KINGDOM OF CAMBODIA

Nation- Religion- King

STRATEGIC FRAMEWORK

FOR

HEALTH FINANCING

2008-2015

Bureau of Health Economics and Financing
Department of Planning & Health Information

April 2008

Abbreviations

ADB - Asian Development Bank
AOP - Annual Operational Plan
CAR - Council for Administrative Reform
CBHI - Community Based Health Insurance
CDHS - Cambodia Demographic and Health Survey
CPA - Complementary Package of Activities
DFID - Department for International Development (UK)
DPHI - Department of Planning and Health Information
GAVI - Global Alliance for Vaccines and Immunization
GDP - Gross Domestic Product
GFATM - Global Fund for AIDS, Tuberculosis and Malaria
GTZ - German Technical Cooperation
HC - Health Centre
HCP - Health Coverage Plan
HEF - Health Equity Funds
HFC - Health Financing Charter
HSP - Health Sector Strategic Plan
HSSP - Health Sector Support Project
ILO - International Labour Organization
IMR - Infant Mortality Rate
MDG - Millennium Development Goal
MOEF - Ministry of Economics and Finance
MOP - Ministry of Planning
MOLVT - Ministry of Labour and Vocational Training
MOH - Ministry of Health
MOSVY - Ministry of Social Affairs, Veterans and Youth Rehabilitation
MPA - Minimum Package of Activities
MTEF - Medium Term Expenditure Framework
NCD - Non-communicable diseases
NGO - Non-government organization
OD - Operational District
OECD - Organization for Economic Cooperation and Development
OOP - Out-of-pocket
PHD - Provincial Health Department
PIP - Public Investment Program
PMG - Priority Mission Groups
RH - Referral Hospital
SFHF - Strategic Framework for Health Financing
SHI - Social health insurance
SWAp - Sector Wide Approach
SWiM - Sector Wide Management
TWGH - Technical Working Group for Health
U5M - Under 5 Mortality
UNFPA - United Nations Population Fund
USAID - United States Agency for International Development
WHO - World Health Organization
WB - World Bank
3YRP - Three-Year Rolling Plan

FOREWORD

The Ministry of Health's Health Sector Strategic Plan advocates for the "Allocation of financial resources to improve the accessibility of health services for the poor through alternative health financing schemes". In a context of under-funded health sector, with population suffering from poor access to health services, the strategy for financing health care advocates for increase and mobilization of resources as well as allocation of funds in a transparent, equitable, efficient and effective way.

Since the introduction of the Health Financing Charter for Cambodia in 1996, various financing schemes have been implemented in the public health sector by the Ministry of Health and our health partners. Those schemes consist in user charges with exemption policy, contacting, health equity fund and community based health insurance etc.

Given the diversity of health financing mechanisms in Cambodia, the Ministry of Health has decided to develop this framework to capture, analyze and streamline all sources of funds and their uses in the health sector. The framework aims at improving access to health services and guides the development and implementation of a social health protection mechanism.

The Ministry of Health hopes that the introduction of the Strategic Framework for Health Financing in Cambodia can contribute to prevent poverty linked to ill-health, improve the level of funding and quality of health care, and pave the way towards universal health insurance coverage. To reach that goal will take time and there will be many challenges ahead. It will require political and social support, adequate financial resources, appropriate human capacity, and effective coordination. We are confident that the Royal Government of Cambodia, other line ministries and our partners in health will support the MoH in implementing this Strategic Framework for Health Financing.

April , 2008

Acknowledgments

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The development was done through a series of consultative process with technical advisory group (TAG) for macro economics and health which consists of representative from Ministry of Health (MoH), Ministry of Economy and Finance (MEF), and Ministry of Planning (MoP). Also the consultation was done with the technical working group for health TWGH and national consultative workshop which participated from all level in the health sector, MEF, MoP, Council Minister, CDC and Health Development Partners, we would like to extend our sincerely thanks to those whom participated.

We appreciate the hard work of Dr. Aviva Ron, Dr. Peter Annear and Ms Maryam Bigdeli for their technical support though out the development process that this framework will provide a guide principle for effective and sustainable health financing development in CAMBODIA.

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1. Background

This document provides a Strategic Framework for the development of health financing during the years 2008 –2015. Health financing deals with the mechanisms for providing the funding required for the delivery of health services to the population, both in terms of sources of funding for the delivery of health care (input) and the way in which these funds are spent (output).

The purpose of the Strategic Framework for Health Financing 2008-2015 (SFHF) is to put the various existing forms of health financing in Cambodia under a single coherent plan.

The Strategic Framework builds on past achievements in the health sector and supports current planning activities. These include:

- The development of health administration and infrastructure through the 1995 Health Coverage Plan (HCP)
- The achievements of the 1996 Health Financing Charter (HFC)
- The health-care targets proposed by the National Strategic Development Plan 2006-10 (NSDP)
- The implementation of the Health Sector Strategic Plan 2003-2007 (HSP)
- Achievement of the targets set by the Cambodian Millennium Development Goals (MDG) for health by 2015.
- The Second Health Sector Strategic Plan 2008-2015

1.1- Funding sources and utilization of funds in the Cambodian health sector

The issues of health financing may be considered both from the perspective of the sources and uses of funding for health care and from the perspective of the supply of and demand for health care services.

The three principal sources of health financing in Cambodia are from (i) the government health budget, (ii) from donors and other health partners and (iii) from households. These funds can be used in various ways to acquire health services through public health service delivery and through the private sector.

On the supply side, financing may come from government, donor agencies or non-governmental organizations. Out-of-pocket expenditures go to either user fees in public facilities or the private sector. Demand-side financing schemes are characterized by health insurance systems of various types or social transfers including health equity funding

The fundamental need in the health financing process is to achieve the best outcomes in terms of both the allocation of resources and their efficient use, based on the need for equitable access to health services.

As detailed in the situation analysis presented in Annex 1, the financing of health care in Cambodia is characterized by:

1. A high level of poverty (35%) and inadequate access to health services for the most vulnerable populations, with substantial impact on equity in health as reported in the Cambodian Demographic and Health Survey 2005.

2. A reasonable level of national health expenditures per capita compared to other developing countries reaching about US$27-37 per capita per year, depending on source of data and estimates of out-of-pocket spending

3. An increasing level of recurrent government spending for health, reaching 12% of national budget, although remaining a low share of GDP at little more than 1% in 2007 (or approximately US$6 per capita per year in 2007

4. A very high level of private, out-of-pocket (OOP) household spending that accounts for approximately two-thirds of all health expenditure (or approximately US$25 per capita per year).

5. High Dependence on donor funding for health care, reaching US$ 103 million or US$7 per capita per year in 2007 .

6. A chronic misalignment of public funding with the priorities of the health sector

7. A low level of salaries and incentives for staff working in the public health sector, preventing effective delivery of health services;

8. A low level of public funding (less than 40%) reaching the service delivery level, with significant impact on service delivery.

9. A high utilization of unregulated private providers.

Within this health financing context, the MOH is committed to providing equitable, quality health care for all Cambodians. The MOH aims to deliver full Minimum Package of Activities (MPA) at all Health Centers and Complementary Package of Activities (CPA) at all Referral hospitals in all health Operational Districts, and to provide access to health services for the poor

The long-term aim of health financing in Cambodia is to achieve universal coverage of the population with funded pre-payment mechanisms. This, however, is still many years away. Already, beside government budget for health and direct out-of-pocket spending, a number of different health financing mechanisms have emerged independently: donor funding, donor funded pools (Health Sector support Project and SwiM), , user fees at public facilities, fee-exemptions for the poor, contracting of public service delivery, health equity funding (HEF), community-based health insurance (CBHI) and proposals for different social health insurance schemes (SHI).

The purpose of the Strategic Framework is to bring various forms of health financing into a single plan. This plan constitutes a 'mixed model' of health care financing that will provide the basis for moving to universal coverage in the longer term.

1.2 Issues and concerns

1. **Poverty and Equity**: With about one-third of the population too poor to pay for health care in the public or the private sector, any plan for national health financing must provide appropriate and satisfactory social-protection measures and other safety nets. Currently, this protection is provided through various fee-exemption systems and through health equity funding; the need is to institutionalize and scale-up these mechanisms in the national framework and to develop new means to protect the poor.
2. **Health transition**: Cambodia is developing rapidly and the population is ageing. The consequence of this is a change in the illness profile away from the complete domination of communicable diseases and towards increasing prevalence of non-communicable diseases. The prevalence of both hypertension and diabetes mellitus has increased faster than would be expected from the increase in life expectancy. The age of onset of chronic disease is relatively low. The number of deaths and injuries from traffic accidents increased by 50% between 2000 and 2005. Consequently, emerging health issues in the areas of prevention, acute care and rehabilitation will require additional resource allocations, especially chronic diseases and traffic accidents
3. **Resource allocation**: The level of total national health expenditure and the resources available to achieve the health MDGs are both adequate. However, the economic allocation of these resources is skewed, with excessive dependence on private sources and services and too little contribution by the public sector. There are many different reasons for this. However, there is a fundamental need to redirect resources from the private to the public sector, especially with regard to current levels of household health spending. And there is a fundamental need to protect the poor and to move from direct OOP expenditures towards pre-payment and social-transfer mechanisms.
4. **Harmonization:** Donors will continue to provide substantial support to the health sector in the foreseeable future. There is therefore an underlying need to increase the harmonization of donor funding in support of national health goals. Some donors have already shown support for a shared sector policy and strategy known as Sector Wide Management (SWiM) that has focused on broad coordination issues such as formulating plans and targets and reviewing progress. This has mainly been achieved through the Health Sector Support Project involving a group of donors (World Bank, DfID, ADB and UNFPA). A Review of SWiM was conducted in 2007 and provides interesting recommendations for moving the process forward. A number of national and international mechanisms are now in place that will improve donor harmonization in the near future[1]

[1] Such as the Harmonization and Alignment Working Group and the International Health Partnership, for which Cambodia is a pilot country.

1.3- Policy statement

Derived from issues and challenges in the health financing situation in Cambodia, the following policy statements form the foundation of this strategic Framework for Health financing:

1. Allocate existing resources and ensure their efficient use at service delivery level
2. Advocate for stronger government taxation and revenue collection
3. Mobilize and allocate resources to under-funded health priorities
4. Implement deconcentration and decentralization, using sound planning and financial management tools, provincial block grants and internal contracting
5. Move aggregate resources from inefficient private health care provision to an efficient health care system through enhanced quality and improved access to public health services
6. Implement social health protection measures and advocate for development of a social health insurance system
7. Use health financing mechanisms as a leverage for quality of health services
8. Support harmonization and alignment for results
9. Empower communities to participate in local policies and decisions that affect their financial access to health services

2- Strategic framework

The Strategic Framework for Health Financing marks the first step in the development of a national health financing strategy. In the broader sense, the pre-requisites for the development of a health financing strategy are: (1) The priorities of the health sector must be clearly defined, (2) the strategies to address sector priorities must be developed and documented, (3) the cost of implementing these strategies must be calculated, and (4) the allocation of resources within the sector must be adjusted for optimum results

The Strategic Framework provides a broad analysis of the sources and uses of funds in the health sector by responding to the situation of excessive OOP spending and the low level of public health spending at service delivery level. It is built on initiatives to improve supply of and access to services and provides direction in the implementation of social health protection mechanisms.

2.1- Aims and objectives

The ultimate goal of national health financing is to provide **universal coverage** of the population with appropriate and affordable pre-payment and social-transfer mechanisms that effectively pool the risks of individual health care expenditures and provide social health protection to the entire population. This long-term aim cannot be achieved during the period proposed by this Strategic Framework. However, the objective of the Framework is to create the path and outline the steps towards the achievement of universal coverage in the longer term (beyond 2015).

The underlying principles of the Strategic Framework are to increase the equity and improve the efficiency of health resources allocation and use. It aims to produce a more appropriate balance in the distribution of resources between the private and public sectors and in the proportion of financing provided by government, donors and households. The implementation of the Strategic Framework aims to remove financial and other barriers to access to health services for the poor and to protect the poor and the non-poor from the effects of catastrophic expenditures on health care. Furthermore, the strategic framework wishes to emphasize the use of health financing as leverage for quality of health services. These aims may be expressed as a vision statement for health financing strategy during 2008-2015:

Vision Statement

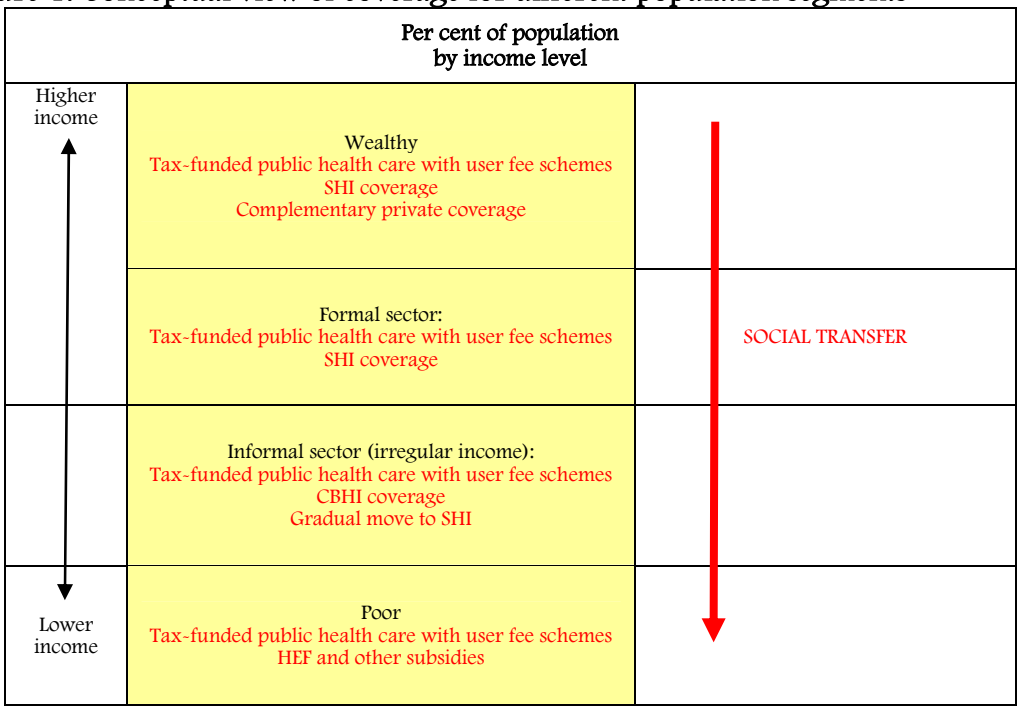
By 2015 the different elements and institutions of the health financing system will be combined under a single strategy guided by national health priorities; social health insurance mechanisms will be in place; the poor will be protected by suitable social-transfer mechanisms; government funding for health will be at a level appropriate for the adequate provision of quality services to the population; donor support will be harmonized and aligned with national priorities; health financing policies will be based on sound evidence from both public and private sectors.

2.2- Strategic approach

For the year 2008-15, the health financing strategy in Cambodia will be based on a mixed model, combining funding from taxation with pre-payment schemes, social health insurance and sustained donor funding for social protection funds.

2.2.1-Population coverage

Figure 1: Conceptual view of coverage for different population segments



All Cambodian citizens are entitled to tax-funded public health care, currently subsidized through government fixed budgets, donor funds and user fees. The aim here is to strengthen public funding for service delivery as well as incentives for efficiency and quality. This may be achieved through implementation of deconcentration and decentralizatin, and expansion of contracting arrangements.

The wealthiest section of the population must participate in the future Social Health Insurance scheme in order to allow appropriate social transfers to take place. This population segment is also considered to have the resources needed to finance their specific needs in the private health sector and by purchasing complementary private health insurance if needed.

The formal employment sector of civil servants and private-sector employees are to be covered by Social Health Insurance schemes with employer and employee funding. While these schemes are yet to begin and may start independently, the aim is to build them in a way that will eventually cover all paid employees under a common system.

The largest part of the population has no formal employment and little disposable income. The not-so-poor (those living just above the poverty line) can afford small premium payments for community-based health insurance as a means to protect themselves against catastrophic expenditures that cause impoverishment. The task is to expand the coverage of CBHI and other pre-payment schemes into those areas with informal-sector workers. However, as a voluntary scheme CBHI cannot provide 'universal coverage' in this segment, which will continue to include fee-for-service and OOP expenditures. The aims here are to strengthen public service

delivery and to keep OOP payments at affordable levels. Eventually, a gradual move of CBHI scheme under SHI umbrella is desirable in order to expand universal coverage to this segment of the population and allow appropriate social transfers.

The poorest part of the population will be protected through a range of social protection measures including fee exemptions, HEF and other subsidies for health care costs, such as voucher schemes. The aim is to provide access to free health care to all those living below the poverty line.

Much work still has to be done to 'scale-up' the identified schemes and to extend their coverage nationally. This work will be carried out within the context of this Strategic Framework. When this is achieved, a pattern of universal coverage may begin to emerge.

2.2.2- Financing mechanisms

Financing mechanisms in place and to be designed shall cover all three healths financing functions of an effective health system:

2.2.2.1-*Revenue collection and resource mobilization*

Increase in government's share of total health spending through overall improvements in national taxation and other revenue collections

Improve financial management, allowing increased availability of government funding at decentralized level and for health service delivery, including linkage with performance of the system

Sustainable, harmonized and aligned donor funding, especially for HEF and contracting arrangements

Implementation of existing government policy on Social Health Insurance and enabling policy environment for scaling-up CBHI schemes

Resource mobilization for under-funded priorities and neglected health problems

2.2.2.2-*Pooling*

Piloting and policy on linkages between HEF and CBHI schemes in a way that increases the efficiency in their implementation, combines administrative resources using a common database of beneficiaries, allows for portability between HEF and CBHI as population status and poverty levels change, promotes progressive subsidization and avoids unwanted transfers.

MOH policy on scaling-up HEF at national level, including policy on pooling of government and donor funds to finance service delivery for the poor and vulnerable population

Implementation of existing government policy on Social Health Insurance, migration of beneficiaries from HEF to other pre-payment schemes and from informal schemes to social health insurance

Implementation of Decentralization and Deconcentration in the health sector through strengthened planning and financial management processes at PHD level

Implementation of provincial and District block grant mechanisms, allowing decentralized pooling of funds

2.2.2.3- *Purchasing*

Enhance local governance and community participation in user fee and demand-side financing schemes and in local health planning processes

MOH policy on quality of health service provision and use of purchasing arrangements as leverage for achievement of quality standards

Definition and funding of MPA and CPA packages and treatment protocols, as well as continuums of care to support achievement of health sector priorities (e.g. Reproductive, Mother, Newborn and Child health services)

MOH policy on contracting arrangements and scaling-up at national scale

MOH policy on HEF and CBHI, and use of those demand-side schemes as leverage for quality health service delivery

Human resources strategy and staff management policy

Integration of provider payment mechanisms at facility level (budget, fees, capitation or staff incentives) to avoid duplication and overlaps at HC and RH level, and to allow a coherent funding of health facilities recurrent costs and staff

Introduce private practice regulations, including licensing and accreditation of private providers, alongside enforcement measures.

2.2.3- Stakeholders

The role of the **Government** is to provide the infrastructure, human resources and operational costs of the public health system, to exercise stewardship over the whole health system, define priorities, increase the delivery of public health services as a proportion of total service delivery, ensure efficiency and quality. **Contracting arrangements** are an essential tool for fulfilling government's role.

The role of **Donors** is to provide technical assistance, to support national health priorities and to fill the gap in funding between resources currently available and those needed to achieve health goals. **Harmonization and alignment**, in particular along defined **contracting arrangements** will be needed for an effective donor support.

Official, regulated **User Fees** will continue to be an important supplementary source of revenue for health facilities to finance staff incentives and running costs, with fee exemptions for the poor and defined packages of interventions. The role of **HEF schemes** is to provide access to health services and to protect the poor from catastrophic health expenditures. The role of **CBHI** is to provide a risk-pooling mechanism for informal-sector workers who live above the poverty line. **SHI** provides universal coverage to wage earners employed in the formal sector. The ultimate objective is to bring all pre-payment schemes under a common Social Health Insurance umbrella.

Through a well-regulated the **private sector**, services may be provided to those who can afford the costs of health care and private health insurance premiums

3-Strategic objectives and interventions

3.1-Government Health Expenditures

Strategic objective 1: Increase government budget and improve efficiency of government resource allocation for health.

This area will focus on increasing the share of government expenditures for health over the total health expenditures, meaning a gradual shift from donor funding towards a sustainable national health budget. Effective yearly and medium term planning tools exist in the health sector: the Strategic Framework recommends their efficient implementation at sub-sector and decentralized level and their use in strategic budgeting at all levels. At the same time, sound financial management tools need to be implemented at all levels of the health sector to allow efficient implementation of government resources for both recurrent and capital expenditures.

Component 1: Allocation of National Resources for Health

Desired Outcomes	Strategic Interventions
• Increased health budget as a proportion of GDP • Decreased dependence on external aid for recurrent costs • Resources allocated efficiently to maximize health outcomes • Increased funding for under-covered areas	• Advocate with MoEF to increase the share of government expenditures for health • Use 3YRP and AOPs in strategic and yearly budget formulation • Identify resources for 3YRP and AOP and perform gap analysis • Monitor allocation of increased funding to health priorities • Mobilize additional resources to cover health care costs of traffic accidents victims and NCD prevention and promotion.

Component 2: Credible government budget for health

Desired Outcomes	Strategic Interventions
• Full commitment to approved national health budget • Full commitment to the approved budget for central, PHD, OD, RH and facilities.	• Strengthen MOH capacity for strategic budgeting and PFM reform implementation • Use 3YRPs and AOPs for budget negotiations and implementation.

Component 3: Efficient implementation of government resources

Desired Outcomes	Strategic Interventions
• Efficient disbursement of approved budgets, particularly provincial budget to OD and facilities level.	• Implement D&D in the health sector, with relevant capacity building in PFM at PHD, OD and facility levels • PFM reform implementation especially Programme-based budgeting, with relevant output indicators

Component 4: Coherent infrastructure development

Desired Outcomes	Strategic Interventions
• Balanced allocations for capital costs with coherent funding for maintenance and recurrent expenditures • Comprehensive budget formulation	• Design a coherent PIP for health including recurrent costs for maintenance and training needs • Integrate PIP for health into AOP and 3YRP • Health Sector budget includes capital funding, recurrent costs for maintenance and training

3.2- External Funding for health

Strategic objective 2: Align donor funding with MOH strategies, plans and priorities and strengthen coordination of donor funding for health

RGC has adopted the Paris Declaration and supports implementation of harmonization and alignment in all sectors. In line with this government policy, donor coordination is already very strong in the health sector but would need to be strengthened for financial and pooling arrangement. At the same time, alignment of donor funding with health sector priorities 2008-15 place in the health sector. The same yearly and medium term planning and budgeting tools as well as financial management tools should be used to plan and monitor donor funding. This harmonization and alignment process should be applied to NGOs working in the health sector, although the important role of the civil society in supporting marginalized populations and engaging in policy dialogue should be recognized and supported.

Component 1: Alignment of external assistance with MOH priorities

Desired Outcomes	Strategic Interventions
• Donor support aligned with priority issues defined in the HSP 2008-15 • Donor support fully coordinated through MOH processes • Predictable donor support in the medium term	• Identify areas of duplication and gaps through AOP and 3YRP gap analysis at all level. • Integrate a core segment of donor funding into the national health budget • Implement financial pooling arrangements at all level. • Strengthen medium and long term forward projection of donor resources for health • Mobilize additional resources for identified under-funded priorities

Component 2: Harmonization of donor funding

Desired Outcomes	Strategic Interventions
• Donor funds coordinated through the SWiM/SWAP process and reflecting the Paris Declaration	• Implement SWiM Review recommendations, especially recommendations on funding arrangements and pooling • Agreement on financing expansion of successful initiatives to national scale.

Component 3: NGO assistance for health service delivery

Desired Outcomes	Strategic Interventions
• NGO assistance in line with HSP 2008-15 • Support NGO assistance for under-funded areas and health needs, and marginalized populations	• Implement contractual arrangements with NGOs for provision of defined services as needed, including medium and long-term sustainability plans • Sustain policy dialogue between NGOs, civil society and health policy makers • Support NGOs in implementation of pilots and innovative interventions

3.3- Household expenditures on health

Strategic objective 3: Remove financial barriers at the point of care and develop social health protection mechanisms

Reducing financial barriers to access depends on coordinated intervention on regulation of user fee schemes, scaling-up HEF arrangements in a sustainable manner and expansion of CBHI as an intermediate measure before an effective implementation of compulsory health insurance. Social Health Protection schemes need to be designed to achieve health sector goals and priorities in terms of financing of services, delivery of priority interventions and avoidance of catastrophic health expenditures.

Component 1: Health seeking behaviour

Desired Outcomes	Strategic Interventions
• Enhanced trust in public health services • Spending from the private/informal sector redirected to the public health sector	• BCC/IEC activities on health seeking behaviour, household health financing methods and all available exemption mechanisms • Develop financial incentives for rational health seeking behaviours (e.g. maternity grants) • Implement financial incentives for delivery of client-oriented services at public health facilities • Support community participation in local decision making and policies that will affect their access to health services, and in monitoring and evaluation of demand-side financing schemes

Component 2: Financial barriers to access public health services

Desired Outcomes	Strategic Interventions
• Increased Access to public health services for all, especially for the poor • Reduced catastrophic expenditures for health	• Regulate user fees at public facilities • Ensure compliance with the exemption regulations at all provider levels • Implement nationwide poverty identification • Scale-up sustainable HEF arrangements • Expand CBHI coverage • Initiate linkage between HEF and CBHI • Encourage pilots of other demand side financing schemes and streamline with HEF and CBHI (e.g. voucher schemes) • Extend availability of social health protection schemes to all households nationally • Explore other financing mechanisms to remove debt for health care such as cash transfers, microfinance initiatives

Component 3: Social Health Insurance

Desired Outcomes	Strategic Interventions
• Social Health Insurance coverage of employees in the private and public sectors	• Establish compulsory health insurance for civil servants and for private sector employed workers • Ensure appropriate design for compulsory insurance schemes to achieve health sector goals and priorities: benefit package, premium levels, provider payment methods • Streamline CBHI, HEF and other forms of subsidized care with formal sector health insurance schemes

3.4- Financing of service delivery at public health facilities

Strategic objective 4: Efficient use of all health resources at service delivery level

Appropriate allocation of credible budgets to service delivery units can be achieved through decentralized budget control and appropriate planning, budgeting and accounting capacities and tools. National health accounts or other types of comprehensive financial flow and expenditure tracking surveys need to be in place and provide a baseline for the implementation of the strategy. Scaling-up contractual arrangements will ensure adequate coverage of health priorities, with

appropriate funding for recurrent budget and staff incentives. All sources of funding, especially demand-side financing schemes should be effectively used as leverage for quality of health services.

Component 1: Effective financing of health priorities

Desired outcomes	Strategic Interventions
• Funding from all sources allocated to meet health care needs at service delivery level	• Perform burden of disease assessment • Cost MPA and CPA delivery, including referral system, and defined continuums of care, including reproductive and women and children health services. • Target public funding to priority health interventions based on health needs

Component 2: Allocation of health resources at service delivery level and effective financial accountability at service delivery level

Desired outcomes	Strategic Interventions
• Effective implementation of funds at health service delivery level	• Use AOPs ans 3YRP for provincial budget negotiations, including facility-level budgets • Decentralize budget and expenditures control • Build financial management capacity at facility, OD and PHD levels and implement accounting procedures at facility level • Implement use of banking system for cash transfers

Component 3: Account for sources and uses of funding at health service delivery level

Desired outcomes	Strategic Interventions
• Effective financial tracking and monitoring at service delivery level	• Perform regular financial flow analysis and expenditures tracking at health service delivery level • Strengthen and integrate monitoring and supervision role of ODs and PHDs in financial management

Component 4: Financing to support quality health service delivery

Desired Outcomes	Strategic Interventions
• Improved health service delivery • Increased quality of health services	• Conduct assessment of service delivery contracting options • Scale-up contracting arrangements • Consolidate annual planning, budgeting and funding for public facilities with provincial and provincial block grants • Arrange pooling of funds at adequate level and use them to leverage quality of services

3.5- Evidence and information for health financing policy

Strategic objective 5: Improve production and use of evidence and information in health financing policy development

Adequate health financing policy making requires production and analysis of evidence, as well as capacity in health systems and health economics research. .This should include the analysis of the health financing situation with the equity and gender perspective, taking in special account the needs of marginalized and vulnerable populations.

Component 1: Health financing monitoring and evaluation

Desired Outcomes	Strategic Interventions
• Comprehensive health financing data on all sources and uses of funding for health • Information on costs of health interventions • Leverage quality of service delivery through health financing monitoring and evaluation • Health financing policy formulation based on sound evidence	• Perform burden of disease and costing studies as needed • Develop and implement National Health Accounts or other forms of expenditure tracking tools • Strengthen reporting of donor and NGO spending in health • Strengthen health financing report system (user fee, HEF, CBHI etc) • Strengthen data collection on OOP expenses • Include private sector spending in expenditure tracking tools • Link health financing monitoring and evaluation to quality assurance • Develop policy makers capacity for using health financing information and evidence in policy making

Component 2: Health economics research capacity

Desired Outcomes	Strategic Interventions
• Health economics research capacity	• Involve research teams in all step of research and study including financial data collection design, analysis and reporting • Build capacity to conduct health economics research • Build capacity for policy research

Component 3: Equity and gender perspectives in health financing

Desired Outcomes	Strategic Interventions
• Equity and Gender perspectives included in health financing data, analysis and policies	• Develop inter-sectoral collaboration for equity and gender analysis • Ensure health financing data collection is designed with appropriate indicators for equity and gender analysis • Build capacity for equity and gender analysis • Perform policy analysis from equity and gender perspectives

4-Implementation, Monitoring and Evaluation

Implementation of the Strategic Framework for Health Financing (SFHF) is a complex process involving a range of different plans, programs and agencies. To implement activities in a timely manner, a comprehensive implementation plan will need to be formulated with short, medium and long-term targets and timelines.

In line with HSP2 implementation, the strategic Framework will adopt a consolidation and a scaling-up phase, that will be further detailed in the full implementation plan. These two phases include:

1. Consolidation phase 2008-2010

- ✓ SFHF implementation and roadmap
- ✓ Institutional arrangements allowing SFHF implementation
- ✓ Perform burden of disease assessment
- ✓ Perform costing studies of MPA and CPA
- ✓ Costing of health programs (RMNCH, CDC, NCD)
- ✓ MOH policy on implementation of Decentralization and Deconcentration
- ✓ Policy on contracting
- ✓ Policy on health equity funds and targeting interventions to the poor and vulnerable
- ✓ CBHI regulations and CBHI network
- ✓ PFM reform implementation, including PBB
- ✓ Strengthen 3YRP and AOP formulation and use in strategic and annual budget formulation
- ✓ Capacity building at central, provincial, district, commune and facility level on health financing, including supervision and monitoring of health financing schemes
- ✓ Strengthen User fees, CBHI, HEF and other demand-side schemes reporting
- ✓ Strengthen health expenditure data collection from all sources – initiate NHA
- ✓ Advocate for equity and gender analysis
- ✓ Initiate health economics research capacity building
- ✓ Prepare for mid-term review

2. Scaling-up phase 2010-2015

- ✓ National implementation of:
  - Contracting arrangements
  - Health equity funds and targeted interventions for the poor and vulnerable populations
- ✓ Routine production and analysis of health financing information
- ✓ Long-term cross-sectoral collaboration including:
  - Phasing-in social health insurance for the formal sector
  - Gradual move to consolidation of all schemes and universal coverage
- ✓ Ongoing capacity building in financial management
- ✓ Ongoing capacity building in health economics research
- ✓ Equity and gender analysis
- ✓ Perform mid-term review
- ✓ Prepare for final review

The SFHF will adopt a **monitoring framework** with

1. An annual health financing report, presenting comprehensive health financing data and analysis, particularly the defined indicator bellow.
2. A mid-term review in 2011, with a thorough situation analysis and amendment of the strategic framework as needed.
3. A final review prior to formulation of the next strategic plan

Indicators for Monitoring and Evaluation

Indicator	Target			Definition/sources
	2007	2011	2015	
Government funding for health				
1- Share of Government as % of GDP	1.08			Health budget/ GDP
2- Government health expenditure per capita	USD 5.94			Health budget/population
3- % of expenditure over approved budget	98%			Health expenditure /approved budget
4- % of budget allocated to PHD	27%			Budget allocated to PHD/ total health budget
Donor funding for health				
5-% of health partner submitted financial report to MoH				Number of submitted health partners/ total number
6- Donor contribution to public health per capita	USD 7			Total donor fund/ population
7- Share of donor funding channeled through budget support				Donor spending in cash to health sector/ total donor funds
Household expenditures for health				
8- # of patient visits exempted at health facilities with user fees systems	1.3 Millions			Number of cases exempted
9- Per capita expend to public health sector	USD 0.8			OOP to public facilities via user fee, HEF, CBHI.
10- Annual household expenditure in public sector and private	USD 37			CDHS2005
11- OOP per capital on health	USD 25			CDHS 2005
Financing health service delivery				
12-Government health funding reaching province, OD and facilities				NHA or PETS
PHD Office	45%			
OD Office	7%			
Referral Hospital	26%			
Health Center	32%			
13- Health financing schemes register at MoH				
HEF scheme coverage cases	246,598			
CBHI members and cases	45,882 and 1Million cases			
Other schemes				
14-Coverage of contracting arrangement (ODs)	19			Monitoring and Evaluation of Contracting
Evidence and information for health financing policy				
15-NHA or other expenditure tracking tool in place and regularly updated				Report
16-Equity and gender analysis of health financing policies performed				Survey
17-Number of research or study or new health financing scheme initiatives introducing for implementation.	1			Case study on financial access to health services

Terminology

Social health protection is an umbrella term used to describe all schemes and procedures that provide an element of protection against health care expenditures for the poor and for other users. This includes fee exemptions, health equity funding, community health insurance and social health insurance.

Social health insurance refers to various compulsory pre-payment schemes within the formal employment sector supported by legislation and usually funded either by the government (for civil servants) or by employers (for formal private-sector employees), often with part-contributions also from the employees.

Community-based health insurance refers to private, non-profit, voluntary pre-payment schemes targeted on the informal employment sector of small scale and self-employed urban and rural workers. Such schemes are usually sponsored by an NGO and operate at community level. These schemes are funded by voluntary

Health Equity Fund is a social-transfer mechanism designed to provide targeted income transfers to the poor for the purpose of paying for health care in the public health system through providers contracted by the equity fund. It is a third-party payer scheme for indigent patients in which a fund is managed at district level by a local agent (usually NGO), supervised by an international NGO, and funded by government and mainly donors (or in some cases through community collections).