SOCIAL
HEALTH
PROTECTION
NETWORK

Institutional frameworks in the area of health financing systems

CAMBODIA Summary

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CONTENTS

1. BACKGROUND ... 3

1.1. Introduction ... 3

1.2. Documents ... 3

2. ANALYSIS ... 6

2.1. Constitutional/Legal/Governance Challenges ... 6

2.2. Political and Socio-Economic Challenges ... 9

2.3. Financial Challenges ... 10

Revenue Raising ... 10

Pooling ... 11

Purchasing ... 12

2.4. Collaborative Challenges ... 13

2.5. Human Resources Challenges ... 13

2.6. Health Information Challenges ... 14

3. WHAT IS NEEDED? ... 15

3.1. Strengthening policy frameworks by ... 15

Adopting conducive policies and strategic plans ... 15

Elaborating costing frameworks ... 16

Promoting equity in health system financing ... 16

Ensuring financial sustainability and the efficient use of resources ... 17

3.2. Strengthening legal and regulatory frameworks by ... 18

Adopting robust legislations ... 18

Adopting implementing/regulatory measures ... 19

3.3. Strengthening institutional frameworks by ... 20

Advocating for new investments ... 20

Establishing close monitoring and accountability for results ... 20

Aligning overall health system and health financing reforms ... 20

Transferring powers and resources to local authorities (decentralization) ... 21

Developing Public-Private Partnerships (PPP) and “contractual arrangements” ... 22

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1. BACKGROUND

1.1. Introduction

The P4H Network develops innovative collaborations in its role as an honest broker, whose mission is to promote, develop and strengthen exchange and collaboration for social health protection and health financing. In this context, a consultant, Virgile Pace, was engaged by the P4H Network Coordination Desk to review the institutional frameworks of ten countries. Virgile worked in countries where the P4H Network was engaged and collaborated with several members of P4H and P4H country focal persons (P4H-CFPs). The summaries Virgile produced were first intended to help familiarize P4H-CFPs with the countries and regions where they work to thus enhance their agency in facilitating their work with national stakeholders. The summaries will also be helpful to anyone interested in institutional frameworks related to SHP and HF in general and in the context of the selected countries.

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2. ANALYSIS

2.1. Constitutional/Legal/Governance Challenges[1]

- Health remains an important challenge and a development priority in Cambodia. Article 72 of the Constitution, dated 21 September 1993, recognizes the right to healthcare for all citizens of the Kingdom of Cambodia. Article 72 provides that: "The health of the people shall be guaranteed. The state shall give full consideration to disease prevention and medical care. Poor people shall receive free medical consultations in public hospitals, infirmaries and maternities. The state shall establish infirmaries and maternities in rural areas."

[1] The hierarchy of law in Cambodia is as follows starting from the highest level to the lowest level of legal force. The Constitution of the Kingdom of Cambodia (the "Constitution") is the supreme law in Cambodia. All laws, legal documents and state body decisions must adhere to it. A Law (Chbab) is adopted by the National Assembly ("NA") and the Senate and promulgated by the King or the acting Head of State. A Royal Decree (Preah Reach Kret) is an executive regulation issued by the King following a request from the Council of Ministers in order to organize the functioning of a public institution, create a new governmental body or appoint officials, ambassadors and judges. A Sub Decree (Anu-Kret) is used to clarify provisions within existing laws, set out the functions and duties of RGC bodies and appoint senior RGC officials. It is drafted within relevant ministries, approved by the Council of Ministers and endorsed by the Prime Minister. It is the most common governmental decision. Ministerial Orders or Proclamations (Prakas) are executive regulations made at the ministerial level to implement and clarify specific provisions within higher-level legislative documents and give instructions. Their scope is limited to the focus and subject matter of the ministry that enacted them. Decisions (Sech Kdei Samrach) are made by the Prime Minister or relevant ministers and are used for a temporary purpose. They disappear once their goal is achieved. A Circular (Sarachor) is issued by the Prime Minister or a Minister and provides instructions relating to certain legal or regulatory measures but is not legally binding. Local Regulations or Bylaws (Deika) are approved by local Councils at sub-national level. They have force of law within the territorial authority of the local Councils, thereby cannot conflict with other regulations at the national level.

- In the early stages after being reconstituted, the Cambodian Government invested significantly in healthcare programmes[2]. Social health programmes such as health equity funds (HEFs)[3], voucher schemes, voluntary community-based health insurance (CBHI) and private insurance were successfully implemented[4]. Social Security schemes were developed in particular for the following targeted groups: civil servants, veterans, people with disabilities, and workers and employees[5].
- In recent years, health financing policy has focused on reducing the barriers to utilising services particularly amongst the most vulnerable. The priority is to develop a comprehensive system of social protection based on social health insurance. Demand side financing policies including HEFs, vouchers and community health insurance have been complemented by supply side measures to improve service delivery incentives through contracting. In March 2016, the Government committed to achieving Universal Health Coverage (UHC), aiming at ensuring that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need with no financial hardship. Although the country has initiatives to provide financial protection to particular population groups, there is not a national system that provides universal health protection to the entire population and Cambodia's social protection system faces structural difficulties that affect the quality of care provided.
- In line with the strategic objective to progressively institute UHC, the Law on Social Security Schemes was adopted on 08 October 2019 to reinforce the healthcare's legal and regulatory framework. The Law replaced the Sub-Decree on the Setting up of the Health Insurance Scheme for those who are under the provisions of the Labour Law. The Law aims to establish social security schemes with a view

[2] Cambodia is confronted with both pathologies characteristic of developing countries (tuberculosis, dengue fever, malaria, etc.) and diseases more typical in prosperous societies (diabetes, cardiovascular diseases, cancer, etc.)

[3] Community-Managed Health Equity Funds (CMHEFs) were also developed to engage a wide range of community representatives from faith-based organizations, local authorities and public health service providers. They covered around 40% of Cambodia's health centres and happened to be more resilient to changes in management and decreased support by NGOs than other HEFs configurations. Today, community-participation arrangements for health may require reconsideration to enhance social accountability of hospital managers.

[4] There are four main forms of social health protection in Cambodia: (i) The HEFs are free-of-charge assistance schemes for people considered "extremely poor", e.g. unable to afford doctors' fees or trips to the hospital. It is the most extensive protection system in terms of the number of individuals covered. In 2018, the Cambodian government categorised 3 million people as extremely poor, which represents around 20% of the population. The prerequisite for this care is what is known as "IDPoor" status with an individual or family-based "membership" card issued as part of a comprehensive identification process; (ii) CBHIs constitute the voluntary insurance scheme for the informal sector. They constitute the second most important social health protection schemes. However, coverage is limited since only 1% of the population is insured by CBHIs; (iii) A third form of social protection, a mandatory scheme for the formal sector, e.g. social health insurance -SHI- is still under construction. The intention is for this type of insurance to be obligatory for people working in the formal sector; The last system is a private health insurance scheme that targets the wealthiest section of the Cambodian population, which represents approximately 0.1% of the population. This system is expensive but quite efficient, giving a reasonable level of social health protection to affiliated individuals. Other types of health financing schemes are also found in Cambodia although these remain minor in terms of coverage, such as maternal health vouchers, global health initiatives and national programmes for patients with tuberculosis, malaria, AIDS and for child vaccination schemes.

[5] The National Social Security Fund (NSSF), the National Social Security Fund for Civil Servants (NSSF-C), the National Fund for Veterans (NFV) and the People with Disability Fund (PWDF) were actually established to provide protection with regard to income insecurity which might result from illness, employment injury, disability, maternity or elderly.

to ensuring equity and social solidarity and promoting the welfare and livelihood of the whole population. The law introduces mandatory social security schemes with compulsory contribution for persons in public sector, former civil servants and veterans as well as persons employed under the labour law including personnel serving in the air and maritime transportation as well as domestic workers. All operations of social security schemes shall be coordinated, monitored and oriented in line with policy levels and strategies of the National Social Protection Council. The Law establishes regulations, standard operating procedures (SOP), and all necessary measures and guidelines required in particular to manage Social Security Funds. A Social Security Regulator is created to provide more transparency, accountability and financial sustainability in this regard. The organization and functioning of the Social Security Regulator is regulated by a Sub-Decree.

- The NSSF becomes the unique operator in charge of implementing social security schemes as stipulated in the provisions of the law[6]. NSSF is a public administrative institution established by Royal Kret under the technical tutelage of the Ministry in charge of social security schemes and the financial tutelage of the Ministry of Economy and Finance. NSSF should ensure the benefit provision of social security schemes to the NSSF members with the purpose to alleviate the hardship of their livelihood when they encounter the most common risks: maternity, illness or injury, elderly, invalidity, or unemployment. The NSSF should also collect and administrate contributions of each social security scheme and other incomes.
- Despite the adoption of the Law, emphasis should be laid on recurrent weaknesses: The coverage of social assistance and social security is limited in such a way that certain groups of population are not protected; The management of the various schemes is not always effective and efficient, leading to high cost and inconsistency of benefits and allowances for various target groups; The identification and registration of people, in particular the poor and vulnerable people, is still inappropriate, causing double identification/registration and overlapping provision of benefits.
- Institutional reforms have to be introduced. Public health service efficiency in Cambodia can actually be improved by strengthening the policy, legal and regulatory frameworks and by increasing the utilization of cost-effective services. This can be achieved by enrolling more beneficiaries into the social health insurance schemes with current supply-side financing levels. Other factors that can lead to increased efficiency are improving health service quality, regulating private sector providers, and

[6] The NSSF is a public, autonomous and self-financed institute under the Ministry of Labour and Vocational Training (MLVT). Daily operations are supervised by the MLVT while the Ministry of Economy and Finance (MEF) administers all finance-related issues. The NSSF protects everyone who works in Cambodia in an enterprise or establishment, trainees, apprentices and persons who are attending a rehabilitation centre, as well as seasonal. and occasional workers. Until the 2019 Law, the NSSF had provided social insurance under two schemes. The first was healthcare for employees relating to accidents at work. It was established by the first Cambodian Social Security Law, currently known as the Law on Social Security Schemes for Persons Defined by the Provisions of the Labour Law, passed by Parliament in September 2002. In 2016 a second scheme has been established to cover the personal (non-work related) injuries of registered persons. This social security scheme was established by Phase II of Healthcare, which was issued in the Rectangular Strategy Phase III of the Royal Government and established by Sub-Decree No. 01 SDE, dated 6 January 2016, concerning the Establishment of Social Security Scheme on Healthcare for Persons Defined by the Provisions of the Labour Law. Both schemes were linked and sufficiently comprehensive to ensure workers are protected.

incentivizing a referral system. In practice, the lack of knowledge or understanding of the concept of “insurance”, the low level of trust of legal institutions, the lack of “willingness to pay” for a hypothetical risk of disease, and the weakness of the medical infrastructure and public care services still explain why so few people are covered by a social protection scheme.

2.2. Political and Socio-Economic Challenges

- The trauma and devastation caused by the Khmer Rouge period and years of war have impoverished Cambodia, fragilizing its healthcare system. Limited and unequal access to quality healthcare is still predominant. Although an effort has been made by the Government to set up social protection systems, the majority of them have not yet been effectively implemented and the proportion of people covered by these insurance schemes remains very low. In 2019, the combined coverage of the four social health protection schemes amounts to less than 10 per cent of the population and the majority of Cambodians (89% of women and 92% of men) still do not have health insurance. Moreover, social health protection schemes usually cover the costs of primary care and hospitalisation, but these do not always extend to medicines.
- Since 2009, households in rural areas have consistently spent more on health[7]. Besides, in Cambodia, where social health protection is limited, a large proportion of households experience “distress financing”: poor households are constrained to borrow money with interest to pay for healthcare, potentially rendering them further indebted and exacerbating the financial consequences of healthcare costs.
- Though major improvements have been made in healthcare, important challenges still need to be overcome. Cambodia is one of the poorest countries in the Asia Pacific region, and rates of healthcare use are among the lowest in the region. The country is characterised by a highly fragmented health system with a dominant and growing private sector. While Government expenditure on health has recently increased, it remains low at just 1.4% of gross domestic product (GDP) and Total Health Expenditure (THE) is 6% of GDP in 2018 and has been increasing in the context of the country's high-growth economy and in the COVID-19 context[8]. Only about 20% of THE are covered by the Government, with another 20% funded by external Development Partners (DPs). Out-of-pocket (OOP) health expenditure by households is high (6% of total health expenditures), some of the highest rates in Asia. The increase in OOP spending may be attributed to more care-seeking coupled with higher

[7] In 2016, rural households spent US$ 232, whereas those in urban areas spent US$ 156. Males and females spent about the same amount on health from 2012 to 2015. However, in 2016, females spent US$ 55 and males US$ 41, which meant that females spent 1.3 times more than males. In 2016, people aged 60 years and above constituted 8% of the population, while accounting for 30% of health spending – US$ 156 per capita. Spending for this age group is likely to increase as the population ages and noncommunicable diseases become more prominent.

[8] Health expenditures are divided between public and private sectors and according to the Health Strategic Plan 2016 – 2020, there are approximately 1,000 public healthcare facilities and 8,000 private healthcare facilities or providers across Cambodia.

costs of care associated with the lack of social health protection schemes and preference for private sector[9].

2.3. Financial Challenges

- Regarding health financing reforms to accelerate progress towards universal health coverage (UHC), Cambodia is pursuing three strategic objectives: (i) To move towards a predominant reliance on compulsory (i.e. public) funding sources; To reduce fragmentation in pooling to enhance the re-distributional capacity of the prepaid funds; and (iii) To move towards strategic purchasing with the purpose to align funding and incentives with promised health services.
- Analysing fiscal space for health, e.g., the possibility to expand the health budget, is a priority, in particular taking into consideration the uncertainty about the future of health financing from donors[10]. It is also necessary to review allocations of national health spending in order to determine where and how the funds are channelled and used, and where efficiency can be improved. The very purpose is to help the Government with the prioritization process for distributing funds[11].

Revenue Raising

- Cambodia has three major health financing sources: (i) The Government's general revenues; (ii) Donors' development assistance; and (iii) OOP payments for receiving services. Tax revenue as a share of GDP is small, despite a slight increase in recent years[12], and there are no taxes earmarked for health, such as a "sin taxes".
- The Cambodian Government needs to urgently find additional budgetary resources in order to move towards UHC. If Cambodia has experienced strong (7,7%) economic growth over the past two decades (1995 -2017), the country's health budget has been increasing in absolute terms but not in real terms.
- Revenue raising options include increasing the contribution ceiling for the private employees' scheme and the progressive adoption of strategic purchasing.
- The National Social Protection Working Group led by the Ministry of Economy and Finance (MEF) has been tasked with advancing the development of a social health protection (SHP) strategy that will help Cambodia achieve its UHC goals. The contributory mechanism set up for the Social Security System under the new Law should serve as a source of domestic financing, thus helping to reduce the dependency on foreign financing and promote the development of the domestic securities market.

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[9] Overall, total OOP spending increased from US$ 534 million in 2009 to US$ 728 million in 2016.

[10] Decreased donor financing for national programmes requires proper preparation and transition measures. Future financing gaps need to be assessed to understand how much domestic financing is necessary to sustain the service coverage or programmes and the fiscal space available to support the transition towards domestic financing of different programmes.

[11] It is unlikely that the Cambodian Government will be able to increase the proportion of health budget out of its total budget in the short run with a predicted 7% economic growth per annum. The proportion of health budget is expected to remain the same, and the revenues raised through pre-payment mechanisms are still too small to benefit the current health system.

[12] Over the past five years, tax collection revenues have increased an average of 20% annually.

Pooling[13]

- Risk pooling is limited in Cambodia[14]. Community-Based Health Insurance (CBHI) schemes have been implemented in recent years, but they cover less than 1% of the population. Till 2019, formal sector social health protection schemes were not operational[15].
- The Ministry of Health (MOH) is currently working to improve pooling by considering expansion of HEFs to vulnerable groups other than the poor, such as the elderly, people with disabilities, and children under five[16]: the Cambodia's national Social Protection Policy Framework (SPPF) 2016–2025, which aims at developing and expanding social health protection schemes to achieve UHC, reconfirmed in Cambodia's highest level strategy document, the Rectangular Strategy Phase IV (2018–2023), clearly states that the Government will "focus on pushing for universal health coverage in Cambodia by expanding the coverage of [the] health equity fund"[17].
- The NSSF, under the Ministry of Labour and Vocational Training (MLVT), manages the civil servants (NSSF-C) and formally employed workers (NSSF-F) health insurance schemes. These schemes currently cover approximately 356,000 and 1.7 million people, respectively and, do not include dependents. Coverage under these schemes provides user fee reimbursements to all contracted public healthcare providers as well as some private facilities. NSSF reimbursement are on average 119% higher compared with HEFs rates.
- Since the recent promulgation of the Law on Social Security, a third scheme was introduced under the NSSF: the pensions scheme, aiming to provide income support to retired workers. This Law was followed by Sub-Decree No. 32 on the Social Security Pension Scheme, dated 4 March 2021, detailing the registration requirement, contribution rate and benefits for the individuals.
- Several micro-insurance organisations allow the most disadvantaged populations to have access to basic healthcare. The GRET for example, a NGO under French law, developed a health micro-insurance offer for the informal sector (SKY project) and offered female workers in the textile sector (HIP project)

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[13] Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable.

[14] In 2015, 2.6 million people, or 17% of the total population, were covered through social or voluntary health insurance or Government subsidies such as Health Equity Funds (HEF).

[15] Except for an injury scheme under the NSSF.

[16] The main activities of the HEFs are threefold: (i) managing and administering the scheme, including reimbursement of user fees for public healthcare providers for services provided to eligible poor patients, reimbursing transport costs for patients admitted at the hospital and providing food stipends when hospitalized, also for caretakers. In addition, proactively identifying hospitalized poor people missed by the IDPoor for eligibility to benefit from HEF services; (ii) promoting the scheme in the community, especially amongst intended beneficiaries, and receiving feedback on quality of services and care received; this information is obtained through outreach visits to discharged patients or by use of exit interview; and (iii) providing other support like counselling and addressing social issues.

[17] The SPPF is a long-term roadmap focusing on two main pillars: Social Assistance and Social Security. The Social Assistance is divided into four components: emergency response, human capital development, vocational training and welfare for vulnerable people. The Social Security consists of five components: pensions, health insurance, employment injury insurance, unemployment insurance and disability insurance.

compulsory health insurance[18]. The low level of premium and a very efficient network of hospitals and clinics, both private and public, made these micro-finance initiatives very popular, even with the extension of the NSSF.

Purchasing[19]

- In order to better allocate funds to providers of healthcare, the Cambodian Government is currently seeking to move from a passive approach to purchasing, characterized by providers automatically receiving funds in the form of budget allocations or payment independent of performance, to a more active or strategic purchasing[20]. This latter supposes to link the transfer of funds to providers, at least in part, to information on aspects of their performance or the health needs of the population they serve. The objectives of strategic purchasing are to enhance equity in the distribution of resources, increase efficiency, e.g. more health for the money, manage expenditure growth and promote quality in health service delivery. It also serves to enhance transparency and accountability of providers and purchasers to the population.
- The expansion of HEFs will increase demand-side financing whereas payment to providers is directly linked to service provision to the patient. This strategic purchasing approach should improve both provider and health system performance. For example, healthcare quality can be improved by linking reimbursements to both service provision and health facility quality scores.
- While HEFs have largely been viewed as a way of funding care for the poor, they can also improve the type of care provided through more careful purchasing of services on behalf of patients and in increasing quality improvement through selective contracting[21]. Benefit packages covered under HEFs include reimbursement for medical services in public facilities and other costs such as transportation, care-taker allowance, food, and funeral costs. Multiple mechanisms have led to fragmented financial management explaining why the Government is currently planning to reform the current provider payment system.

[18] In 2011, the SKY project covered nearly 73,000 vulnerable rural and urban families for US$5 per year. Following a change in the institutional context and in consultation with the MoH, the GRET transferred the SKY and HIP schemes in 2011 to local operators subsidised by the Government.

[19] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up will have significant implications for provider behaviour and efficiency.

[20] Provider purchasing mechanisms in Cambodia include line items from the Government budget, user fees, performance-based payments, case-based payments from the HEFs, capitation, case-based, and fee-for-service payments from small community-based health insurance, output-based payments to midwives for facility deliveries and subsidization of user fees from national programs, donors, and NGO.

[21] HEFs are implemented through a third party implementer and a third party operator according to a standard benefit package and payment mechanism.

2.4. Collaborative Challenges

- There are fundamental differences in how DPs operate: The World Bank and GFF pursue a comprehensive approach to health system strengthening. Gavi and the Global Fund focus on targeted technical interventions in line with their disease-specific mandates[22].
- Coordination and alignment among DPs are complicated by the fact that Gavi and the Global Fund do not have a presence in the country.
- Because effective health financing for UHC requires a comprehensive approach, also through collaboration and coordination with actors from beyond the health sector, several DPs – including GIZ – came together to form the Health Financing / Social Health Protection Network (P4H) in Cambodia.
- In view of harmonizing DPs' work, facilitating and fuelling the dialogue among DPs and governmental institutions is a core challenge that P4H Cambodia has ahead. This challenge is pointed out in the highest strategy document, the Rectangular Strategy Phase IV (2018-2023), which fosters key national and international actors to efficient collaboration and alignment of resources.
- P4H has been active in Cambodia since 2013. This long-lasting presence has enabled P4H to pursue its mission of promoting, developing and strengthening exchange and collaboration for health financing and social health protection. A tangible example of this fruitful collaboration is the establishment in 2017 of P4HC+, a local platform represented by organisations that have joined P4H at global level and bilateral and multilateral organisations that provide technical and financial support in Cambodia to activities for health financing and social health protection towards universal health coverage.

2.5. Human Resources Challenges

- Health facilities lack sufficient human capital and resources, which prevents them from meeting the needs and expectations of the population. However, a significant success has been achieved in rebuilding the health workforce since 1979, after the Khmer Rouge[23].
- The main provider of primary healthcare in Cambodia is the private sector and two-thirds of public health staff also work privately. The low remuneration of Government health workers and the general shortage of health professionals, remain major problems. As a result, many public health sector employees work for both the public and private sectors.
- In line with its Health Workforce Development Plan Strategy 2006 - 2015, Cambodia is committed to strengthen pre-service education as a pillar to improving quality of new graduates. Centers for Development of Health Profession (CDHP) should also be further developed. In addition, the Government has set up a Licensing and Registration System for Health workforces whose very purpose

[22] While the World Bank and GFF are guided by the principles of performance-based financing that ties the release of funds to the achievement of results, Gavi and the Global Fund provide traditional input-based funding on the assumption that better outcomes follow from better inputs and processes.

[23] Major human resources planning documents included the 1995 Health Coverage Plan and two Health Workforce Development Plans for 1996-2006 and 2006-2015.

is to improve quality care services to the population with the delegation and empowerment to the professional councils.

- Financial and training incentives have been introduced recently to deploy and retain health workers in remote and underserved areas. Ensuring appropriate employment and distribution of qualified health workforces across the territory will strengthen equity access and safety of population. In addition, focus has been placed on developing the capacity and capability of stakeholders at central and governorate levels to ensure an effective coordination and governance of human resources for health services.

2.6. Health Information Challenges

- Cambodia's Health Management Information System (HMIS) was formally launched in 1993 and then migrated over to a web based database in 2010[24]. The HEFs database was developed in 2004 at individual referral hospitals and since 2012, all HEFs Operators have successfully transitioned their activities into the Patient Medical Registration System (PMRS).
- A Health Information System (HIS) Master Plan has been developed for 2016-2020 by the Health Information System Bureau of the Department of Planning and Health Information (DPHI) of the MoH. Main objective is to provide harmonization with national health needs and plans (such as health information needs and health strategic plans) and to foster coordination between multiple sector stakeholders.
- Information collected serves to inform policy-making. For example, based upon the inputs provided, the need to draft new legislations and regulations concerning storage, privacy, confidentiality, security, retrieval and use of patient medical records, has been pointed out. Likewise, introducing a clear policy and law enforcement for private sector reporting, improving compliance by private sector health facilities through education, advocacy and legal measures, and follow up of private providers have emerged as core priorities
- Building capacity in Cambodia to routinely produce data on health expenditure is also a core objective to generate accurate and timely data on expenditure by source, provider, factor of provision, health-care function, disease, age and sex. The very purpose is to support monitoring and evaluation of policy goals, track household OOP spending and inform resource allocation by comparing health expenditure with the burden of disease.
- National Health Accounts (NHA) produces robust health expenditure data that are used to monitor health system performance and inform policy-making on resource allocation and prioritization. Tracking of health expenditure allows for measuring the progress of health reforms, informing

[24] HIS 3.0 version is in use since 2015

evidence-based health policy, monitoring the efficiency of resource allocation and encouraging accountability[25].

3. WHAT IS NEEDED?

3.1. Strengthening policy frameworks by

Adopting conducive policies and strategic plans

- The MoH launched its first Health Coverage Plan in 1996. It divided the country into operational health districts (ODs)[26]. The same year, the Government endorsed the National Charter on Health Financing, which allowed public health facilities to levy nominal user fees with the approval of the MoH[27].
- Many interventions were thereafter developed to enable the population, or specific subgroups, access to selective health services or a comprehensive package of care[28]. This plethora of interventions and schemes, often with different designs and a variety of operators and implementers, resulted in considerable fragmentation and impaired the oversight and regulatory capacity of MOH.
- Developing clear financial policies for the NSSF is today a priority, in particular in light of the lack of clarity regarding its governance structure[29]. Recommendations include to establish the periodical performance of actuarial reviews and to adopt explicit Funding and Investment policies for each of its branches. This aims at formalizing the long-term funding objectives of the scheme, better understanding the risks and advantages of financing options and enhancing corporate governance by increasing transparency[30].

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[25] The NHA report is used as an input for data analysis, and results are disseminated widely to encourage dialogue around the findings, which is critical for policy application.

[26] The Health Coverage Plan was soon accompanied by Guidelines for Developing Operational Districts (1997), which specified the roles and terms of reference for all institutions within ODs and reinforced the district health system concept.

[27] User fees were designed to formalise payment arrangements and provide facilities with additional income. The fees were set in accordance with the population's capacity to pay and exempted the poor.

Fixing fees with clear exemptions was designed to make fees more transparent and predictable. Retention of a large proportion of the revenue by facilities was supposed to improve services but it also encouraged facilities to collect from those that are unable to pay.

[28] HEFs were successively established to safeguard the positive effects of user fees on service delivery while enabling access to public health care by the poor at the same time.

[29] The NSSF sits technically under the Ministry of Labour and Vocational Training (MoLVT) and financially under the Ministry of Economy and Finance (MEF). According to the law, the NSSF is governed by a tripartite board of directors, comprising representatives of workers, employers and Government. The Governing Body has, among others, the authority to approve the contribution rate of each benefit, determine investment, set its administrative structure and establish internal regulations on personnel statute, recruitment and incentives. The NSSF draws this authority from its status as an Institution of Public Administration, which makes it a legally and financially autonomous entity. However, in practice, the NSSF seems to continue to operate as a Department of the MoLVT. The limitation to act on the functions listed above constitute a key structural challenge for the Fund to operate efficiently.

[30] The development of such functions will require the adaptation of the administrative structure. It is recommended that the setting up of new units such as Human Resources and Investment are considered under the appropriate departments.

- One of the main challenges faces by the NSSF is to adapt its existing mechanisms to all employment arrangements, in particular in the informal economy. This is all the more complicated that these contractual relationships vary according to industries and employment type.

Elaborating costing frameworks

- Awareness about the costs of health services is a prerequisite to delivering these services effectively and efficiently in the context of limited financial resources. The results of costing exercises both inform development of the health strategic plans, and contribute to the evidence base for improved budgeting, resource mobilization strategies and stronger overall public sector financial planning.
- Elaborating costing frameworks allows managers at health facilities and administrative entities for delivering optimal health care by facilitating accurate planning and budgeting, as well as efficient resource allocation[31]. Cost projections for the health sector have already been done using the OneHealth tool during the development of the third national health strategic plan 2016–2020[32]. Likewise, the establishment of a routine health service costing system among a nationally representative sample of public health facilities appears feasible in Cambodia. Experiences aiming at improving recording, stock-keeping and accounting procedures have already been carried out in this regard[33]. Information on service costs by health facility level can provide useful information to optimise the use of available financial and human resources.
- It should be noted, however, that the unavailability of data at the health facility level, and the lack of personnel with the necessary skills to reliably conduct the assessments still jeopardize appropriate and updated costing analyses in Cambodia. They are rare and infrequent.

Promoting equity in health system financing[34]

- Crucial issues to be dealt with are the equity implications of the different financing mechanisms. Main challenge remains to determine what is the best mix of financing mechanisms to protect people outside the formal employment sector.
- HEFs have improved access to health services of the poor, reduced OOP spending and household health related debt, and increased public health facilities utilization. However, HEFs may not be sustainable in the long-run.

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[31] Social health protection schemes can for example use knowledge of health service costs to determine reimbursement rates and improve purchasing, thereby potentially improving the quality of care

[32] The MoH estimated the needed and available resources to implement the strategic plan through a consultative process. Cost estimates covered implementation of health programmes including commodities and programme management costs. A financial space analysis indicated that Government and donor funding jointly could be sufficient to cover the cost of the strategic plan from 2018 to 2020.

[33] For example, variations in costs per service and patient contact were observed between similar health facilities and within provinces, and costs increased by health facility level, suggesting the need to reinforce the referral system.

[34] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

- Introduced from 2007, vouchers are complementary to equity funds. They provide incentives to access lower levels of the health system and address non-facility financial barriers to care[35]. If qualitative studies pointed out that the voucher programme was popular because it provided a guarantee of reimbursement including covering transportation costs, an important factor discouraging voucher use was the confusion with other programmes as well as the precise procedure for qualifying[36].
- A priority for the MoH is improving efficiency and equity in the distribution of resources, as well as transparency and accountability. From this point of view, it is important to continue routine monitoring of OOP spending on health, given its implications for equity and efficiency, as a measurement of performance of social health protection schemes. The results of monitoring also support assessment of progress towards UHC and Sustainable Development Goal key indicators[37].
- Cambodia is currently exploring new financing mechanisms designed to promote access to effective and affordable healthcare for its population, especially the poor. These include internal contracting and a Government midwifery incentive scheme to boost facility deliveries, voluntary health insurance schemes targeting the informal sector as well as a range of voucher schemes designed to increase the uptake of reproductive and safe motherhood services by poor rural communities.

Ensuring financial sustainability and the efficient use of resources

- Performance-based financing (PBF) is increasingly deployed in low-income and middle-income countries with the aim of raising the quantity and quality of health care delivered. PBF involves paying providers, at least partially, on the basis of what they deliver, rather than allocating budgets in relation to historic costs or inputs. PBF offers incentives intended to redress the underperformance, notably high worker absenteeism, frequently observed in poorly funded public health systems that lack accountability.
- Cambodia was the first low-income country to experiment PBF for public health care. Since 1999, a variety of programmes have contracted the management of district health authorities to NGOs and made the funding of districts and facilities contingent on performance targets[38]. These arrangements are intended to increase healthcare provision, particularly of maternal and child health services. Performance based financing initiatives have been a central part of attempts to improve the delivery of health services. These initiatives have been implemented through the use of contracting models

[35] Vouchers cover costs of family planning, antenatal, delivery and postnatal care and also provide reimbursement for transport to reach the facility for these services. Government and non-government facilities must be accredited by the programme in order to receive reimbursement which may stimulate competition to improve quality and expand choice to patients. Some voucher schemes are targeted at the poor while in other cases all are entitled to benefit.

[36] It should be noted however that the overlap between financing mechanisms is often deliberate since aspects of one mechanism are meant to enhance or complement those of another. Vouchers, for example, enhance the effect of equity funds by covering demand side costs and services below hospital level.

[37] Such monitoring may be conducted as part of the National Health Accounts and the Annual Health Financing Report by the MoH, and the results should feed into the evaluation of national policy reforms and health-related strategies and plans.

[38] or directly linked revenues to services delivered.

that permit health facilities to manage resources and receive funding in a way that is distinct from the Government's line budgeting system.

- To avoid that the poorest are left behind when average rates of utilization are raised, it is necessary to combine PBF with demand-side mechanisms that waive the cost of user fees.

3.2. Strengthening legal and regulatory frameworks by

Adopting robust legislations

- Lack of regulation has led to abuses in the pricing of services and the quality of prescriptions[39]. A true and authentic legal and regulatory framework is available only for the marketing and promotion of healthcare services and products[40].
- With regard to social security schemes, till the adoption of the 2019 Law on the Social Protection System, the existing legal instruments provided only a framework to operate compulsory pension schemes[41]. To ensure an effective, transparent and accountable governance and management structure, the Government has developed a legal framework for supervising the implementation of all public pension schemes in the new 2019 Law. But a legal framework for the management and operation of voluntary pension schemes still has to be established in a separate regulation from that law. In addition, establishing a tax policy related to social protection transactions is necessary. This would provide for additional options for the investment of the social security fund.
- The development of a social health insurance system actually required a genuine and comprehensive legal and regulatory framework to establish operational standards, especially with regard to the roles and responsibilities of main stakeholders, financial management procedures, financial resources, contribution rates, benefit packages and customer protection. It was also necessary to provide for mechanisms ensuring a certain level of quality, integrating social security operators, and specifying the roles of different regulators to ensure the smooth and effective operation of the whole system.
- Laws and regulations about facility management, quality standards, and monitoring are not uniformly implemented or enforced. As the private sector is key to improving equitable and sustainable access to high-quality healthcare, the MoH should improve dissemination, implementation, and enforcement

[39] Informal fees are for example often added to the formal costs of care.

[40] See in particular: the Law on Management of Private Medical, Paramedical, and Medical Aide Profession promulgated by Royal Kram No. NS/RKM/1100/10 dated 22 November 2000; the Law on Management of Pharmaceuticals promulgated by Royal Kram No. NS/RKM/0696/02 dated 17 June 1996; the Law on Amendment of the Law on Management of Pharmaceuticals promulgated by Royal Kram No. NS/RKM/1207/037 dated 28 December 2007; Prakas No. 028 on Private Practice Advertisement in Medical, Paramedical and Medical Aid Practices dated 23 August 2004; Prakas No. 0053 dated 6 February 2009 amending Prakas No. 083 on Conditions of Advertisement of Pharmaceutical, Curative and Preventive Products dated 31 March 1999; and Joint-Prakas No. 007 between the Ministry of Health and the Ministry of Information on Conditions of Advertisement of Modern Medicines, Traditional Medicines, Cosmetics, Feeding Products for Infants and Children, Tobacco and Private Medical, Paramedical and Medical Aid Services dated 21 February 2006.

[41] The level of benefits or other allowances facilitating voluntary exits for civil servants have not been fully considered and amended to reflect social changes and recent developments in the public administration system.

of regulations. It is necessary to further clarify and disseminate roles and responsibilities of entities and health levels. For example, although regulations regarding hospital management and clinical care exist, providers are not clear about the roles and responsibilities of different government agencies or professional councils.

Adopting implementing/regulatory measures

- Like other countries that have made significant progress toward UHC, Cambodia must consider how to effectively engage private providers to expand access to healthcare, while ensuring that appropriate regulations are in place to promote quality of care. The MoH now aims at regulating the private sector more effectively by putting in place required licences and strengthening law enforcement[42]. If Cambodia's private sector is already a significant provider of healthcare services and must play a major role in achieving UHC[43], the current policy and regulatory environment is oriented more toward the public sector[44]. Policy-makers should now identify opportunities to improve engagement with private sector providers and strengthen the whole health system.
- In addition, the MOH should extend or modify the complementary package of activities to include private health facilities. Public and private facilities should be subject to the same clinical practices and standards of care[45].
- In accordance with the Health Strategic Plan 2016–2020, the MoH currently aims at strengthening regulatory mechanisms to enhance continuous quality improvement efforts. Quality of care in both public and private facilities remains actually inadequate. Improving quality of care requires a comprehensive legal and regulatory framework together with appropriate engagement and enforcement mechanisms to ensure that laws and regulations are implemented.
- Regulation of healthcare professions in Cambodia is still hindered by limited understanding and lack of enforcement of professional councils' regulatory authority. The MoH is currently in the process of drafting a law on the management of healthcare facilities and services, pharmacies, dentists, paraclinics, and supporting medical services.

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[42] An assessment has been carried out recently to determine how existing laws and regulations are implemented and perceived in the private health sector. The purpose was to figure out what laws and regulations currently govern the private health sector, how these measures are being implemented, what gaps exist, and how regulatory mechanisms can be strengthened. The analysis explored laws and regulations pertaining to opening, operating, or transferring ownership of a private health facility, including accreditation, facility management, and quality assurance, as well as interaction between private facilities and government entities.

[43] The private sector dominates the provision of outpatient curative consultations while the public sector provides most preventive and inpatient services.

[44] Both the HEF, which focuses on reducing financial barriers to accessing care for poor and vulnerable populations, and the NSSF, which manages social health insurance schemes for private sector employees and civil servants, provide services almost exclusively through public sector providers. It should be noted, however, that in 2018, the NSSF did begin contracting with private providers.

[45] Where guidelines on the complementary package of activities are not applicable, standard guidelines for public and private facilities should be developed in collaboration with providers.

- Improving the quality of care is now the most pressing need in health-system strengthening. For the private sector, it poses the immediate necessity for extended regulation, accreditation and enforcement. Actually, while the private sector continues to dominate curative health care delivery, private providers remain insufficiently regulated[46].

3.3. Strengthening institutional frameworks by

Advocating for new investments

- Channelling a proportion of future budget increases to the health facilities through HEFs expansion and rate alignment would inject new investment to financially incentivize efficiency and quality.

Establishing close monitoring and accountability for results

- Facility monitoring is inconsistent, with inspections happening less frequently than required and not in accordance with a standardized inspection checklist. Lack of standardized tools and requirements for monitoring and inspection compromises their perceived objectivity and benefits.
- There is also a need to further clarify which agencies are responsible for monitoring and inspection and to strengthen these agencies' enforcement capacity. To avoid conflict of interest, an independent department for inspection within the MoH should be established.
- Clarifying reporting requirements and enhancing data use is also core to Monitoring and Evaluation (M&E). Developing review, analytical, and feedback processes for routine reports is necessary to monitor quality. Data collected can be used for example to ensure that clinical activities align with service delivery standards and service guidelines for each facility level[47].
- The General Secretariat for the National Social Protection Council is tasked with developing the M&E mechanism. It should comprise a system for data collection for analytical purposes and program monitoring to capture key indicators such as coverage expansion, efficiency and quality of services, access to benefits and investments[48].

Aligning overall health system and health financing reforms

- Advancing alignment of the international financing institutions with national health priorities and systems is a core challenge. An option could be for the DPs to channel their funds through Cambodia's

[46] In the meantime, the MoH and donor partners should direct their efforts principally towards attracting patients to the public sector, where average cost per visit is considerably less to receive treatment under controlled conditions.

[47] Routine reports can also be used to monitor whether facilities have unusual levels of morbidity or mortality.

[48] The M&E mechanism consists of three main components: (i) the Decision on the Implementation of the Social Protection System Monitoring and Evaluation Mechanism to define the stakeholders' obligations and reporting indicators; (ii) the Operational Manual to define logical framework and levels of input, output, outcome, and impact indicators; and (iii) the Management Information System (MIS) to facilitate a web-based data entry, automatic calculation, and graphic display of the result indicators.

health financing mechanisms instead of managing grants through their own procedures. It would provide for more efficiency[49].

- To push for greater alignment: If the country's institutions were unable to access and use RSSH resources efficiently and timely enough through the Global Fund's systems, why not route the money directly through the government's existing health financing setup? Later in 2019, when several development partners commissioned an 'options analysis' for how to structure Cambodia's proposal for the upcoming Global Fund funding cycle (2021-23), Jacobs and a group of consultants came up with a practical suggestion for how this could be done.

Transferring powers and resources to local authorities (decentralization)[50]

- The Cambodian Government recently engaged in reforms for administrative deconcentration and political decentralization. The Government has just decided to transfer $166 million to municipal and provincial administrations to manage their respective health service provision[51].
- Nevertheless, the administration of the public health system in Cambodia is still centralized at the level of the MoH, as with other Government ministries[52]. To date, local autonomy is insufficiently articulated within this system. In 2001, the Government initiated a process of political decentralization through two laws: the Law on the Administration and Management of Communes and the Law on Commune Elections.
- The MoH is responsible for governing healthcare, the healthcare industry, public health and health-related NGOs. It governs and regulates the activity of medical professionals, hospitals and clinics in the country. On a local level, the public health service is provided by the 24 provincial health departments, which themselves manage a provincial hospital and govern several operational health

[49] For example, the Global Fund's grant allocation for Resilient and Sustainable Systems for Health (RSSH) was US$ 6 million for Cambodia for the 2018-20 period. By half time, in mid-2019, only 12% of the budgeted amount had been spent. A portion of the new RSSH grant could flow through the HEFs for work streams in line with the Global Fund's mandate such as supporting health facilities to improve quality of care for providing HIV, tuberculosis and malaria services.

[50] Decentralization is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. There are at least three aspects of decentralization: devolution, deconcentration and delegation. Devolution is the transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions. Deconcentration is the transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local). Delegation is the transfer of authority and responsibility from central government ministries to organizations not directly under the control of those ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments.

[51] The Government has issued a sub-decree to transfer over 20,000 health officials, and the budget of $166 million to municipal and provincial administrations. Through the sub-decree, the MoH is cooperating with concerned institutions to prepare for the utilisation of the transferred officials and budget. This reflects the Government's effort in promoting decentralisation and deconcentration principles for the public services.

[52] More than 70% of the health budget is managed centrally, e.g. allocated principally to salaries and the procurement of drugs and medical supplies. District health care is underfunded. However, it should be pointed out that the decentralization of resources to service-delivery level is gradually improving, with an increasing share of budget disbursed through Health Centres and Referral Hospitals.

districts. Responsibilities for implementation and service delivery are also assigned to MoH officials at provincial and district levels.

- The MoH is undertaking several reforms to transfer more effective powers to local authorities regarding health financing. For example, it has developed a system to institutionalize the NHA process by building more local ownership and engaging various ministries, provincial-level representatives and agencies to develop the NHA. Generating NHA data is actually a collective responsibility that requires coordination and inputs from multiple stakeholders, including provincial-level support.
- Under the three-tier health system, the MoH activities are administratively deconcentrated but with considerable upward accountability to central level and limited decision-making discretion at provincial and district levels. A first step towards more effective deconcentration has been to convert almost one quarter of health Operational Districts (ODs) and Provincial Hospitals to the status of Special Operating Agency (SOA). SOA status was established as one part of the Government's 2006 Policy on Public Service Delivery as a means to provide greater management autonomy to district health and hospital managers through internal contracting arrangements and community monitoring.
- A possible consequence of the national decentralization process is a potential move away from the health ODs model and a return to the management of public health-care delivery through the Government's official Administrative Districts. The move would require the MoH to engage in a mapping exercise of functions and associated resources to prepare for the transfer of administrative duties to the subnational level. This in turn would require devolution of the responsibility for health plans and budgets to health officials working at the Administrative District level (replacing the ODs), ensuring dissemination of health information to local authorities, and promoting community monitoring of health services.

Developing Public-Private Partnerships (PPP) and "contractual arrangements"[53]

- Experiences from other sectors in LMICs have pointed out how critical it can be to use contractors to improve the effectiveness and efficiency of the delivery of primary healthcare services in resources-limited countries.
- In some cases, such as malaria, tuberculosis or immunization services, PPPs have already been developed in Cambodia to standardize quality of care and establish pathways between the public and private sectors. Provision of Primary Health Care (PHC) services only via the public sector providers has actually laid emphasis on strong limitation in Cambodia due to recurrent obstacles e.g., shortage of human resources, inefficient institutional frameworks, inadequate quality and efficiency due to a

[53] PPPs are voluntary cooperative arrangements between two and more public and private sectors in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks and responsibilities, resources and benefits. The flexible nature of PPPs provides a framework for developing and adapting existing structures to meet the specific needs of each project. PPPs can have a large scope of interventions: the establishment of a sustainable financial system, capacity-building reforms, management reforms in the public and private sectors, cost control, improving the health of the community, facilitating socio-economic development, and improving PHC services coverage, quality, and infrastructure.

lack of competition, particularly in remote and rural areas. Initiatives such as contracting with NGOs to provide primary health-care services and improve the immunization status of children from poor households have already shown to be successful[54].

- Three delivery models have emerged in Cambodia with regard to contractual arrangements, based upon initiatives conducted at districts level: (i) "Contracting-out" model, in which the contractors have complete line responsibility for service delivery[55]; (ii) "Contracting-in" model, in which the contractors work within the Government's system to strengthen the existing district administrative structure[56]; and (iii) "Government model", in which the management of services remains with the Government, and drugs and supplies are provided through normal Government channels.

[54] From this point of view, it has been demonstrated that living in a "contracted area" is related to a more equitable distribution of immunization coverage.

[55] Including hiring, firing and setting wages, procuring and distributing essential drugs and supplies, and organizing and staffing health facilities.

[56] The contractors could not hire or fire health workers, though they could request their transfer. Drugs and supplies were provided through the normal Government channels.