SUMMARY REPORT
OF
THE HEALTH FINANCING SYSTEM
ASSESSMENT
IN
CAMBODIA

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Contents

Background ................................................................................................................................. 3

I. Objective of the health financing system review .......................................................... 3

II. Organizational Assessment for Improving and Strengthening Health Financing (OASIS) ................................................................................................................................. 4

III. Performance Indicators ................................................................................................. 5

IV. Overall institutional and organizational assessment ..................................................... 7

  IV.1 Main financing channels to be reviewed ................................................................. 7

  IV.2 Revenue collection and mobilization .................................................................... 9

      a) Level of funding ........................................................................................................ 9

      b) Level of population Coverage .............................................................................. 10

      c) Method of financing / Degree of financial risk protection .................................. 12

  IV.3 Pooling ..................................................................................................................... 13

      a) Composition of risk pools/ level of equity in health financing ......................... 13

      b) Fragmentation of risk pooling .............................................................................. 15

      c) Management of risk pools .................................................................................... 16

  IV.4 Purchasing.................................................................................................................. 18

      a) Equity in benefit package (BP) delivery .............................................................. 18

      b) Provider payment mechanisms ............................................................................ 20

  IV.5 Stewardship ............................................................................................................... 21

  IV.6 Piloting approaches and experimenting in Cambodia ............................................ 22

V. Conclusion ......................................................................................................................... 23

VI. Annexes ............................................................................................................................ 24

  VI.1 List of interviewed stakeholders ............................................................................ 24

  VI.2 References .................................................................................................................. 26
Background

This report presents the findings and areas of study to be further developed to complete the health financing system review initiated in Cambodia with a technical support mission of the Providing for Health Partners initiative (P4H) from 29 June to 10 July 2009. It presents a summary assessment by financing functions: collection, pooling and purchasing. It also proposes further issues to be developed and complemented with evidence to provide a final health systems review and subsequent recommendations for the improvement of those functions. It also briefly addresses the challenges in governance issues, including policy setting and stewardship role of the Ministry of Health (MoH). The objective of the final product of the review is to provide suggestions and options for the implementation of the Cambodian Social Health Protection Master plan and the institutional and organizational long-term development of the national health financing systems.

This summary assessment will be completed with short term studies and quantitative secondary analyses of household socio-economic surveys and health insurance simulations. It should also build on a participative approach including social health protection stakeholders at country level with the support of P4H local partners.

I. Objective of the health financing system review

Cambodia's Strategic Framework for Health Financing (SFHF) provides the first step of the development of an operational health financing policy towards universal coverage. The SFHF states strategic objectives with specific components for intervention to improve resource mobilization, planning, allocation and use of those in a transparent, equitable, efficient and effective way. The health financing strategy bases on a mixed model, combining funding from taxation with pre-payment schemes, social health insurance and sustained donor funding for social protection funds. The strengthening of the chosen financing mechanisms in the SFHF still require to improve institutional and organizational structures in line with national strategic interventions. The proposed health financing system review aims at providing recommendation to achieve such an improvement. The approach is based on a conceptual framework for the "Organizational Assessment for Improving and Strengthening Health Financing (OASIS)" developed by the World Health Organization (WHO) with the financial and technical support of the Korean Foundation for International Healthcare (KOFIH).
II. **Organizational Assessment for Improving and Strengthening Health Financing (OASIS)**

The OASIS approach serves to analyse the performance of a health financing system and its respective health financing schemes along performance indicators related to resource collection, pooling and purchasing and stewardship, as outlined above.

The distinct characteristic of the OASIS approach is its particular attention to institutional design issues, including the rules and regulations that specify and determine health financing functions. At the same time, the OASIS approach applies a new institutional economics view \((1, 2)\) on health financing systems and concentrates on the way these rules and regulations are implemented by organizations, i.e. how these rules and regulations really operate in practice \((3, 4)\).

This type of analysis allows for the identification of bottlenecks in the way institutions and organizations function. It also helps to inform policy and to find institutional and organizational alternatives and solutions to improve health systems performance. Recommendations are to be assessed with respect to what incentives can be anticipated and other impacts. At the same time, the related (institutional) requirements are identified in order to assess both political and technical feasibility.

As such, the OASIS approach consists of three steps:

1. Review the health financing system and assess health financing performance
2. Detailed institutional-organizational analysis of rules and how these are implemented
3. Recommendations to improve performance through institutional and organizational modifications by anticipating incentives and potential other impacts of these suggested measures.

To achieve this analyse, the methodology has consisted in a first step to a documentary data-collection, then in a second time to key-stakeholders in-depth interviews and group-interviews during a two week period.

For the present review the analysis will be completed with short term studies and quantitative analyses of available data provided by household socio-economic surveys and social health insurance simulations. It should also build on a participative approach including social health protection stakeholders at country level with the support of P4H local partners.
Figure 1: Summary overview of the OASIS analytical framework

III. Performance Indicators

Different performance indicators can be used in order to assess a system performance. In 2005, Carrin and James have developed a set of indicators providing an evaluation framework for performance of SHI systems around the targets of resource generation, optimal use, and financial accessibility for all (5). These indicators related to the core function of health financing systems (collection, pooling and purchasing and stewardship) are integrated in the OASIS conceptual framework, and will be used to assess the Cambodian financing health system.

These performance indicators (Table1) can be extended to most health financing systems and insurance schemes and will be used in this study with adequate adjustment to take into account country context. Thus, they to be are complemented with indicators on the institutional policy framework for health financing and stewardship.
## Table 1. Performance indicators of core functions of Social Health Insurance

<table>
<thead>
<tr>
<th>Health financing function/ key dimension</th>
<th>Indicator</th>
<th>Normative performance indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and stewardship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear health financing policy available that guides design of the various HF schemes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strong stewardship capacity available that steers and controls the design and functioning of the various HF schemes.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Revenue collection

<table>
<thead>
<tr>
<th>Level of funding</th>
<th>THE p.c.</th>
<th>GGHE p.c.</th>
<th>THE/GDP</th>
<th>GGHE/THE</th>
<th>Level of population coverage</th>
<th>% of population covered by a financial risk protection mechanism</th>
<th>Population coverage as high as possible - 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method of finance</td>
<td>Ratio of prepaid contributions to total healthcare costs THE-OOPs in %</td>
<td>% of households with catastrophic expenditure in each scheme</td>
<td>Prepayment as high as possible (70%) of total health expenditure 0%. Payments for health care are based on capacity-to-pay (fair financing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of financial risk protection</td>
<td>% of households impoverishing through catastrophic spending</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pooling

<table>
<thead>
<tr>
<th>Level of equity in health financing</th>
<th>Inclusion of the poor</th>
<th>Compulsory membership for all/some contributing population groups</th>
<th>Poor are included in the risk pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composition of risk pool(s)</td>
<td>% of each contributing group is covered by SHI</td>
<td>Compulsory insurance coverage of dependants of contributing groups</td>
<td>Equal amount available per type of risk across pools</td>
</tr>
<tr>
<td>Fragmentation of risk pooling</td>
<td>Existence of single risk pools; If multiple risk pools, existence of risk equalization mechanisms</td>
<td>0% of households with catastrophic expenditure</td>
<td></td>
</tr>
<tr>
<td>Health financing function/ key dimension</td>
<td>Indicator</td>
<td>Normative performance indicator</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Management of risk pool(s)</td>
<td>• Efficiency incentives for risk pool(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Purchasing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity in benefit package (BP) delivery</td>
<td>• BP based on explicit efficiency and Equity criteria</td>
<td>The benefit package (BP) meets equity and efficiency goals. The BP is based on cost-effectiveness and equity criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Existence of monitoring mechanisms – patient appeals mechanism, information on claimant rights, peer-review committee and claims review</td>
<td>Optimal use of resources</td>
<td></td>
</tr>
<tr>
<td>Provider payment mechanisms</td>
<td>• Provider incentives encourage the appropriate level of care</td>
<td>Benefit package is consumed rationally (efficiently)</td>
<td></td>
</tr>
<tr>
<td>Level of administrative efficiency</td>
<td>• Total administrative costs for all health financing schemes as a share of THE</td>
<td>&lt;10%, declining over time</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fund management is guided by efficiency principles</td>
<td></td>
</tr>
</tbody>
</table>


**IV. Overall institutional and organizational assessment**

**IV.1 Main financing channels to be reviewed**

The Cambodian health system has been profoundly impacted by the turmoil that the country has faced in the last century (6). The current health system includes many characteristics from transitional systems (7). The national health system has been completed with a patchwork of contracting agreements with international NGOs that cover 11 so-called operational districts (OD). In addition, three provinces have being piloting "performance-based-contracting" in 8 ODs with the support of the Belgian Technical Cooperation. Available evidence highlights that contracting has improved health systems performance in those experiences (8). In parallel, financially supported by development partners to new mechanisms such as health equity funds (HEF) were
introduced in combination with contracting experiments. This in an effort to increase access of vulnerable population groups to health services. Thus, HEF compensated health providers for services provided to identified poor households and compensate users for non-medical costs of illness (9). In addition, prepayment and pooling mechanisms for the non-salaried sector were piloted under multiple variants of voluntary Community Based Health Insurance (CBHI) (10).

Vertical programmes supported by international initiatives cover the entire country and play an important role in the provision of essential health services and prevention measures such as distribution of impregnated bed-nets.

Five broad channels of funding can be categorized from the current health financing system situation, and for the purpose of the present assessment:

1. Private health expenditure from households and private companies;
2. General government funding from general taxation;
3. Prepayment and insurance schemes including, CBHI and social health insurance;
4. Social safety nets including, HEF and voucher schemes;
5. Specialized programmes such as the second Health Sector Support Program financed by development partners;

From the last available data on the structure of the total health expenditure (THE) in Cambodia, it appears that the major channels remain private health expenditure and government funding. In fact, households directly finance the bulk of the health care in the country. The last available data from National Health Accounts, published by WHO for 2005, point out that over 66% of THE was funded through out-of-pocket and an additional 11% through government contributions. This situation, linked to the absence of data on catastrophic expenditure and impoverishment supports the rationale for the rechanneling of households expenditure through pooling mechanisms, either through insurance schemes or through taxation mechanisms to reduce risk for populations (11, 12).

New developments in the channels of financing of health services are foreseen to be scaled-up over the next years with the implementation of the SHHF and the recent Social Health Protection master plan in 2009. These will include the coverage of public and private salaried workers through dedicated pooling mechanisms financed by payroll contributions if these mechanisms have the potential to provide a substantial part of the
population with social protection including, health and income benefits. Their implementation requires however adequate political commitment and resources (financial and technical).

### IV.2 Revenue collection and mobilization

#### a) Level of funding

**Normative performance indicator:**

There is no predetermined ideal level of health care expenditure, other than a minimum.

Cambodia has seen its THE rapidly increasing over the last years as highlighted in its health financing report for 2008. This trend was driven by the increase in available income of the country and disbursements of development partners. The commitment of the government to match the support to health of its partners shows that investing in human capital formation is now part of the country's policies. Providing health services with public funding is also a valuable peace dividend that contributes to social and national cohesion. The efforts of the government to bring national budget for health at over 12% of the general public expenditure outstands many countries of comparable socio-economic background.

Unfortunately, the low base of taxation and the remaining high level of out-of-pocket expenditure in the THE suggests that additional strategies are needed to re-channel private expenditure and to mobilize more resources. This will however to be done without jeopardizing the macro-economic environment of Cambodia. If payroll taxes and contributions may be preferable from a fairness point of view, it is important for promoting direct investment that the use of such financing mechanisms remains reasonable. The current large salaried (formal) sector provides a potential for the development of social insurance like schemes. However, as wages are still very low in Cambodia this potential may be relativised. Payroll contributions would also only be acceptable to employers and employees if accountability and quality of the institutions and services provided are sufficient. This will only be possible with substantial reinvestment of resources in monitoring and management of social insurance schemes, leaving only limited resources for cross-subsidization to other categories of the population. Thus, complementary financing approaches need to be considered.
If recent evaluations of the resources available for the achievement of the Millennium Development Goals (MDG) suggest that the gross health resources may be sufficient to achieve those (13), these estimations do not take into account the inequity and allocation of health expenditure across population groups and health priorities which are dictated by out-of-pocket. This may in part explain why despite its reasonably high health expenditure and improvements in many MDGs, Cambodia still experiences weaknesses in its health system as suggested by key indicators such as maternal mortality rates that remain high.

Part of the government health budget is organized around three major programme areas: Reproductive, Mother, Newborn and Child Health (RMNCH), Communicable Diseases (CD) and Non-Communicable Diseases (NCD).

Dependence on of the national public budget on external resources is rapidly reducing but remains sufficiently significant to represent serious challenges for the coordination, alignment and harmonization of resources to national programmes. Indeed, there is a substantial proportion of aid tied and transaction costs are most probably high. However, it exists a commitment of development partners to budget support and pool-funding through mechanisms such as the second Health Sector Support Program (HSSP2).

**b) Level of population Coverage**

*Normative performance indicator: Population coverage as high as possible*

The current health insurance coverage in Cambodia is very low. This implies that the third channel that we identified as “prepayment and insurance schemes” is still only of marginal importance in the overall picture of health financing.

Various safety nets have been introduced with some success despite obvious challenges on their sustainability. Public subsidies through exemption policies, as supported by the government and Health Equity Funds (HEF) and mainly financed by development partners, play a major role in the Cambodian context. Nevertheless, these targeted approaches are only part of the necessary approaches to achieve universal coverage.

**Health Equity Funds**

Currently most of the focus of development partners seems to be on the extension of HEF, social transfer mechanisms implemented by NGOs, INGOS. These mechanisms are support
public health service delivery with direct funds of donors and contributions of the government. Nearly 50 different schemes exist at OD level and those cover around 50% of the poor population who are identified through a national process of identifying the poor. The population coverage and performance of HEF has been recognized as globally positive. HEF have increased access and utilization of health facilities by the poor. However, these schemes are not yet implemented in all provinces. The identification of the poor is also difficult to standardize and the cost of this identification may slow the process as resources may not be adequate (see below on inclusion of the poor).

**Community Based Health Insurance**

There are 12 community based health insurance (CBHI) schemes, implemented by 5 different international NGOs (GRET/SKY; RACHA; PBHI, CAAFV, CHHRA) with support of local NGOs. Those schemes cover 11 OD level and less than 0.6% of the population. CBHI have a serious challenge in being extended and it is unlikely that this voluntary approach can be extended to cover a substantial part of the population.

**National Social Security Fund for formal private employees**

National Social Security Fund for formal private employees (NSSF) is a compulsory social health insurance for formal public and private sector salaried workers and their dependants. Companies which have eight employees or more are required to pay contributions for occupational risks to the NSSF. Currently, 600 companies of 3 provinces are registered for a total of 23.5% of workers (400,000 people) are covered by the NSSF, this represents 3% of the total population covered. This is illustrative of the rapid development of the scheme which will also benefit of its extension to all provinces in the future.

The project of the National Security Fund for the coverage of the civil servants has been officially established but has not started yet. The civil servants represent 1.25% of the population which can potentially be covered.
c) **Method of financing / Degree of financial risk protection**

<table>
<thead>
<tr>
<th><strong>Normative performance indictor:</strong></th>
<th>Prepayment as high as possible and achieving a minimum.</th>
</tr>
</thead>
</table>

The majority of the health system and population are still relying on out-of-pocket and public subsidies from the national budget. The cost-sharing was introduced in 1996, by the National Health Financing Charter. It is reported to have contributed to the reduction of informal payments and to the improvement of the quality of services. The reliance on user-fees was rational in the absence of sufficient and efficient pooling mechanisms, but it also brought major challenges for the equity of the health system (14, 15). Exemption mechanisms were introduced but resources to enable their efficiency in public facilities were lacking which motivated the piloting of HEFs.

<table>
<thead>
<tr>
<th><strong>Normative performance indictor:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No households experiencing catastrophic expenditure, i.e. 0%.</td>
</tr>
<tr>
<td>No households impoverishing through catastrophic expenditure, i.e. 0%.</td>
</tr>
</tbody>
</table>

Out-of-pocket expenditure by households represents a major part of the THE and it is mainly absorbed by an unregulated private sector. This points at problems of financial accessibility even if HEF have significantly reduced direct payments for the poor. Out-of-pocket expenditure is a proven burden for the economic and human development of the population.

Large scale evidence on the impact of out-of-pocket on impoverishment and slowing of economical development of households because of debt related to health is scare in Cambodia. However, small scale studies and anecdotal evidence suggests that the situation needs attention (16, 17). If half of the poor population may now be covered by HEF and so protected from catastrophic expenditure and debt, the available information suggests that out-of-pocket may not only drive the poorest to financial difficulties. It is not possible to provide a full assessment of this indicator because of the limitation of the available data. The assessment of the current situation will therefore need to be complemented by a secondary data analysis of household survey data including the Cambodian Social and Economic Surveys (CSES) 2004 and 2007, and Cambodian
Demographic Health Survey (DHS) 2005. This analysis will also need to look at the determinants of catastrophic expenditure and debt for health.

**Normative performance indicator:** Payments of health care are based on capacity-to-pay

As mentioned above the two major channels for financing health care remain direct private and government funding. Out-of-pocket expenditure may very well be linked to capacity-to-pay of households but are proved from international evidence to be strongly regressive and to bring high financial risk (11, 12, 18, 19). The absence of indebt analysis of the distribution and determinants of out-of-pocket expenditure and financial burden makes it difficult to draw conclusions on the distribution of out-of-pocket across population groups. In other words, it could be assumed that the main current financing channel in Cambodia is inequitable but conclusions will need to await the secondary analysis mentioned above.

It is also not possible to assess from the available evidence the regressivity or progressivity of general taxation. Individual and income taxation is recent in Cambodia and statistics and analyses are still required. General taxes such as consumption taxes have the disadvantage to be regressive but may be less prone to tax evasion and more acceptable to the population. Intermediary, strategies such as the use of earmarked consumption taxes may be considered for complementing current government allocations to health (20).

Contributions of households to CBHI are not based on capacity-to-pay and are regressive and to some degree exclude the poor. On the other side, contribution rates to the NSSF are progressive on salaried income. The contribution rate for occupational risks is 0.8% of an employee’s average monthly wage.

**IV.3 Pooling**

*a) Composition of risk pools/ level of equity in health financing*

**Normative performance indicator:** Equal amount available per type of risk pools/unit

The assessment of this indicator is difficult as the current pooling systems are very much voluntarily segmented, i.e. dedicated pools such as HEF, CBHI and NSSF do not enable to equalize funds across populations and pools. The sole nation wide pooling mechanism that could be discussed is the national health budget.
Benefit incidence analyses do not seem to have been conducted in Cambodia and therefore it is not possible to assess if public resources are pro-poor or equitable. A more detailed analysis could also be made on the priorities and resources allocation by national programmes in comparison of their cost-efficiency and disease burden of the country. Such exercises are important for the development of multi-year plans as already institutionalised in Cambodia but will not be of major impact if external resources are not aligned with identified priorities.

**Normative performance indicator:** Poor are included in the risk pool

A major achievement of Cambodia, and which has provided international evidence for designing safety nets in other countries, is the scaling-up of HEFs. This mechanism has been successful in improving access and utilization of services by poor and vulnerable groups (21, 22). However, the separation of the funds from the developing insurance mechanisms imposes that the sustainability of HEF will have to be supported by domestic resources, probably funded by general taxation. We already mentioned that the taxation base in Cambodia is low and therefore needs to be extended if such mechanisms as the HEFs are to be institutionalised. Certain countries have relied on earmarked taxation for the poor on gambling or consumption taxes.

HEF are only active in part of the country and are mostly managed by international and local NGOs. The provision of this public service could be institutionalised but would require a stronger involvement of the government in the monitoring and regulation of private providers. The major challenge remains, the identification of the poor. HEF are currently only covering 50% of the large poor population in Cambodia. Identifying the poor and reducing unwanted stigmatization has an important monetary but also social cost. The role of the Ministry of Planning in normalising and leading this process will require substantial capacity building that needs to be supported by development partners (23).

**Normative performance indicator:** Membership is compulsory for all population groups

Social and health insurance coverage through the NSSF has been made compulsory by the "Law on social security schemes for persons defined by the provisions of the labour law". The law identifies obligations for registry of all workers in Cambodia as defined by the "Labour law", state workers that are not civil servants and trainees. Further the
mandatory membership could be extended by *Prakas* (ministerial decrees) of the ministry in charge of social security schemes. The official translation or article 6 of the law on social security schemes also specifies that procedures for registration and payment of contributions shall be determined by sub-decree on the formulation of the NSSF. However, it appears that this is not fully implementing as a result of resistance of employers due in part to the lack of accountability perceived by those. A detailed analysis of the implementation of these sub-decrees was not part of the scope of the present assessment. A detailed organizational and institutional analysis would be useful, as the NSSF has clearly the potential to cover a substantial part of the population as suggested by the large salaried population which may account for around 41% of the total workforce and up to 60% if HEF population targets are excluded\(^1\).

The development of private health insurance in the country will also provide opportunities for cream-skimming and reduce the potential of direct social/health contributions to equalize risk pools. Therefore the nature of the services that should be covered by private health insurance needs to be clarified.

b) **Fragmentation of risk pooling**


\begin{tabular}{|p{\textwidth}|}
\hline
**Normative performance indicator:** Risk pools are unfragmented or, at default, risk equalization measures are in place. \\
\hline
\end{tabular}

The current prepayment channel is highly fragmented inside individual schemes such as the CBHI. There are at the moment not sufficient resources collected by CBHI schemes to enable an adequate pooling and risk-equalization. The slow development of CBHI makes it also unlikely to generate in the short-term sufficient resources for covering the real costs of management of the structures but more importantly to equalize risk.

The NSSF is currently not fragmented but it is too early to assess its potential role in cross-subsidizing other schemes and health financing mechanisms. It is also unlikely that stakeholders such as workers and employers unions will be favourable to cross-subsidization. Therefore, the risk-equalization role will need to be given to the government health budget. Contributions to social health insurances would need therefore

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\(^1\) Source: Estimations provided by the Ministry of Health and other agencies during a health insurance simulation organized in 2009 (SimIns): Total workforce of 4.151 million people including: "formal sector" employees 1.7 million people and 1.287 millions people targeted by HEFs.
to be kept to a strict minimum and be may be complemented by public subsidies. Again the improvement of general public financing management and tax collection seems to be of core importance to ensure that segmentation of channels is acceptable.

However, even in the case risk-equalization mechanisms are put in place with the support of general or earmarked taxation it appears important to assess the cultural feasibility of insurance and taxation mechanisms in the Cambodian context. Public trust may currently not be sufficient to make those mechanisms sustainable. Households may prefer to rely on their own when possible and also national solidarity may not be sufficiently developed to make them perceived as acceptable. Management of risk pools

**Normative performance indicator:** Efficient management, i.e. health insurance and social schemes are efficiently managed.

The efficient management of a multiple channel, and to some extent, fragmented health financing system such as in Cambodia represents a major challenge. The CBHI and HEFs schemes currently existing are well managed. It was not however possible to assess the cost of this management and the associated opportunity cost that the country may occur of choosing a multiple targeting strategy compared to an universal publicly financed approach. However, part of the high costs of management of these two schemes may be seen as an initial investment but it is difficult to assess without a detail organizational, economic and institutional assessment if they could be sustained.

Accountability and public trust needs also to be granted at the level of promising schemes such as the NSSF. Administrative inefficiencies need to be tackled very early to ensure the trust of workers and employers unions. Increasing, the role of the private sector and contributors in its administration and governance could be considered as an appropriate mitigations strategy. This could also be important in promoting a continuous social-dialogue between the government and the civil society.

Public financial management (PFM) has been a focus of the government efforts over the last years and the platform approach supported by development partners is considered to be providing improvements, even if at a slower path as expected (24). A key challenge remains to extend the PFM reform to the health sector and to ensure alignment of the health sector public interests with the reform's objectives. This challenge may be best illustrated by the differences in the vision of budgeting and planning approaches between
the Ministry of Health and the Ministry of Finance. The former has adopted a laborious and comprehensive programme budgeting approach build on a multi-year planning programme and annual operation plans. This approach responds to the need to allocate and monitor the sectors resources according to sub-sectoral priorities. It also enables to respond to the requirements of accountability of development partners. However, the Ministry of Finance has introduced a performance budgeting which enable to allocate resources according to outcomes (25). This dual process requires substantial skills, capacities and work to conciliate, which has been granted until know by the departments of the MoH. However, as both tools have respective advantages but have high management and transaction costs it may be considered to harmonize rather than align the processes. Historical and item budgeting seems also to still be used at least at lower levels of the health sector; this reduces the relevance of any other more elaborated budgeting process. Delays and discrepancies in cash flow also hamper the credibility of the national budget as an instrument for service delivery, but this issues are been addressed in the framework of the current PFM reform.

The major challenge may however be the monitoring of the implementation of budgets and plans indecently of the budgeting approach. In order to properly steward and allocate resources according to national strategic priorities and local needs the MoH needs to be timely and accurately informed of budget executions. This feedback is still weak and should be rapidly strengthened; this becomes more important as autonomy of health providers in public sector is to be increased with the introduction of contracting-in through Special Operating Agency (SOA) model. For the same reason strengthening accountability and transparency of public financial management in the health sector should be priority.

As mentioned earlier only a minority of the existing 77 ODs are supported by international NGOs under "contracting-out" arrangements. The willingness of the government to internalise contracting and to build on the evidence from contrasting-out responds to a need to harmonize health services across the country and to ensure that his stewardship is granted.
IV.4 Purchasing

a) Equity in benefit package (BP) delivery

**Normative performance indicator:** Benefit package(s) are based on explicit efficiency and equity criteria.

The Health Financing Strategic Framework foresees that benefit packages across health insurance schemes should be harmonized in order not only to ensure equity and reduce disincentives to for people to move across schemes but more importantly to enable merging of the schemes in the long-term. Certain CBHI schemes have adopted the same benefit package as HEF and even reimburse non medical expenses incurred for the seeking of treatment. This strategy is rational but also means that individuals will have incentive to opt for the cheapest scheme from a point of view of their contribution and opportunity cost. A merging of the schemes does not seem feasible in the short- or medium-term, and the acceptance of schemes with the highest potential for expansion such as the NSSF may be fostered by a reasonable differentiation of its health insurance benefits.

It was not possible from the collected evidence to access if benefit packages provided through the different financing channels are based on cost-effectiveness criteria. However, The Health Strategic Plan 2008-2015 clearly states that interventions to be provided with public funds should be based on the disease burden and be cost effective, including preventive, curative, rehabilitation and palliative care. The tools for this identification of interventions will require skills and tools that still need to be build. Fundamental tools have however already been introduced in the country such as essential medicine lists that are used for reimbursement criteria.

**Normative performance indicator:** Benefit package is consumed rationally (efficiently).

Evidence from CBHI and HEFs quarterly reports indicate a very high utilization levels for CBHI members: with an average of 1.93 OPD visits per member per year, this is almost double the national average. Average length of stay fir CBHI beneficiaries is variable between schemes and can be as high as 17 days, compared to a national average of 6 days. In comparison ALOS for HEF beneficiaries is on average 6.7 days nationally.
This indicates an expected trend to over-utilization of services by population enrolling in voluntary schemes while the access for the poor through HEF is still weak on average.

As most CBHI schemes use a capitation payment system for purchased services, one would expect an under-provision of services that is not reflected in the above figures. However a thorough assessment of nature, extent and quality of services provided to CBHI members may show a different kind of under-provision. As HEF payments are usually based on a flat rate per case, one would expect a demand-driven over-utilization that is not reflected in the above data. This may be due to the fact that other barriers to access for the poor exist that are not addressing by waving user fees at health facility: although HEFs reimburse transport costs, patients need to borrow money to pay for this up-front. In addition, opportunity costs (absence from work, farming, children care) are more important to overcome for people who need a daily income to be able to eat.2

| **Normative performance indicator:** Monitoring mechanisms are in place, including patients’ appeals mechanisms, information on claimant rights, peer-review committees and claims review. |
| Quality assurance mechanisms are a major issue that needs urgent measures as monitoring and supervision of facilities, in particular, in the private sector is lacking. It would require important resources to finance an independent board with sufficient power and capacities to control the private sector and protect patients. This may be difficult in the present context but is essential to ensure the protection of consumers and the adequate use of public resources. Quality assurance and control challenges is not limited to private facilities as the move towards SOAs will imply an increase in public facilities autonomy which may see their activities increased as result of the additional resources that are to be transferred to them. Additional strategies could also be considered such as improve patient information to promote quality improvements, but this could only be effective for services with sufficient providers (competition) and would still require important investments.

2 Annual Health Financing Report 2008 – Ministry of Health Cambodia
b) **Provider payment mechanisms**

<table>
<thead>
<tr>
<th>Normative performance indicator: Optimal use of resources by providers</th>
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<td>(Performance indicator: Provider incentives encourage the appropriate level of care and a minimum of administrative costs.)</td>
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How healthcare providers are paid affects both their ability to provide adequate health services and to control their costs activity.

In the Cambodia system, many different approaches and schemes exist for providers payments at facility level (budget, fees, capitation or staff incentives). Thus, there is a need to harmonize the mechanisms for paying providers to allow coherent funding of health facilities running costs and staff.

CBHI scheme pay the contracted facility a capitation amount to cover for the cost of services delivered to its members. Generally, the health care services or good delivered are contracted at public health facilities (health centers and referral hospital).

Health Equity Funds allow to poor patients to receive free or discounted care at public facilities. The poor are identified according to eligibility criteria and the HEF scheme reimburses the public health care providers for the cost of services provided. It also reimburses poor patients for the costs of transport and food during hospitalization.

In public facilities, there exist also criteria and exemption mechanisms for poor people. The exemption system allows poor people to receive care at government facilities for free when needed. In practice, the exemption system does not achieve the desired results, covering less than half of those considered too poor to pay for services. Moreover, transportation and food costs are not included in the exemption. Structurally the current reimbursed system through the government budget is complex and slow which reduces incentives of staff at lower levels and health centers to provide exemptions for low amounts.

At visited hospitals collected evidence suggests that exemptions schemes are continued and made available as a result of internal cross-subsidization funded by resources of schemes such as CBHI but more importantly from revenues from User Fees in places where targeted subsidies for the poor are not in place.

As already highlighted, provider payment mechanism should be simple to ensure minimal costs of administration and should provide adequate incentives for providers to use
resources optimally\(^3\). Interestingly, as satisfaction of staff across health centers visited varied with the source of major revenues (GAVI-HSS, CBHI or government) if appeared from presented statistics that there was no difference in output of facilities. Also the monitoring of the satisfaction of consumers with facilities and schemes was not systematic.

Out-of-pocket payments are made as user fees to public and private providers, payments to government staff working privately and direct purchase of medicines from pharmacies and drug sellers. Regulated user fees will continue to be an important supplementary source of revenue for health facilities to finance staff incentives and running costs, with fee exemptions for the poor provided wherever appropriate.

Despite the introduction of new incentives schemes, there is still a low level of salaries and incentives for staff working in the public health sector preventing effective delivery of health services. However, these incentives seem to have triggered changes in the behaviour of providers, e.g. all interviewed providers reported having to some extend change their attitude to skilled birth attendance at facilities level with the introduction of midwifery incentives paid by the government. Further quantitative assessment of such incentives schemes is require to enable their rationalizing and harmonization to avoid dissatisfaction of staff due to deceived expectations which could negatively impact service delivery and drive inequities across regions.

There is also a high utilization of unregulated private providers and there is a need to introduce private practice regulations, including licensing and accreditation of private providers.

**IV.5 Stewardship**

The political commitment at highest level in Cambodia for reforms and social health protection is per se already an achievement and provides the fundaments to the achievement of universal coverage.

The level of sophistication and reflection of the central leaders and stewards is illustrated by overall strategic documents such the Rectangular Strategy, NSDP, HSP and Social Health protection master plan. These documents seem to be very well understood at the central level but it is unclear how they are distilled to decentralized levels of the health

\(^3\) For a detailed reference on various purchasing methods see G. Carrin and P. Hanvoravongchai, "Provider Payments and Patient Charges as Policy Tools for Cost-Containment: How Successful Are They in High-Income Countries?," *Hum Resour Health* 1, no. 1 (2003).
and social sector which will soon see their autonomy and responsibilities in achieving national goals increased. Thus, appropriate dissemination of national strategies needs to be addressed at the same time as monitoring and evaluation to feedback in national planning.

If domestic resources are continuously replacing external resources for health the importance of development partners in influencing priorities out-side policy-dialogue mechanisms may be reduced. In the transition phase however it will be important to strengthen multi-donor pools and policy-dialogue platforms. The switch from a Sector Wide Management framework to a full Sector Wide Approach with its joint funding arrangement and technical working groups is a notable step in this direction.

Challenges remain however in a political and administrative context that has been rapidly evolving over the last two decades. Strengthening inter-ministerial and inter-department coordination for planning and budgeting has already been mentioned as an area that needs focus. The role of the Council for Administrative Reform (CAR) and of the Council for Agriculture and Rural Development (CARD) in leading the social health protection agenda will be fundamental. The role of this two entities in mediating across sectors the agenda will require the supported of development partners. In the health sector, the integration of cross-cutting national policies such as the PFM reform and decentralization (D&D) is likely to be a slow process.

**IV.6 Piloting approaches and experimenting in Cambodia**

Piloting of financing approaches in Cambodia has been profuse. Those pilots have been well documented and major literature has been released on their implementation. This has contributed to the growth of international evidence and has strengthened Cambodia's image as a source for best practices on health financing. However, the extensive experimentation has resulted in a fragmented system with high management cost and has complicated the steward-role of central and local governments.
V. Conclusion

The health financing system in Cambodia has been rapidly developing over the last two decades. It has supported as fundamental component the health system to provide better outcomes and improve equity. The political commitment of the Royal Government of Cambodia in making this happen has been essential and is reflected by the financial commitment of the national budget to health. However, as for other sectors the health sector is still in a transitional phase and is now at a critical point of its development. Ensuring social health protection for all populations with access to quality health care is still a challenge to be overcome.

The harmonization of the numerous approaches piloted in Cambodia and the subsequent scaling-up of financing and protection mechanism that are feasible will require going beyond the elaboration of plans. Capacities of organizations such as the MoH, provincial health authorities and facilities to deal with their own responsibilities and manage change will require important investments across the country in individual and institutional development, e.g. for the developing appropriate administrative implementation tools and regular monitoring systems. Building up capacities to manage change across organizations should be a priority.

At the same time, scaling-up financing channels to move towards universal coverage will require to make hard choices on the tools to benefit from the investment of scarce resources. Not all successful experimentations at small scale seem to be appropriate for scaling-up.

The present summary assessment did identify several points that need to be further developed to inform the strengthening of the health financing system in Cambodia. A first step will be to include in the initiated Health Financing Systems Review the results of the secondary analysis of Cambodian household survey. A series of detail institutional and organizational assessments of main financing channels and specific schemes would also be required to fully inform the recommendation of the review.
VI. **Annexes**

VI.1 List of interviewed stakeholders

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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</tr>
<tr>
<td>Name</td>
<td>Role/Position</td>
<td>Organization</td>
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<td>Jean-Marion Aitken</td>
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<tr>
<td>Ms Ly Nareth</td>
<td>Health Financing leader</td>
<td>JPIG</td>
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VI.2 References


