WORKING PAPER

Toward universal health coverage: the Cambodian experience formulating a health financing policy

Summary

Universal health coverage is high on the international policy agenda, and appears set to become the post-2015 overarching sustainable development goal. Achieving universal coverage is by no means an easy undertaking that can be attained in a relatively short time period, and as such requires a roadmap. Despite its relevance, surprisingly little has been written about the process of developing and formulating a health financing policy.

In Cambodia, the Ministry of Health has stated the processes and interventions it intends to use to achieve universal health coverage in a health financing policy. This essay provides an overview of the Cambodian health financing policy formulation process, by applying a modified analytical framework that covers priority setting, policy option formulation and appraisal, and policy finalisation. Formulation of policy options was steered by the policy's vision as well as its guiding principles. In addition, this process was informed by a comprehensive situation analysis. Policy formulation happened in a relative short time period, and involved extensive stakeholder consultations for general guidance in tandem with teasing out more detailed options by a core group of technical people.

Processes related to the endorsement or rejection of the policy by upper legislative bodies are not discussed, although caution was applied to consider political actors' viewpoints during formulation. This should facilitate positive receipt of the document by them.

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Introduction

Universal health coverage (UHC) is increasingly embraced by the global health community. It is the subject of World Health Organization and United Nations declarations, and is often mentioned as the post-2015 overarching sustainable development goal for health (Vega 2013). Many low- and middle-income countries (LMICs) are seeking ways to ensure that their populations can access health care at affordable costs. High-income countries, the United States of America being the exception, achieved UHC through a combination of insurance and taxation, the proportions of which depended on their political nature and degree of economic development (Carrin et al. 2008).

The move towards UHC in high-income countries was triggered by social movements of the early 20th century and resulted in the establishment of social health insurance systems financed by contributions from employers and employees. General taxation filled deficits, or entirely financed public health services (Wagstaff 2010). In general, the limited revenue base of governments, together with technical and political factors, determined the policy options selected to accomplish UHC. Limited fiscal space to finance large social health protection schemes from general revenues, together with political considerations, may partly explain the preference of decision-makers to contributory systems of UHC. Such approaches can be lengthy, as illustrated by Carrin and James (2005); countries such as Germany, Belgium and Japan required more than 100 years to achieve UHC. Nevertheless, in industrialised countries the path towards UHC was facilitated by a large formal sector where social insurance contributions and other taxes could be levied to raise the required financial resources.

Over the last decades, some LMICs have shown that rapid gains can be made toward UHC if governments and international partners assume more holistic approaches to financing and equitable delivery of health care (Gottret et al. 2008). Transposing high-income countries' current social health protection models on LMICs is likely to result in a two-tier system whereby the salaried workforce and their dependents benefit from health insurance, while the remainder of the population relies on out-of-pocket (OOP) payments to access health care (Gwatkin and Ergo 2011). This is because a considerable proportion of the workforce in LMICs is in the informal sector, without the benefits of a regular salary coupled to a tax system which is also likely to be underdeveloped. The reliance on OOP expenditures for health care is a major cause of impoverishment (van Doorslaer et al. 2006; Xu et al. 2003).

This situation also prevails in Cambodia, a low-income country, where the Ministry of Health (MOH) decided to formulate a comprehensive health financing policy (HFP) as a guide to achieving UHC. Here, we provide an overview of the process for developing the HFP, something that is hardly covered in existing literature (Gilson and Raphaely 2008).

Health financing in Cambodia

In 1996, the Ministry of Health launched its Health Coverage Plan, which divided the country into operational health districts (ODs). Based on population coverage, ODs were the cornerstones of public health service delivery. 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. Also in 1996, the government endorsed the National Charter on Health Financing, which allowed public health facilities to levy nominal user fees with the approval of the ministry (Ministry of Health 1996). The fees were set in accordance with the population's capacity to pay, and exempted the poor. Ninety-nine percent of user fee revenue was retained at the health facilities, and 49% (currently 59%) could be used as staff incentives. Contrary to the experience of other LMICs, utilisation of health services initially increased at public facilities that charged user fees (James et al. 2006). This phenomenon was attributed to a reduced tendency of staff members to request under-the-table charges, in tandem with an increase in perceived quality of care, especially interpersonal skills (Barber et al. 2004). However, fee waivers for the poor were extremely limited, ranging from 1% in a district hospital to 3% in a provincial hospital (Jacobs et al. 2007), and studies suggested that user fees discouraged the poor from seeking care at public hospitals (Jacobs and Price 2004).

Nevertheless, attracting patients to the public sector, especially those in the lower socioeconomic segments of society, is a step towards financial protection, as OOP expenditures at such facilities are considerable lower than in the private sector (Van Damme et al. 2004, World Bank 2013). The private health sector, composed of various qualified and unqualified health providers, is the main source of health care in the country but remains largely unregulated (Meessen et al. 2011). Thus, to safeguard the positive effects of user fees on service delivery while concurrently enabling access to public health care by the poor, health equity funds (HEFs) have been established throughout the country (Ir et al. 2010). Health equity funds are third-party schemes that reimburse selected public health facilities for services rendered to the poor, and are operational in 52 of the country's 81 ODs (2013 data). The initiative enjoys considerable government support (MOH 2013) and is scheduled for nationwide expansion by 2015. The poor are identified through proxy means testing under the guidance of the Ministry of Planning (Ministry of Planning 2008).

Besides HEFs, a variety of health financing interventions have been or are operational in the country, including performance-based financing (Jacobs et al. 2012), community-based health insurance for the non-poor informal sector (Jacobs et al. 2008), and vouchers for reproductive health services (Ir et al. 2010). Cambodia also initiated a pilot programme by which nongovernmental organisations (NGOs) managed ODs on behalf of the government (Loevinsohn and Harding 2005). This initiative was transformed into internal contracting, known as special operating agencies (SOAs), by which public service delivery organisations are provided with a degree of autonomy, delegated by MOH, over management of human and financial resources (Kim and Annear 2013). Staff performance is crucial to the success of SOAs, and is achieved by applying performance incentives and sanctions. To date, 26 ODs and 10 provincial hospitals have SOA status. Institutes applying for SOA status are assessed along specified eligibility criteria.

A social security scheme for salaried private sector employers and employees started in 2007, and focuses on three main areas: employment injury insurance, social health insurance, and pensions. These make up the National Social Security Fund (NSSF), under the administrative authority of the Ministry of Labour and Vocational Training and governed by a tripartite board of directors comprised of representatives of workers, employers and the government (International Labour Office 2012). At the time of writing, only the employment injury scheme is operational. The health insurance is in a pilot phase, operating on a voluntary basis in 10 garment factories. A similar fund for civil servants and veterans was established in 2008 under the Ministry of Social Affairs, Veterans and Youth Rehabilitation, although only its pension programme was operational at the time of writing.

Issues related to health financing and social health protection for the informal sector fall under the responsibility of the Department of Planning and Health Information (DPHI) of MOH. With guidance from this department, the inter-ministerial Social Health Protection Committee formulated the Master Plan for Social Health Protection, intended to serve as a guide for integrated planning and coordinated implementation of all such schemes under their respective ministries (MOH 2009). This document built on the second Health Financing Strategy, and called for the consolidation of existing schemes under a national social health protection system. Despite providing some guidance towards achieving UHC, it lacked detailed policy statements for the different functions and dimensions of UHC. To respond to this challenge, a health financing policy that built on the latest international evidence and Cambodian developments was needed.

Methods

This paper addresses the issue of health financing policy formulation, and uses participants' observations as its main study method. All authors were involved in the entire HFP formulation process. As the focus of the paper is on the formulation of HFP, we explain the framework used for the situation analysis, but provide the respective findings as an annex.

Situation analysis framework

To assess the country's performance/ability to achieve UHC, a framework was developed based on the generally accepted functions of health financing, namely: resource mobilisation, pooling and purchasing (Kutzin 2000). Optimal performance of these functions is perceived to be conducive to attaining UHC (Mathauer and Carrin 2011). We also took into account the fact that focusing only on securing financial resources is insufficient to achieving UHC (Hsiao 2007, Kutzin 2013).

Carrin and James' (2005) analytical framework, developed to assess the performance of social health insurance, formed the basis for our evaluation of the Cambodian health financing system against its three core functions. We added the overarching function of stewardship (Mathauer and Carrin 2011, Kutzin 2000) and modified health financing objectives from Kutzin (2008), Gottret and Schieber (2006) and McIntyre (2007) as performance measures. Instead of taking a social insurance scheme perspective, as applied by Carrin and James (2005), we took a systems approach (Kutzin 2013). Also, instead of mainly focusing on the availability of required financial resources to enable UHC, we chose to focus on optimising available resources, as advanced by Kutzin (2013).

The performance measures used to analyse the health financing system were: financial risk protection, equitable and sufficient funding, equity in utilisation, quality of health services, efficiencies (allocative, technical and administrative), benefit package, provider payments, regulation and information for policy-makers. Table 1 presents these performance measures by health financing functions, together with respective indicators. The choice of the latter was iterative, formulated from research into available peer-reviewed and grey literature relating to Cambodia and the health system building blocks.

Health financing policy formulation process

To describe the HFP formulation process, we applied the analytical framework first proposed by Hercot et al. (2011) to assess the soundness of user fee exemption policies for population groups. We modified this framework to capture process elements related to formulating a comprehensive HFP. The major difference between the original framework and ours is the number of issues to consider; while the exemption of population groups from user fees concerns one clear policy option, a UHC health financing policy has a wide range of options to consider.

We respected the three sections of the original framework in Hercot et al. (2011), but modified the respective practices as shown in Table 2. In the third section, option formulation and appraisal, we grouped the original seven practices into three to reflect their interrelatedness when formulating health financing policy. This results from the breadth of issues to consider, which requires concurrent reflection on cause, effect and the impact of decisions. The policy option formulation practice encompasses mapping the findings of the situation analysis and identifying realistic and relevant responses, with consideration for the local context and international experiences. Key actors were consulted to make sure that the formulated policy met their preferences as much as possible, with the understanding that this would facilitate endorsement, and we refer to this practice as "policy option appraisal". In the last practice, policy finalisation, we present activities related to completion of the draft HFP.

Results

Setting priorities

The request for a health financing policy evolved out of a series of previous developments. As seen earlier, many interventions were developed to enable the population, or specific subgroups, access to selective health services or a comprehensive package of care. This plethora of interventions and schemes, often with different designs and a variety of operators and implementers, resulted in considerable fragmentation and impaired the already constrained oversight and regulatory capacity of MOH (Annear et al. 2013).

As articulated by DPHI, development of the policy had to conform to the following objectives:

- The document had to state what the government intends to do to attain UHC.
- The documents had to be understandable for people who are not financing or social health protection experts, maximum 20 pages in length, and duly consider the Cambodian context and characteristics.
- Previous strategies and the Master Plan on Social Health Protection had to be incorporated.
- Through social health insurance, a gradual shift in funding of public health providers from the supply side to the demand side was to be achieved.
- Due consideration had to be given to the preferences of major stakeholders, such as the Ministry of Economics and Finance, and to a lesser extent development partners.
- HEFs were to be the basis from which to operationalise issues related to social health protection at the district level.
- Access to health services for the poor had to be ensured.

Two consultants, one supported by a multilateral organisation and the other by a bilateral one, worked jointly on the policy formulation, under the guidance of DPHI. During a one-day workshop with DPHI staff members and representatives of selected development partners, the vision for the HFP was defined as:

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

This vision was further supported by the following underlying principles, designed to guide the formulation and appraisal of policy options:

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

Option formulation and appraisal

Policy option formulation

Based on the situation analysis, historical developments, consideration of contextual factors and the vision and underlying principles of the HFP, six policy issue domains needing particular attention were identified: population coverage, benefits, purchasing services, institutional arrangements, source of funds, and regulation. For each of these domains,

an associated objective was formulated (Table 3). Following this exercise, interventions that should enable the realisation of the policy goals were developed for each domain. These interventions were formulated as policy statements. At a later stage, these statements are to be translated into supporting legislation and institutional arrangements.

"Population coverage" (Domain 1) concerns the establishment of mechanisms which provide the entire population with access to an essential social and medical benefit package through inclusion in social health protection schemes. The social security funds' role for including formal sector workers and their dependents in social health insurance is reiterated. This increased population coverage should allow for equalisation, risk pooling and consequent increases in purchasing power, which in turn should stimulate the delivery of high quality health services. Enrolment in these institutions should also reduce the need for cash-on-hand when accessing care. The informal sector population is to be automatically enrolled in the to-be-established National Social Health Protection Fund, which will gradually replace HEFs.

"Benefits" (Domain 2) relates to the social and medical benefit package that will be extended to the entire population, to reduce the need for cash-on-hand when accessing health care services. The HFP foresees that this package will be based on morbidity and mortality patterns, public good nature and externalities, technical feasibility, costs and benefits. This package will have to be reviewed at regular intervals, with cost estimations. Public health services will require adjustments to cope with emerging conditions. While the public sector adjusts to these new conditions, NGOs should ensure the continuing provision of rehabilitative and promotive services. NGOs should also address the needs of population groups currently incurring the highest health care costs while the public sector matures: people with noncommunicable chronic diseases, psychological disorders, and the elderly. Proposed interventions further concern quality of care by contracted providers, including the monitoring system and use of essential medicines.

"Purchasing services" (Domain 3) captures the gradual move away from the current supply-side funding, complemented by user fees and a mix of donor-induced incentives, to a system in which most of the money for curative health services is channelled through the demand side. As such, money to pay providers is to follow patients, through third-party payments. This implies defining which items or interventions remain covered by the conventional supply-side budgeting, and which are to follow the patients or be routed through social health protection funds. Other decisions include the distribution of revenue among staff within districts and facilities, and the objectives of the provider payment mechanism. The criteria for service quality should be based on the Standard Treatment Guidelines, which in turn require regular updating. To improve the quality of health services, an accreditation system will guide the informed selection of health providers to be contracted. Autonomisation of the national hospitals also has to be considered.

Core administrative institutions in Cambodia are relatively young and still maturing (Ballard et al. 2007) which is a major reason for the preference to initially develop three separate social health protection institutions. However, this development implies a major risk of fragmentation (McIntyre et al. 2008), with negative impacts on risk pooling due to potential limitations of cross-subsidies between the schemes. It is therefore essential that the schemes develop similar attributes, to enable a merger of the three institutions in the long term, including the pooling of risks and funds, as anticipated.

"Institutions" (Domain 4) specifies the harmonious development of the three social health protection institutions (the National Social Health Protection Fund for the informal sector population, and the social security funds for the private sector and civil servants). All three institutions will focus on coordinating provider payment methods and amounts, benefit packages and associated quality of care criteria, claims processing, information management and disease qualification systems. These institutions will share the same financial intermediaries at the district level, to run the operational aspects of purchasing health services. In the long term, the three institutions will merge into one administrative authority, with risk and fund equalisation mechanisms. Lastly, this domain describes the establishment of an interministerial committee for strategic and policy directions, as well as institutional oversight to ensure alignment of developments between the social health protection schemes.

"Source of funds" (Domain 5), specifies the sources of overall health system funding, as well as for each institution. Whereas this is straightforward for formal sector employees, through salary deductions and employer contributions, collecting contributions from the informal sector remains contentious. Because of the challenges associated with enrolling the non-poor informal sector population in voluntary insurance schemes, the Thai approach was opted for, which implies that this population group is automat-

ically covered through tax subsidies (Tangcharoensathien et al. 2013). This calls for increased resource allocation, derived from earmarked taxes and/or general revenue. User fees will remain for services not covered by the benefit package, though this money should not be retained at the facility to minimise supplier-induced demand.

"Regulation" (Domain 6) is a challenging issue, though a prerequisite if the HFP is to succeed. It calls for establishment of an ombudsman to act on behalf of the public in cases of suspected medical malpractice and irregularities by social health protection institutions and health providers. The Patients' Rights Charter will be used to guide the formulation of legislation to promote the population's right to quality health services. Existing legislation is rarely implemented or enforced, most likely because of a lack of financial resources, as in most LMICs (Teerawattananon et al. 2003, Ensor and Weinzierl 2007). Therefore, regulatory bodies will be funded by facility revenues, and will be able to penalise practitioners for breaching laws concerning staffing of private facilities and sales of pharmaceuticals. Other sources of money are also being considered. Professional standards are to be enforced by health professional councils, which will fully execute their functions to register and regulate health professionals. Financial incentives will be employed to ensure delivery of essential health services by the private sector in underserved areas.

Policy option appraisal

An intense series of workshops was conducted over a three-month period, during which many issues were addressed. Three such workshops were held, each lasting three days and attended by about 90 representatives of all MOH departments, national programmes and national hospitals, provincial health departments, national social security funds, the Ministry of Planning, the Council of Minsters (the Council for Administrative Reform and the Council for Agriculture and Rural Development), major development partners and MEDiCAM (an umbrella organisation for NGOs operating in the health sector). DPHI led the initiative, as mentioned.

These workshops were an interactive process, whereby the decisions and conclusions made in group sessions and discussions led to refinement of the HFP. Issues included:

- Means to ensure coverage of the informal sector population, with and without applying premiums and/or co-payments.
- Provider payment methods, including criteria to be considered and ways to minimize supplier-induced demand.
- Benefit package, including current shortcomings of the minimum and complementary packages of care, and the realistic content of optimal packages.
- Gradual shift towards demand-side funding and monitoring, while guaranteeing efficiencies in the health sector.
- Whether the informal sector requires a separate social health protection institution, or could be merged with social security funds for the formal sector or civil servants .
- Operational arrangements for social health protection institutions at the district level.
- Approaches to strengthen regulation of health care providers.
- Motivation and remuneration of the health care workforce, including distribution of revenue from demand-side funding and regulation of incentive payments.
- Sources of funding for social security funds, and the possibility to offer complementary benefit packages.
- Criteria and approaches to achieve equity in resource allocation.
- Kinds of budgets for public health programmes to be channelled through social health protection institutions or directly to public providers.
- Retaining user fees and/or co-payments at the facility level, or pooling for re-distribution.
- The extent of discretion over revenue by health facilities.

Finalisation of the policy

An international retreat was organised through a south-south cooperation initiative, and allowed the core team to receive valuable input from colleagues in other countries. Afterwards, three additional one-day workshops were held in Cambodia to address unresolved issues. DPHI staff members and representatives of selected development partners mainly attended these intensive sessions. Following agreement on the proposed resolutions, the HFP was adjusted and readied in accordance with the policy document requirements of the Council of Ministers. The final statements are summarised in Table 4.

Discussion

A health policy is a formal document stating what the authorities of a country want to undertake to improve the health of their population, as well as the ways they plan to achieve this (Sheikh et al. 2011). Many related studies focus on policy changes, but few examine policy formulation, especially technical approaches (Gilson and Raphaely 2008). Those that do address the formulation process focus on the actors (Thomas and Gilson 2004, Agyepong and Adjei 2008) or political realities that shape the policy (Gilson et al. 2003). These studies have found that the influence of politicians and senior civil servants can override the most sound technical proposal, irrespective of the reputation of its authors, especially if the content is at odds with their political positions. Thus, those formulating and advancing policies should consider the viewpoints of political actors, and create a favourable climate among everyone involved in the process, including those that are disinterested. It has been suggested that the availability of a common vision may be a prerequisite to successful coordination of all stakeholders (Thomas and Gilson 2004).

A common vision was formulated at the start of the Cambodian HFP formulation process. During this process, potential negative political interference was mitigated to a certain extent by inviting representatives from a wide range of institutions involved in policy-making, including institutions outside the health sector. Additionally, apart from the technical issues, political sensitivities were considered throughout the formulation of the document. Policy formulation also built on the many schemes that were operating in the country at the time, and were thus politically accepted to a considerable extent. This is especially the case for HEFs (Ir et al. 2010). Thus, a common vision was formulated from the start.

For formulation of the policy, we utilised a small core team consisting of DPHI staff members and representatives of selected development partners, and consulted with additional stakeholders through workshops. Other countries have used task forces comprised of various actors, including those from other sectors (Basazal et al. 2013, Seddoh and Akor 2012), or consulted stakeholders through questionnaires prior to formulating the policy (Kirigia et al. 2012). The fact that the Cambodian HFP was formulated in a relatively short but intense period of about four months may have been conducive to gathering momentum, as all stakeholders remained engaged throughout and turnover of their representatives was minimal. As such, all participants were familiar with previous discussions and associated arguments. In Uganda and South Africa, for example, policy formulation took years (Basaza et al. 2013, Thomas and Gilson 2004), producing a product that had a mixed degree of support, making it challenging to push through the anticipated reforms.

The formulation of the Cambodian HFP was also well informed by a comprehensive situation analysis. The framework we applied for this purpose was derived from earlier frameworks using the same health financing functions (Carrin and James 2005, Mathauer and Carrin 2011, Ekman et al. 2008), but with the addition of financing objectives. As such, we assessed the performance of the country's current health system and social health protection arrangements against these objectives in a systematic way. Applying financing objectives as performance measures enabled the solicitation of issues requiring attention. The choice of performance measures in turn was determined by the available information, which requires contextualisation by country. The performance indicators to perform the situation analysis can be considerably expanded, as was the case in Turkey (Atun et al. 2013).

Hercot et al.'s (2011) framework assisted us in outlining the HFP formulation process in Cambodia. However, we grouped seven of the original practices into three, due to their close interrelatedness, and the need for concurrent consideration of many factors that are challenging to categorise individually.

Discussing the appropriateness of the HFP itself is outside the scope of this paper. Instead, we provide an overview of the HFP formulation process, though we did not touch upon the processes related to its endorsement and subsequent implementation. To facilitate the former we carefully considered potential obstacles, as explained above, though not all such factors may be anticipated. The policy itself provides broad directions while details regarding its implementation will have to be formulated in the appropriate legislative framework.

In summary, we provide an overview of the formulation of the health financing policy in Cambodia. This happened in a relative short time period, and involved wide stakeholder consultations for general directions, in tandem with working out more detailed options by a core group of technical specialists. The basis of the HFP was founded on a situation analysis which examined the functions and objectives of health financing together with consideration for historical development and contextual factors. The formulation of policy options was steered by the vision expressed in the HFP, as well as its guiding principles.

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Tables

Table 1: Cambodian situation analysis indicators

Function/performance measure	Indicator
Resource generation	
Equitable funding	• Out-of-pocket expenditure by age group
Sufficient funding	• Fiscal space and amount spent by government
Pooling	
Financial risk protection	• Incidence of impoverishment due to health care • Proportion of women unable to access care because of lack of cash-on-hand • Proportion of care seekers resorting to borrowing to pay for health care
Allocative efficiency	• Meeting the needs of vulnerable groups (disabled, mentally ill, old people) • Geographical budget allocation • Flexibility of budget use
Administrative efficiency	• Fragmentation of fund pooling and administrative structures • Procurement practices
Purchasing	
Equity in utilisation	• Annual hospitalisation rate and outpatient visits by socioeconomic quintile • Utilisation of selected preventive services (ANC, vaccinations, institutional deliveries) by socioeconomic quintile • Quality of care for ANC* by socioeconomic quintile
Quality of health services	• Proportion of patients seeking care for same condition at 2nd and/or 3rd provider • Proportion of counterfeit and/or substandard medicines • Proportion of diabetes patients uncontrolled for blood sugar and proportion of hypertension patients uncontrolled for blood pressure
Technical efficiency	• Source of staff incentives and degree of alignment among sources • Distribution of incentives among district health staff • Interventions to improve staff productivity
Benefit package	• Adequacy of benefit package: availability of care for and management practices of emerging conditions
Provider payment	• Prevailing payment methods and effect on service delivery
Stewardship	
Regulation	• Existing legislation for private sector and degree of enforcement • Patient appeal mechanisms, ombudsman
Information for policy-makers	• Source and use of information concerning health financing

* Blood pressure monitoring, iron folate provision, tetanus vaccination.

Table 2: Practices against which the health financing formulation is assessed.

Good practice by level	Description of the practice
Situation analysis	
1. Situation analysis	Assessment of the situation using an analytical framework against the functions and objectives of health financing to identify issues hampering or potentially contributing to achieving universal health coverage. Agreement on indicators against which to assess the situation; includes consultation of peer reviewed and grey literature.
Setting priorities	
2. National vision, ownership and leadership	National ownership of the policy is essential, together with a vision supported by policy-makers and experts. This vision should consider key national government policies concerning the nation's developments. Leadership is a prerequisite to guide the formulation and consideration of all actors.
3. Clear policy objectives	Well articulated intentions of the policy with consideration for its design and limitations on content, together with issues that will have to be mentioned and the target audience. These intentions should also build on previous health financing developments, including both successes and failures.
Option formulation and appraisal	
4. Policy option formulation	Formulation of options to achieve policy objectives and the vision, with due consideration for crosscutting measures and coordination mechanisms. Options are formulated in accordance with national and regional experiences, and consideration of their appropriateness for the country's political, economic, historical and social context. Potential obstacles to policy options are identified and considered. Policy options are grouped by domains of issues to be addressed. Options are narrowed down according to their likelihood of acceptance or rejection, as well as feasibility of implementation.
5. Policy option appraisal	Select options or measures that are contentious, undecided, risky in nature and/or potentially prone to rejection, and subject them to consultations with key individuals of powerful ministries or other important stakeholders. Return to policy option formulation if necessary.
6. Policy finalisation	Finalisation of the policy in accordance with the country requirements for policy documents, including formatting and language, and incorporation of final key actors' decisions.

Adapted from Hercot et al. (2011)

Table 3: Domains and objectives of the health financing policy.

Domain	Objective
Universal population coverage	To enroll all people in Cambodia in social health protection institutions, to enable risk pooling and financial protection against the cost of illness.
Benefits	To provide an affordable, uniform and locally appropriate benefit package, ensuring access to needed health services for common, emerging and priority health conditions.
Purchasing services	To employ provider payment methods, to make optimal use of available money and ensure delivery of quality health services in sufficient quantity.
Institutional arrangements	To establish uniform, unified social health protection institutions for the formal and informal sector that allow for equal access to health services for all population groups.
Source of funds	To equitably and efficiently mobilize sufficient resources to finance the delivery of essential health services.
Regulation	To provide a robust regulatory framework to establish and enforce rules and regulations, with clear roles of stakeholders.

Table 4: Summary of health financing policy statements.

Universal population coverage
• An essential (social and medical) benefit package of health services will be made available to all through SHPI and MOH. • NSSF for formal sector employees will be mandatory and cover dependents. • The poor will be identified through the Ministry of Planning IDPoor process and covered by NSHPF, while the non-poor informal sector population will be automatically enrolled into NSHPF..
Benefits
• MOH will decide the content of the benefit package, criteria for quality of health services, and which services will be funded through them and which will be purchased through the demand side. • The benefit package will be regularly reconsidered in line with actuarial projections, available resources and changing health care needs. • NSSF can decide upon complementary services for their members, to be funded by them.
Purchasing services
• MOH will purchase defined public health interventions and other items (e.g. vaccinations, capital, training, regulations, etc.) directly. • SHPIs will purchase services on behalf of their members, only from accredited providers. • Common provider payment methods will prevail, and information on quality of services and efficiencies will be obtained through an integrated monitoring system. • Staff remuneration, including incentives and distribution among facilities and staff members, will be harmonised and regulated. • Overtime funding will shift from the supply to the demand side, with resources transferred to SHPIs. • Allocative efficiencies of supply side funding will be improved, while the MOH procurement committees will have an independent board.
Institutional arrangements
• The three SHPIs will initially develop separately but apply similar provider payment methods and amounts, benefit packages, and have a common system for claims processing, information management and disease classification, while using the same intermediaries at the district level. • An inter-ministerial social health protection committee will provide strategic and policy oversight to ensure harmonious development of SHPIs and ultimately ensure their merger, with risk and equalisation mechanisms. • In the long term, the three SHPIs will merge into one administrative authority, the Social Health Protection Organisation, with risk and fund equalisation mechanisms.
Source of funds
• The health system will be funded through a mix of government budget (general and earmarked), international donors, employee and employer contributions. • NSSFs will be funded by contributions from members and employers (the government for civil servants). • The informal sector population's enrolment in NSHPF will be financially subsidised through earmarked taxes and/or general revenues. • Fees will be charged for services not covered in the benefit package, while nominal and capped co-payments will be charged for the non-poor. This money will be pooled with SHPI payments, but facilities will have a reserve fund to ensure available money.
Regulation
• An ombudsman will be established and legislation, based on the Patients' Rights Charter, will be formulated to define the population's right to quality health services. • Regulatory bodies will be provided with sufficient money, derived from the providers that will be regulated. • Private providers will have to follow financial management guidelines set by the Ministry of Economics and Finance, and visibly display fees for services and products.

MOH = Ministry of Health; **NSSF** = National Social Security Fund; **NSHPF** = National Social Health Protection Fund; **SHPI** = Social Health Protection Institutions.

Annex 1

Results of the situation analysis

This annex and its table provide an overview of the situation analysis conducted during the HFP formulation process. The cost of treatment and thus the amount of OOPE has increased over time, but the proportion of the population impoverished as a result has decreased, most likely because of a sustained annual economic growth of 7%. Government spending for health increased steadily over the same time. Access to cash-on-hand in society remained an issue, however, whereby a considerable proportion of care seekers resorted to borrowing, with all potential consequences on livelihoods (Ir et al. 2013). While HEFs assist a proportion of the poor to access health care at lower costs, they do not reduce indebtedness among beneficiaries (Flores et al 2013).

Some conditions that are relatively prevalent in Cambodia, such as physical impairments and mental disabilities, are poorly catered for despite the needs; in 2001, 22% of adults aged 20 years or older were physically impaired as a result of a health problem, and 25% reportedly were limited in social activities due to a health or emotional problem (Dubois et al. 2004). The health system appears insufficiently developed to cope with emerging conditions such as hypertension and diabetes, of which the estimated prevalence rates among adults range from 12% to 25% and 3% to 11%, respectively (King et al. 2005, Oum et al. 2010). Among those aware of their condition, only about half were properly managed (Oum et al. 2010).

Budgeting in the public health sector is incremental, with little consideration for actual output, as indicated by per capita per annum hospital budgets (Martin 2012). This is less of a concern in SOA districts, which also experience more flexibility in their use of money through performance-based budgeting. It is estimated that improved procurement practices can increase the available government budget for health by 40% (World Bank 2011).

Inequity in utilisation has persisted over time, and also in the quality of preventive services, though to a lesser extent. The quality of curative care appears suboptimal, with a considerable proportion of patients having to consult multiple providers in their search for treatment while those with known conditions such as diabetes and hypertension often have no routine monitoring of their status. The quality of available medicines varies, with a considerable proportion being counterfeit or of substandard quality (Okumura et al. 2010, Khan et al. 2011). Equally worrying, a survey conducted in 2001 using simulated client visits at 200 private practitioners in Phnom Penh found that about half of the recommended treatments were potentially hazardous (Vickery et al. 2000). Thus, one should not only consider the cost of treatment, but also the cost to patients resulting from poor or hazardous treatments.

Incentives hold great potential to improve quality of care as well as technical efficiencies (Jacobs et al. 2010) but are insufficiently applied in a concerted manner to be conducive to system building. They do so, however, when used under the SOA concept. Although ascribed many positive attributes in the Cambodian context, such as staff motivation and reduction in OOPE due to less under-the-table payments (Barber et al. 2004, James et al. 2006), user fees create issues with staffing of primary care facilities and posting in remote areas. These issues appear to be resolved to a certain degree in SOA districts.

Cambodia has considerable experience with interventions aimed at improving staff productivity. These experiments stem mainly from the external contracting experience (Jacobs et al. 2010), although other donors piloted their own initiatives (Van Damme and Meessen 2001). Currently, the contracting experience has been internalised and formalised into the SOA districts.

A variety of provider payments are applied, although user fees dominate at both public and private facilities. Since most recurrent costs at public health facilities are funded by the central budget and by supplies from the medical stores, these user fees are nominal and mainly intended as staff incentives. User fees, as discussed above, can have ramifications for staff allocation and qualified provision of primary care.

Despite the availability of a legal framework for staff-

ing health facilities and the sale of pharmaceuticals, insufficient work is being done to address the situation of informal sector providers, where most care is initiated. There are also no provisions for the population to address malpractice or discrimination by health care providers. Information concerning care seeking, OOPE, borrowing practices and indebtedness is regularly derived from the Cambodian socioeconomic surveys and demographic and health surveys. The Health Management Information System was revamped in 2007. A recent review found a nearly 100% facility reporting and completeness of indicator reporting rate, and high consistency rates between source documents and monthly reported values. About 160 private health facilities, clinics and laboratories participate in the Health Management Information System, although none of the pharmacies or drug sellers have joined.

Table 6: Results of the situation analysis

Performance issue	Indicator	Findings
Resource generation		
Equitable funding	Out-of-pocket expenditure (OOPE)	Within a 5-year period (2005–2010) average cost of treatment rose from USD 3.10 to USD 8.80 for a minor illness and USD 47.20 to USD 93 for a serious condition. OOPE for those seeking treatment in the month preceding interview was USD 41 for those aged 20–59 versus USD 64 for the elderly. In 2009, annual OOPE per person was USD 29.50.
Sufficient funding	Fiscal space and amount spent by government on health	Government spending on health was USD 187.5 million, equivalent to 12% of total government expenditures in 2012, versus USD 104.6 million in 2008. Sin taxes do not exist.
Pooling		
Financial risk protection	Incidence of impoverishment due to health care	From 2004–2009, the proportion of households indebted as a result of illness decreased from 5.3% to 3.8%, while the proportion becoming poor due to health care costs decreased from 3% to 1.6%. The respective average outstanding amount of debt for health increased from USD 145 to USD 322 over the same period.
	Proportion of women unable to access care because of lack of cash-on-hand	In 2010, 65% of women interviewed reported having problems obtaining money quickly to pay for anticipated treatment costs. 79% of women in the poorest quintile reported this problem, versus 48% in the richest.
	Proportion of care seekers resorting to borrowing to pay costs	In 2010, of those with a serious illness, 21% resorted to borrowing money with interest to pay for treatment, while 16% sold assets.
Allocative efficiency	Meeting the needs of vulnerable groups, including the disabled and mentally ill	Although prevalent among the population, there is a considerable shortage of services for mental illnesses and people with physical disabilities. HEFs enable targeting of the poor and reduce OOP expenditure for health care, but not indebtedness.
	Geographical budget allocation	Incremental budgeting dominates, with resulting limited considerations of population or geographical needs. AOP provides budget according to output; pcpa allocation to hospitals ranged from US$0.27 to US$0.97.
	Flexibility of budget use	There is greater flexibility in use of budgets in SOA districts because of performance-based budgeting.
Administrative efficiency	Procurement practices	A considerable amount of the annual government budget can be saved through competitive procurement practices.

Table continued next page.

Performance issue	Indicator	Findings
Purchasing		
Equity in utilisation	Annual hospitalisation rate by socioeconomic quintile	In 2007, 3.1% of the poorest quintile population were hospitalised, versus 5.5% of the richest.
	Utilisation of selected preventive services by socioeconomic quintile	In 2010, 35% of pregnant women in the poorest quintile had an institutional delivery, compared with 88% in the richest quintile. Respective figures for caesarean section rates were 1.1% and 9.6%. Similarly, 88% of children in the richest quintile received all basic vaccinations, versus 65% of the poorest quintile children.
Quality of health services	Quality of ANC by socioeconomic quintile	Of the poorest quintile women, 83% received iron folate during their last pregnancy, versus 96% of the richest. 87% of the poorest quintile women had their blood pressure measured, versus 96% of the richest. The proportion of women vaccinated against tetanus during their last pregnancy were 77% and 96%, respectively.
	Proportion of patients seeking care for same condition at 2nd and/or 3rd provider	15% of people suffering a minor condition sought care from a second provider because of unsuccessful initial treatment, and 5% continued to seek help from a third. For those with a serious ailment, the figures were 35% and 14%.
	Proportion counterfeit and substandard medicine	In 2006, counterfeit drugs accounted for about a tenth of the total sample of essential medicines, and 92% of a sample of aspirin tablets from retailers were substandard.
	Proportion of diabetes patients uncontrolled for blood sugar and hypertension patients uncontrolled for blood pressure	In 2010, 58% of diabetes patients being treated had uncontrolled blood sugar levels, while 39% of treated hypertensive patients had no blood pressure measurements.
Incentives	Source of incentives and degree of alignment	Different programmes and donors apply numerous financial incentives, with no alignment of interests or pooling of funds, undermining system building. User fees provide a major source of incentives for staff members. SOA districts outperform other health districts.
	Distribution of incentives among district health staff	With user fees, staffing in remote and primary care facilities, as well as administrative areas, is impaired as hospital staff profit the most from these incentives. Even within tertiary hospitals discrepancies exist, with surgery departments having the most revenue. Global health initiatives benefit a few, especially health centre chiefs and those focusing on the three diseases. Incentives are better distributed in SOA districts and hospitals
Technical efficiency	Interventions improving staff productivity	Contracting arrangements, internal and external, increase staff productivity, especially when conducted in tandem with performance pay.
Benefit package	Adequacy of benefit package: availability of care and management practices for emerging conditions	The health system was developed to mainly deal with MCH and infectious conditions, while there has been little adjustment to deal with emerging conditions such as chronic noncommunicable diseases.
Provider payment	Prevailing payment methods and appropriateness	User fees are the main provider payment method, although these fees are nominal. HEFs use a case-based system, while CBHIs apply capitation. Both payment systems are based on nominal user fees.

Table continued next page.

Performance issue	Indicator	Findings
Stewardship		
Regulation	Existing legislation for private sector regulation and enforcement	Laws exist to regulate staffing of private health facilities and sales of pharmaceuticals in such facilities, but are poorly enforced.
	Patient appeal mechanisms and ombudsman	There is no legal provision for dealing with malpractice or discrimination by health care providers.
Information for policy-makers	Sources and use of information concerning health financing	At regular intervals, information is available through CSES and DHS reports, including OOPE and borrowing practices. Other information is derived through commissioned studies and valid information on service delivery through HMIS.

AOP = annual operational plan; **ANC** = Antenatal care; **CBHI** = community-based health insurance; **CSES** = Cambodian Socio-economic Survey; **DHS** = Demographic and Health Survey; **HEF** = health equity fund; **HMIS** = Health Management Information System; **MCH** = maternal and child health; **OOPE** = out-of-pocket expenditure; **pcpa** = per capita per annum; **SOA** = special operating agency.

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