KINGDOM OF CAMBODIA

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ANNUAL HEALTH FINANCING REPORT 2013

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BUREAU OF HEALTH ECONOMICS AND FINANCING
DEPARTMENT OF PLANNING AND HEALTH INFORMATION

APRIL, 2014

FOREWORD

The Annual Health Financing Report has been annually developed by the Bureau of Health Economics and Financing, Department of Planning and Health Information of the Ministry of Health. The report gathers and analyses health financing information on both budget and expenditures by different sources of financing to the health sector. Those sources include the Government funding, external assistance, out-of-pocket spending, user fees, health equity fund, voucher scheme and voluntary health insurance, as well as other health financing schemes that are currently available in Cambodia.

We would like to thank Provincial Health Departments, Operational District and Health Facilities, National Hospitals and Institutions, National Social Security Fund (NSSF) and Department of Insurance and Pension of the Ministry of Economy and Finance as well as Health Equity Funds, Voucher and Voluntary Health Insurance Schemes (operators) and others for their technical inputs and contribution to the production of this report.

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

We hope that the Annual Health Financing Report **2013** will provide comprehensive trend and updated health financing information and it is useful document to support the monitoring and development of health system financing in the future.

Phnom Penh, 07 April 2014

Prof. Eng Huot
Secretary of State for Health

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The report is written by Mr. Ros ChhunEang, Chief of the Bureau of Health Economics and Financing of the Department of Planning and Health Information, Ministry of Health. The input of this report is mainly based on a routine facility-based reporting from provincial health department, national hospital, social health protections 'operators, while other information collected from concerned Ministries/ Institution and fields.

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EXECUTIVE SUMMARY

The Annual Health Financing Report has been produced by the Bureau of health Economics and Financing of the Department of Planning and Health Information, Ministry of Health since 2007. The objective of the report is to present health financing information on both budget and expenditures by different sources of financing to the health sector, including government funding, external assistance and out-of-pocket expenditure. The report also provides an overview of health financing schemes currently in place in Cambodia, such as Health Equity Funds, voucher schemes and voluntary health insurance.

How much was spent on health?

Total health expenditure is financed by three main sources – Government, development partners, and household out-of-pocket spending, Total Health Expenditure (THE) has substantially increased over the last five years, from USD 564 Million in 2008 to USD 812 Million in 2013, representing more than 5.34% of the GDP. In 2013, THE was approximately USD 55 per capita, 25.61% of which comes from Government spending, 14.81% from development partners, and the remaining 59.58% from out-of-pocket spending.

Where did the money go?

The Government of Cambodia highly recognized health is a priority sector for investment. National budget allocation for health has consistently increased over the last ten years. The current national budget allocation is 70% (including equipment, supplies and drugs to be distributed to health facilities) -30% central and provincial level allocation, respectively. So as development partner has strongly support technically and financially either direct support to particular health institution or health facility or through pooled fund of health sector support program (HSSP2) to both supply and demand sides financing. While out of pocket expenditure for health is individually paid by people or households to public and private health facilities when using health services.

Who provided the funds?

National Health Expenditure as a percentage of the approved budget is generally over 95%, but only 93% in 2013. Total Government expenditure for health in 2013 was estimated at US 208 Million, approximately USD 14 per capita, representing approximately 25.61% of THE. As a percentage of total Government recurrent spending, government health expenditure has been increased over the years, it is estimated around 12.28% in 2013.

Development partner support to the health sector in 2013 was US 141 Million, approximately USD 10 per capita. External spending for health was estimated at 14.81% of THE in 2013.

Household health expenditure, via OOP, contributes the greatest part of the THE. Since 2008, OOP has increased from USD 25 per capita in 2008 to USD 33 per capita in 2013 or approximately USD 484million, accounting for 59.58% of THE.

Equitable funding

Since there is no pre-payment schemes or social health insurance and limited of risk pooling mechanism, fee-for-services payment is dominated for private or public health providers,. This form of payment is highly regressive since the poor spend a higher share of their income than the non-poor to obtain the same treatment. Furthermore, since user fees are paid on an

individual basis whereby each patient or caretaker spends for his/her treatment, risk sharing is not possible.

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

The Cambodian health system is financed by both supply and demand side financing interventions. (1) Supply-side schemes aim to increase access to services by the poor while improving service quality. These schemes include regular budget, user charges with exemption for the poor, special operating agency and service delivery grant, midwifery incentive and government subsidy for the poor. (2)Demand-side schemes aim to remove financial barriers to access and increase utilization of health services. These schemes include Health Equity Funds (HEF), Voucher schemes, and Community Based Health Insurance (CBHI).

Health Financing of Schemes

In additional to regular budget support and drug supplies, the public health facilities are allowed to implement user charge. Although this income is a minor proportion of the total facility income, it plays a significant role for reduced under-table payment, improved service quality and management practice, and increased financial incentives for providers. However, user charges remain a major financial barrier for access to hospital services. To date a majority of public health facilities formally implement user charges. The total fee income collected in 2012 is approximately at USD 28 million, including USD12 million generated by Calmette hospital and USD 30.4 million including USD 14 million from Calmette hospital in 2013.

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

To boost the delivery at public health facility with trained staff and contribute for reduction of MMR and IMR, the government of Cambodia has initiated midwifery incentive for a live birth delivery. Government midwifery incentive scheme (GMIS) is a government initiated and funded supply-side and output-based health financing mechanism aimed at motivating skilled birth attendants (or trained health personnel) to promote deliveries in public health facilities or *institutional deliveries*. It became operational nationwide in late 2007, following a joint *Prakas* (directive) by the Ministry of Health (MOH) and the Ministry of Economy and Finance to allocate government budget to the payment of an incentive for midwives of 60,000 Riels (USD15) for each live birth attended in health centers and 4,000 Riels (USD10) in hospitals.

In health sector, SOAs is intended to deliver health care of a good quality to Cambodians especially the poor. Up to 2013, there are 30 SOAs established under the Royal Government's Sub-degree, located in 9 provinces covering 8 provincial hospitals and 22 Operational Districts that further cover 16 referral hospitals, 291 health centers and 63 health posts. SOAs receive funds for recurrent cost from the national budget in addition to Service Delivery Grant (SDG) via Health Sector Support Project phase 2 (HSSP2). SDG is released directly from HSSP2 account to individual SOAs' account via banking system. From January 2014, there are 6 additional SOAs, so total SOA will be 36 made of 26 ODs and 10 Hospitals, 387 HCs and 84 HPs cover population of 4,884,079 persons.

Subsidy scheme (SUB) has been established by the Inter-ministerial *Prakas* of the MoEF and MoH (No. 809, dated 13th October 2006). A main purpose of the scheme is to encourage the poor to use health services free of charges at public health facilities by providing compensation for cost of health services provided to them. Subsidy is financed by the national budget through MOH budget. So far, there are 6 National hospitals, 11 RH and 57 HCs implementing subsidy scheme. Total expenditure for 2012 was USD 419,972, 55% of which was spent at national hospitals, while the remaining 43% at referral hospitals and 2% at health centers.

Health Equity Funds is a pro-poor health financing mechanism and widely recognized as a social-transfer mechanism. HEFs are designed to reimburse a full or partial cost of health services provided to the poor at public health facilities. To date, 49 HEF schemes have been implemented in 49 ODs in 20 provinces through contract arrangements with 50 hospitals including 1 national hospital of 92 totally, 41 former district hospitals, 458 HCs out of 1,088 HCs in total and 47 health posts. HEFs currently protect an estimated 2.6 million identified poor-estimated around 71% of target population in 2011, and up to 76% in 2012 and 93% in 2013.

The total number of utilization cases supported by HEF has increased from 1,176,161 cases in 2012 to 1,299,046 cases in 2013. Of which total OPD cases was 88% in 2012 and 90% in 2013, while only 12% and 10% for IPD cases in 2012 and 2013 respectively.

It is observed that, total expenditure of HEF has seen decreased from USD 9,457,954 in 2012 to USD 9,384,595 in 2013. Within this spending, the direct benefit cost was 84% and 82% in 2012 and 2013 respectively, while management cost was 16% in 2012 and 18% in 2013. It is estimated that an average trend of the share for HEF expenditure was around 82% and 18 % for direct and indirect cost respectively for the last 5 years.

The voucher schemes have been implemented since 2011. To date the schemes have contracted with 5 referral hospitals and 121 HCs in 9 ODs in 3 provinces and with 4 private clinics for providing safe abortion services. Currently, voucher scheme covers an estimated 107,763 women of reproductive age from 15-49 years-old in those 9 ODs, 225,354 women in 2013 and 226,674 women in 2014.

Total utilization of reproductive health services supported by the voucher project in 2013 was 53,772 cases, mostly at health centers (87%), followed by 9% at private clinics and 4% at referral hospitals. Table 15 provides detailed information about utilization of reproductive services in 2012 by location, including funding sources and voucher operator. The voucher project is financed by KFW as a grant. Total expenditure, including direct cost and indirect cost in 2013 was USD 1,229,255, 50% of which was spent for direct cost and 50% for indirect cost occurred in both AFH and EPOS. This expenditure is excluded consultancy firm budget from KFW to EPOS.

All of the CBHI schemes are implemented by NGOS and Community based organization (CBO).CBHI schemes provide benefit package including medical services available at public health facility (MPA service at health center and CPA services at hospital) and other associated costs such as transportation cost, allowances for a patient's care-taker, and funeral cost. CBHI schemes contract with public health facilities to provide health services to their beneficiaries, with the payment mechanism could be varied from schemes to schemes. It is noted that there is no standard benefit package and payment mechanism for CBHI yet. So far there are 19 CBHI schemes being implementing by mostly NGOs in 9 provinces including Phnom Penh, 19 ODs,

contracted to 240 Health Centers, 10CPA1, 7CPA2, 7CPA3 and 2 National Hospitals. Total membership of CBHI schemes in 2013 was around 455,648 persons. There have been 19 CBHI schemes implementing in 19 ODs in Cambodia so far. The total members, who enrolled with those schemes, have decreased from 79,873 persons in 2008 to 445,648 persons in 2013, even though a bit plunge in 2012.

Total utilization covered by CBHI was 256,707 cases, in which 96% was OPD cases, 3 IPD cases and 1 delivery cases. With OPD cases, most of the case used by female (53%), 29% by female and 15% by Children, similarly most of IPD case used by female (43%), 34% by male and 13 by children. The revenue of CBHI scheme is estimated around USD 1.057 million in 2013 composed of 60% from subsidy from partners and 40% from premium collection. It is observed that there has no any CBHI scheme can function without any subsidy from partners. The total expenditure in 2013 was USD 1.228 million with 52% spent for direct benefit packages and 48 sent on management and operating cost. Within total direct cost, 86% was spent on health services benefit, while on 14% was spent for associated cost such transportation, food allowance and others. Within total expenditure of indirect cost, 82% was spent on management cost, 17% was spent on outreach and marketing activity and less than 1% spent for other.

Employment Injury scheme has been implemented since 2008. According to Social Security Law, private enterprises employing 8 workers and more have to register with NSSF. The premium is 0.8% of gross salary, 0.5% and 0.3% of which was contributed by employers and the Government, respectively. Since 2011, the contribution of 0.8% has been made by employers only. It is reported that the premium varies from a minimum level of 1,600 riels to a maximum level of 8,000 riels per month. Up to 2013, 5,345 enterprises were registered with NSSF, and 89.26% of those enterprises (4,771 enterprises) paid contribution for 847,175 employees. Working jury scheme has been implementing in 24 province and municipality so far. Total expenditure of work injury scheme in 2013 was 6,926,229,300 riels (approximate 1.7 million US dollars), 76% of this was spent for health care services (8,245 persons).

Health insurance for formal private sector population, particularly Garment sector employees without dependents started in 2009. The project has been implemented by GRET, and then transferred to NSSF in October 2013. The premium rate is 1.6 US dollars per month. The current number of targeted enterprises is 11. The coverage in 2013 was 7,733 employees, while the number of health service contacts was 9,679 cases, comprised of 96% OPD, 3% IPD and 1% delivery. Compulsory social health insurance for the formal private sector population (employees of private enterprises with eight or more employees, and their dependents) is under development in terms of benefit package and payment mechanism, and is planned to be officially launched in late 2014.

What were the changes in health policy?

The current status of the health care system in Cambodia is one of a publicly funded district-based health sector and a fast growing private sector primarily funded by out of pocket. Each operational health district has multiple health centers providing the first line of health services (Minimum Package of Activities) with a catchment of 10,000 and a referral hospital providing second or third line health services (Complementary Package of Activities) to a population of 100,000 – 200,000. To improve health service quality, policy of human resource has set and implemented at least 1 secondary midwife per health center. Introduction of annual operational plan (AOP) requires all health facilities to develop their AOP based on local priority

need within availability of resources, currently to create responsibility and accountability both input and outputs, Program Based Budgeting is introduced. Innovative health information management system (HMIS) by using debased application to collect and store data from individual health facilities including private. The introduction of user charge with exemption policy as well as other financing scheme initiatives including midwifery incentive and demand sides financing which result in emerging concept of social health protection to universal health coverage (UHC). However MoH needs to go along with Decentralize & De-concentration program, and other reform such as public administrative and financial management reforms of the government.

Coverage of Universal Health Coverage (UHC)

The total coverage by HEF, CBHI, Voucher, work injury and social health insurance is 27%. Ninety-three percent of the poor (19.8% of the population) covered by HEF, similarly work injury scheme covered formal private employees almost 90% as well, while CBHI covered less than 5%.

Moving Forward to UHC

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

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

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

1. INTRODUCTION

In the context of health sector reform introduced in 1995, the Health Financing Charter 1996 allows public health facilities to implement user charges together with an exemption policy for the poor, and pilot other health financing initiatives. Since then Cambodia has become a grounds for pilot experimentation of both supply and demand side health financing initiatives. Demand side financing to leverage quality of health service through purchasing power of the third party payers includes schemes such as Health Equity Funds (HEFs), community based health insurance (CBHI) and voucher schemes. HEFs in particular have become the Ministry of Health (MoH)'s key health financing mechanisms to improve access to health service for the poor and vulnerable people. Supply side financing to improve health service delivery includes schemes such as user fees with exemption mechanism for the poor, a subsidy scheme, autonomous hospitals and Special Operating Agency (SOA). Despite the multiple demand and supply-side initiatives, financing through budget and subsidization through the general government resources remains an important source of funding of health services, particularly those provided by the public sector.

This report provides updated information until 2013 about the status and financial information of health system financing as well various health financing schemes, which are currently implemented in Cambodia. The report is organized as follows. This section provides some background on the infrastructure and human resource components of the health system. Section 2 describes key health financing strategies and policies in place, and being developed, in Cambodia. Section 3 presents the current progress on achieving universal health coverage (UHC). Section 4 provides 2013 budget and expenditure data and analyses of trends over time. Section 5 describes the multiple financing schemes currently in operation in Cambodia.

1.1 HEALTH INFRASTRUCTURE

The Health Coverage Plan (HCP) of 1995-1996 provided guidelines for strengthening District Health Systems. During this time, the Ministry of Health also issued Circular No 85 to support the development and implementation of the Health Coverage Plan for Districts and Communes. The country health care system is composed of a district-based public health sector mainly funded by government and a fast growing private sector mainly funded by out of pocket expenditure. For the public health sector, each operational health district has a number of health centers providing first line health services (Minimum Package of Activities) with a catchment population of 10,000 and a referral hospital providing second or third line health

services (Complementary Package of Activities) to a population of 100,000-200,000. In general, those facilities are fairly well equipped and staffed. However, they are facing a number of constraints to offering quality health services, ranging from insufficient funding and inadequate management capacity to low staff remuneration and limited medical clinical skills to some extent.

1.1.1 Public health facilities

There has been a remarkable development of health infrastructure over the last five years. Table 1 presents the number of public health facilities: referral hospitals, health centers and health posts from 2008 to 2013. As of December 2013, the public health facility is comprised of 8 national hospitals (NH), 86 referral hospitals (RH), 1,088 health centers (HC) and 86health posts (HP).The expansion of health infrastructure has increased geographical access to health services by the population, but not automatically increased the utilization of health service unless financial barriers have been removed or reduced at the point of service use. It is noted that investment in infrastructure will have significant implications for the human and financial resources required to support health service delivery.

Table 1: Number and distribution of public health facilities, 2008-2013

Description	2008	2009	2010	2011	2012	2013
No of Operational district	77	77	77	77	79	81
Total hospital	87	88	89	90	91	94
Number of Natiuonal Hospital including MCH and TB	8	8	8	8	8	8
Number of Referral Hospital	79	80	81	82	83	86
Number of Referral Hospital with CPA1		34	34	33	36	39
Number of Referral Hospital with CPA2		28	30	31	29	29
Number of Referral Hospital with CPA3		17	17	18	18	18
Number of Health Center	967	984	997	1,004	1,024	1,088
Number of Health Post	107	111	117	123	124	86

Source: Bureau of HIS, DPHI, MoH 2013

1.1.2 Private health facilities

According to the report from the Department of Hospital Services, MOH, for the Annual Health Congress Report 2013, there are officially 5,644 private facilities providing health services including three health facilitation offices.

Table 2: Number and types of private health facilities, 2008-2013

Type of services	2009		2010		2011		2012		2013	
	License	Un-license	License	Un-license	License	Un-license	License	Un-license	License	Un-license
Health Care Room	758	394	1,252	150	1,505		1,733		1,630	
Maternity Room	242	97	331	23	428		485		520	
Physiotherapy Room	5	-	12	-	19		21		22	
Consultation Room	2,268	431	2,516	101	2,473		264		2,768	
Dental Care Room	284	97	313	22	318		368		411	
Dental Treatment Room	29	6	26	3	33		36		39	
Beauty Salon		-	2	-	6		6		8	
Health Laboratory	29	13	25	7	20		23		27	
Maternity Services	8	1	7	1	7		7		7	
Clinic	95	18	102	13	110		130		156	
Poly Clinic	37	3	36	1	41		48		48	
Private Hospital		-		-			4		8	
Total	3,755	1,059	4,622	321	496		5,501		5,644	

1.2 HUMAN RESOURCES

Although human resource remains a pressing issue, there has been a positive trend in recruitment and deployment of public health personnel. As of December 2013, the total number of health personnel employed in the public health sector is 20,668. The distribution of health personnel by level is 77.62% at provincial level (including district level) and 22.38% at central level including Phnom Penh (10.15% at national hospital, 6.31% at national centres and other central health institutions, 3.6% at Phnom Penh Municipality and 2.32 % at the central MoH).

Table 3: Number and types of health workers, 2008-2013

Description	2008	2009	2010	2011	2012	2013
Total number of health workforce	**18,096**	**18,113**	**18,302**	**18,814**	**19,237**	**20,668**
Medical Doctor, specialist doctor, professor	2,173	2,162	2,139	2,180	**2,178**	2,377
Medical Assistant	1,220	1,147	1,087	1,052	1,018	962
Dentist , Dental Doctor	172	177	189	212	214	283
Pharmacist	427	435	464	474	2	529
Secondary Nurses	5,084	5,098	5,155	5,366	2,432	5,619
Primary Nurses	3,407	3,404	3,359	3,381	5,662	3,387
Secondary Midwife	1,806	1,825	1,863	1,994	2,164	2,803
Primary Widwife	1,439	1,616	1,815	1,997	3,366	2,332
Secondary laborator	428	420	424	442	454	460
Others include doctor of pharmacy, assistant and primary, other skills.	1,940	1,829	1,807	1,716	1,747	1,916

Source: Department of Personnel, MoH 2013

2. HEALTH SYSTEM FINANCING POLICIES AND STRATEGIES

The Government of Cambodia stipulated in its 1999 Constitution (article 72) that the health of each citizen is to be guaranteed and that the poor should receive free medical care. The importance of improving health services and ensuring access to them for the poor was reiterated in the 2004 Rectangular Strategy for Growth, Employment, Equity and Efficiencies in Cambodia.

2.1 Strategic Framework for Health Financing 2008-2015

The Strategic Framework for Health financing 2008-2015was introduced in 2008. The framework included the following policy objectives:

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.

To achieve these objectives set out a number of strategies:

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

2.2 National Health Financing Policy

The draft National Health Financing Policy has been developed in 2012-2013 through a consultative inter-ministerial process. It has recently been submitted to the Council of Ministers for review and approval. The goal of the policy is to guide the country's development towards achieving universal health coverage (UHC), so that all people of Cambodia can obtain the health care they need without facing financial hardship.

The vision of the policy is to enable active participation of all residents of Cambodian in society through a health system that provides universal access to an essential package of quality health interventions in a regulated health market based on fairness of contributions and equity in access, thereby providing protection against impoverishment due to ill health.

The underlying principles for the Cambodian health financing system as stated in the policy are:

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

The policy outlines strategies and mechanisms to achieve its goal under six headings: universal population coverage, benefits, purchasing services, sources of funds, institutions and regulation.

3. STATUS OF UNIVERSAL HEALTH COVERAGE (UHC)

Universal Health Coverage (UHC) is a universal goal endorsed by the United Nations and the Association of Southeast Asian Nations (ASEAN) community with strong commitment from member states. As stated in several policy and strategy documents, Cambodia has expressed a strong commitment to UHC.

However, development approaches is considered different to other countries where most countries have started with social health insurance for the formal sector followed by expansion to the informal sector. Currently, there is no social health insurance for the formal private sector, but there is a work injury scheme implemented by the National Social Security Fund (NSSF). As reflected in the draft National Health Financing Policy, NSSF is preparing for the introduction of social health insurance to employees in companies with eight or more employees without their dependents in 2014.There is currently no social health Insurance for civil servants, only a pension scheme. However, as stated in draft National Health Financing Policy, social health insurance for civil servants, their dependents and pensioners are to be provided by the National Social Security Fund for civil servants (NSSFC), but the process of development is not yet informed. There are a number of health financing schemes targeting the informal sector, user fee exemptions, government subsidies, Health Equity Funds (HEF), voluntary health insurance, and vouchers. All the above mentioned schemes are considered as an integral part of the social health protection system in Cambodia.

Figure 1 summarizes the current coverage of social health protection mechanisms in Cambodia by population groups. The total coverage by HEF, CBHI, Voucher, work injury and social health insurance is 27%. Ninety-three percent of the poor (19.8% of the population, based on the official national poverty line of 3,871 Riels per day; 1 US$ = 4,000 Riels) covered by HEF, similarly work injury scheme covered formal private employees almost 90% as well.

Figure 1: Coverage of social health protection mechanisms by population groups

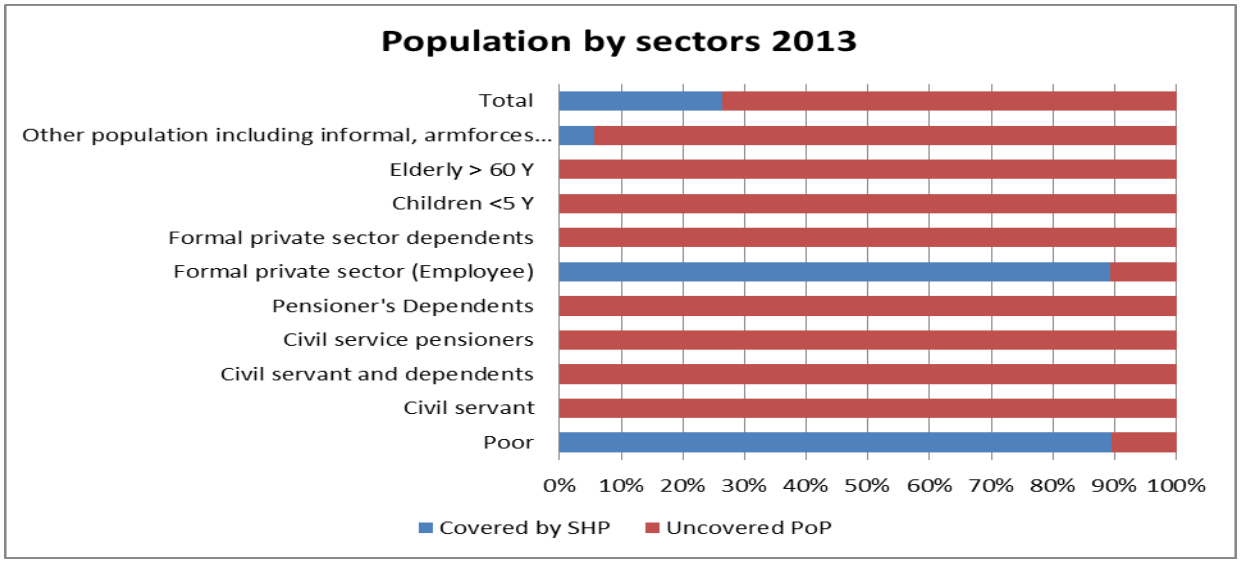
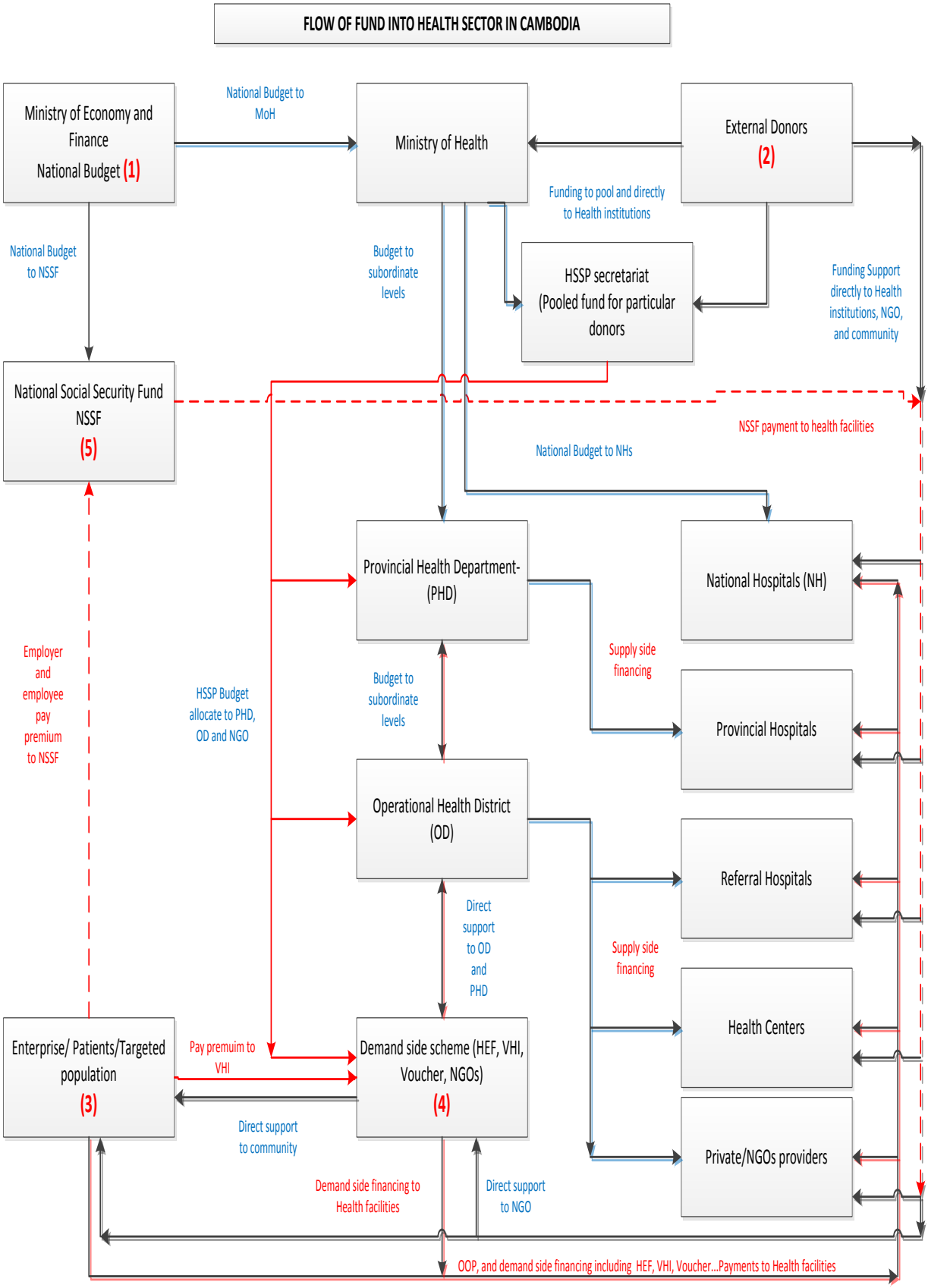


Table 4: Overview of health financing mechanisms in Cambodia

Financing Mechanism	Implementer/ Operator	Target population	Benefit/services	Provider Payment	Coverage
Tax funding via Government budget	MEF/MOH/PHD/OD/RH/HC	All population sectors	Recurrent budget, drug and material supplies	Line item budget and in	Nationwide public health facilities
User fee exemptions	MOH/healtfacilities	Poor patients	MPA and CPA123	User fee exception	Nationwide
Global health initiatives and national programs	National programs	Patients with TB, malaria, AIDS, and children for vaccination	TB, Malaria, AID patients and children age under 1 year	Free of charge	Nationwide
Health Equity Fund (HEF)	NGOs for HEFs	The eligible poor (those under the national poverty line)	MPA and CPA services , food, transport, funeral expenses	Official standardized Case base payment	In 51 Referral hospitals and 458 health centers, covering approx. 93% of the target group
Government Subsidy schemes (SUBO)	MOH/PHD/OD	The eligible poor (those under the national poverty	MPA and CPA services	Official case based Flat rate	In 6 National Hospital and 11 referral hospitals and 57 health centres
Community base health insurance (CBHI)	NGOs	Mainly informal sector, people living above poverty line	MPA and CPA services , food, transport, funeral expenses	Capitation, case base, fee for services.	19 schemes with 17 RHs and 1 NH and 240 HCs, covering 455,648 persons. . <1% of the population
Vouchers for reproductive health	NGOs	Poor women	Reproductive health services	Fee for services	In 9 ODs with 5 Hospitals and 121 HCs and 4 private clinics. Covering 255,324 women.
Occupational Risk	MOLVT/NSSF	Formal private sector workers with >8 employees.	Medical treatment, temporary/ permanent disable, funeral expenses and survivor benefit	Fee for service	Current coverage 4,771 enterprises with 847,165 workers
Midwifery incentive	MoH, PHD, OD and HF	Midwife attending delivery	$15 per live birth at HC, $10 per live birth at RH	Case reimbursement	All public health facilities
Social health insurance (SHI)	NSSF	Formal private sector workers	Health care services	Case reimbursement	Current coverage 7,733 persons
Social health insurance (SHI)	NSSFC	Civil servants	*No social health insurance for civil servants, hence whenever any civil servant seeking for health care services, they have to pay.*		
Special Operating Agency (SOA) facilities	MOH/Donors/ HSSP	All population in the coverage area	Decentralize together with Performance-Based Incentives for Providers		In 30 Operational Health Districts and additional 6 in 2014.

Figure 2: Health financing flows

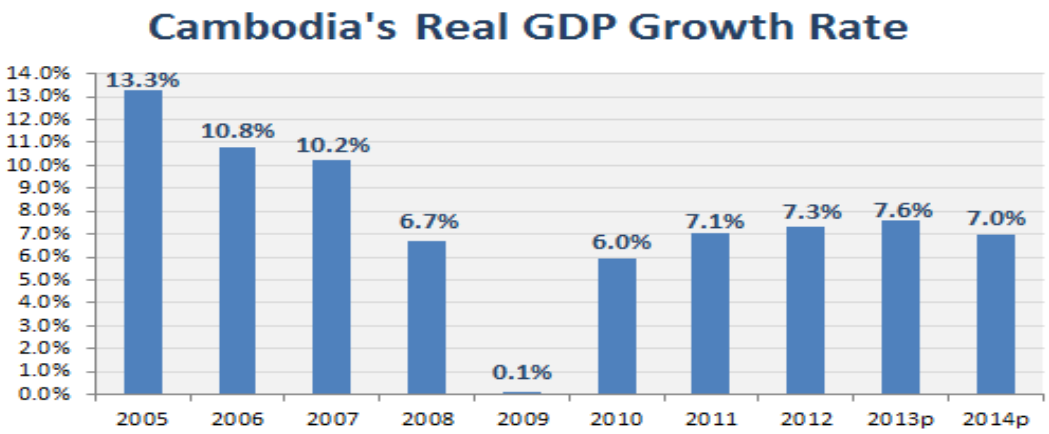


HEALTH BUDGET AND SPENDING ANALYSIS

3.1 MACRO-ECONOMIC INFORMATION

According to the Ministry of Economy and Finance (www.mef.gov.kh), the GDP of Cambodia has increased by 7.6% at constant prices between 2012 and 2013 (Figure 3). The GDG in 2013 is estimated to reach 61,525 billion riels or approximately 15,191 million US dollars, which is equivalent to about 1,036 US dollars per capita.

Figure 3: Real GDP growth rate, Cambodia 2005-2014

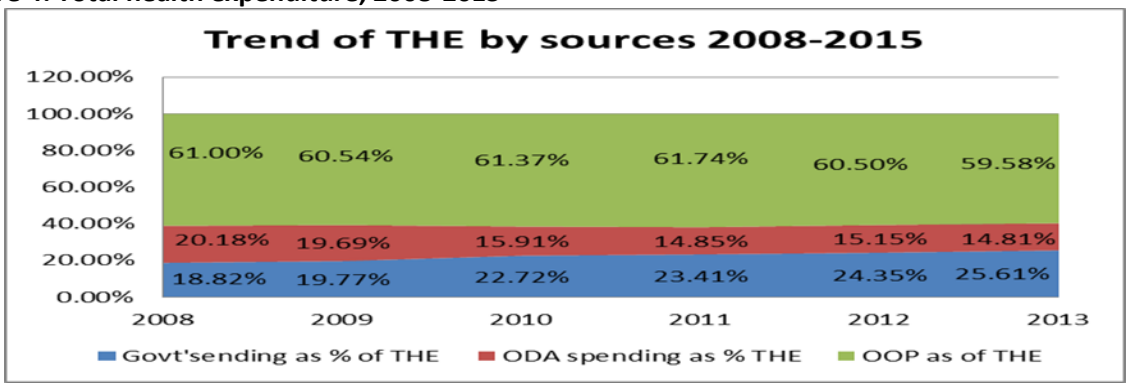


Source: www.mef.gov.kh,) accessed on February 5, 2014 11:30 AM

3.2 TOTAL HEALTH EXPENDITURE (THE)

The Cambodian health system is financed by three main sources: the Government, development partners and households' out-of-pocket spending. Total health expenditure (THE) has substantially increased over the last five years, from USD564 Million in 2008 to USD 812 Million in 2013, which is approximately 5.34% of GDP and approximately USD 55 per capita. Of THE, 25.6% is from Government spending, 14.8% from development partners and the remaining 59.6% from out-of-pocket spending (Figure 4).However, however the THE could be different according to the available and reliable data of external partners and OOP estimation.

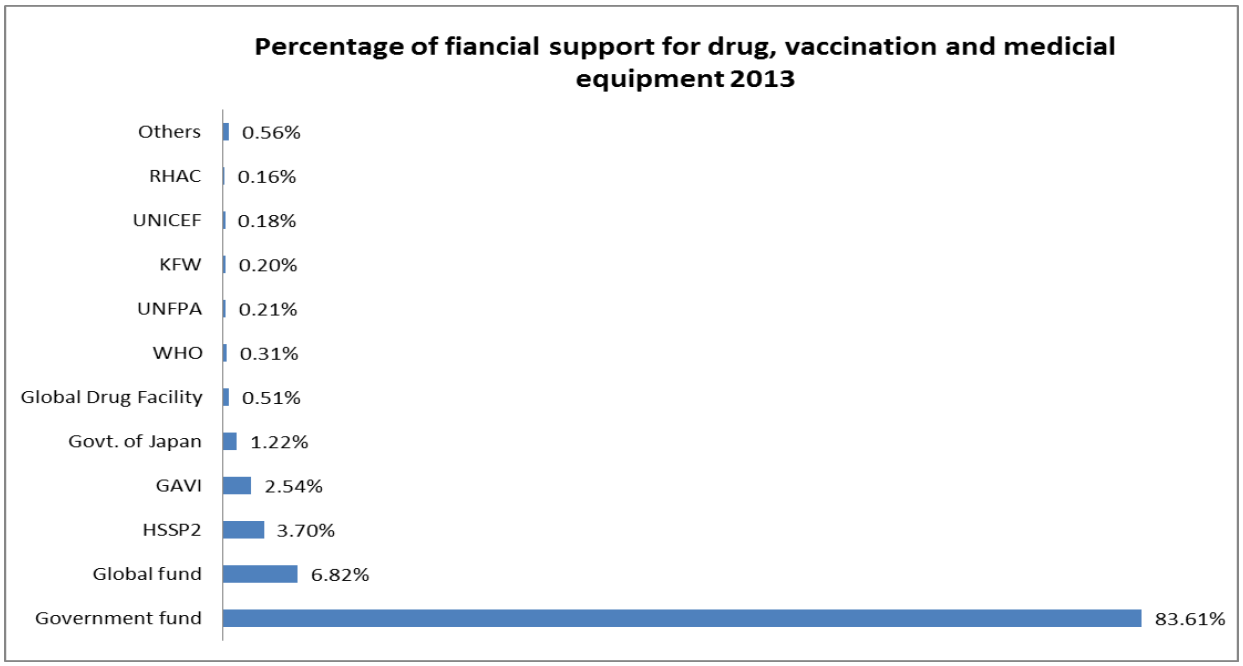
Figure 4: Total health expenditure, 2008-2013



Note: OOP is estimated based on base line 2009 CSES analysis with inflation rate

Specifically, it is reported by the Central Medical Store (CMS) to the Annual Health Congress that the expenditure for drugs, vaccines and medical equipment in 2013, which is financially supported by the government and development partners, was 4,025,711 kilograms with approximately cost US 152,352,476 dollars. Most of the fund came from government budget (84%), followed by the Global Fund to Fight AIDS, Tuberculosis and Malaria (6.8%), HSSP2 (3.7%), the GAVI Alliance (2.5%) and Government of Japan (1.22%) and the rest from others (Figure 5). The proportion of distribution to provincial level was 80.29% (451.6 billion riels), 11.48% (64.5 billion riels distributed to national hospitals and 8.23% (46.2 billion riels) to central institutions.

Figure 5: Distribution of financial support for drugs, vaccines and medical equipment, 2013

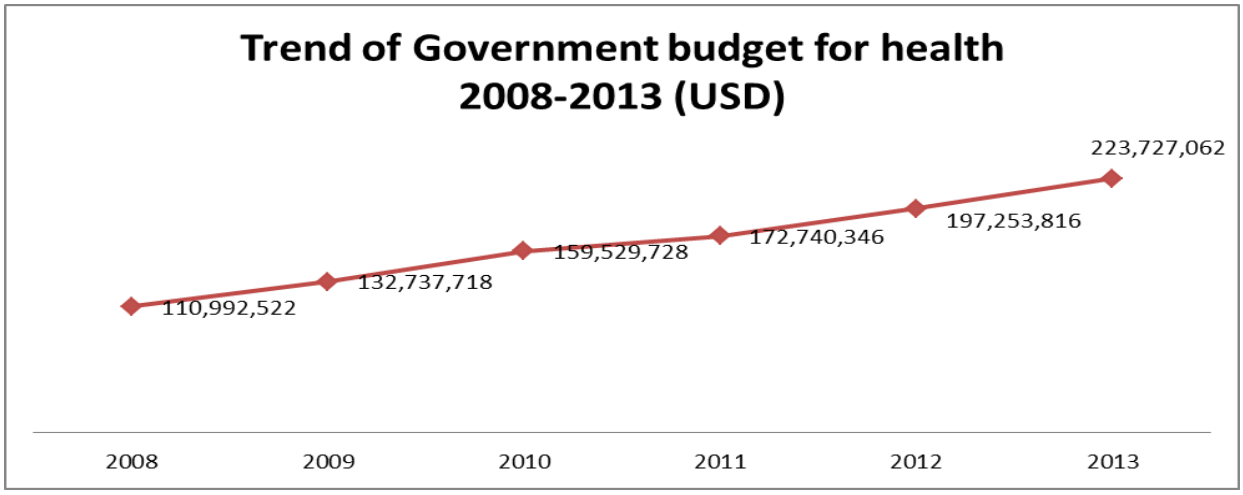


3.3 GOVERNMENT BUDGET ALLOCATION AND EXPENDITURE FOR HEALTH

3.3.1 Budget allocation

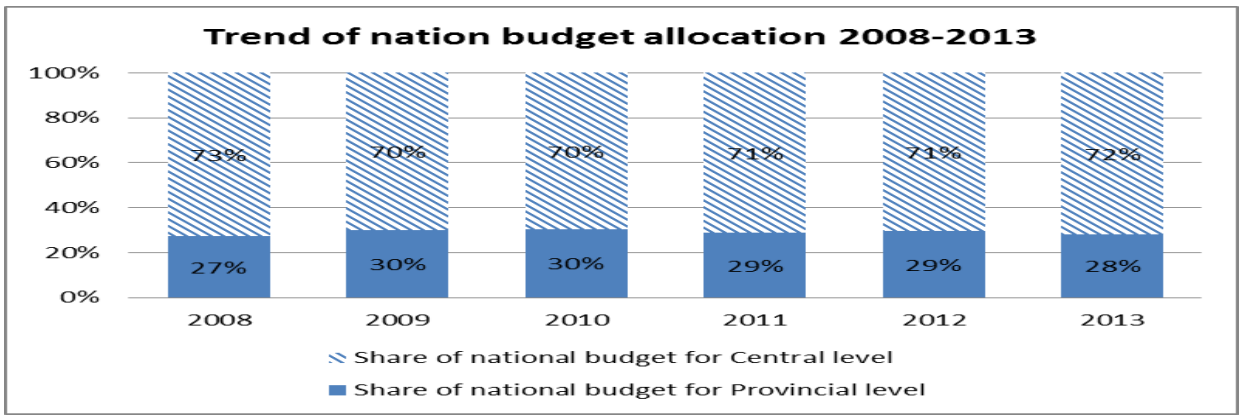
Health is recognized by the Government of Cambodia as one of the priority sectors for investment. The national budget allocation for health has increased from year to year, notably from 404.6 Billion Riels (approximately 110.9 Million US dollars, 1.05% of GDP and 10.8% of total government current spending) in 2008 to 906 Billion Riels (223.7 Million US dollars, 1.37% of GDP and 12.28% of total government current spending) in 2013.

Figure 6: Government budget for health, 2008-2013 (USD)



Of the national budget, 70% is allocated by the central level and 30% by the provincial level (Figure 7). The centrally allocated budget includes the budget for procurement of drugs and medical consumables that are distributed and used at service delivery levels.

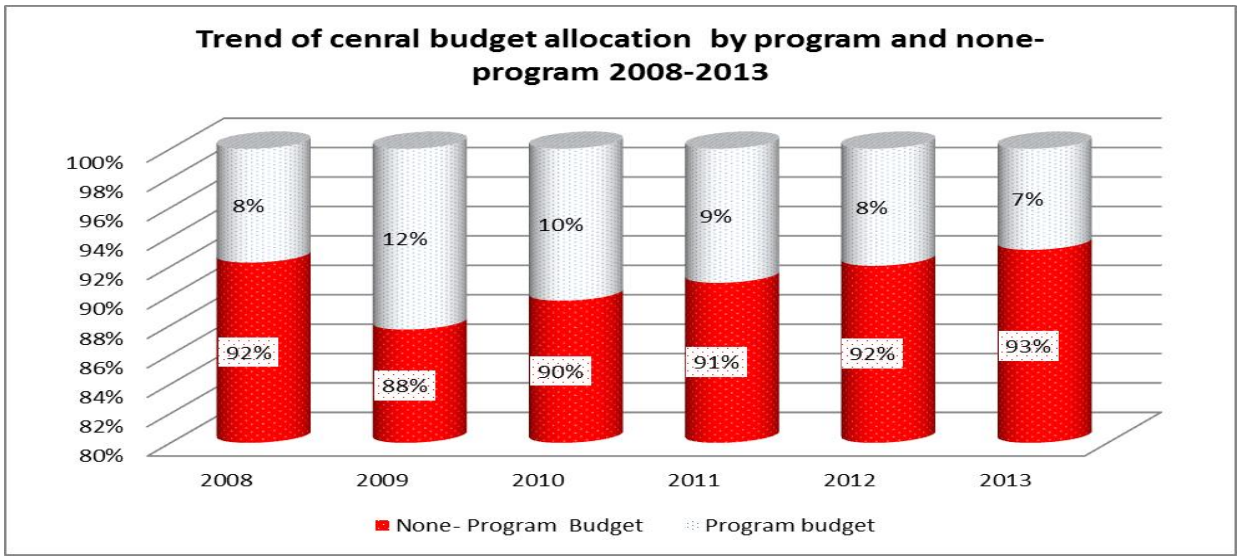
Figure 7: National budget allocation by provincial and central level, 2008-2013



3.3.2 Central budget allocation by Program Vs Non-program

In line with public financial reform, the Ministry of Health has been implementing a mix of program based and non-program budgeting at central level only, while provincial level is still implementing the non-program budget (Figure 8). Even though program based budgeting has been introduced, budget preparation and expenditure tracking is still classified according to national line items.

Figure 8: Central budget allocation program and non-program budget, 2008-2013



3.3.3 National Budget Expenditure for Health

In recent years national health expenditure as percentage of the approved budget has been over 95%, while in 2013 the proportion was around 93%. Total Government expenditure for health in 2013 is around842.2 billion riels (USD 207.9 Million), approximately 57,295Riels (USD14) per capita.

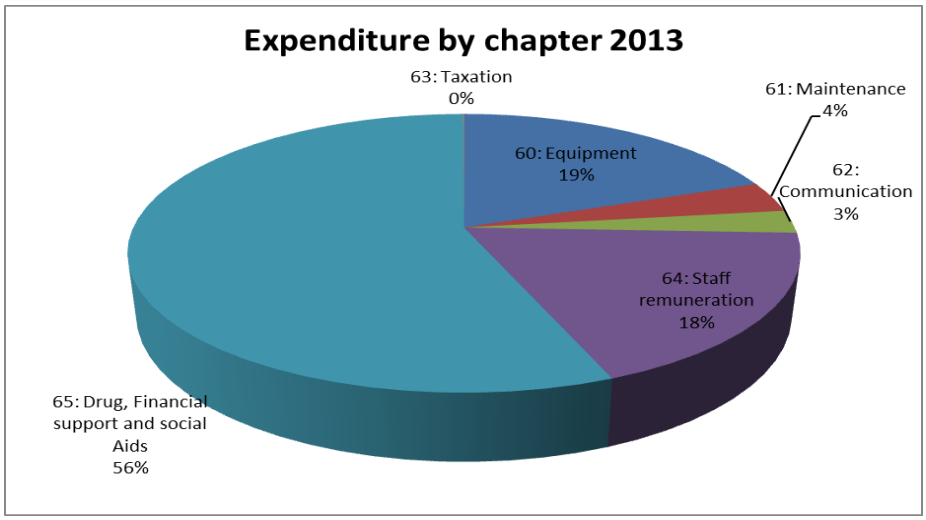
Table 5: National budget and expenditure on health

National budget and expenditure for health	Currency	2,008	2009	2010	2011	2012	2013
Total Government expenditure on health	Million Riel	426,790	524,146	615,375	655,099	759,207	842,230
Government expenditure on health CENTRAL Level	Million Riel	302,383	368,083	445,469	460,695	563,579	609,177
Government expenditure on health PROVINCIAL Level	Million Riel	124,407	156,063	169,906	194,404	195,628	233,053
Total Government expenditure on health	USD	104,605,441	125,393,660	151,832,026	161,752,840	187,458,420	207,958,138
Government expenditure on health as % of total current govt expenditure	%	10.80%	10.67%	11.94%	10.91%	11.54%	12.28%
Government expenditure on health as % of GDP	%	1.05	1.11	1.31%	1.26%	1.31%	1.37%
Government expenditure on health per capita	Riel	31,874	37,213	43,027	45,114	51,855	57,295
Government expenditure on health per capita	USD	8	9	11	12	13	14
Government expenditure on health as % of THE	%	18.82%	19.77%	22.72%	23.41%	24.35%	25.61%

3.3.4 Expenditure by chapter

The detailed expenditure by chapter is presented in Figure 9.Most of the spending was on drugs and social support (chapter 65) at around 56%, followed by 19% on equipment (chapter 60) and staff remuneration at about 18% (chapter 64). Small amounts were spent on maintenance (chapter 61) and communication (chapter 62) which was around 4% and 3% respectively and less than 1% paid for taxation (chapter 63).

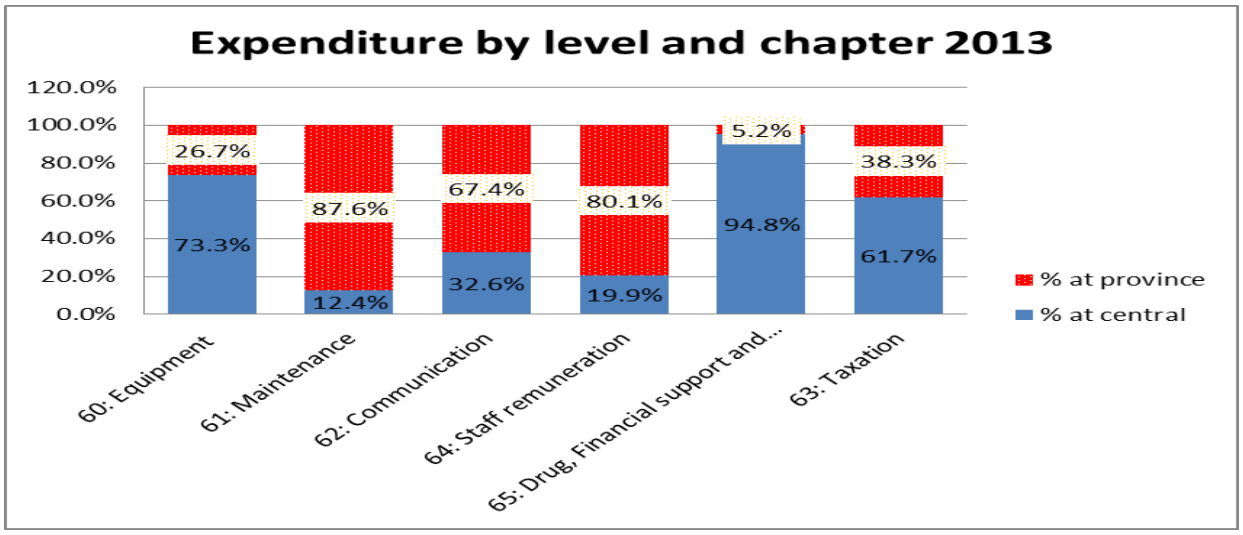
Figure 9: Expenditure by chapter, 2013



3.3.5 Expenditure at MoH's central and provincial level

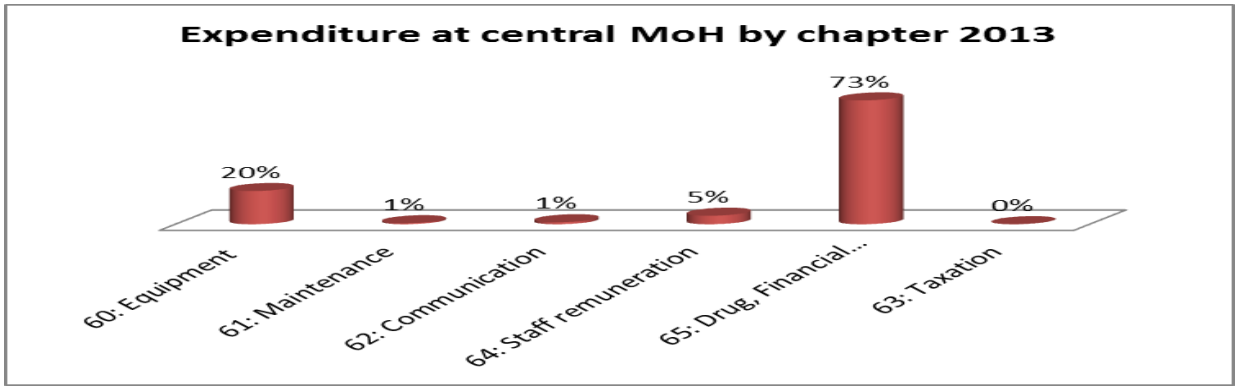
Spending on drugs and financial support (chapter 65) was done mostly by the central MoH which 94.8% was compared to only 5.2% at the provincial level (Figure 10).Of spending on chapter 60 (equipment), 73.3% was spent by central MoH and 26.7% was spent at provincial level. The spending on taxation (chapter 63) was mostly also done by the central MoH (61.7%). Most of the spending for chapter 61 (maintenance), chapter 64 (staff remuneration) and chapter 62 (communication) was incurred at the provincial level (87.6%, 80.1% and 67.4%, respectively).

Figure 10: Expenditure by level and chapter, 2013



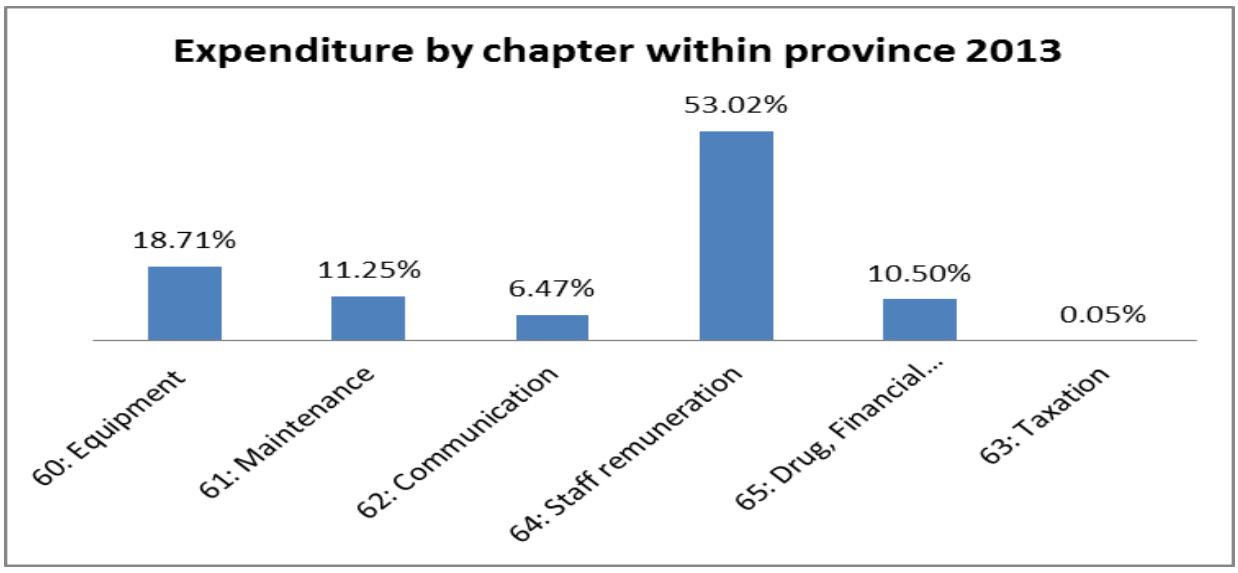
Of expenditure incurred by central MoH (609.1 billion riels), most of the funds were spent on chapter 65, followed by chapter 60 (equipment) and chapter 64 (staff remuneration) (Figure 11). Small amounts were spent on maintenance, communication and taxation.

Figure 11: Expenditure at central MOH by chapter, 2013



Within the expenditure occurred at provincial level (223 billion riels), most spending (53%) was on chapter 64 (staff remuneration), followed by 18.71% on chapter 60 (equipment), 11.25% and 10.5 % spent on chapter 61 (maintenance) and chapter 65 (drug and support) respectively, 6.47% was spent on communication (chapter 62) and less than 1% for taxation (chapter 63) (Figure 12).

Figure 12: Expenditure by chapter in provinces, 2013



3.4 HEALTH PARTNER EXPENDITURE

Financial contributions to the health sector by development partners are generally committed based on multilateral and bilateral agreements. Such funds are channeled into the health sector through different funding modalities. According to the Council for Development of Cambodia (CDC) database (accessed 4:50 PM, 27 January 2014), the external spending is around 120 Million US dollars, or approximatelyUSD8 per capita, while health partners' planned expenditure reported in the Health Sector Annual Operational Plan for 2013 is 141 Million US dollars, approximately USD10 per capita. The external spending for health is estimated at15% of THE in 2013. It is noted that capturing external financial information is a challenge; hence it could be different from different sources.

Table 6: External Expenditure for Health 2008-2013

External Donor	Currency	2008	2009	2010	2011	2012	2013
External expenditure on health based on CDC database	USD	110,731,129	128,290,512	107,983,969	106,811,827	116,601,457	120,178,126
External expenditure on health per capita based on CDC database	USD	8	9	8	7	8	8
External Planned expenditure on health based on HS AOP	USD	55,998,745	85,200,498	88,196,043	114,481,024	141,188,876	141,426,823
External Planned expenditure on health per capita based on AOP	USD	4	6	6	8	10	10
External expenditure on health as % of THE (infalation)	%	20%	20%	16%	15%	15.15%	14.81%
External expenditure on health as % of THE (CSES)	%	20%	20%	15%	18%	12%	11.68%

2. Household Health Expenditure

Out-of-pocket health expenditure (OOP) by households constitutes the largest part of total health expenditure. According to the latest Cambodian Socioeconomic Survey (CSES), OOP expenditure on health per capita was USD28 in 2009, excluding transportation cost for seeking care. Based on applying inflation to the 2009 data, OOP has increased from USD28 per capita in 2009to USD 33 per capita in 2013 or approximately USD483 million, accounting for 60% of THE (Figure 11). According to recent analysis of CSES 2012 data (smaller dataset than 2009), OOP has increase dramatically from USD28 per capita in 2009 to USD48 in 2012, approximately USD698 million, accounting for 70% of THE in year 2013.

Figure 13: Out-of-pocket expenditure

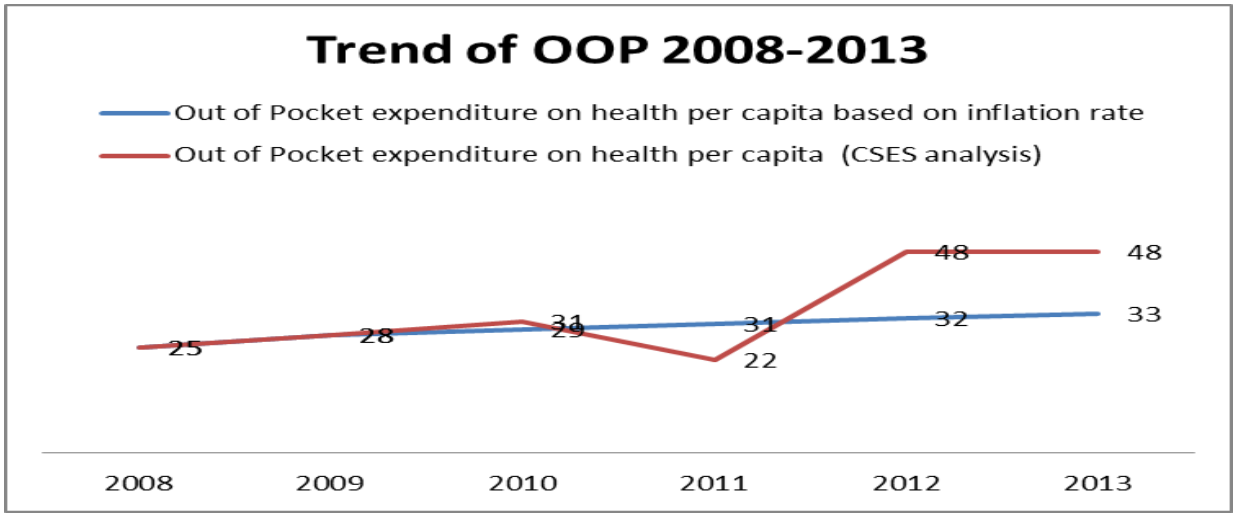


Table 5: Household Health Expenditure 2008-2013

Out of Pocket Expenditure	Currency	2009	2008	2010	2011	2012	2013
Total out of pocket expenditure	USD	334,750,000	394,380,000	416,474,240	443,994,096	465,704,044	483,759,021
Total out of pocket expenditure (CSES)	USD	334,750,000	394,380,000	443,791,060	319,026,370	697,936,470	700,749,000
Total out of pocket expenditure	Billion Riel	1,366	1,649	1,688	1,798	1,886	1,959
Out of Pocket expenditure on health per capita based on inflation rate	USD	25	28	29	31	32	33
Out of Pocket expenditure on health per capita (CSES analysis)	USD	25	28	31	22	48	48
Out of Pocket expenditure on health per capita	Riel	102,000	117,040	118,023	123,833	128,823	133,281
Out of Pocket expenditure on health per capita (CSES analysis)	Riel	102,000	117,040	125,765	88,979	193,064	193,064
Out of Pocket expenditure as % of THE (CSES)	%	61.00%	60.54%	62.86%	53.69%	69.65%	68.11%
Out of Pocket expenditure as % of THE based in inflation rate	%	61.00%	60.54%	61.37%	61.74%	60.50%	59.58%

ANALYSIS OF HEALTH FINANCING SCHEMES

Currently, Cambodian health system is financed by both supply interventions the forms include free of charge for particular diseases (vaccination, HIV/AID, Tuberculosis), user charges with exemption for the poor, midwifery incentive, Special Operating Agency (SOA is transformed from contracting model), and subsidy. While demand side intervention includes Health Equity Fund (HEF), Community-Based Health Insurance (CBHI), and Voucher schemes.

3.5 SUPPLY SIDE FINANCING SCHEMES

3.5.1 User Charges and Exemption for the Poor

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

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

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

Although fee income is a minor proportion of the total facility income, it plays a significant role for reduced under-table payment, improved service quality and management practice, and increased financial incentives for providers. However, user charges remain a major financial barrier for access to hospital services. To date a majority of public health facilities formally implement user charges. The total fee income collected in 2012 is approximately at USD 28 million, including USD12 million generated by Calmette hospital and USD 30.4 million including USD 14 million from Calmette hospital in 2013.

3.5.2 Exemption for the poor

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

3.5.3 Midwifery incentive

To boost the delivery at public health facility with trained staff and contribute for reduction of MMR and IMR, the government of Cambodia has initiated midwifery incentive for a live birth delivery. Government midwifery incentive scheme (GMIS) is a government initiated and funded supply-side and output-based health financing mechanism aimed at motivating skilled birth attendants (or trained health personnel) to promote deliveries in public health facilities or *institutional deliveries*. It became operational nationwide in late 2007, following a joint *Prakas* (directive) by the Ministry of Health (MOH) and the Ministry of Economy and Finance to allocate government budget to the payment of an incentive for midwives of 60,000 Riels (USD15) for each live birth attended in health centers and 4,000 Riels (USD10) in hospitals. The number of deliveries is reported monthly by health facilities through the routine health information system. The report must be signed by the director of the health facility and, for health centers, also by the commune chief. Based on the number of reported deliveries, health facility submits their reimbursement claim quarterly basic through public administrative and financial channels.

3.5.4 Special Operating Agency and Service Delivery Grant

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

using its human and financial resources to deliver the highest possible services with improved quality in an effective way.

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

The objectives of SOAs in the health sector are to:

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

In health sector, SOAs is intended to deliver health care of a good quality to Cambodians especially the poor. Up to 2013, 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 Health Sector Support Project phase 2 (HSSP2). SDG is released directly from HSSP2 account to individual SOAs' account via banking system. From January 2014, there are 6 additional SOAs, so total SOA will be 36 made of 26 ODs and 10 Hospitals, 387 HCs and 84 HPs cover population of 4,884,079 persons.

Table 6: Coverage of Special Operating Agencies

No	Operational Disrict/ PRH	# of HCs	# of HPs	# of RH	# PRH	Population 2014, HMIS
1	Memut OD	11	1	1	NA	137,682
2	Punhea Krek OD	16	0	1	NA	216,045
3	Cheung Prey OD	14	1	2	NA	201,457
4	Chamkar Leu OD	15	0	1	NA	234,098
5	Prey Chhor OD	15	0	1	NA	195,319
6	Daun Keo OD	15	1	0	NA	223,535
7	Prey Kabas OD	14	1	1	NA	164,627
8	Bati OD	14	0	1	NA	202,612
9	Kirivong OD	22	2	1	NA	233,583
10	Ang Rokar OD	11	1	1	NA	141,989
11	Smach Meanchey OD	7	4	0	NA	59,624
12	Sre Ambel OD	5	0	1	NA	62,049
13	Ban Lung OD	11	18	1	NA	201,113
14	Sen Monorum OD	9	16	0	NA	68,779
15	Tbeng Meanchey OD	20	15	0	NA	203,102
16	Samrong OD	24	9	1	NA	231,387
17	Siem Reap OD	27	3	0	NA	357,046
18	Sotnikum OD	24	1	1	NA	280,809
19	Angkor Chum OD	21	1	1	NA	227,552
20	Krolanh OD	14	0	1	NA	124,220
21	Preah Sdach OD	9	0	1	NA	119,300
22	Pearaing OD	16	3	1	NA	201,914
23	Poipet OD	16	2	1	NA	198,729
24	Preah Netpreah OD	15	5	1	NA	146,679
25	Bakan OD	11	0	1	NA	131,557
26	Stueng Treng OD	11	0	0	NA	128,057
27	PRH Takeo	NA	NA	NA	1	966,346
28	PRH Kampong Cham	NA	NA	NA	1	1,812,642
29	PRH Siem Reap	NA	NA	NA	1	989,627
30	PRH Koh Kong	NA	NA	NA	1	121,673
31	PRH Ratanakiri	NA	NA	NA	1	201,113
32	PRH Mondulkiri	NA	NA	NA	1	68,779
33	PRH Preah Vihear	NA	NA	NA	1	203,102
34	PRH Oddar Meanchey	NA	NA	NA	1	231,387
35	PRH Batambang	NA	NA	NA	1	1,175,816
36	PRH Stueng Treng	NA	NA	NA	1	128,057
	Total	387	84	21	10	

3.5.5 Government Subsidy for the Poor

Key Features

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

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

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

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

Coverage of SUBO

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

Table 7: Coverage of SUBO schemes 2013

Province	No.	Operational District(s)	Source of Fuding	HEFI	HEFO	Level Hospital	No. RHs with SUBO	No.HCs with SUBO
Kampot	1	Kampong Trach	Government Funding	Kampong Trach	Kampong Trach	CPA2	1	12
	2	Angkor Chey	Government Funding	Angkor Chey	Angkor Chey	CPA2	1	10
	3	Chouk	Government Funding	Chouk	Chouk	CPA2	1	16
Prey Veng	4	Kampong Trabek	Government Funding	Kampong Trabek	Kampong Trabek	CPA2	1	8
Svay Rieng	5	Romeas Hek	Government Funding	Romeas Hek	Romeas Hek	CAP2	1	
	6	Chi Pou	Government Funding	Chi Pou	Chi Pou	CAP1	1	
Kampong Speu	7	Kampong Speu	Government Funding	Kampong Speu	Kampong Speu	CPA3	1	
Kampong Chhang	8	Kampong Chhang	Government Funding	Kampong Chhang	Kampong Chhang	CPA3	1	
Kandal	9	Takmao	Government Funding	Takmao	Takmao	CPA3	1	
	10	Ksach Kandal	Government Funding	Ksach Kandal	Ksach Kandal	CPA1	1	11
Pailin	11	Pailin	Government Funding	Pailin	Pailin	CPA2	1	0
Total 7 Provinces		**11 Ods**					***11***	***57***

National hospital	No.	Operational District(s)	Source of Fuding	HEFI	HEFO
Phnom Penh	1	National Pediatric Hospital	Government Fudning	National Pediatric Hospital	National Pediatric Hospital
	2	Ang Doung Hospital	Government Fudning	Ang Doung Hospital	Ang Doung Hospital
	3	Khmer Soviet Hospital	Government Fudning	Khmer Soviet Hospital	Khmer Soviet Hospital
	4	Kossamak Hospital	Government Fudning	Kossamak Hospital	Kossamak Hospital
	5	Calmette Hospital	Government Fudning	Calmette Hospital	Calmette Hospital
	6	MCH	Government Fudning	MCH	MCH

Total utilization supported by subsidy fund of government was around 55,928 cases which 24,591 cases were IPD and 31,337 cases were OPD. 55% of total was at referral hospitals, 15% at national hospitals, and 30% at health centers.

SUB is exclusively financed by the national budget through MOH budget. The total expenditure for 2013 was USD 419,972 that 55% of which is spent at national hospitals, while the other43% at referral hospitals and the remaining 2% at health centers.

3.6 DEMAND SIDE FINANCING SCHEMES

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

3.6.1 Health Equity Funds

Key Features

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

Institutional arrangement, using third party implementer (HEFI) and third party operator (HEFO); was according to standard benefit package and payment mechanism, July 2012, MoH. A health equity fund operator (HEFO) is an agency (NGO or other type of organization in the civil society) that acts in the interest of poor people in an operational district to facilitate access and purchase of health care services from a health care provide from which it is independent. A health equity fund implementer (HEFI) is an agency identified by the MoH which supervises the activities of a cluster of HEFOs through field level output monitoring certification of direct benefit invoices, and technical assistance to ensure validity of expenditure and harmonization of HEF operators.

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

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

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

Geographical Coverage

To date, 49HEF schemes have been implemented in 49 ODs in 20 provinces through contract arrangements with 50 hospitals including 1 national hospital of 92 totally, 41 former district hospitals, 458HCsout of 1,088 HCs in total and 47 health posts.

Population Coverage

HEFs currently protect an estimated 2.6 million identified poor. In other words, the proportion of the poor living under the national poverty line (national average 31% in 2007) supported by HEFs has increased significantly from 11% in 2008 to 21% in 2009 and reached 35% in 2010. Currently poverty rate is estimated at 19.8% (Ministry of Planning), HEF coverage was therefore estimated around 71% of target population in 2011, and up to 76% in 2012 and 93% in 2013.

Utilization of Health Services

It is noted that HEFs have increased the utilization of health services in both OPD and IPD by the poor over the period from 2008 to 2012. Particularly, the total number of utilization cases has increased from 1,176,161 cases in 2012 to 1,299,046 cases in 2013. Of which total OPD cases was 88% in 2012 and 90% in 2013, while only 12% and 10% for IPD cases in 2012 and 2013 respectively.

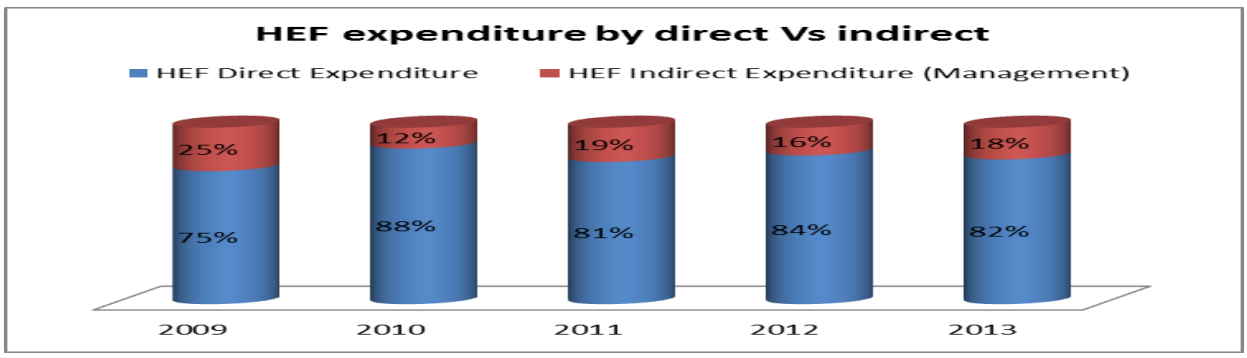
It is estimated that within the total number of utilization, It is seen that IPD case at hospital decreased from 135,637 cases in 2012 to 127,077 cases in 2013 (approximately 6%), in contrast OPD cases increased by 18% between 2012 and 2013 (990,524 cases and 171,969 cases respectively). The proportion of OPD utilization rate at hospital level was level off between year 2012 and 2013 (around 15% and 14% respectively). While OPD rate at health center was 73% in 2012 and 76% in 2013, whereas IPD case was around 12% in 2012 and 10% in 2013.

Financing of HEFs

HEF is financially supported by health development partners and government counterpart fund through Health Sector Support Program (HSSP2) with 60% and 40% respectively in 2013, the share of counterpart fund increases annually by 10% so that proportion of development partner fund decreases by 10% too. This share is to spend for direct benefit only, while indirect (management cost) still fully rely on donor fund.

It is observed that, total expenditure of HEF has seen decreased from USD 9,457,954 in 2012 to USD 9,384,595 in 2013. Within this spending, the direct benefit cost was 84% and 82% in 2012 and 2013 respectively, while management cost was 16% in 2012 and 18% in 2013. It is estimated that an average trend of the share for HEF expenditure was around 82% and 18 % for direct and indirect cost respectively for the last 5 years.

Figure 14: Direct and indirect expenditure of Health Equity Funds, 2009-2013



Among the total HEF expenditure for direct benefit in 2012 and 2013, expenditure for health care services OPD was 24% in 2013 compared to only 19% in 2013. IPD was 50% and 55% in 2012 and 2013 respectively. While around26% was for associated cost such as transportation, funeral and food allowance for both years.

Within the total pending for direct benefit (health care cost for OPD and IPD), most of fund was spent to referral hospital 86% in 2012 and 80% in 2013, While only 14% and 20% to health center. It is seen that expenditure to health center was increased due to the expansion of HEF coverage to health center.

Based on the analysis, an average cost per cases spent by HEF was estimated around USD23 at hospital and around USD1 at health center in 2012 and 2013 (total direct cost divided by total utilization). Cost per IPD at hospital was around more than USD 29 in 2012 compared to USD 33 per IPD case in 2013. It is observed that an overage cost per OPD case at referral hospital was around USD6 in 2012 and USD 8 in 2013, while it was only around USD1 at health center in both years.

Table 8: Summary of data on Health Equity Funds

Particular	2012			2013		
	RH	HC	Total	RH	HC	Total
Total cost ($) 1+2	***7,084,119***	***883,258***	***9,457,954***	***6,550,871***	***1,139,866***	***9,384,585***
Direct cost ($) 1	**7,084,119**	**883,258**	**7,967,377**	**6,550,871**	**1,139,866**	**7,690,737**
OPD	1,096,872	825,523	1,922,395	346,597	1,124,750	**1,471,346**
IPD	3,977,202		3,977,202	4,232,529	-	**4,232,529**
Associated	2,010,045	57,735	2,067,780	1,971,745	15,117	**1,986,862**
Management cost ($ 2			**1,490,577**			**1,693,848**
Utilization case	***306,085***	***820,076***	***1,126,161***	***307,885***	***991,161***	***1,299,046***
OPD	170,448	820,076	990,524	180,808	991,161	**1,171,969**
IPD	**135,637**		135,637	127,077	-	**127,077**
Total per case ($)	23.14	1.08	7.07	21.28	1.15	5.92
Cost per OPD ($)	6.44	1.01	1.94	1.92	1.13	1.26
Cost per IPD ($)	29.32		29.32	33.31		33.31
Direct cost as % of total cost			**84.24%**			**81.95%**
OPD spending as % of total direct cost	14%	10%	24%	5%	15%	19.1%
IPD spending as % of total direct cost	50%	0%	50%	55%	0%	55.0%
Associated cost as % of total direct cost	25%	1%	26%	26%	0%	25.8%
Managment cost as % of total cost			**15.76%**			**18.05%**
OPD utilization as % of total utilization	15%	73%	88%	14%	76%	90%
IPD utilization as % of total utilization	12%	0%	12%	10%	0%	10%
Spending for health care service to RH and HC as % of total health service cost	86%	14%	100%	80%	20%	100%

A side from the above total and detailed expenditure of HEF, there is expenditure occurred within organization which acts as Health Equity Fund Implementer (HEFI) so called University Research Company (URC), this expenditure is supported by USAID. Total expenditure of HEFI is USD 587,722 in 2012 and USD 570,873 in 2013.

It is noted that among HEFI expenditure, most of expenditure is for salary and compensation (76%), followed by travel 6%.

Table 9: Distribution of expenditure by the Health Equity Fund implementer

Expenditure of HEF implementer		
Implementer	**2012**	**2013**
Salaries and Compensation	446,183.03	446,952.38
Travel Expenses	93,727.88	92,578.38
Vehical and moto	9,600.00	-
Computer Equipment	16,266.00	4,631.00
Vehicle and moto insurance	4,342.69	3,304.24
Maintenance Vehicle and moto	1,979.00	2,421.78
Operating expenditure*	14,373.57	13,427.61
Printing**	1,280.10	11,557.47
Total	**587,752.27**	**574,872.86**
* Bank fees, office supplies, postage & Freight, telephone, office cleaning fees.		
** HH surveys, Post-ID cards, Patient cards for PMRS		

3.6.2 Voucher scheme for reproductive health services

Key Features

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

Identified poor women (by pre-ID poor) are beneficiaries of the voucher project. "Vouchers" are distributed to those poor women by voucher promoters. The vouchers entitle them to use reproductive health service at contracted public and private health facilities.
Benefit packages covered by the voucher include ANC, delivery, PNC, family planning and safe abortion (for all women). The voucher also reimburses transportation cost and hospital services at referral hospitals, where HEFs are not available.

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

Geographical Coverage

The voucher schemes have been implemented since 2011. To date the schemes have contracted with 5 referral hospitals and 121 HCs in 9 ODs in 3 provinces and with 4 private clinics for providing safe abortion services (Table 10 below).

Table 10: Geographical coverage voucher scheme 2013

No.	Provinces	Operational Districts	Voucher						
			Implementing Agency		Year		Facility covered		
			Int. NGO	Local NGO	Start	End	RH	HC	Clinic
1	Kampong Thom	Kampong Thom	EPOS	AFH	Jun-10	Jul-16	0	21	1
		Staung	EPOS	AFH	Jun-10	Jul-16	0	10	
		Baray and Santuk	EPOS	AFH	Jun-10	Jul-16	1	19	1
2	Kampot	Angkor Chey	EPOS	AFH	Jun-10	Jul-16	1	10	1
		Chhouk	EPOS	AFH	Jun-10	Jul-16	1	16	
		Kampong Trach	EPOS	AFH	Jun-10	Jul-16	1	12	
3	Prey Veng	Kampong Trabek	EPOS	AFH	Jun-10	Jul-16	1	8	1
		Pearaing	EPOS	AFH	Jun-10	Jul-16	0	16	
		Preah Sdach	EPOS	AFH	Jun-10	Jul-16	0	9	
TOTAL							**5**	**121**	**4**

Population Coverage

Currently, voucher scheme covers an estimated 107,763 women of reproductive age from 15-49 years-old in those 9 ODs, 225,354 women in 2013 and 226,674 women in 2014 (Table 11).

Table 11: Population coverage by voucher schemes 2012-2014

Province	OD Name	Targeted Pop 2012	Targeted Pop 2013	Targeted Pop 2014
Kampong Thom	1. Baray and Santuk	21,650	34,815	35,092
	2. Kampong Thom	20,254	38,936	39,157
	3. Stong	11,043	19,790	19,790
	Total Province:	***52,947***	***93,541***	***94,039***
Kampot	1. Angkor Chey	***5,724***	16,968	17,057
	2. Chhouk	8,465	25,779	25,916
	3. Kampong Trach	8,179	23,739	23,863
	Total Province:	**22,368**	**66,486**	**66,836**
Prey Veng	1. Kampong Trabek	13,928	20,375	20,829
	2. Pearaing	9,106	28,256	28,267
	3. Preah Sdach	9,413	16,696	16,703
	Total Province:	**32,447**	**65,327**	**65,799**
Total		**107,762**	**225,354**	**226,674**

Table 12: Summary of data on vouchers for reproductive health services

Voucher Scheme_Voucher for Reproductive Health	2012	2,013
Voucher_Coverage of ODs	9	9
Total Hospitals	5	5
Voucher_Coverage of CPA3	1	1
Voucher_Coverage of CPA2	4	4
Voucher_Coverage of CPA1		
Voucher_Coverage of National Hospital	-	
Voucher_Coverage of HC	118	121
Voucher_Coverage of clinics	4	4
Total utilization cases	36,299	53,772
Utilization at HC	31,204	46,693
Utilization at RH	1,248	1,981
Utilization at Private-None profit	3,847	5,098
Total expenditure	1,119,632	1,229,255
Expenditure for Direct and associated cost	614,391	614,391
Expenditure for Operating cost	505,241	614,864
Coverage of population	107,763	225,354

Utilization of Health Services

Total utilization of reproductive health services supported by the voucher project in 2013 was 53,772 cases, mostly at health centers (87%), followed by 9% at private clinics and 4% at referral hospitals. Table 12 provides detailed information about utilization of reproductive services in 2013 by location, including funding sources and voucher operator.

Financing of Voucher Schemes

The voucher project is financed by KFW as a grant. Total expenditure, including direct cost and indirect cost in 2013 was USD 1,229,255 that 50% of which was spent for direct cost and 50% for indirect cost occurred in both AFH and EPOS. This expenditure is included consultancy firm budget from KFW to EPOS.

The operating costs (excluded EPOS's expenditure) of these schemes were on average 29%. The highest operating cost (management cost) were the schemes operating in OD Pearaing (46%), OD Stong and Kg. Trabek around 42%, followed by Preah sdech, kg trach and chhuok ODs around 37%, whereas the lowest operating cost was the scheme in Kg. Thom%(15%).

3.6.3 Health insurance

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

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

Social Health Insurance

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

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

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

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

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

Employment Injury scheme has been implemented since 2008. According to Social Security Law, private enterprises employing 8 workers and more have to register with NSSF. The premium is 0.8% of gross salary, 0.5% and 0.3% of which was contributed by employers and

the Government, respectively. Since 2011, the contribution of 0.8% has been made by employers only. It is reported that the premium varies from a minimum level of 1,600 riels to a maximum level of 8,000 riels per month. Up to 2013, 5,345 enterprises were registered with NSSF, and 89.26% of those enterprises (4,771 enterprises) paid contribution for 847,175 employees. Working jury scheme has been implementing in 24 province and municipality so far.

Table 13: Summary of data on NSSF work injury scheme

Work injury	2009	2010	2011	2012	2013
Register enterprise	983	1,910	3,105	4,583	6,107
Paid enterprises	884	1,564	2,429	3,921	4,771
Memberships	387,064	594,686	674,217	768,134	847,175

Total expenditure of work injury scheme in 2013 was 6,926,229,300 riels (approximate 1.7 million US dollars), 76% of this was spent for health care services (8,245 persons).

Social health insurance: A voluntary health insurance project (HIP), which targets the formal private sector population, particularly Garment sector employees without dependents started in 2009. The project has been implemented by GRET, and then transferred to NSSF in October 2013. This scheme, which provides benefits in terms of health care services; patient and death transfer and cash referral, has contracted with five public health facilities namely Khmer Soviet, Preah Kossamak, and Pochintong hospitals, and Tuolkork and Stung Mean Chey health centers. The premium rate is 1.6 US dollars per month. The current number of targeted enterprises is 11.Three enterprises have paid 100% of the premium for their employees, while the other eight enterprises have paid 50% of the premium, with the other 50% paid by employees. The coverage in 2013 was 7,733 employees, while the number of health service contacts was 9,679 cases, comprised of 96% OPD, 3% IPD and 1% delivery. It is noted that only 2,564 cases occurred under the management of NSSF. Compulsory social health insurance for the formal private sector population (employees of private enterprises with eight or more employees, and their dependents) is under development in terms of benefit package and payment mechanism, and is planned to be officially launched in late 2014.

Table 14: Summary of data on NSSF social Health Insurance

SHI	2009	2010	2011	2012	2013
Membership	1862	4818	5945	6522	7733
Female	1648	4039	5180	5839	6924
Male	214	779	765	683	809
Revenue (USD)	7,263	62,480	107,002	117,594	133,172

(2) Ministry of Social Affairs, Veterans and Youth (MOSVY), which is responsible for the development of social security for civil servants, has recently drafted a sub-decree on the provision of pensions, occupational injury and other benefits including maternity and sick leave. The RGC Sub-Decree on *the Establishment of National Civil Servant Social Security Fund*

(NCSSF) adopted in February 2008 paves the way for *the "Creation of an Institution of Public Administration with the Mission to provide Social Security Services to the Public, and manage Social Security Benefits to Civil Servants and their Dependents".*The NSSFC was officially established in February 2009.

VOLUNTARY HEALTH INSURANCE

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

COMMUNITY BASED HEALTH INSURANCE (CBHI)

In Cambodia, Voluntary health insurance refers to community based health insurance (CBHI) which is designed on the basis of the principles of risk pooling and pre-payment for health care. The CBHI is non-for-profit, voluntary insurance scheme whereby the premiums are sold at low-cost to community members who have willing to register as members of the schemes. The insured persons and their family are entitled to use the defined health services at contracted public health facilities i.e. health centers and referral hospitals. The CBHI reimburses the cost of services consumed by its members. The first CBHI scheme has been implemented since 1998.

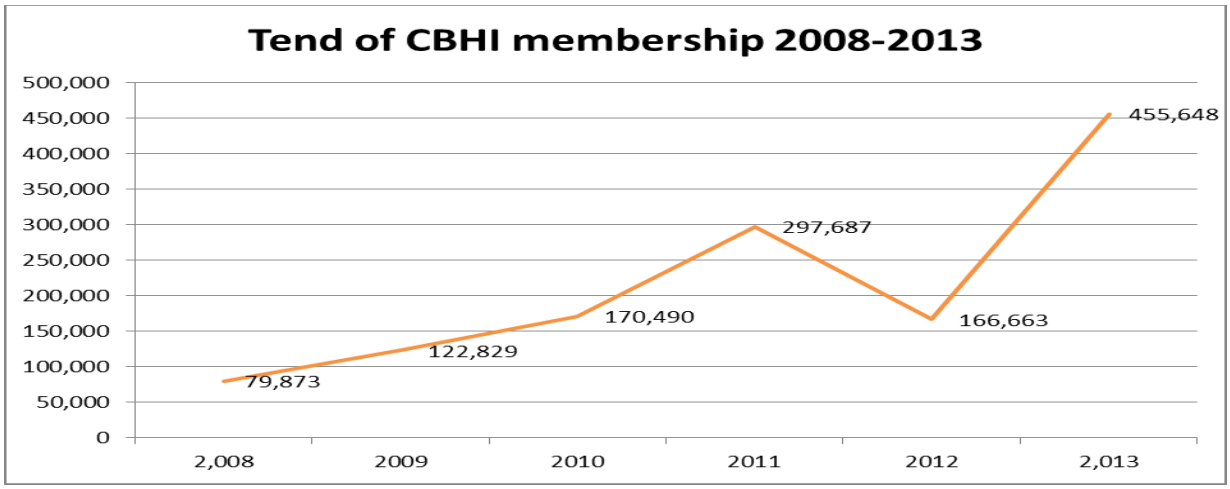
All of the CBHI schemes are implemented by NGOS and Community based organization (CBO).
CBHI schemes provide benefit package including medical services available at public health facility (MPA service at health center and CPA services at hospital) and other associated costs such as transportation cost, allowances for a patient's care-taker, and funeral cost. CBHI schemes contract with public health facilities to provide health services to their beneficiaries, with the payment mechanism could be varied from schemes to schemes. It is noted that there is no standard benefit package and payment mechanism for CBHI yet.
So far there are 19 CBHI schemes being implementing by mostly NGOs in 10 provinces including Phnom Penh, 19 ODs, contracted to 240 Health Centers, 10CPA1, 7CPA2, 7CPA3 and 2 National Hospitals. Total membership of CBHI schemes in 2013 was around 455,648 persons.

Table 18: Coverage of community-based health insurance, 2008-2013

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

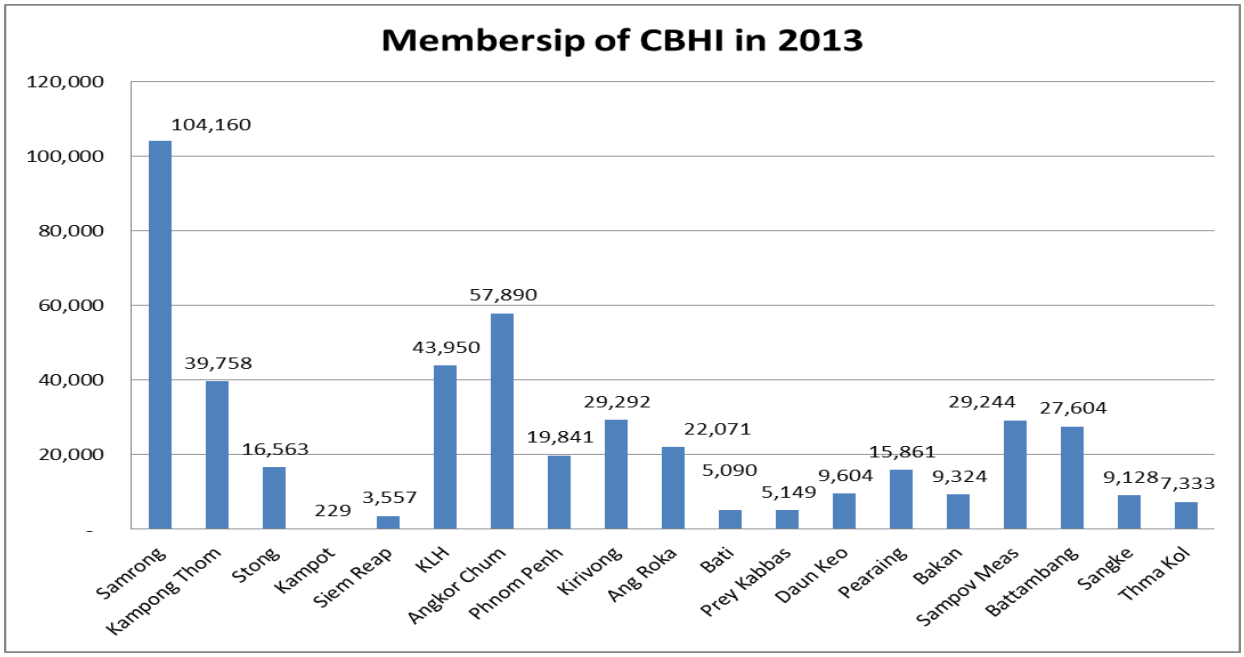
There have been 19 CBHI schemes implementing in 19 ODs in Cambodia so far. The total members, who enrolled with those schemes, have decreased from 79,873 persons in 2008 to 445,648 persons in 2013, even though a bit plunge in 2012.

Figure 15: CBHI membership, 2008-2013



From Figure below, it is noted that CAAFW in Samroan in Ordor Mean Chey Province has highest memberships, followed Scheme in Angkor Chum and Kralanh (KLH), while Kampot and Siam Reap have lowest memberships.

Figure 16: Distribution of CBHI membership, 2013

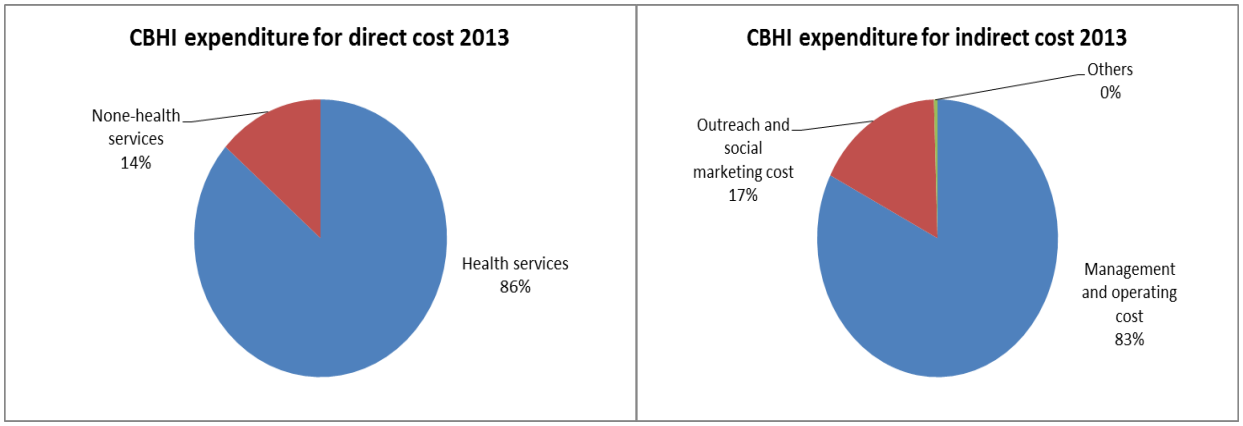


Total utilization covered by CBHI was 256,707 cases, in which 96% was OPD cases, 3 IPD cases and 1 delivery cases. With OPD cases, most of the case used by female (53%), 29% by female and 15% by Children, similarly most of IPD case used by female (43%), 34% by male and 13 by children.

The revenue of CBHI scheme is estimated around USD 1.057 million in 2013 composed of 60% from subsidy from partners and 40% from premium collection. It is observed that there has no any CBHI scheme can function without any subsidy from partners.

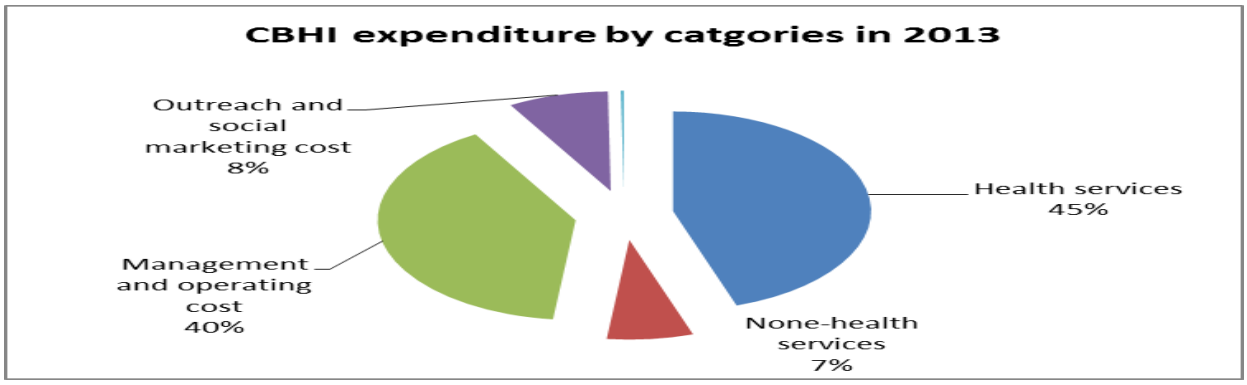
The total expenditure in 2013 was USD 1.228 million with 52% spent for direct benefit packages and 48 per cent on management and operating cost. Within total direct cost, 86% was spent on health services benefit, while on 14% was spent for associated cost such transportation, food allowance and others. Within total expenditure of indirect cost, 82% was spent on management cost, 17% was spent on outreach and marketing activity and less than 1% spent for other.

Figure 17: CBHI direct and indirect expenditure, 2013



By taking to all cost within the total expenditure of CBHI, it is found that44% was spent for medical fee, 34% spent for administrative cost, 8% spent for outreach and marketing and 7% spent for transportation cost of patients.

Figure 18: CBHI expenditure by categories, 2013



VOLUNTARY PRIVATE HEALTH INSURANCE

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

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

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

So far there private general insurance companies namely ASEA, CAMINCO, CAMPUBANK LONPAC, CAMBODAI-VIETNAM, FORTE and INFINITY. All of these operate health care benefit insurance except CAMBODIA –VIETNAM COMPANIES.

According to report of MEF, all insurance premiums have increased from around 4 million US dollars in 2008 to 20 million US dollars in 1999, 35 Million US dollars in 2012 and 41 Million US dollars in 2013. Expenditure for health benefit was around USD 2 and USD 2.4 million in 2012 and 2013 respectively.

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

4. GLOSSARY

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 to implement 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, however in practice the exemption system does not work effectively and cannot achieve its desired results, because less than half are considered too poor to pay for services.
Health Equity Fund	A social-transfer mechanism designed to remove financial access to public health facilities by the poor by paying fees for services via a third-party payer, mainly local NGOs. Pre-identification and post-identification are commonly used to identify the poor, who are entitled to get health services free of charge at the point of use. The third party then reimburses directly the cost of such services used at facilities on a monthly basis.
Health Equity Fund Implementer (HEFI)	An agency which manages health equity fund Operator(s).
Health Equity Fund Operator (HEFO)	An agency (NGO or any other type of Civil Society Organization) responsible for implementing HEFs, with oversight HEFOs, and representing the voice of and acting in the interest of the poor in coverage areas of HEFs schemes by purchasing health services from public health providers.
Subsidy (SUB)	Subsidy 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)	Any Public Health Authority that is authorized by the Government to receive and manage SUB scheme(s).
Social health Protection	Umbrella term used to describe all schemes and procedures that provide an element of protection against health care disbursements for the poor

	and for other users. This includes fee exemptions, health equity funding, community based health insurance and social health insurance.
Social health Insurance	Refers to various compulsory pre-payment schemes within the formal employment sector supported by legislation and usually funded either by the government (for civil servants) or by employers (for formal private-sector employees), often with part-contributions also from the employees.
Voluntary Health Insurance Scheme	Refers to private, non-profit, voluntary pre-payment schemes targeted on the informal employment sector of small scale and self-employed urban and rural workers. Such schemes are usually sponsored by an NGO and operated at community level. These schemes are funded by voluntary premium payments by beneficiaries and commonly require subsidies from other donors. Services are provided by contracted health providers usually in the public sector but may also include qualified private providers.

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