*Prey Veng*	*No*	*No*	*No*				
18	Pursat	61	Bakan	HSSP/WB/USAID	URC-CHS	PFD	1	CS	10	
		62	Sampov Meas	HSSP/WB/USAID	URC-CHS	PFD	1	CS	22	
19	Ratanakiri	63	Banlung	HSSP/ADB	URC-CHS	AFH	1	FFS	0	
20	Siemreap	64	Kralanh	BTC	BTC	CHHRA	1	FFS	0	
		65	Siem Reap	BTC	BTC	CHHRA	1	FFS	0	
		66	Sot Nikum	BTC	BTC	CHHRA	1	CB	16	FFS
		67	Ankor Chhum	HSSP/UNFPA	RHAC	RHAC	1	CB	14	CB
21	Sihanouk Ville	68	Sihanouk Ville	HSSP/USAID	URC-CHS	RHAC	1	CB	7	
22	Stung Treng	69	*Steung Treng*	*No*	*No*	*No*				
23	Svay Rieng	70	*Chi Phu*	*MoH*	*PHD*	*ODO*				
		71	*Romeas Hek*	*MoH*	*PHD*	*ODO*				
		72	Svay Rieng	UNICEF	UNICEF	HFSC	1			
24	Takeo	73	*Bati*	*No*	*No*	*No*				
		74	Daun Keo	SRC	SRC	CRC	1	FFS		
		75	Kirivong	HSSP/ADB	URC-CHS	BFH	1	FFS	20	
		76	*Prey Kabass*	*No*	*No*	*No*				
		77	Ang Rokar	HSSP/ADB	URC-CHS	BFH	1		10	
Total							42		323	

Coverage of Service Utilization under HEF schemes

Total number of cases used by the poor and subsidized by HEF in 2010 was approximately 702,632 cases, in which 531,235 cases and 171,397 cases of which were used at health centers and at referral hospitals, respectively.

No	Province	No.	Operational District	Operator	Utilization at RH				Utilization at HC				Utilization			
					OPD	IPD	Delivery	Total	OPD	IPD	Delivery	Total	OPD	IPD	Delivery	Total
1	Banteay Meanchey	1	Mongkol Borei	PFD	2850	5,239	417	8,506	61,267	0	885	62,152	64,117	5,239	1,302	70,658
		2	Ou Chrov	PFD	164	2,995	315	3,474	28,467	0	265	28,732	28,631	2,995	580	32,206
		3	Preah Net Preah	PFD	1064	1,433	81	2,578	28,961	0	449	29,410	30,025	1,433	530	31,988
		4	Thma Puok	CAAFW	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
2	Battambang	5	Thma Koul	No	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		6	Mong Russei	AFH	1587	3,393	368	5,348	60,606	0	557	61,163	62,193	3,393	925	66,511
		7	Sampov Luon	No	0	401	24	425	0	0	0	0	0	401	24	425
		8	Battambang	AFH	693	5,842	829	7,364	78,979	0	750	79,729	79,672	5,842	1,579	87,093
		9	Sangkae	AFH				0				0	0	0	0	0
3	Kampong Cham	10	Chamkar Leu - Stueng Trang	AHRDHE	523	2,803		3,326				0	523	2,803	0	3,326
		11	Choeung Prey - Batheay	AFH	1044	2,572		3,616				0	1,044	2,572	0	3,616
		12	Kampong Cham - Kampong Siem	AFH	255	6,522		6,777				0	255	6,522	0	6,777
		13	Kroch Chhmar - Stueng Trang				244	244	7,374		104	7,478	7,374	0	348	7,722
		14	Memut	RHAC	63	3,859	359	3,922	1,560	0	0	1,560	1,623	3,859	359	5,482
		15	O Reang Ov - Koh Soutin	No								0	0	0	0	0
		16	Ponhea Krek - Dambae	RHAC	4005	4,624	232	8,629	0	0	0	0	4,005	4,624	232	8,629
		17	Prey Chhor - Kang Meas	AHRDHE	52	3,163	312	3,527	0		0	0	52	3,163	312	3,527
		18	Srei Santhor - Kang Meas	No				0				0	0	0	0	0
		19	Tbong Khmum - Kroch Chhmar	RHAC	0	1,260	415	1,260	19,931	0	576	20,507	19,931	1,260	991	21,767
4	Kampong Chhnang	20	Kampong Chhnang	RHAC/OD	0	1,173	627	1,173	13,909	0	991	14,900	13,909	1,173	1,618	16,073
		21	Kampong Tralach	RHAC	34	847	440	881	29,360	0	677	30,037	29,394	847	1,117	30,918
		22	Boribo	RHAC	0	212	168	212	13,130	0	845	13,975	13,130	212	1,013	14,187
5	Kampong Speu	23	Kg Speu (Including PRH)	ODO				0				0	0	0	0	0
		24	Kong Pisey	No				0				0	0	0	0	0
		25	Ou Dong	No				0				0	0	0	0	0
6	Kg Thom	26	Baray Santouk	No				0				0	0	0	0	0
		27	Kg Thom	AFH	2835	2,998	184	6,017	0	0	0	0	2,835	2,998	184	6,017
		28	Stong	AFH	452	1,649	222	2,323	0	0	0	0	452	1,649	222	2,323
7	Kampot	29	Angkor Chey	ODO				0				0	0	0	0	0
		30	Chhouk					0				0	0	0	0	0
		31	Kampong Trach	ODO				0				0	0	0	0	0
		32	Kampot	GRET				0				0	0	0	0	0
8	Kandal	33	Ang Snuol	No				0				0	0	0	0	0
		34	Kean Svay	No				0				0	0	0	0	0
		35	Koh Thom	No				0				0	0	0	0	0
		36	Ksach Kandal	ODO				0				0	0	0	0	0
		37	Muk Kam Poul	No				0				0	0	0	0	0
		38	Ponhea Leu	No				0				0	0	0	0	0
		39	Saang	No				0				0	0	0	0	0
		40	Takhmau	ODO				0				0	0	0	0	0
9	Kep	41	Kep	No				0				0	0	0	0	0
10	Koh Kong	42	Smach Mean Chey	RHAC	3865	1,467	302	5,332	0	0	0	0	3,865	1,467	302	5,332
		43	Srae Ambel	RHAC	0	1,922	324	1,922	0	0	0	0	0	1,922	324	1,922
11	Kratie	44	Chhlong	AFH	74	3,766	181	4,021	10,324	0	73	10,397	10,398	3,766	254	14,418
		45	Kratie	AFH	0	4,729	442	5,171	0	0	0	0	0	4,729	442	5,171
12	Mondulkiri	46	Senmonorum	AFH	0	1,836	1	1,837	0	0	0	0	0	1,836	1	1,837
13	Oddar Meanchey	47	Samraong	CHHRA	4760	3,218	127	8,105				0	4,760	3,218	127	8,105
14	Pailin	48	Pailin	ODO				0				0	0	0	0	0
15	Phnom Penh	49	Cheung	FHD				0				0	0	0	0	0
		50	Kandal	FHD	3,702	1,851	429	5,982	25,327		166	25,493	29,029	1,851	595	31,475
		51	Lech	FHD				0				0	0	0	0	0
		52	Tbong	FHD				0				0	0	0	0	0
	Preah Vihear	53	Tbeng Meanchey	AFH	460	3,007	169	3,636	0	0	0	0	460	3,007	169	3,636
17	Prey Veng	54	Kamchay Mear	No				0				0	0	0	0	0
		55	Kampong Trabek	ODO				0				0	0	0	0	0
		56	Mesang	No				0				0	0	0	0	0
		57	Neak Loeung	No				0				0	0	0	0	0
		58	Peareang	AFH	211	2,162	136	2,509	0	0	0	0	211	2,162	136	2,509
		59	Preah Sdach	AFH	0	2,194	121	2,315	0	0	0	0	0	2,194	121	2,315
		60	Prey Veng	No				0				0	0	0	0	0
18	Pursat	61	Bakan	PFD	392	1,987	118	2,497	32,982	0	479	33,461	33,374	1,987	597	35,958
		62	Sampov Meas	PFD	1960	4,194	438	6,592	64,522	0	1,296	65,818	66,482	4,194	1,734	72,410
19	Ratanakiri	63	Banlung	AFH	0	3,486	119	3,605	0	0	0	0	0	3,486	119	3,605
20	Siemreap	64	Kralanh	CHHRA	821	1,383	98	2,302				0	821	1,383	98	2,302
		65	Siem Reap	CHHRA	4248	4,785	72	9,105				0	4,248	4,785	72	9,105
		66	Sot Nikum	CHHRA	7593	1,774	74	9,441				0	7,593	1,774	74	9,441
		67	Ankor Chhum	RHAC	1322	588	98	1,910	20,048	0	886	20,048	21,370	588	984	21,958
21	Sihanouk Ville	68	Sihanouk Ville	RHAC	1925	4,263	577	6,765	26,004	0	371	26,375	27,929	4,263	948	33,140
22	Stung Treng	69	Steung Treng	No				0				0	0	0	0	0
23	Svay Rieng	70	Chi Phu	No				0				0	0	0	0	0
		71	Romeas Hek	ODO				0				0	0	0	0	0
		72	Svay Rieng	HFSC	3,425	1,623	338	5,386				0	3,425	1,623	338	5,386
24	Takeo	73	Bati	No				0				0	0	0	0	0
		74	Daun Keo	CRC	0	1,045	85	1,130				0	0	1,045	85	1,130
		75	Kirivong	BFH	3070	2,366	261	5,697	0	0	0	0	3,070	2,366	261	5,697
		76	Prey Kabass	No				0				0	0	0	0	0
		77	Ang Rokar	BFH	5074	1,387	74	6,535	0	0	0	0	5,074	1,387	74	6,535
Total					58523	106,018	9,821	171,397	522,751	0	9,370	531,235	581,274	106,018	19,191	702,632

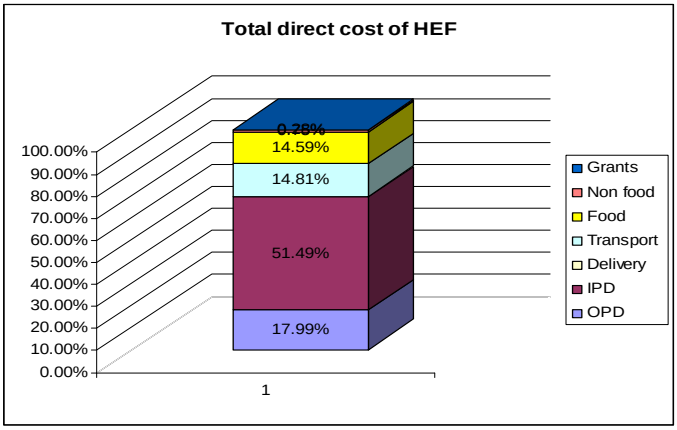
Financing HEF

The total disbursement of HEF in 2010 was USD 4,652,391. USD 4,099,096 (88%) and USD 553,295 of which was spent for direct cost and indirect cost, respectively. 88.6% (USD 3,629,954) of direct cost was spent for benefit packages of the poor at referral hospitals, while the remaining 11.4% was spent at health centers.

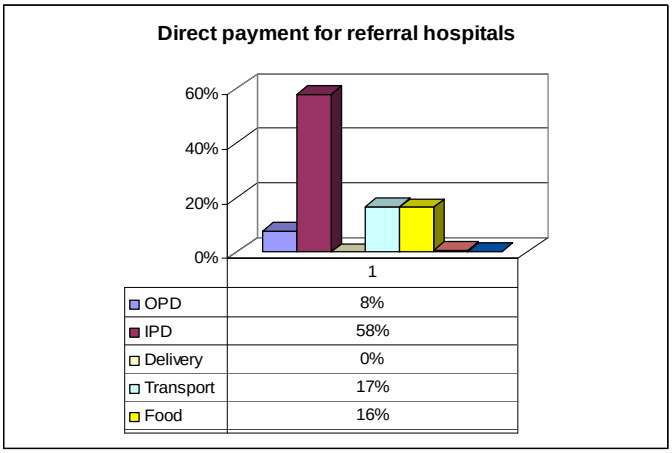
Categories	Amount ($)	%
Total direct cost	4,099,096	88.1%
Referral Hospital	3,629,954	88.6%
Health Centers	469,143	11.4%
Indirect cost	553,295	11.9%
Total cost	4,652,391	

Disbursement for direct cost

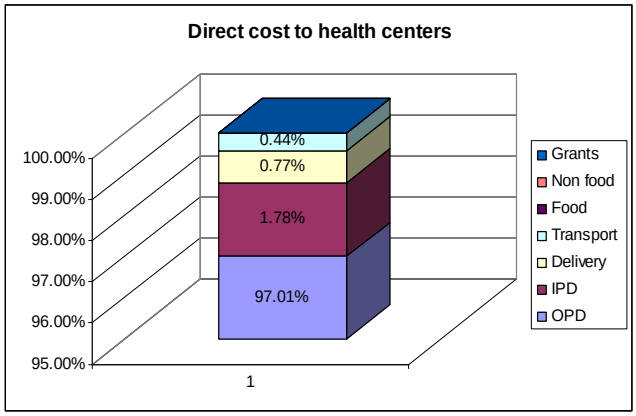
The share of total direct cost of USD 4,099,096 was spent 51.49% for IPD, 17% for OPD,—14.59% for foods and 14.81% for transportation, and the rest was spent for none food expenditure and grants.



The share of the total direct payment for referral hospitals was spent 58% for IDP, 17% for and 16% on transportation, 16% for foods , 8% for OPD, and 1% for none foods.

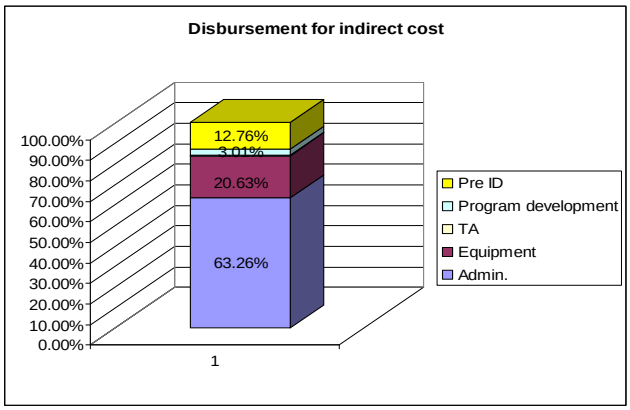


The total direct payment for health centers was USD 469,143, 97% of which was spent for OPD, followed by 1.78% for IDP, 0.77% for delivery, and 0.44% for transportation.



Disbursement for indirect cost

The total disbursement of indirect cost of HEF was USD 553,295. 63.26% of which was spent for administrative cost, followed by 20.63% and 12.76% for equipment and pre-identification of the targeted population, respectively. The remaining 3% was spent for the program development.



5.2.2 Government Subsidy

Subsidy: Subsidy (SUB)" is Government-funded scheme, aiming 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.

Subsidy Operator: A Subsidy operator (SUBO) is any public health authority that is entitled to receive subsidy from the Government. Currently, SUBOs are national hospitals and operational districts.

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

Coverage of Subsidy Scheme

So far, the subsidy scheme are implemented in 6 national hospitals, 10 referral hospitals and 88 health centers in 10 operational districts in 7 provinces.

No	Province	No.	National hospitals	Funding Source	HEFI	Operator	Contracted RH		Contracted HC	
							No.	Payment type	No.	Payment type
1	Phom Penh	1	National Pediatric	Government	Hospital	Hospital	1	Fixed case based		Fixed case based
2	Phom Penh	2	Ang Dong	Government	Hospital	Hospital	1			
3	Phom Penh	3	Kampuchea Sviet	Government	Hospital	Hospital	1			
4	Phom Penh	4	Kossamak	Government	Hospital	Hospital	1			
5	Phom Penh	5	Calmet	Government	Hospital	Hospital	1			
6	Phom Penh	6	MCH	Government	Hospital	Hospital	1			
Total national hospital							**6**			
No	**Province**	**No.**	**Operational District**	**Funding Source**	**HEFI**	**Operator**	**Contracted RH**		**Contracted HC**	
							No.	**Payment type**	**No.**	**Payment type**
1	Kampong Chhnang	1	Kampong Chhnang	Government	PHD	ODO	1	Fixed Case based	15	Fixed Case based
2	Kampong Speu	2	Kg Speu (Including PRH)	Government	PHD	ODO	1		22	
3	Kampot	3	Angkor Chey	Government	PHD	ODO	1		10	
		4	Kampong Trach	Government	PHD	ODO	1		12	
4	Kandal	5	Ksach Kandal	Government	PHD	ODO	1		8	
		6	Takhmau	Government	PHD	ODO	1		13	
5	Pailin	7	Pailin	Government	PHD	ODO	1			
6	Prey Veng	8	Kampong Trabek	Government	PHD	ODO	1		8	
7	Svay Rieng	9	Chi Phu	Government	PHD	ODO	1			
		10	Romeas Hek	Government	PHD	ODO	1			
Total referral hospital							**10**		**88**	

5.2.2 Social Health Insurance

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.

The draft of Social Health Protection Master Plan revised from the first SHI 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. For instance, 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 Labor 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 informal sectors, which includes CBHI and HEF schemes. And the Ministry of Economics and Finance will have a regulatory function. According to the Master Plan, these development processes are carried out by Inter-ministerial Technical Working Group and coordinated by Inter-ministerial Social Health Insurance Committee (SHIC).

To facilitate implementation of CBHI, the Ministry of Health has developed the Guidelines on Community Based Health Insurance with aim at providing guidance for (i) the design, arrangements and operation of CBHI schemes, which are subject to the MoH's approval, and (2) facilitation of the creation of a network of 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 a draft Sub-decrees on Micro-insurance of the MoEF. An overall purpose of this Sub-degree is to provide a legal tool for regulation, including licensing, of Micro insurance providers. Micro-insurance services specified by the Sub-degree 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 involve in micro insurance schemes. The first one is "Micro-insurer- a company" and the second is "CBHI Implementer".

As mentioned earlier, *plural approaches* will be adopted for the development of Social Health Protection in Cambodia. These approaches include (1) **compulsory** social health insurance will be developed through the social security framework for public and private sector salaried workers and their dependents, (2) **voluntary** insurance through the development of community-based health insurance schemes, and (3) **social assistance** schemes including health equity funds and other funds proposed by government for the poor.

5.2.2.1 Compulsory Health Insurance

Two types of Compulsory Health Insurance scheme are developed, implemented and managed by two different institutions according target population.

(1) MOLVT is responsible for the development of compulsory social security and health insurance for private-sector salaried workers 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.

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

Employment Injury scheme has firstly started its implementation in 2008, and covers private enterprises employing 8 workers and more. In 2010, 1,910 enterprises were registered with NSSF. 1,564 enterprises had paid the premium for a total 530,599 employees. The premium is 0.8% of gross salary, 0.5% and 0.3% of which is contributed from employers and the Government, respectively, for the period of 2009 and 2010. From 2011 onwards, the contribution of employer will cover the whole premium of 0.8%. It is reported that the premium varies from a minimum level of 1,600 riels to a maximum level of 8,000riels per month. Under the Employment Injury Scheme, the NSSF has contracted with 13 Hospitals (Calmette, Preah Kossamak, Khmere-Soviet, Chey Chum Neas (Kandal Province), Kg. Speu, Chiphou, Svay Rieng, Seam Reap, Sihanouk province, Kg. Chhnang, Kg. Tralach, Prea Angduong, and Poy Pet hospitals) and 1 Health center (Bek Chan health Center) to provide agreed and defined health services for beneficiaries. Fee for services are payment mechanism. It is noted that Health insurance scheme has been planned to implement in 2012.

(2) 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.

5.2.2.2 Voluntary Health Insurance Scheme

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 used the defined health services at contracted public health facilities i.e. health centers and referral hospitals. The CBHI reimburses the cost of services consumed by its members. The first CBHI scheme has been implemented since 1998 by the longest scheme called Sokapheap Kruosa Yeung (SKY), which is operated by a project of a French non-governmental organization (NGO), namely Groupe de Rechercheet d'E´ changes Technologiques (GRET), and funded by France Development Agency (AFD).

General Information of CBHI

So far, there are 18 CBHI schemes being implemented in 17 ODs in 10 provinces and Phnom Penh municipality, covering a total membership of 170,490 in the catchment's areas of 164 Health Centers and 13 district-based referral hospitals and 9 provincial-based referral hospitals and national hospitals. Benefit packages covered by all CBHI schemes are CPA at hospitals and MPA at health centre in addition to other associated cost. All of CBHI operators are local NGOs. In General the enrolment is done by family based, where premium are varied according to the side of family. All CBHI scheme contract only with public health facilities and mixed provider payment methods are implemented.

No.	Scheme	Start date	Province	OD	Health Center	Payment Model	Primary Referral Hospital	Payment Model	Secondary Referral Hospital
1	**SKY**	Dec, 2006	Phnom Penh	Phnom Penh	*3*	*Fee*	Chamkar Morn, Pochentong, Tuo Svay Prey,Samdch Ov, Khmer Soviet Hosp.	*Fee, Lumpsum*	Kosamak
2	**SKY**	2001	Takeo	Ang Roka	10	Capitation	AR RH	Capitation	Takeo Hospital
3	**SKY by BFH**	January, 2006	Takeo	Kirivong	20	Capitation	Kirivong Referral Hospital	Capitation	Takeo RH
4	**AFH**	January, 2010	Kompong Thom	Kompong Thom	9	Capitation	Kompong Thom Provincial Hospital	*Case based + User fees*	
5	**SKY**	1998	Kandal	Ta Khmoa	1	Capitation	Chey Chum Neah Hospital	Capitation	
6	**SKY**	2008	Kampot	Kampot	12	Capitation	Kampot Hospital	Capitation	
7	**SKY**	2008	Kandal	Koh Thom	6	Capitation	Koh Thom Referral Hospital	Capitation	Chey Chum Neah Hosp
8	**SKY**	2008	Takeo	Daun Keo	15	Case	Takeo Hospital	Case	
9	**SKY**	2010	Takeo	Bati	13	Capitation	Takeo Hospital	Case	
10	**SKY**	2010	Takeo	Prey Kabass	13	Capitation	Takeo Hospital	Case	
11	**CAAFW**	Feb, 2005	Banteay Mean Chey	Thmar Pouk	10	Case	Thmor Pouk Referral Hospital	Case	Monkol Borey Hospital
12	**CAAFW**	January, 2009	Oddar Meanchey	Samrong	11	Case	Anlong Veng Referral hospital	Case	Samrong
13	**PFD/URC**	Apr-10	Pursat	Sompov Meas	8	Capitation	Pursat Referral Hospital	Capitation	
14	**CHHRA**	August, 2005	Oddar Meanchey	Samrong	3			Case	Oddar Meanchey
15	**CHO**	October,2009	Battambang	Battambang	7	Case	0	Case	Battambang SRH
16	**CHO**	January, 2010	Battambang	Sanke	3	Case	0	Case	Battambang SRH
17	**RACHA/HN**	July, 2010	Prey Veng	Pearaing	3	Capitation	Pearaing Referral Hospital	Case based	Khmer So Viet
18	**STSA**	August,2010	Siem Reap	Ang Kor Chum	17	Case	Angkor Chum and Puok RH	Case	Siem Reap RH, Khmer Soviet
Total	**18**		**11**	**17**	**164**		**13**		**9**

Coverage of CBHI

No	Scheme	OD	Total Beneficiaries (Individuals)	New beneficiaries in 2010	Drop out in 2010	% beneficiaries covered by social assistance scheme (HEF)
1	SKY	Phnom Penh	5,906	3,470	3,362	0%
2	SKY	Ang Roka	10,706	5,986	3,878	0%
3	SKY by Bf	Kirivong	10,624	981	308	0%
4	AFH	Kompong Thom	4,833	4,337	456	28.92%
5	SKY	Ta Khmoa	857	395	191	0%
6	SKY	Kampot	25,608	16,211	8,214	75%
7	SKY	Koh Thom	3,178	3,252	2,816	0%
8	SKY	Daun Keo	8,600	8,512	7,734	0%
9	SKY	Bati	2,487	2,805	313	0%
10	SKY	Prey Kabass	2,263	2,541	280	0%
11	CAAFW	Thmar Pouk	40,299	11,847	1,503	0.00%
12	CAAFW	Samrong	25,683	16,128	4,401	0.00%
13	PFD/URC	Sompov Meas	5,036	672	4,531	0%
14	CHHRA	Odor Mean Chey	5,571	1,735	1,244	
15	CHO	Battambang	2,235	580	161	0
16	CHO	Sanke	566	115	15	0
17	RACHA/ HN	Pearaing	2,283	2,283	0	
18	STSA	AngKor Chum	13,755	13,755	0	81.62%
	Total		**170,490**	**95,605**	**39,407**	

It is observed that SKY scheme has been implemented in 7 different locations, with one scheme sub- being contracted to a local civil society, namely Buddhism for Health (BFH) in Kirivong OD, Takeo province. All of the SKY schemes, including a formerly-operated SKY scheme in Kampong Thom province and currently transferred to Action for Health (AFH), are adapted a common implementing arrangements including management structure, premium collection, benefit packages, payment method mainly capitation at Health Centres, and Referral hospitals.

Under this originally designed model by GRET-SKY, two schemes in Kampot and Kampong Thom provinces have linked up CBHI and HEF with intention of targeting population including the poor by subsidized premium from other projects. These schemes are technically backed up by GIZ. The total member of membership in Kampot is 24,202 persons (17% of targeted population) and around 75% is subsidized premium members. There is a low coverage in Kampong Thom but similar proportion of subsidy member is seen too. It is noted that SKY members account for about 41% of all schemes' members. This indicates that SKY schemes have a larger coverage in terms of geographical area and the number of the schemes. However, membership coverage remains small compared to the total number of target population in those areas.

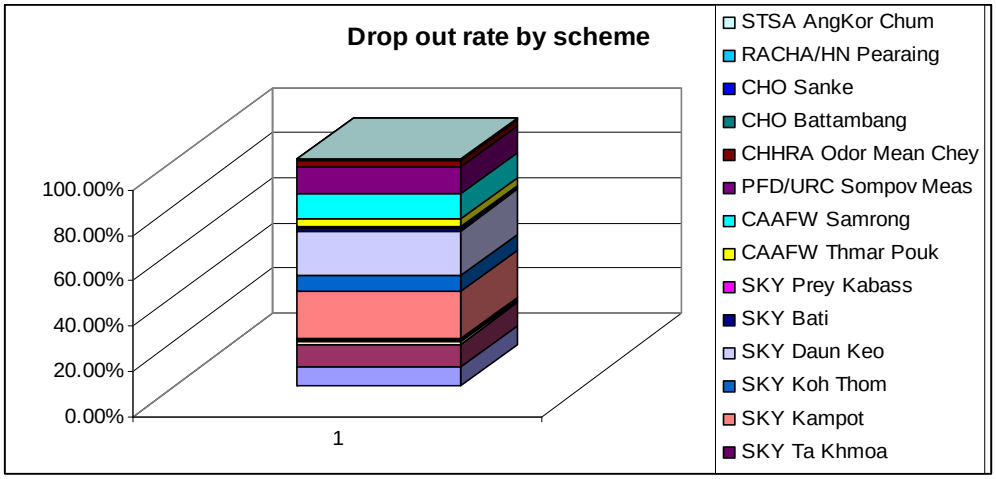
In addition, other two schemes have been are operated by a local NGO, namely the Cambodian Association for Assistance to Families and Widows (CAAFW), with backup-funds from German International NGOs, Malteser International. The schemes cover as around 40,299 persons in Thmor Puok (34% of targeted population) and 25,683 persons in Samrong ODs (11% of targeted

population), accounting for around 40% of the total members of all schemes, although implementing in only two sites. It is noted that the schemes have higher number of membership than all the other CBHI schemes.

A new scheme, Samakum Theanearabrong Srok Angkor chum (STSA) known as Health Insurance in Angkor Chum District, has recently been launched with financial and technical back-up from the University Research Company, LTD (URC) and funding of USAID. The scheme is operated by Community Based Organization, known as operator, and oversight by a Board with full involvement of community. The CBO is officially recognized by the Ministry of Interior and the Board consists of local authorities, OD, and community. The family based premium is collected by commune council according to terms of contract arrangement. The target populations are people living in the Angkor Chum District regardless their economics and health status. Premiums for the poor are paid by URC. Currently, there are 13, 755 members, 81% of them is subsidized members.

Drop out rate

It is estimated that drop out rate is around 23%. The highest drop out rate is SKY schemes in Kampot 20% and Daunkeo 19%, followed by CAAFW in Samrong 11% and URC in Pursat 11%, SKY scheme in Angroka 9%, and Phnom Penh 8%.



Financial Information of CBHI

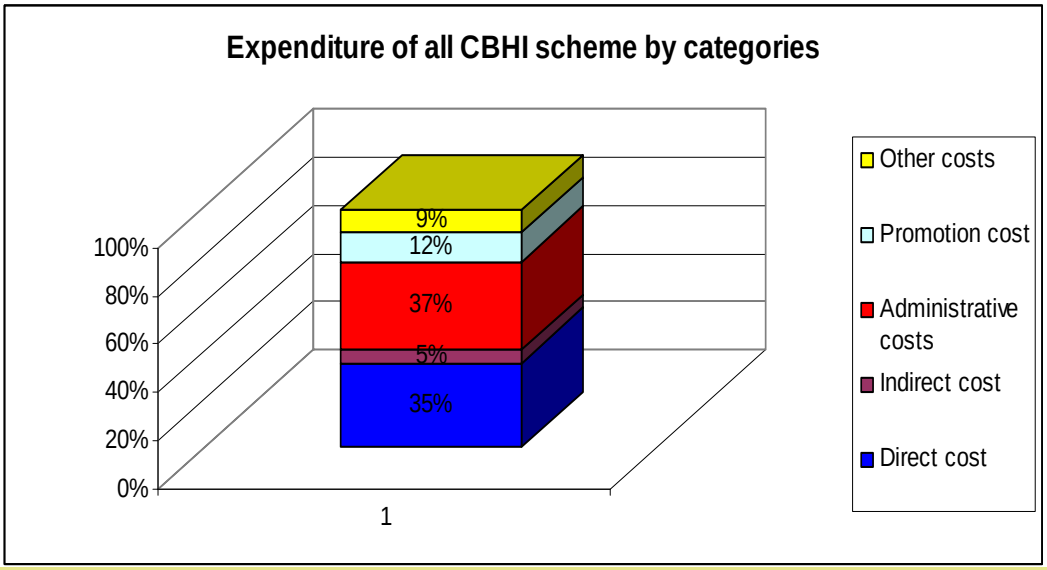
No	Scheme	OD	Income			Expenditures					
			Total Premiums	Other Income	Total Income	Direct cost	Indirect cost	Administrative costs	Promotion cost	Other costs	Total
1	SKY	Phnom Penh	82,572	952	83,524	68,795	1,287	40,228	7,212	0	117,521
2	SKY	Ang Roka-Zone2	32,803	801	33,604	27,886	6,125	48,733	11,470	0	94,214
3	SKY by BfH	Kirivong	22,649	99	22,748	24,313	1,083	35,342	19,043	0	79,781
4	AFH	Kompong Thom	15,868	10,213	26,080	17,208	2,838	81,730	6,645	2,662	111,083
5	SKY	Ta Khmoa-Zone 1	1,196	19	1,215	3,326	59	2,777	674	0	6,836
6	SKY	Koh Thom-Zone 7	13,067	898	13,965	12,159	1,323	32,456	8,191	0	54,128
7	SKY	Kampot-Zone 6	72,487	1,068	73,555	78,942	6,914	53,809	12,505	0	152,170
8	SKY	Daun keo-Zone 8	34,718	2,030	36,748	33,293	3,786	52,622	19,027	0	108,727
9	SKY	Bati-Zone 9	1,542	4	1,546	1,402	92	34,692	8,254	0	44,440
10	SKY	Prey Kabas-Zone 10	1,529	5	1,534	883	198	27,097	10,435	0	38,613
11	CAAFW	Thmar Pouk	68,690	79,330	148,020	83,003	12,059	7,455	10,876	34,627	148,020
12	CAAFW	Samrong	48,111	185,693	233,804	44,491	17,847	12,320	31,883	79,153	185,693
13	PFD/URC	Sompov Meas	8,201	0	8,201	17,318	0	11,949	0	0	29,267
14	CHHRA	Oddar Meanchey	7,362	6,605	13,967	7,648	6,411	1,979	0	0	16,038
15	CHO	Battambang	6,958	450	7,408	2,456	1,077	1,027	329	98	4,987
16	CHO	Sanke	1,570	306	1,876	643	816	526	329	98	2,412
17	RACHA/HN	Pearaing	9,357	10	9,367	2,492	1,106				3,598
18	STSA	Ang Kor Chum	11,340	5,600	16,940	6,830	1,672	7,388	0	9	15,899
	Total		**440,020**	**294,084**	**734,103**	**433,085**	**64,695**	**452,128**	**146,874**	**116,646**	**1,213,428**

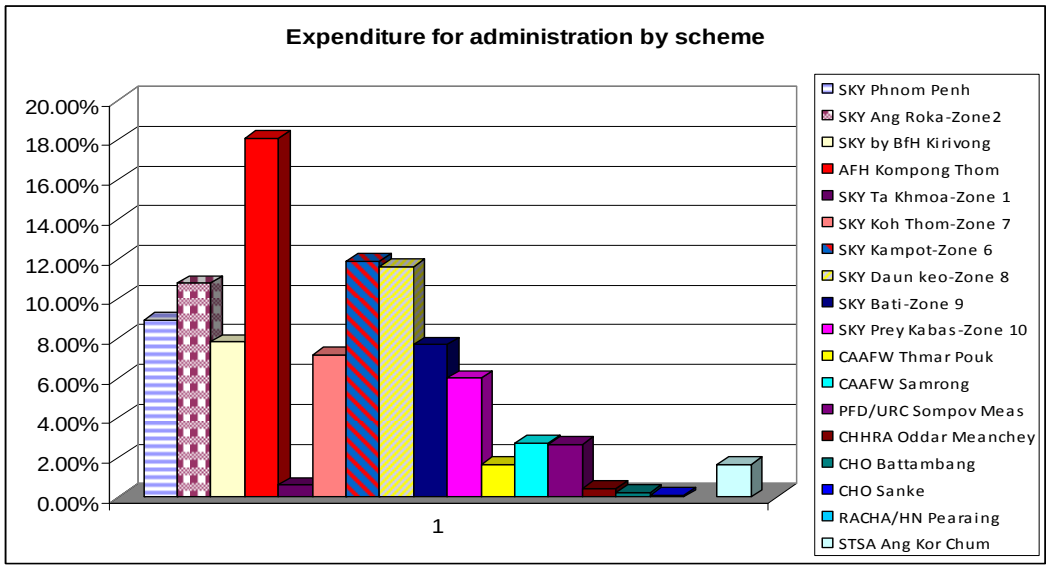
Revenue

The total revenue of all CBHI scheme in year 2010 was USD 728,104, 60% of which came from premium paid by the beneficiaries and the remaining 40% came from other support.

Expenditure

The total CBHI expenditure for 2010 was USD1, 213,428, which is exceeded 65% of the total revenue. However extra revenue to cover this exceeded amount was not reported. Based on available data, analysis indicates that in average spending, CBHI schemes spent 37% for administration, 36% for direct payment for health services, 5% for other benefit package, 12% for promotion activities and 9% for other expenses.





It is interesting to note that CBHI is relied on external funds. Such funds are directly provided to operators, except funds for three schemes that link up with HEFs are channeled through Health Sector Support Program under MoH management.

In fact, CBHIs in Cambodia are initiated and implemented by NGOs based on their individual design and their choice for targeted sites, with financial and technical support from their respective donors. There is limited involvement from the communities and financial support from the government, except regular budget to public health services.

The MoH, in consultation with health partners, has developed a number related policy and guidelines to support the implementation of health financing schemes, in general, and Guideline for CBHI in particular. The Guidelines are not consistently implemented across all schemes, except quarterly performance reports that are submitted regularly by CBHI operators to the Bureau of Health Economics and Financing, MoH/DPHI. Therefore it is a critical need for further strengthening the implementation of the CBHI Guidelines in more consistent and coordinated fashion. On other hand, there is also a need for strengthening capacity of Bureau of Health Economics & Financing, especially, in monitoring area.

TECHNICAL IMPROVEMENTS OF THE ANNUAL HEALTH FINANCING REPORT

The Annual Health Financing Report is considered as a tool for monitoring the progresses of the implementation of the Strategic Framework for Health Financing 2008-2015, and the second Health Strategic Plan's objectives, in general. In addition, further improvements and in-depth analysis will contribute to provide evidences for health financing policy.

The next year Health Financing Report should focus on the proposed outline for the report as the followings:

INTRODUCTION

- Country context
- Health infrastructures
- Key performance indicators of health sector
- Key health financing schemes
- Health expenditures

DEVELOPMENT PROCESS (OF REPORT)

- Objectives
- Data sources
- Limitation

HEALTH SYSTEM FINANCING

1. National Budget
   Trends of national budget allocation and expenditure

2. User fees Scheme
   Incomes generation
   Management of revenue including expenditure
   Exemption rate
   Discussion

3. HEFs and Subsidy Schemes
   Geographical coverage
   Population coverage
   Benefit packages
   Provider payment
   Budget and expenditure
   Health service utilization
   Discussion

4. Voucher Schemes for Reproductive Health
   Geographical coverage
   Population coverage
   Benefit packages
   Provider payment
   Budget and expenditure
   Health service utilization

Discussion

5. Community Based Health Insurance
   Geographical coverage
   Population coverage
   Benefit packages
   Provider payment
   Budget and expenditure
   Health service utilization
   Discussion

6. Others, *if information available*
   - NSSF
   - NSSFCS
     (note: each of the schemes will focus on the same elements as described for the above-mentioned schemes)
   - Catastrophic health expenditures, including disaggregated data by income quintile and if desired other disaggregates (e.g. rural/urban, province, etc)

CONCLUDING REMARK

- Policy Implications

Therefore to be able to produce the next health financing report according to the proposed outline report, there are needs as follows:

- Need to have a comprehensive financial report within the public health system (Revenue from all sources and their expenditure).
- Improve donor reporting, especially disaggregating by programs and by cost categories: this may involve coordination with the Cambodian Development Council Database.
- Improve donor expenditure report to measure the actual spending of development partners by year in comparison to AOP.
- Continue do OOP analysis annually by using available data
- Examine payments methods in the private sector and see if there is any informal financing mechanism that encourages health care seeking in the private sector (e.g. delayed payments, flexibility of payment methods such payments in kind etc).
- Disaggregate household spending by sub-populations to have a closer look at equity and gender aspects: level of OOP in poorer and remoter districts, in lowest income quintiles, for women patients.
- Compare utilization levels between HEF and non HEF beneficiaries, between CBHI and non-CBHI members
- Perform surveys of CBHI and HEF beneficiaries to examine debt for health care of CBHI and HEF beneficiaries as well as examine CBHI and HEF coverage and utilization from an equity and gender perspective

TERMINOLOGY

Approved budget	refers to budget approved by legislative bodies i.e. National Assembly and Senate.
Adjusted Budget	refers to budget envelope given by the MEF
Committed Budget	refers to budget approved by the MEF after negotiation
Mandated budget	refers to budget disbursed by MoH
Cash Disbursed	refers to cash released
User fees	refers to decentralized and affordable user charges at 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 allowed implementing this 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, because less than half of those who are considered too poor to pay for services.
Health Equity Fund	A social-transfer mechanism is designed to remove financial access to public health facilities by the poor by paying fees for services via a third-party payer, mainly local NGOs. Pre-identification and post identification are commonly used for identification of the poor, who are entitled to get health services free of charge at the point of use, but the third party will-reimburse directly the cost of such used services to facilities on monthly basis.

Health Equity Fund Implementer (HEFI) An agency manages Health Equity Fund Operator(s).

Health Equity Fund Operator (HEFO) An agency (NGO or any other type of Civil Society Organization is responsible for implementing HEFs, and oversight by. HEFO represents the voice of and acts in the interest of the poor in coverage area of the HEFs schemes by purchasing health services from public health providers.

Subsidy (SUB) Subsidy is Government funded scheme(s) whereby public health facilities provide services free of charge to the poor patients and their caretakers, but receives by financial-compensation from 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 manage SUB scheme(s).

Social health protection is 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 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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