

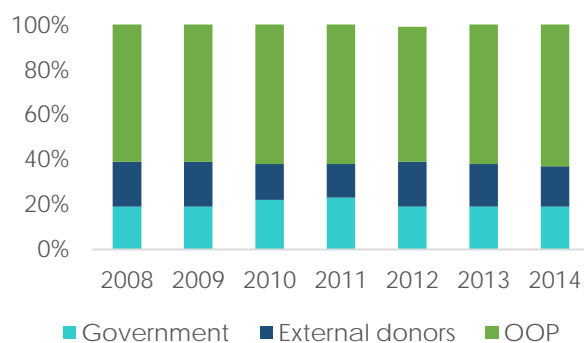


Key Indicators	
Population (2014)	15.3 million
GDP per capita (current USD, 2014)	\$1,095
Income classification	Low
Health Financing (2014)	
THE per capita (USD)	\$69
THE as % of GDP	5.8%
GHE as % of THE	18.5%
GHE as % of GGE	6.1%
OOP as % of THE	63.2%
DAH as % of THE	18.3%
HIV Financing	
Adult HIV/AIDS prevalence (2015)	0.6%
DAH for HIV as % of TAE (2014)	84%
TAE per PLHIV (USD) (2014)	\$690
GAE as % of GGE (2014)	0.05%
GAE as % of TAE (2014)	16%

Source: Kingdom of Cambodia, 2015a; Kingdom of Cambodia, 2015b; UNAIDS, 2015; Work Bank, 2015.

THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out of pocket payment, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure.

Figure 1: Shares of Total Health Expenditure (THE)



Source: Kingdom of Cambodia, 2015a.

## Overview

Per capita government expenditure on health in Cambodia has increased from an estimated US\$7.84 in 2008 to US\$12.70 in 2014 in current U.S. dollars. However, government health expenditure (GHE) as a proportion of total health expenditure (THE) has remained virtually unchanged (Figure 1). Further, GHE as a percentage of both gross domestic product (GDP) and general government expenditure remains low—1.3% and 6.1%, respectively (Figure 2). Although the government increased the health budget as a percentage of the total budget from 6.8% to 7.6% from 2008 to 2014, this increase falls short of the recommended 15% of the government budget to be allocated to health. The majority of THE is from out-of-pocket (OOP) payments. Insufficient financial protection in Cambodia led to 6.3% of the total population experiencing catastrophic health expenditures in 2013. Funding from external donors decreased slightly, from 20% to 18% of THE from 2008 to 2014, and is anticipated to continue declining. According to the latest National Health Accounts (2012–2014), nearly half (48%) of health expenditures are at public providers; this share has increased over time. Public health facilities charge user fees; only those with an ID-poor card receive services for free. Poor quality healthcare remains a challenge in the private and informal sectors.

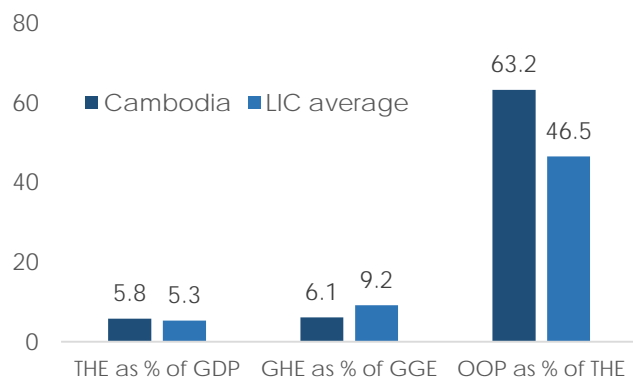
Cambodia has the building blocks to achieve universal health coverage (UHC) in the long-run, with UHC strategies outlined in its draft *National Health Financing Policy*. The draft policy, developed in 2014, calls for three social health protection schemes for formal private sector employees, civil servants, and the poor and non-poor informal sector population. Cambodia already offers high coverage among the poor; the Health Equity Funds (HEF), a pro-poor health financing mechanism that reimburses the full or partial cost of health services provided to the poor at public health facilities, covered 90% of the identified poor in 2014. The Ministry of Health (MOH) aims to expand HEF to other vulnerable populations and include it under a proposed National Social Health Protection System.

## Health Financing Functions

### *Revenue contribution and collection*

Cambodia has three major health financing sources: (1) the government's general revenues; (2) donors' development assistance; and (3) individuals' OOP payments for receiving services. The government and donors finance about the same share (~20%) of the health sector. Although THE as a percentage of GDP is among the highest for low- and middle-income countries in the region, GHE as a percentage of GDP is among the lowest, suggesting room for growth in government

**Figure 2: Comparative Health Expenditure (2014)**



Source: Kingdom of Cambodia, 2015a; WHO, 2015.  
LIC = low-income country

expenditure on health. Tax revenue as a share of GDP is small but has increased slightly, from 9.6% in 2009 to 11.6% in 2012. There are no taxes earmarked for health, such as a “sin tax.”

### Pooling

There is insufficient risk pooling in Cambodia. In 2015, 2.6 million people, or 17% of the total population, were covered through social or voluntary health insurance or government subsidies such as HEF. Cambodia has at least seven community-based health insurance schemes that cover less than 1% of the population. Formal sector social health protection schemes are not operational, except for an injury scheme under the National Social Security Fund, but the government decided in 2016 to launch a health insurance scheme for employees in the private sector and public servants. This will be rolled out over the next few years. The MOH is working to improve pooling by considering expansion of HEF to vulnerable groups other than the poor, such as the elderly, people with disabilities, and children under five.

### Purchasing

Provider purchasing mechanisms in Cambodia include line items from the government budget; user fees; performance-based payments; case-based payments from the HEF; capitation, case-based, and fee-for-service payments from small community-based health insurance; output-based payments to midwives for facility deliveries; and subsidization of user fees from national programs, donors, and nongovernmental organizations. Government budget line items pay for infrastructure, health worker salaries, and in-kind distribution of pharmaceuticals and commodities. HEF is implemented through a third party implementer and a third party operator according to a standard benefit package and payment mechanism. Benefit packages covered under HEF include reimbursement for medical services in public facilities and other costs such as transportation, care-taker allowance, food, and funeral costs. Multiple mechanisms have led to fragmented financial management. As a result, the government is planning to reform the current provider payment system.

## HIV Financing

Approximately 75,000 people are living with HIV (PLHIV) in Cambodia, with an HIV prevalence rate of 0.6% among adults. HIV accounts for only 2.4% of deaths but 5% of THE in Cambodia (Figure 3). Further, HIV spending represents 16% of communicable disease spending—the second largest share following respiratory infections.

An estimated US\$50.2 million was spent on HIV in Cambodia in 2014, of which approximately 84% was funded by donors. PEPFAR provides an estimated 20–30% of HIV funding; the Global Fund to Fight AIDS, Tuberculosis and Malaria provides about 45–55%. Antiretroviral treatment is one of several services provided free of charge to all PLHIV.

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**Figure 3: 2014 THE, by Disease, Total = US \$1,057 million**

