



Assessing government's fiscal space for moving towards universal health coverage in Cambodia

Kouland Thin^{1,2}, Sokbunthoeun SO³*

ABSTRACT

Background

In line with the global trend, it becomes clear that the Cambodian government's policy direction is leaning toward universal health coverage, the agreed target within the newly ratified Sustainable Development Goals. Thus, the health system will need to be further reformed to achieve this target by 2030. To assess if the Cambodian government is able to increase the proportion of health budget out of the total government expenditure, this study will evaluate the government's fiscal space and propose feasible options where and to what extent new resources can be generated for improving the health system.

Design

The data used for this analysis were obtained from World Bank online database and a series of Cambodia's economic updates produced by the World Bank office in Cambodia. We observed the trends over time from 2011 to 2018 to provide insights into the extent to which fiscal space for health can be expanded.

Findings

By assessing the key fiscal indicators, it is unlikely that the Cambodian government is able to increase the proportion of health budget out of its total budget in the short run. Health budget is increased in absolute terms but not in real terms, which is linked tightly to the predicted 7% economic growth per annum.

Conclusion

The proportion of health budget from now until 2018 is expected to remain the same, and the revenues raised through pre-payment mechanisms are still too small to address the pressing issues in the current health system. The Ministry of Health could benefit from putting a much stronger effort on improving efficiency and equity in the distribution of resources, as well as transparency and accountability, to achieve the immediate objectives for universal health coverage.

Keywords: Fiscal Space, Efficiency in Health Spending, Health Financing Reforms, Universal Health Coverage, Cambodia

INTRODUCTION

Health system in Cambodia has been built from very few resources left after the genocide regime ended in 1979. In the past three decades, although there have

been many pressing issues that need to be addressed in order to increase the health coverage and enhance the quality of healthcare services, Cambodia has

GJMEDPH 2017; Vol. 6, issue 3

¹Swiss Development Cooperation (SDC), Cambodia

²ABT Associates, United States

³Independent Researcher

*Corresponding Author:

Kouland Thin
Swiss Development Cooperation (SDC),
Cambodia
ABT Associates, United States
No. 104, Russian Blvd, Phnom Penh,
Cambodia
koulandthin@hotmail.com
Telephone No: +855-17-354-004

Conflict of Interest—none

Funding—none

made significant progress in improving the health status of its population. Key achievements include reduced maternal and child mortality rates; decreased prevalence of communicable diseases such as malaria, tuberculosis, and HIV/AIDS,¹⁻⁴ expanded coverage and increased access to essential health care services; and scaled-up Health Equity Funds (HEFs) that provide a measure of financial protection, particularly for the poor, nationwide.⁵⁻⁷ These improvements can be attributed in part to long-term political stability, which has provided space for development to occur, and to strong and coherent collaboration between the Royal Government of Cambodia (RGC) and its Development Partners (DPs).

Despite these achievements, Cambodia, as many other developing countries in the South East Asia (SEA) region, has faced tremendous challenges in funding healthcare services out of the government budget and supporting Cambodians, especially the poor and the near poor, to access health services they need without risks of financial catastrophes or impoverishment. Since the health financial reform in 1996, followed by the establishment of the HEFs to improve access to health services for the Cambodian poor, Out-of-Pocket (OOP) expenditure has remained at about 60% of total health expenditure (THE).⁸⁻¹⁰ This level of OOP payment is the second highest in the Association of South East Asian Nations (ASEAN). In addition, the country's health system has been heavily funded by donors, accounting for about 20% of THE. This share is almost equal to the government spending for health.^{8,11}

Overall, the share of THE to Gross National Product (GDP), at approximately 7%, is within the recommended range by the World Health Organization (WHO) for countries that aim to make progress towards Universal Health Coverage (UHC),¹² but its composition is not. The high OOP and dependency on contribution from donors, together with the low government budget for health, slows down the progress to reach UHC in Cambodia. The concept of UHC centers mainly on pre-payment mechanisms and access to quality of care.^{13, 14} As recommended by the WHO to its member states that

want to achieve UHC, the population who is insured by pre-payment schemes should be around 90%.¹² Currently, the gap between the insured and uninsured populations in Cambodia is huge. Among 15.4 million people, 3.2 million poor are covered by HEFs, 0.13 million are insured by Community-Based Health Insurance (CBHI), and a little bit over one million formal sector employees are entitled to work injury insurance,^{15,16} while the rest finance their health services through either OOP expenses or private health insurance schemes. However, the proportion of the population who has private health insurance is quit small, as health insurance for formal sector population just started in mid 2016.

In line with the global trend, it becomes clear that the RGC policy direction is leaning toward UHC, the agreed target within the newly ratified Sustainable Development Goals (under SDG 3, the health goal).¹³ Thus, the health system will need to be further reformed to achieve this target by 2030.

Global evidence suggests that an adequate investment in the health system from the government will solve a wide range of issues, such as staff absenteeism, drug stock-outs, overcrowding, and insufficient medical equipment, that substantially affect quality health services.¹⁷ To assess whether the RGC is able to increase the proportion of its health budget out of the total government expenditure, this study will evaluate the government's fiscal space and propose feasible options where and to what extent new resources can be generated for health along the path towards UHC in Cambodia. Such analysis will underscore fiscal opportunities and challenges faced by the Ministry of Economy and Finance (MoEF) when the health-financing system gets more complicated as insurance schemes for the formal sector population are currently being scaled up gradually.

DESIGN

This study based its assessment on the fiscal space framework discussed in the WHO report on health financing diagnostics and guidance in 2016 in which fiscal space is defined as the government's capacity to allocate more resources needed to health sector to provide equitable access to quality healthcare

services to its population without affecting the sustainability of its financial position.¹⁸ Four key fiscal indicators: government expenditure to GDP ratio, government revenue to GDP ratio, budget deficit, and government debt to GDP ratio were used to assess government fiscal's space. The data used for this analysis were taken from a series of Cambodia's economic updates produced by the World Bank (WB) office in Cambodia and the WB database.¹⁹⁻²¹ For all fiscal indicators, we observed the trends over time from 2011 to 2018 to provide insights into the extent to which fiscal space for health can be expanded, and assume that the economic situation in Cambodia is stable as predicted by the WB in the short run (2017-2018).

HEALTH FINANCING AND ONGOING ISSUES IN CAMBODIA

The health system in Cambodia is mainly financed by the government, development partners, and OOP payment. Table 1 shows the total health expenditure, by source of financing, from 2008 to 2014. The

government spending remained between 19% and 22.7% of THE. The rise in OOP spending offsets the decline in donor and government spending, which is financed by revenues from general tax and social health insurance. Cambodia's social health insurance comprises of HEF schemes for the poor population and National Social Security Fund (NSSF) for the formal private sector workers. Donors and Non-Government Organizations (NGOs) also support HEF schemes and Community-Based Health Insurance (CBHI) schemes.²² The total health spending as a share of GDP remained between 5% and 7%, while per capita total health expenditure rose from US\$41.1 in 2008 to US\$68.3 in 2014. The total amount of health expenditure, according to the

recent estimates, did not vary much in the past three years, increasing from US\$1.032 billion in 2012 to US\$1.057 billion in 2014. This was driven mostly by increased OOP expenditures (US\$622 million in 2012 to US\$658 million in 2014).⁸

Table 1 Health Expenditure by Sources of Financing from 2008-2014

Category	2008	2009	2010	2011	2012	2013	2014
OOP	60.9%	60.9%	61.6%	62.3%	60.2%	61.9%	63.2%
Donors	20.1%	19.8%	16.0%	15.0%	20.2%	18.7%	18.3%
Government	19.0%	19.3%	22.5%	22.7%	19.3%	19.4%	18.5%
THE (%GDP)	5.3%	6.2%	5.8%	5.5%	7.2%	7.0%	5.8%
THE per capita (US\$)	41.1	46.0	47.3	49.0	70.4	72.3	68.3
GDP per capita (US\$)	772	738	813	885	974	1,033	1,188

Source: MoH, Health Financing Report, 2014.

GDP, Gross Domestic Product; OOP, Out of Pocket; THE, Total Health Expenditure.

Demand and Supply Schemes

The Health Financing Charter in 1996 allowed Public Health Facilities (PHFs) to charge user fees and grant fee waivers to the poor. However, after this reform, the proportion of poor patients who received fee exemption remained very low because the reimbursement system to PHFs did not work well. As a result, PHFs that were operating at or near to full capacity had no incentive to provide fee exemption, as it affected the salary supplement of their staff.²³ When this mechanism was not favorable, a series of health financing reforms addressing both the demand and supply sides emerged in the late 1990s

to overcome access barriers to health services, especially for the poor, and to expand the health coverage to the population at large.²⁴

The demand-side mechanism for financing health services is channeled through third party payers. The HEF schemes, CBHI schemes, voucher schemes, and SHI were initiated one after another, starting from the late 1990s. As outlined in the strategic framework for healthcare financing 2008-2015, the role of HEF scheme is to help the poor who live under the national poverty line as defined by the Ministry of Planning (MoP) to access health services and to

protect them from falling deeper into poverty. The role of CBHI is to provide a risk-pooling plan for the

informal sector population. The formal sector population is covered by SHI.^{5,6,25}

Table 2 Summary of Social Health Protection Schemes 2008-2014

Category	2008	2009	2010	2011	2012	2013	2014
Health Equity Funds							
Operational District	42	42	44	44	45	49	51
National Hospital			1	1	1	1	1
Referral Hospital	44	44	44	45	46	50	63
Health Center	110	141	235	272	313	458	602
Total Cost (US\$)		4,820,215	4,652,391	6,429,228	10,045,676	9,959,458	11,559,134
Population's coverage	469,038	909,606	1,535,478	2,028,739	2,244,852	2,693,373	2,620,759
Community-Based Health Insurance							
Operational District	12	13	18	18	19	19	20
National Hospital			2	2	2	2	1
Referral Hospital	11	12	20	20	18	24	20
Health Center	81	81	164	182	231	240	183
Total Cost (US\$)	448,944	697,089	855,604	901,361	662,715	1,213,722	284,883
Population's coverage	79,873	122,829	170,490	297,687	166,663	455,648	139,971
Voucher							
Operational District				9	9	9	21
National Hospital							1
Referral Hospital				5	5	5	19
Health Center				78	118	121	297
Clinic				2	4	4	8
Total Cost (US\$)				307,606	1,119,631	1,229,255	1,804,337
Utilization cases				13,712	36,299	53,772	68,276
Subsidies							
Operational District				12	12	12	12
National Hospital				6	6	6	6
Referral Hospital				11	11	11	11
Health Center				47	57	57	57
Total Cost (US\$)				351,606	284,955	424,561	214,940
Utilization cases				71,078	75,771	55,928	48,827

Source: MoH, Health Financing Report, 2014

Table 2 presents the progress of the demand-side schemes from 2008 to 2014. By 2014, 63 out of 97 Referral Hospitals (RHs) and 602 out of 1105 Health Centers (HCs) were contracted by the HEF schemes. These schemes supported approximately 2.6 million poor. The total cost, including operational costs for Health Equity Fund Operators (HEFOs) and Health Equity Fund Implementers (HEFIs), rose nearly 2.5 folds in a five-year period (US\$4.8 million to US\$11.5).²⁴ This was driven by the expansion of coverage. The HEF schemes have been further scaled

up to cover all RHs and HCs across the country by the end of 2016.¹⁵ The CBHI schemes had been operational in 20 Operational Districts (ODs), with about 139,971 beneficiaries, as of 2014. The total cost of all CBHI schemes was about US\$284,883 in 2014. A voucher scheme began in 2011 with the aim to reduce maternal mortality. The scheme provided support to poor women to use reproductive health services at contracted public and private health facilities.⁹ This scheme supported 68,271 women of reproductive age in 21 ODs, with a total cost of US\$1.8 million in 2014.

For the formal sector, there are two types of SHI schemes, one for private sector employees and the other for civil servants. The National Social Security Fund (NSSF) for the private sector is managed by the Ministry of Labour and Vocational Training (MoLVT), and the National Civil Servant Social Security Fund (NCSSF) is managed by the Ministry of Social Affairs, Veterans, and Youth (MoSAVY).²⁴ The NSSF provides work injury compensation and comprehensive health insurance for private sector employees. The work injury insurance scheme began in 2008 which mandated owners of the registered enterprises with 8 employees or more to contribute 0.8% of the average wage of employees to NSSF. As of 2014, there were around 7,041 enterprises with 1,021,588 employees registered with the NSSF. The comprehensive health insurance scheme for private sector workers has been rolled out in Phnom Penh, Kandal, and Kampong Speu by mid 2016 and will further be scaled up in 2017 based on the lessons learnt from the initial phase. For civil servants, a sub-decree on the provision of pension, occupational injury benefits, and other benefits have been drafted, but not yet finalized. Currently, MoSAVY is working closely with other relevant ministries, especially the MoH and the MEF, to determine who should be included in the scheme, the benefit package, and the payment method for outpatients and inpatients. The scheme for civil servants is expected to be launched in mid 2017.²⁶

The supply-side mechanism includes fee exemption, Special Operating Agency (SOA), and Subsidy Scheme (SUBO). The exemption fees for the poor are reimbursed by the MoH, of which 40% is used to cover operational cost and 60% for staff incentives.²⁷ The SOA aims to improve the quality of public health services in response to health needs, change the behavior of health staff, and develop sustainable service delivery capacity.²⁴ SOA health facilities are eligible to charge fees for services or contract with HEFO to deliver services to people in their catchment area. As part of the contract with the MoH, managers of SOA have the authority to terminate staff who conduct private practices, hire or rotate staff, and implement a range of performance-based staff incentives.²⁸ As of 2014, there were 36 SOAs operating in 26 ODs.²⁴ SUBO emerged in 2006 where

PHFs were reimbursed for user fee exemption for the poor. This is one of the HEF schemes, but it does not go through a third-party implementer. Basically, PHFs get payment through the provincial treasury on a quarterly basis.²⁹ The SUBO is mainly implemented in the areas with no HEF scheme. As shown in Table 2, the scheme had not been scaled up, and the total expenditure had substantially decreased.

Challenges

The Cambodian government has implemented several SHI schemes to improve access to health services and expand health coverage to the population at large. These initiatives also help PHFs that are underfunded to improve quality of care and expand health services. Although SHI schemes provide a range of benefits to the insured population and PHFs, the schemes from both the demand and supply sides also face challenges, which require increased support from the government as well as development partners in order to expand the health coverage effectively.

From the demand side, the operation of HEF schemes involved multiple partners, such as the MoH, DPs, HEFIs, and HEFOs, which created a fragmented system with complex reporting requirements and high operational costs. As a result, the reimbursement was regularly delayed. This situation affected the operation of PHFs that depended heavily on funding from these schemes.^{27,30-32} The Health Equity for Quality Improvement Program (HEQIP), the successor of Health Sector Support Program 2 (HSSP2) which was implemented from 2008 to mid-2016, launched in September 2016, was designed to tackle all bottlenecks mentioned above. CBHI also faces ongoing challenges. Many organizations that operate CBHI schemes are unable to expand their coverage and have difficulties sustaining operation without support from the government and DPs. As shown in Table 2, the number of insured persons has declined by approximately 70%.

For the supply side, the SUBO scheme was reported to have various issues related to its design and implementation, which severely reduced the effectiveness of the scheme. There were no contracts

or Memorandum of Understanding (MoU) between the Department of Planning and Health Information (DPHI) and ODs to implement the scheme; staff at the health facilities did not receive sufficient training on how to operate the scheme; and some poor patients with or without poor identification card still had to pay for services. With these constraints, researchers suggested that SUBO be pursued with an improved design; integrated into the HEF scheme in which the government budget is used for user fee reimbursement and where DPs' fund is reserved for transportation, food allowance, and other costs; or completely replaced by the HEF scheme.³³

ASSESSING FISCAL SPACE FOR UNIVERSAL HEALTH COVERAGE

In the last two decades, a key challenge in Cambodia has been the high level of OOP spending, indicating insufficient financial protection. To be able to reduce OOP expenditure, the majority of the Cambodian population will need to be insured through pre-payment schemes. The application of pre-payment schemes has been successful in Thailand, and in other countries like the Philippines and Indonesia, such schemes have covered 78% and 60% of their population, respectively.¹¹ Prior to the introduction of UHC, 75% of the Thai population not enrolled in a civil servant medical benefit scheme or social security scheme were not covered, but they are now covered by the universal coverage scheme, which is financed by general tax.³⁴⁻³⁶ OOP spending for the Thai decreased from 18.3% before universal health scheme to 8%-10% after the launch of this universal health scheme.³⁷ In Cambodia, UHC can be expanded by filling gaps in the current schemes while expanding the pre-payment schemes. All of the formal sector employees should be insured by the SHI schemes, and the poor can be covered by the HEF. The remaining population in the informal sector (of which a very small proportion is enrolled in CBHI) can be covered with the expansion of the pre-payment schemes.

Using tax revenues to fund the coverage expansion is the most sustainable way to support this large informal sector to enroll into a pre-payment scheme. This would hang on the fiscal space of the RGC. Fiscal space refers to "the government's ability or

willingness to mobilize public revenue, which in turn allows it to spend money on public services and programs, including health." When the fiscal space is high, public spending on health can also be enlarged. The higher public spending on health is, the lower dependence on OOP spending for health services becomes. This is essential for achieving the UHC goals as it implies higher financial protection when seeking health services.¹⁸

To gauge the fiscal space of the RGC, we look at four indicators: Government revenue to Gross Domestic Product (GDP) ratio, government expenditure to GDP ratio, budget deficit, and government debt to GDP ratio. Figure 1 shows the trends of these four indicators from 2011 to 2018.

Government revenue to GDP ratio

Stable economic growth in the past decades allows the Cambodian government to expand its tax base and tax capacity. Tax revenue collection, for both direct and indirect taxes, rose steadily each year from around 10.1% of GDP in 2011 to 15.8% of GDP in 2016 (Figure 1). Despite this gradual increase, until 2016, Cambodia still had a very low fiscal space according to the rule of thumb suggested by the IMF and the WB: 15%-20% is equivalent to low fiscal space; 20%-25% low to medium; 25% to 35% medium; 35%-45% medium to high; and 45% or above very high. From 2016 to 2018, tax revenue probably will not be increased far beyond the 2015 level as the domestic revenue is predicted to be the same in the next three years. Based on this prediction, Cambodia will maintain its low fiscal space in the next two years. To move from low to medium level, it will take several years with continued improvement in tax administration and compliance management.

Government expenditure to GDP ratio

The government expenditure remained stable in the past five years, about 21% to 22.8% of the GDP. This expenditure is predicted to be the same in the next two years. According to the rule of thumb above, which also applies to government spending, it indicates that the Cambodian government has medium-low fiscal space. The expenditure trend from Figure 1 reflects that the overall government

spending from 2011 to 2015 barely increased beyond 1% to 2% of the GDP and will remain the same in the next two years. When the overall expenditure does not increase, it is difficult to argue for more public

spending on health because increasing real spending on health may require decreasing spending on other prioritized sectors.

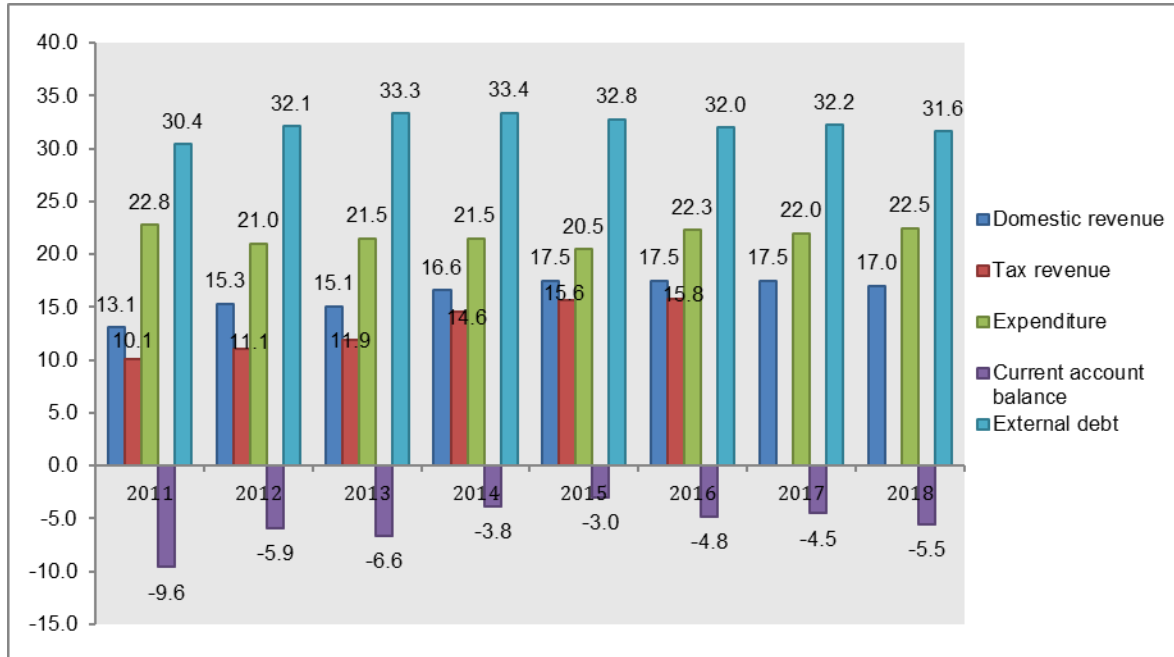


Fig 1 Key Fiscal Indicators as Percentage of GDP: 2011 – 2018

Source: The World Bank Cambodia Economic Update 2015 and 2016; tax revenue in 2011-2014 was taken from the World Bank online database and tax revenue in 2015-2016 was calculated from the World Bank Economic Update 2016.

Current Account Balance and Debt to GDP Ratio

The current account balance discussed here does not include grants. The Cambodian government has been running a budget deficit from 2011 to 2015. Although the amount of budget deficit was smaller in 2015 compared to 2011, this will not be reduced further in the next two years as the revenue and expenditure are predicted to be the same (Figure 1). This budget deficit generally indicates that the Cambodian government will have difficulties in increasing its spending. Concerning debt, it remained stable in the past five years and will not be increased beyond 32% of GDP, according to the prediction from the WB. This ratio of debt to GDP is still within the recommended range. For low- and middle-income countries, as suggested by the IMF and the WB, crisis occurs when debt to GDP ratio exceeds 40% of GDP.¹⁸

By looking at the key fiscal indicators, the room to increase fiscal space in Cambodia links tightly to GDP

growth. The real GDP growth, which is predicted to be 7% annually, will translate into higher government revenue in absolute terms. Although the share for health out of the total government expenditure remains the same, the real amount increases because of the positive GDP growth. After 2018, the proposal for an increased percentage share of the total government expenditure for health is more realistic if the total government expenditure increases in real terms. In this context, increased real health expenditure does not affect spending on other sectors. However, it is not easy to argue for more in practice. For an increase in funding support to this sector, the MEF usually requests the MoH to provide proof that the existing resources are being used efficiently.¹⁸

DISCUSSION

As the share for health out of the total government expenditure is predicted to be the same until 2018, a



key area that the MoH should focus on is to demonstrate that the ministry is using the existing public fund efficiently and effectively in order to make the case for increased budgetary resources after 2018.

A 2011 study conducted by the WB showed that the Cambodian government can reap substantial savings by improving procurement and logistics management for drugs and medical supplies, coordinating budgeting and planning processes better, and integrating demand-side and supply-side mechanisms for health financing schemes. According to this study, the government could save up to one-third of the 2010 health budget (0.4% of GDP) with efficient purchasing of drugs and medical supplies. The government can further save through converging the budget strategic plan (BSP), the annual operational plan (AOP) and annual budget in terms of coverage, types of spending, and sources of financing.³⁸ The government can reduce administrative costs and minimize misunderstanding between contractors (health facilities) and purchasers (MoH and not-for-profit organizations) by consolidating some of the demand-side and supply-side schemes. The government in the past years has initiated several health financing schemes and incentives, such as HEF, subsidies, user fee exemption, special operational agencies (SOAs), vouchers, and midwifery payments, to provide additional compensation and motivation to government health workers. Each scheme has different rules regarding the allocation of revenues collected for health facilities' staff, and there is no clear guideline on how much additional incentive staff should receive. This permits health facilities to maximize their revenues through costly services and makes the services less efficient and accessible for the informal sector population who live slightly above the poverty line.³⁸ Besides, patients are less likely to understand their benefit entitlements or know which providers are contracted for what services.

CONCLUSION

Despite the success in improving health outcomes in the past decades, Cambodia's health system falls short of professional services that its citizens require. The health system needs sufficient public funding to

tackle many pressing issues along the path toward UHC, including adapting to the changing disease patterns, rising complexity of non-communicable diseases (NCDs), and emergence of new infectious diseases. Non-communicable disease risks are high, and prevention and surveillance are insufficient. The public sector is highly centralized and not well managed, while the private sector has only been regulated loosely. A large chunk of the government budget for health, other than personnel cost, is mainly spent at the central level for procurement of drugs, medical equipment, and other supplies, to be distributed to public health facilities, but stock-outs at local level persist. Recent estimates have shown that medicines accounted for 39.7% of the total health spending in 2012, 46.5% in 2013, and 39.7% in 2014.⁸ The shortage of qualified and trained human resources also has adverse effects on the government's efforts to move toward UHC. Therefore, achieving UHC requires action across the health system, not just the health financing reforms.

The proportion of health expenditure out of the total government expenditure from now until 2018 is expected to remain the same, while the revenues raised through pre-payment mechanisms are still too small to address the issues above. The MoH in the short run should improve efficiency, equity in the distribution of resources, and transparency and accountability, which are the immediate objectives for UHC. Working to improve efficiency in the distribution of resources has almost the same potential effects as increasing the level of public health spending, as the savings through efficiency gains can be redistributed within the health system.

ACKNOWLEDGEMENT

We would like to thank development partners and local public health experts for their excellent comments on this study. Without such extensive support, this study would have been impossible.

REFERENCES

1. National Institute of Statistics (NIS). Cambodia Demographic and Health Survey 2000. Phnom Penh, Cambodia: National Institute of Statistics 2000.

2. National Institute of Statistics (NIS). Cambodia Demographic and Health Survey 2005. Phnom Penh, Cambodia: National Institute of Statistics 2005.
3. National Institute of Statistics (NIS). Cambodia Demographic and Health Survey 2010. Phnom Penh, Cambodia: National Institute of Statistics 2010.
4. National Institute of Statistics (NIS). Cambodia Demographic and Health Survey 2015. Phnom Penh, Cambodia: National Institute of Statistics 2015.
5. Ministry of Health (MOH). Master Plan on Social Health Protection. Phnom Penh, Cambodia: Ministry of Health, 2009.
6. Ministry of Health (MOH). Strategic framework for health financing 2008-2015. Phnom Penh, Cambodia: Ministry of Health, 2008.
7. World Health Organization (WHO). The Kingdom of Cambodia Health System Review. Geneva, Switzerland: World Health Organization, 2015.
8. Ministry of Health (MOH). Estimating health expenditure in Cambodia: National health accounts report (2012 -2014 data). Phnom Penh, Cambodia: Ministry of Health, 2016.
9. Ministry of Health (MOH). Annual health financing report. Phnom Penh, Cambodia: Ministry of Health, 2012.
10. Ministry of Health (MOH). Estimating health expenditure in Cambodia: National health accounts report (2012 data). Phnom Penh, Cambodia: Ministry of Health, 2014.
11. Van Minh H, Pocock NS, Chaiyakunapruk N, Chhorvann C, Duc HA, Hanvoravongchai P, et al. Progress toward universal health coverage in ASEAN. *Global health action*. 2014;7.
12. World Health Organization (WHO). Health Systems Financing: The path to Universal Coverage. Geneva, Switzerland: World Health Organization, 2010.
13. Schmidt H, Gostin LO, Emanuel E. Public health, universal health coverage, and Sustainable Development Goals: can they coexist? *Lancet*. 2015;386:928-30.
14. Boerma T, Eozenou P, Evans D, Evans T, Kienny M-P, Wagstaff A. Monitoring progress towards universal health coverage at country and global levels. *PLoS Med*. 2014;11(9):e1001731.
15. Ministry of Health (MOH). Health sector progress in 2015 Phnom Penh, Cambodia: Ministry of Health, 2016.
16. Ministry of Health (MOH). Health sector progress in 2014 Phnom Penh, Cambodia: Ministry of Health, 2015.
17. Hipgrave DB, Hort K. Will current health reforms in south and east Asia improve equity? *The Medical journal of Australia*. 2014;200(9):514-6.
18. McIntyre D, Kutzin J. Health financing country diagnostic: a foundation for national strategy development. Geneva: World Health Organization. 2016.
19. World Bank (WB). Cambodia Economic Update: Improving macroeconomic and financial resilience. Phnom Penh, Cambodia: World Bank, 2016.
20. World Bank (WB). Cambodia economic update: Improving macroeconomic and financial resilience Phnom Penh, Cambodia: World Bank, 2016.
21. World Bank (WB). Cambodia economic update: Adapting to stay competitive Phnom Penh, Cambodia: World Bank, 2015.
22. Royal Government of Cambodia (RGC). National Social Protection Policy Framework. Phnom Penh, Cambodia: Royal Government of Cambodia, 2016.
23. Cambodia Health Development Partners Group (CHDPG). Cambodia health sector induction pack. Phnom Penh, Cambodia: Cambodia Health Development Partners Group, 2013.
24. Ministry of Health (MOH). Special operating agency manual Phnom Penh, Cambodia: Ministry of Health, 2009.
25. Ministry of Health (MOH). Health sector strategic plan 2008-2015. Phnom Penh, Cambodia: Ministry of Health, 2008.
26. Ministry of Health (MOH). Annual health financing report Phnom Penh, Cambodia: Ministry of Health, 2014.
27. Ministry of Health (MOH). Guideline for implementation of health equity funds and government subsidy schemes. Phnom Penh, Cambodia: Ministry of Health, 2008.
28. Tim K, Heng S. The Political Economy of Inclusive Healthcare in Cambodia. Manchester, United Kingdom Effective States and Inclusive Development Research Center (ESID), 2014.
29. Ministry of Health (MOH). Implementation of Health Equity Funds Guideline. Phnom Penh, Cambodia: Ministry of Health, 2009.
30. Annear P, Ahmed S. Institutional and operational barriers to strengthening universal coverage in

- Cambodia: Options for policy development. Melbourne, Australia The Nossal Institute for Global Health, 2012.
31. Jacobs B, Price N, Sam SO. A sustainability assessment of a health equity fund initiative in Cambodia. *The International journal of health planning and management.* 2007;22(3):183-203.
 32. Crossland A, Conway T. Review of mechanisms to improve equity in access to health care, Cambodia. London: DFID Health Systems Resource Centre. 2002.
 33. Men C, Ir P, Peter A, Lyon S. Evaluation of subsidy schemes under Prakas 809 to support the Ministry of Health of Cambodia to achieve universal social health protection coverage. Phnom Penh, Cambodia: Ministry of Health, 2011.
 34. Nitayarumphong S. *Struggling Along the Path to Universal Health Care for All.* Bangkok, Thailand: National Health Security Office (NHSO); 2006.
 35. Tangcharoensathien V, Prakongsai P, Limwattananon S, Patcharanarumol W, Jongudomsuk P. From targeting to universality: lessons from the health system in Thailand. *Building decent societies: rethinking the role of social security in development.* 2009:310-4.
 36. Tangcharoensathien V, Prakongsai P, Limwattananon S, Patcharanarumol W, Jongudomsuk P. Achieving universal coverage in Thailand: what lessons do we learn. 2007.
 37. Limwattananon S, Tangcharoensathien V, Prakongsai P. Catastrophic and poverty impacts of health payments: results from national household surveys in Thailand. *Bulletin of the World Health Organization.* 2007;85(8):600-6.
 38. World Bank (WB). *More Efficient Government Spending for Strong and Inclusive Growth: Integrated Fiduciary Assessment and Public Expenditure Review (IFAPER).* Phnom Penh, Cambodia: World Bank, 2011.