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*The NGO Forum on Cambodia*

ធ្វើការរួមគ្នាដើម្បីការវិវឌ្ឍសង្គមឡើងវិញ  
*Working Together for Positive Change*



# MAPPING OF BUDGET INFORMATION IN HEALTH SECTOR

April 2009

Phnom Penh, Cambodia

## **Mapping of Budget Information in Health Sector**

This study was commissioned to **Mr. PAK KIMCHOEUN**, by the National Budget Project of the NGO Forum on Cambodia, in cooperation with MEDiCAM, as part of the project's effort to promote budget transparency.

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## List of Abbreviations

3YRP	Three year rolling plan
AOP	Annual Operating Plan
AusAID	Australian Agency for International Development
CDC	The Council for the Development of Cambodia
CDCF	Cambodia Development Cooperation Forum
CMS	Central Medical Stores
COA	Chart of Accounts
CPA	Complementary Packages of Activities
CSOs	Civil Society Organizations
D&D	Decentralization and de-concentration
DFID	Department for International Development
DIC	Department of Investment and Cooperation (of MEF)
DIP	Development Issue Program
DOF	Department of Finance (of MOH)
DPHI	Department of Planning and Health Information (of MOH)
DPs	Development Partners
FMIS	Financial Management Information System
H&A	Harmonization and Alignment
HC	Health Centres
HCP	Health Coverage Plan
HEF	Health Equity Fund
HIS	Health Information System
HISSP	Health Information Strategic Plan
HSP	Health Sector Strategic Plan
HSSC	Health Sector Steering Committee
HSSP	Health Sector Support Program
IMF	International Monetary Fund
JAPR	Joint Annual Performance Review
JTWG-H	Joint Technical Working Group on Health
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MOH-DIC	Department of International Cooperation of MOH
MOI	Ministry of Interior
MOP	Ministry of Planning

MPA	Minimum Packages of Activities
MTEF	Medium Term Expenditure Framework
NA	National Assembly
NGOs	Non-Governmental Organizations
NIS	National Institute for Statistics
NSDP	National Strategic Development Plan
OD	Operating Districts
PBB	Program-based budgeting
PFMRP	Public Finance Management Reform Program
PHD	Provincial Health Department
PIP	Public Investment Program
Pro-JITWG-H	Provincial Joint Technical Working Group on Health
R&D	Research and development
RGC	Royal Government of Cambodia
RH	Referral Hospitals
SOA	Special Operating Agencies
SWAp	Sector Wide Approach
SWiM	Sector Wide Management
TB	Tuberculosis
TOFE	Tableau des Operations Financieres de l'Etat
USAID	U.S. Agency for International Development

## List of interviews

Institutions	Date of meeting
MEF – Treasury	December 08, 2008
MEF – Budget Department	January 27, 2009
MEF – Dept of Investment and Cooperation	February 03, 3009
MOH – DPHI	November 12, 2008; December 18, 2008
MOH – DOF	November 12, 2008; December 18, 2008
MOH – DIC	December 18, 2008
MOH – PHD/OD	December 26, 2009; February 20, 2009
MOH – HC/RH	December 26, 2009; February 20, 2009

## Executive Summary

This budget mapping exercise was conducted in the period from December 2008 to February 2009. It seeks to provide a comprehensive overview of publicly available documents which will be helpful for NGOs to better understand planning and budgeting process in health sector. That understanding is expected to enable the NGOs to make sure that their programs are complementary to the efforts of the Royal Government of Cambodia.

The study evaluates (i) budget information or documents that are available through well defined procedures that ensure simultaneous release of public documents to all interested parties, as well as (ii) those that are available only with request and approval from appropriate authority.

It found that some types of budget information are readily available, and some can be made available only with approval from the higher level, namely, Ministry of Economy and Finance (MEF) and Ministry of Health (MoH) and/or through the Joint Technical Working Group (JTWG). It found further that to be able to properly and regularly track and use budget information in health sector, NGOs need to also understand its service delivery and financing arrangement.

First is to understand the sector's policy, planning and evaluation process. A number of key documents are relevant for this task, including: the Millennium Development Goals, the National Strategic Development Plan (NSDP), Public Investment Program (PIP), the more detailed Health Sector Strategic Plan (HSP) 1 and 2, the 3 Year Rolling Plan (3YRP) and the Annual Operational Plan (AOP), Annual Health Statistics and Joint Health Review.

The financing arrangement and the link between policy/planning and the budget is another important aspect to be comprehended. Budget in health is divided between recurrent and capital spending and currently, the national budget and donor/NGOs support are the sources of funding for both types of spending, including that of the Central Medical Store (CMS) whose responsibility is to procure and distribute drugs to national hospitals and other frontline service providers at the sub-national level.

The 2008 Public Finance Law (Article 84) provides that “... *all accounting and financial reports must be transparent and publicly disclosed.*” In practice, however, a number of accessibility constraints are identified. For the national budget, the challenge comes from the centralization of budget information at the MEF and MoH. The fragmentation between the recurrent (which is managed under the Budget Department of the MEF) and the capital spending (which is under the Department of Investment and Cooperation (DIC)) poses as another challenge.

Fragmentation is even more challenging to the collection and analyzing information about donors/ NGO support to the sector. These development partners work in various aspects of health service delivery, ranging from providing drugs, health equity fund (HEF), and other operational aspects of frontline service providers. Trying to mobilize information about these supports, various attempts have been made, including the efforts to update the CDC database, MEDiCAM database, and the information system initiated and being strengthened by the MOH's Department of International Cooperation (MOH-DIC).

Despite these efforts, bringing all information into one place is still a problem. The MoH and development partners have been taking several initiatives to address such a challenge, including: the use of the AOP which is jointly prepared and evaluated by the MOH and development partners. This document is very detailed and made publicly available; the establishment of the JTWG in health to enhance better access to budget information of the sector. Other initiatives

including the strengthening of the AOP and 3YRP mechanism, the Program-Based Budgeting (PBB), Special Operation Agency (SOA) and Health Information System (HIS).

At the sub-national level, the Provincial Health Department (PHD) is responsible for consolidating the AOPs sent from referral hospitals (RHs), health centre (HCs), and operating districts (ODs) and sending it to the MoH. The provincial consolidated AOP is prepared jointly by relevant health agencies and development partners. At that level, a Provincial JTWG (Pro-JTWG) mechanism is also established and convenes on monthly and quarterly basis. Through the Pro-JTWG, relevant budget information can be requested and scrutinized. The RH, HC and OD level also keep certain types of health statistics and budget information. However, those pieces of information can be made available only with approval from appropriate agencies, or through the Pro-JTWG.

To keep track of budget information in health sector, it is important to understand and get updates on the above initiatives that happened in the health sector. But that is not enough. Attention should also be made to other cross-cutting reforms, especially the Public Finance Management Reform Program (PFMRP) and the Decentralization and De-concentration (D&D). Under the PFMRP, the introduction of the New Chart of Account (COA), the improvement in the comprehensiveness and coverage of the National Budget, and the more complete aid database are particularly relevant to making health budget information more accessible.

The progressing D&D reform, in addition, is introducing a deep but gradual reform in the way public services and resources are provided and allocated. With a more functioning and responsive sub-national administration (SNAs) in place, NGOs and the public will find it easier dealing with each SNA council when requesting for information. Certainly, this will be much more convenient than having to put a formal request through the central ministry hierarchy. Of similar effect, responsive SNA councils will also help ensure better monitoring of NGO and donor project activities, one consequence of which is better information sharing on budgetary issues.

Lastly, ensuring and promoting access to budget information in health is not a task that can be accomplished by working in that sector alone, nor can it rely on a one-time action. Instead, it requires a mechanism that allows regular interaction among key stakeholders and well updated information about the progress of relevant reforms. That said, however, one does not need to “re-invent the wheel”. Strengthening what is already in place (such as existing JTWG and various financial and aid monitoring databases) should be a more preferred option than creating new ones.

## Budget information availability for health sector in Cambodia

Institutions	Documents	Frequency	Availability*
RGC	National Budget Law	Annual	PA
	Budget Execution	Annual	PA
MEF	National Budget (four volumes)	Annual	PA
	State Budget Implementation	Monthly/Annual	PA
MoP	National Strategic Development Plan (NSDP)	Every five years	PA
	Public Investment Program (PIP)	Annual	PA
CDC	ODA database	Continuously updated	PA
MOH – Planning Dept	Annual Health Statistics	Annual	PA
	AOP and 3 YRP	Annual	PA
	Joint Health Review	Annual	PA
MOH – Finance Dept	Annual Budget Plan	Annual	JTWG
	Report on spending	Monthly/Quarterly/Annual	
MOH – CMS	Drugs and consumables report	Quarterly/Annual	
MOH - DIC	Database on external assistance to health sector	Continuously updated	
PHD & OD	Health Information System (HIS)	Continuously updated	Pro-JTWG
	AOP and 3 YRP	Annual	
	Budget Plan	Annual	
	Status of monthly and annual spending and revenues	Monthly/Annual	
	Report on Health Equity Fund (HEF)	Quarterly	
	Drugs and consumables report	Quarterly/ Annual	
	Report on Pro-JTWG	Monthly/ Quarterly	
HC/RH	Monthly and annual performance report	Monthly/ Annual	
	Report on revenue-spending analyses	Monthly/ Annual	
	Table on HEF	Monthly	
<p><b>*Notes:</b>  <i>PA: Publicly available</i>  <i>JTWG: Made available through JTWG</i>  <i>P-JTWG: Made available through Pro-JTWG</i></p>			

## 1. Introduction

This study aims to assess the availability of financial (budget) information and non-financial information (outputs of spending) in Cambodia's health sector at the national, provincial and local levels and has three specific purposes: i) set the advocacy agenda for demanding increased public availability of budget information; ii) identify the expenditure types that can be monitored by civil society groups; iii) identify groups of NGOs/ CSOs that are interested in working on budget issues in the health sector.

## 2. Background

This study is an output of the Development Issues Programme (DIP)'s work on national budget monitoring and links to DIP's work on monitoring the National Strategic Development Plan (NSDP) 2006-2010, analysing the national budget, research for the Open Budget Index, and the recent publication of the National Budget Guide. This study is carried out in close cooperation with the study on "Mapping of Budget Information in Education" which is carried out by DIP's Aid Effectiveness Project.

Although successful implementation of the NSDP depends on effective and efficient funding of the underlying sectoral plans (health, education, agriculture etc.), there is little CSOs monitoring of government and donor expenditures in these sectors. The lack of CSOs monitoring can, at least partially, be explained by lack of capacity within Cambodian CSOs and the lack of transparency and accessibility of public expenditure information in these sectors and its results.

In order to enable civil society organisations to engage with the Royal Government of Cambodia (RGC) and its development partners, this study will assess what budget information is publicly available, what information is not available, which public expenditures can be monitored by civil society groups, and which NGOs/ CSOs are potentially interested in carrying out this work.

This study on access to budget information in the health sector will be overseen by the reference group consisting of:

- **MEDiCAM**, the leading membership organization in the health sector with over 100 NGOs active in the health sector in Cambodia. MEDiCAM acts as a bridge between NGOs in the health sector and the RGC. Its mandates are to exchange information, to facilitate advocacy, to build capacity for local NGOs, and to represent NGOs voice. MEDiCAM is an active member of the Government-Donor Technical Working Group on Health, and the Government-Donor Technical Working Group on HIV/AIDS.
- **Health Unlimited (HU)**, an active member of MEDiCAM and the NGO Forum, has been active in Cambodia since 1990. The organisation has offices in 4 provinces: Ratanakiri, Preah Vihear, Mondulhiri and Kampot. Their work includes delivery of health services, advocacy and empowerment including maternal and child health, water sanitation, HIV/AIDS and malaria prevention, indigenous people rights, community health education, and community tuberculosis (TB) directly observed treatment , short-course (DOTS).
- **CARE Cambodia**, an active member of MEDiCAM and the NGO Forum, has worked with Cambodian people since 1958, first in transferring medical supplies, opening an office in 1973 and from 1975 working with Cambodian people in the Thai/Cambodian border camps. In 1990, CARE supported the repatriation of 350,000 Cambodians back home. CARE manages extensive health programs in Cambodia including health system strengthening, supporting the continuum of care for people infected with or affected by HIV, support to education including non-formal and bilingual educational programs, rural development including

pandemic and disaster preparedness and mitigation, food security and integrated de-mining as well as emergency response in flood or draught situations. CARE has provincial offices in Pailin, Koh Kong, Prey Veng and Ratanakiri.

- ***The NGO Forum on Cambodia*** is a membership organization of over 80 NGOs that seek to discuss, debate and advocate the concerns of NGOs regarding Cambodia's development. The NGO Forum has 3 main programs including a Development Issues Programme (Development Policy and Economic Policy, National Budget and Aid), an Environment Programme, and a Land and Livelihood Programme. The NGO Forum is an active member of the Government-Donor Technical Working Group on Public Financial Management Reform, and the Government-Donor Technical Working Group on Planning and Poverty Reduction.
- ***The University Research Company (URC)***: Health Systems Strengthening in Cambodia (HSSC) Project (awarded by USAID with the objective to strengthen the capacity of the Ministry of Health (MOH) in Cambodia to plan, manage, and implement programs addressing HIV/AIDs, tuberculosis, and family health in seven provinces): The URC team provides technical assistance to the MOH by applying a comprehensive systems approach to strengthen the capacity of the Cambodian health system to better plan, finance, and deliver the basic package of reproductive and child health services. Applying a comprehensive systems approach to identify and address health system performance issues, URC provides technical assistance to the MOH and its partners at the provincial health departments (PHDs), operational districts (ODs), and health centers (HCs) levels in 4 component areas including management capacity development, outreach system strengthening, integration and linkage of HIV/AIDS services with referral hospitals (RHs) and TB, program monitoring, evaluation, and advocacy for health system improvement in Cambodia.

### 3. What information will the study evaluate?

This study looks at budget information in the health sector and their availability at both central and sub-national levels. It focuses on what happens in practice, rather than on what is said in the law/ regulations. Definition of public availability is taken from the **International Budget Partnership** (IBP), which includes:

- Information that is available through well-defined procedures that ensure simultaneous release of public documents to all interested parties, as well as,
- Information or documents that is/are available only on request.

In Cambodia, health service delivery is financed mainly by two sources: national budget and donors/NGOs. This study will look at both. The current focus is on the quantity of the available information. The study assesses whether it is comprehensive, timely and appropriate for policy analysis. The budget data that has been produced is a product of the constantly changing budget management system. This system changes as a result of various government-wide sector reforms and therefore assessed in this context.

The study identifies:

- Information that is available to the public;
- Information that is provided on a regular basis to, for instance, members of Technical Working Groups at the national or sub-national level, provided that the RGC confirms that this information can be shared publicly;

- Information that is provided on a regular basis to members of facility management committees.

#### 4. Methodology and structure of the report

The study employs the following methodologies:

- Desk research: The study starts by reviewing sectoral policies, evaluation reports and related service delivery policies and reforms such as those relating to Public Financial Management Reform Program (PFMRP) and Decentralization and De-concentration (D&D).
- Interviews with key members of reference groups: This is to get comments from various NGOs experienced about the sectors and also to ensure that key documents and reports are not missed for the purpose of producing literature review.
- Interviews with central institutions: These central institutions include the Ministry of Health, Ministry of Economy and Finance, and Ministry of Interior. As a note, the MOI is particularly relevant here because of the D&D, which has been happening, and is going to have significant impacts on health service delivery as well as access to its financial and non-financial information.
- Interviews at the field level with representatives at the provincial, operating district and health centre level: This includes the two fieldtrips; one to Kandal province on December 26, 2008 and the other to Sihanoukville province on February 20, 2009.

To respond to the objectives of the study and to reflect the nature of the financing and budgeting system in the sector both as of now and when factoring in the upcoming policy changes, this report is structured in the following:

- Sector policy and financing overview: It starts by providing a brief overview of policy context and financing arrangements in the sector. It discusses key sources of financing, key budget items and the flow of funds from the sources to various spending entities at central, provincial, district and front-line levels.
- Budget documents produced and its accessibility: Attached to each type of budget are various budget documents prepared and reported by different levels of spending agencies. It then identifies and describes key budget documents produced at each level, what key budget information it contains, and how accessible they are.
- Budget information availability in health: Expected changes in the short and medium term: Even more importantly, health budget system and budget information accessibility continuously evolve, as a result of reforms both within the sector and within the overall budgeting and institutional arrangements. This section then points to upcoming changes in budget policies in the sectors, and the opportunities and challenges that may arise, and
- Recommendations: A set of recommendations are provided as to what NGOs should do in their advocacy works on budget information accessibility in the health sector for short, medium and long term.

## 5. Sectoral overview: policy, progress and financing arrangement

### 5.1. Policy and planning

The big umbrella policies for the health sector are the Cambodian Millennium Development Goals (4, 5, and 6) and National Strategic Development Plan 2006-10. The health sector is also a part of the strategic sector for implementing the Rectangular Strategy (2004 and 2008) with the focus on the fourth pillar: capacity building and human resource development. Development in health therefore needs to be justified as to how it helps to achieve these bigger development policies of the state.

The more detailed policy for health is the Health Sector Strategic Plan 2003-07, known as HSP1. HSP1 provides a framework for which the government, development partners (DPs) and NGOs work together to achieve a well defined set of objectives. HSP1 adopted 20 strategies of which 8 form the essential core. Of the core strategies, the top priority is to improve health service delivery, including (i) improving access and coverage for the poor; (ii) delivery of Minimum Package of Activities (MPA) at health centre level; (iii) delivery of Complementary Package Activities (CPA) at referral hospitals. Also of priority are behavioural changes of health providers, quality improvement, human resource development focused on midwife training and other institutional reforms. In late 2007, an HSP review found that in the period, Cambodia has made some improvements in increasing utilization of health services, reducing HIV prevalence rate, and infant and children mortality. However, the achievement fell short when it comes to improvement of maternal mortality rate (Ortendahl, Donoghue et al. 2007).

In April 2008, the Ministry of Health adopted the HSP2 for 2008-15. HSP2 proposes the following priorities: (i) reduce maternal, new born and child morbidity and mortality with increased reproductive health; (ii) reduce morbidity and mortality of HIV/AIDS, malaria, TB, and other communicable diseases; and (iii) reduce the burden of non-communicable diseases and other health problems. HSP2 continues some key missions from HSP1, but provides a different view on what the future priority health will be. First, as it is captured by the World Bank document (HSSP2, p.28), Cambodia needs to focus more on maternal health, keep improving child health, and tackling communicable diseases. The health system needs also to prepare to tackle both newly emerging infectious diseases and the non-communicable ones. Inter-sectoral interventions will also be of importance when it comes to issues such as girl education, access to sanitation and clean water.

To put the policy objectives into operation, health has adopted the following planning and budgeting process which has two key pillars: the 3 year rolling plans (3YRPs) and Annual Operational Plans (AOPs). The 3YRPs are essentially medium term expenditure frameworks prepared by the various units at MOH, departments, national centre and provinces. These plans are based on the sector's financing needs (bottom-up) and projections of the resource envelope from all sources (top-down). The bottom-up costs and top-down resource envelopes are matched in the context of the annual planning and budget process to inform resource allocation decisions on priorities, both within and across sectors. The 3YRPs are broken down into AOPs which contain detailed activity plans and budgets with specific performance indicators. Although not currently the case, the AOPs will ultimately include all activities, regardless of funding source (e.g., government budget, donors, and NGOs) (World Bank, 2008, p. 60). It is important to note that the AOPs are plans that are submitted to MEF for approval /negotiation. The AOPs do not contain actual allocations or entitlements. For more information on the AOPs, please refer to Section 6.1 (on budget information at the national level).

The process starts in January with an update of the 3YRPs followed by the annual health congress in March which is used to assess the overall sectoral performance. It is attended by both

the government and development partners. The Congress is then followed by the Joint Annual Performance Review (JAPR) where (a) health policies are discussed amongst a broad group of stakeholders; (b) progress against the core indicators is measured; and (c) national targets for the next round of identified health sector priority areas are set. This Review sets the stage for the preparation of the following year's AOPs. The AOPs are prepared by all health centers, hospitals, operating districts, provincial health departments, and MOH central departments, training institutions, and national centers. These are aggregated at the provincial and central levels and used by the Department of Planning and Health Information (DPHI) to negotiate the budget with MEF in July. The DPHI also conducts a review and appraisal of the consolidated AOPs in August and September including Joint MOH and development partner appraisal. After approval of the government budget in legislature, the finalized sectoral AOPs are submitted to the Health Sector Steering Committee (HSSC) for approval (World Bank, 2008, p. 60).

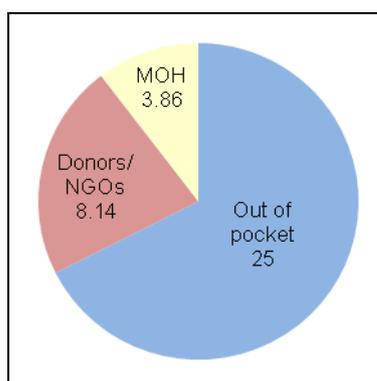
## 5.2. Financing

The health sector in Cambodia is financed from various sources including (i) out of pocket spending of households, (ii) national budget, and (iii) donors and NGOs assisting and working in the sector. Like many other developing countries, Cambodian health financing is dominated by out-of-pocket spending. Compared to neighbouring countries, a large proportion of Cambodia's health expenditures come from private households (Figure 1).

In 2005, with national per capita income of USD430, per capita spending on health was estimated at USD37, 68% of which was from out-of-pocket, 22% from donors/ NGOs and 10% from MOH.

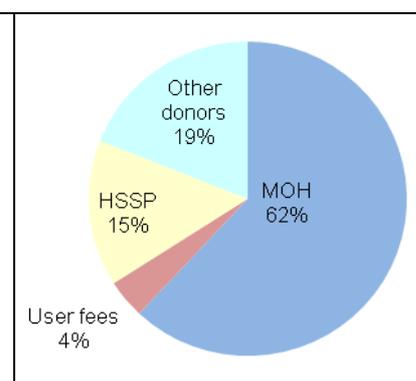
Regardless of the out-of-pocket spending, the share of the government spending has been increasing constantly from one year to another. Compared to 2007, the national budget for the sector increased by 20% in 2008, according to the National Budget Law 2007 and 2008. Also from AOPs 2008, as shown in Figure 2, national budget represents 62% of total financing of USD165 million. Donor/ NGOs contribution represents almost 35%, 15% of which comes through the pool resource program called Health Sector Support Program (HSSP) which is a type of Sector Wide Approach of foreign aid financing. The AOPs, however, realize that the financing from the donors/ NGOs might not have been fully captured due to incomplete financing information given from development partners and partner NGOs.

**Figure 1: Per capita health spending in 2005 (USD)**



Source: HSP2

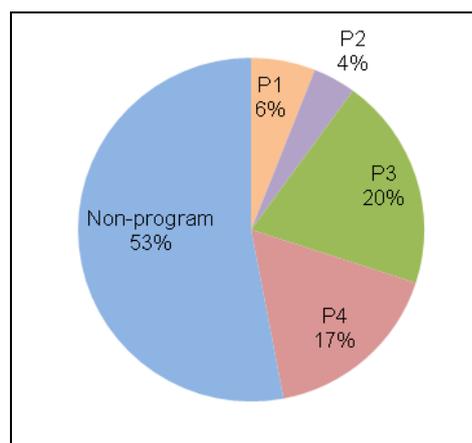
**Figure 2: Health Financing for 2008**



Source: AOPs 2008

As mentioned earlier, the AOPs/3YRPs are the main planning and budgeting document of the health sector. they show both the main sources of financing (i.e. national budget and donors/ NGOs) and the programs and sub-programs to be financed by the funding. In 2008, for instance, there were four programs and one non-program to be funded. Those four programs are: (i) institutional development, (ii) mother and child health, (iii) communicable diseases, and (iv) non-communicable diseases. The non-program refers mainly to supply of drugs and medical supplies. Just to give a rough picture of how the total financing is distributed, for 2008, the proposed<sup>1</sup> budget of about USD201 million (compared to only USD165 million approved, as presented above) was divided in proportion as shown in Figure 3. As shown there, the non-program spending takes up most of the total proposed budget. Financing from the national budget is managed according to the state budgeting system, which is different from that applied to donors/ NGOs money. According to sub-decree no. 170 ANKR dated December, 30, 2006, the national budget has the following components:

**Figure 3: Allocation of the funding by programs and non-program**



Source: AOPs 2008

### Recurrent spending

- Purchase of goods (Chapter 60 - This chapter covers a large part of Chapter 11 of the old Chart of Accounts; it has 7 sub-chapters, and 21 sub-sub-chapters.) Main spending items under this component include general operation and maintenance, furniture and utility expenses.
- Purchase of services (Chapter 61 -this chapter covers some parts of Chapter 11 of the old Chart of Accounts; it has 8 sub-chapters and 11sub-sub-chapters.) Main spending items under this component include training, repair, insurance and transportation.
- Other services (Chapter 62 -this chapter also covers some parts of Chapter 11 of the old Chart of Accounts; it has 8 sub-chapters and 18 sub-sub-chapters.) Under this component are key spending items including compensation for contractual staff, “hospitality” expenses, various ceremony expenditures and media promotion.
- Personnel expenses (Chapter 64 -this chapter covers a large part of what used to be under Chapter 10 of the old Chart of Accounts; it has 5 sub-chapters and 30 sub-sub-chapters.) Main spending items under this component include basic salary, allowances, priority mission groups and social welfares (e.g. pension).

### Capital spending

- Intangible investments (Chapter 20) including mainly R&D
- Tangible investments (Chapter 21) including construction, renovations, vehicles and other durable assets

It should be noted that similar to the case of other sectors, only recurrent budget is allocated to the health sector. Capital spending financed by state budget is managed under the Department of

<sup>1</sup> Information as to how the USD165million was actually distributed was not available.

Investment and Cooperation (DIC) of the Ministry of Economy and Finance. Those allocated recurrent budget is mainly spent on personnel and operational and consumable costs.

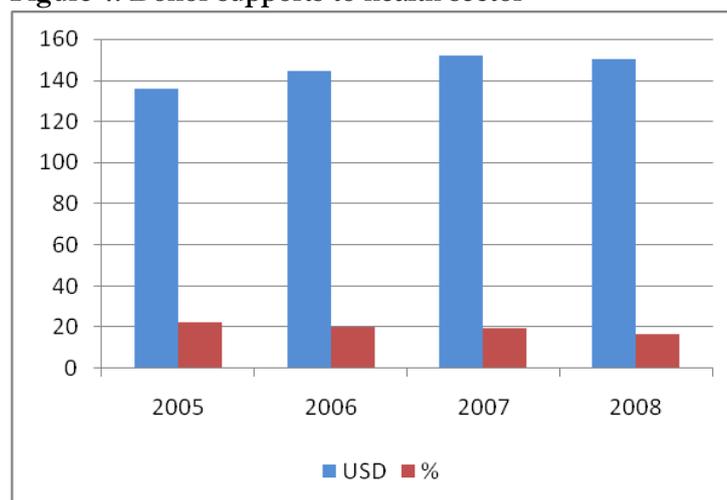
Within this recurrent spending, the health sector also has the so-called Program Based Budgeting (PBB), a new reform initiative based on experience from the two financial management initiatives, i.e. Accelerated District Disbursement (ADD), which started since 1996, and Priority Action Program (PAP), which started in 2000 and ended in 2006. Unlike education, however, PBB in health has been limited in coverage, accounting for only 10% of total recurrent spending in 2008 and has been applied only to national level.

National budget also contributes to the HEF and insurance starting from 2007. However, in that year, government contribution to the funds accounted for only 27%, leaving the rest to be financed by donors/ NGOs (MOH Health Progress Report from 2003-07 issued in 2008).

### 5.3 Coordination of Donors and NGOs in Health

Cambodia is an aid-dependent country, with a lot of external funding given to various sectors. Health has been among the sectors receiving most of that support. Donors finance the sector through various ways including pooled resources, stand-alone projects, and through NGOs. The financing arrangement has been very fragmented and it is not clear exactly how much the support has

Figure 4: Donor supports to health sector



Source: AER 2008

been for each year. The Aid Effectiveness Report (AER) which came out recently, (which might be the most reliable source) indicates that the health sector, including support specifically to HIV area, has been the largest recipient of foreign aid thus far, as indicated in Figure 4.

A large share of donor funding also implies higher activities of donors and NGOs. Out of the 32 DPs working in Cambodia, 22 have been working in the sector running 109 projects. Out of the USD183.5 million coming from NGOs, about 25% was allocated to the health sector. Also, according to interviews with officials of the Department for International Cooperation of the MOH, there are about 120 NGOs now working in the sector.

Donor money has been used to finance all types of spending, i.e. personnel, operation, drugs, and others, and the modalities by which such financing is provided varies a lot. Donor money has been given to both supply side (i.e. improving health services) and demand side (i.e. Health Equity Fund and other insurance financing). It is also noted that donors have been giving more to various national programs such HIV/AIDS, malaria, TB and others, and less on primary health care (MOH 2008).

The size of donor support and the various modalities it has used impose a big challenge for harmonization and alignment (H&A). H&A in health means all financing available is used harmoniously to support a single national priority (MOH 2008). Various measures have been taken to achieve this objective in health (HSSP2, p.62):

- Adoption of HSP1 and then HSP2 which sets out sectoral priorities to which donors and other supports need to align.

- Uses of SWAp/SWiM to pool donor resources to support the sector (now only a few donors are included under the HSSP2 and SWiM, including the World Bank, AusAID and DFID)
- Establishment of Joint Technical Working Group on Health (JTWG-H) and similar mechanisms at provincial level called Pro-JTWG-H
- Establishment of other forum including the Health Partner Group and the Government Task Force on H&A
- Conducting of Joint Annual Performance Reviews (JAPRs), Annual Operational Planning Review and Appraisal in MOH's planning and budgeting cycle, etc.
- The adoption of AOPs (see above).

#### **5.4. Organizational structure and service delivery system**

The MOH is the main agency responsible for health service provision. MOH is organized through a vertical structure which has the following:

- Central: MOH, national programs, and national hospitals
- Provincial: (provincial health departments)
- District (operating districts)
- Front line service provider (referral hospitals, health centres, and health posts)
- NGOs working as contractors
- Community based committees for health, and
- People

Since its early stage of organizational development, health has emphasized the importance of 'district' level, i.e. the ODs. Jurisdiction of an OD is not necessarily compatible with an administrative district, for its boundary is drawn based on the size of population and not the traditional administrative ones. In the current system (2007), according to HSP2 (MOH, 2008, p. 16), about 22% of the population seeks health service from the public sector and get such services from a network predominantly consisting of:

- 77 operating districts under which there are
- 956 health centers and
- 74 referral hospitals

A Health Coverage Plan (HCP), adopted in 1996, systematized the reconstruction and staffing of the public facilities network according to population-based norms, and defined the package of services that should be provided at each level. A health center providing an MPA is expected to cover about 10,000 people, and be within 10 km, or about a 2 hour walk from the population it is serving. The MPA focuses predominantly on cost-effective disease prevention activities and mother and child health services. Referral hospitals, on the other hand, provide the

Complementary Package of Activities at three levels of service (CPA 1,2,3) and are expected to cover 100,000-200,000 people and be within 20-30 km of the population it is serving, or a maximum of 3 hours by car or boat. Higher level CPA services are provided at the provincial level in all of the 24 Provinces, and at the regional level in 8 regional centers. Additionally, national hospitals provide a mix of secondary and tertiary services, with some also providing clinical training, including medical specialization training. National hospitals account for the fastest growing share of total public hospital sector activity, rising from 29% of all hospital discharges in 2002 to 44% in 2006 (World Bank 2008).

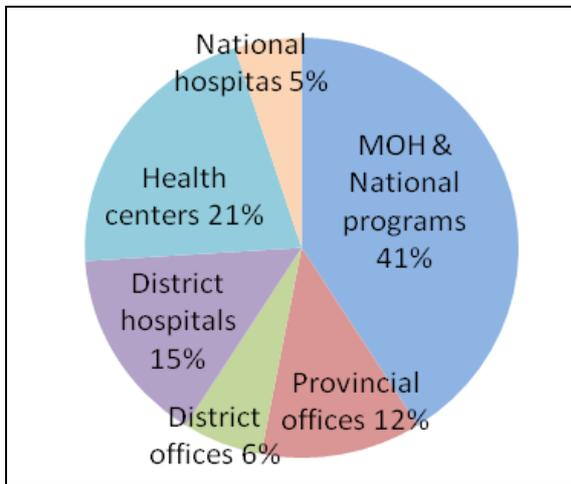
The ministry had implemented a number of contracting-in and contracting-out arrangements at ODs and HCs. In such arrangements, NGOs were given discretion over budget, staffing and technical content in the day-to-day management. Lessons learnt from this NGOs contracting arrangement have led to the introduction of another innovation in the sector, i.e. the plan to establish the so-called 'Special Operating Agencies (SOAs).' Under new legislation, SOAs have a considerable degree of autonomy in decision making and how to organize themselves. While salaries are to be based on government pay scales, they may be supplemented by other revenues derived in part from patient fees and donor funds. SOAs in the health sector will also be allowed to set their own user charges presumably subject to MOH guidelines and monitoring, and revenues from services may be apportioned to operating costs and salaries. However, it is not sure how fast the SOAs will be introduced into practice despite the plan to go ahead with this structure in 11 ODs in 2009.

In addition to their standard health services, the ministry also houses a number of programs for special purposes, such as the prevention and treatment of dengue, malaria and HIV / AIDS. These programs are largely funded by donors and run independently with their own guidelines for service delivery and their own procedures for planning, financing, staff incentives, monitoring and supervision. Most of them work directly with ODs and HCs, but their separate modes of operation make it difficult for ODs and HCs to coordinate activities and integrate them into routine programming. The centralized administration of these programs also undermines local accountability.

## **5.5. Allocation and flows of fund**

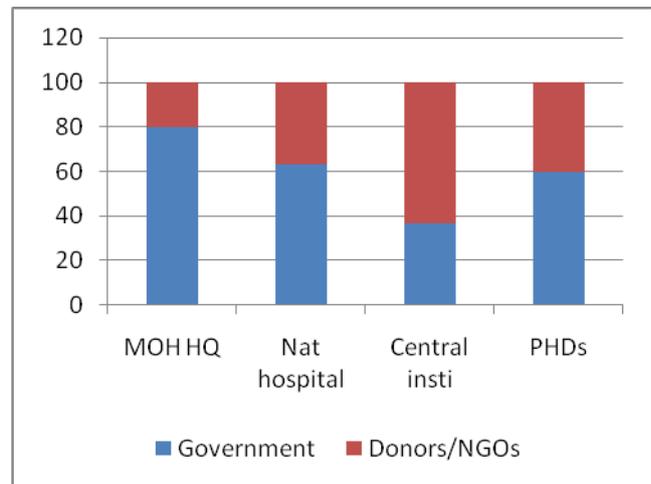
Funding from different sources (as discussed in financing Section) flows through the described organizational structure and financing from all sources (government, user fees, donors and NGOs) has been allocated and spent on all types of areas (e.g. salary, operation). As Figure 5 shows, much of the support has been channelled to central MOH and national programs, accounting for more than 40% in 2004. Figure 6 also shows that donors have been focusing much of their support on those national programs.

**Figure 5: Allocation of funding for 2004**



Source: PETS, 2008

**Figure 6: Percentage by funding sources and uses**

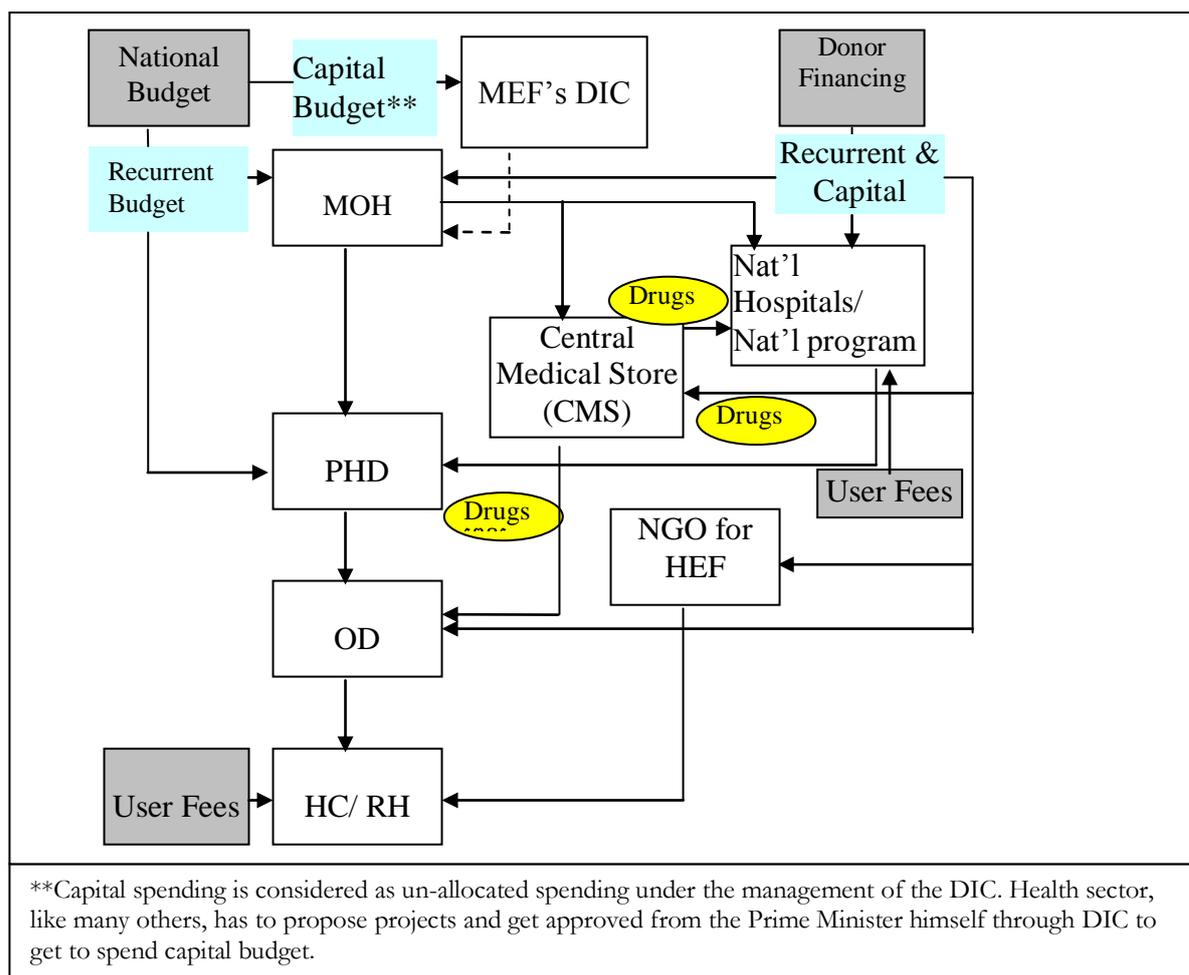


Source: AOPs 2007

Another diagram below indicates the flow of funds from the central down to the facility level. Basically, as presented, financing sources can come from both national budget and donors/NGOs and can flow to various levels of MOH operation, plus the contracting NGOs working on HEF and other forms of medical insurance. One note to make is that drugs and various medical supplies are procured centrally by the MOH and stored at the Central Medical Store (CMS). Donors/NGOs also contribute such supplies to the MOH which end up at the CMS. The CMS distributes the drugs and medical supplies to various levels of health operation.

Another important note is that for the most part the national budget has been used to finance recurrent spending and less on capital spending. Donors and NGOs, on the other hand, due to their heavy support, have contributed substantially on both recurrent spending (e.g. drugs and medical supplies) and capital spending (e.g. building of hospital). However, research conducted for this report was not able to obtain information as to how much recurrent versus capital spending has been financed by donors/NGOs. Please refer to Section 6 for more description on how budget information, both national and donors/NGOs', are documented and how available they are.

Figure 7: Flows of funds and supports



Source: Interviews and literature review

## 6. Budget information and its availability at different levels

In this part, the report starts from central down to HC/community level, identifying which budget documents and information get produced and whether they are accessible. Such budget information is classified into national budget and donors/ NGOs financing. For each type of budget document produced, it will be identified as to whether it is produced:

- Regularly? If so, how often?
- For internal purposes only, and not made available to the public?
- Made available to the public, but only with formal request? and
- Made available to the public without formal request?

Where applicable, the report will make explicit if certain type of information can be made available:

- To the public at large,
- Regularly to members of Technical Working Groups at the national or sub-national level, provided that the RGC confirms that this information can be shared publicly, and

- Regularly to members of the facility management committee and other local councils, provided that the RGC confirms that this information can be shared publicly

## 6.1. National level

### On national budget (mainly)

There are various institutions producing and issuing documents on the national budget, both overall and for health in particular. The National Assembly (NA) adopts and issues the **National Budget Law**. Since 2007, such Law has covered both the recurrent and capital expenditures funded by donors, classified by sectors/ministries. The recurrent budget shows allocated amounts per government agency (and the allocation between central and provincial level); the capital side of the budget shows a list of projects per government agency. Annually, around March, the MEF also issues **a four-volume of national budget documents** which provides more details on how the budget is allocated by sector and by province<sup>2</sup>. Concerning the health sector, you can find the following information:

- *Volume 1*: National budget which includes both the body of the national budget as approved by the National Assembly, together with background analyses on economic performance, forecasting, various reform agendas for the year, and any legal instruments published in the year relating to budget management issues.
- *Volume 2*: Budget allocation for central ministries which indicates details of ministries budget allocation by central and provincial levels, and for each individual province. It however covers only recurrent spending for the year.
- *Volume 3*: Budget allocation by provinces, detailing allocation by line departments. Again, it only covers the recurrent spending.
- *Volume 4*: Budget allocation to provincial authority, usually known as Salakhet, detailing by provinces. This fund (i.e. for Salakhet), it should be noted, includes both recurrent and a small share of capital spending.

The aforementioned documents can be used along with the **Public Investment Program (PIP)**, which are three-year rolling investment plans for all sectors to get a picture of both recurrent and capital budget for the whole sector. The PIP is published by (and available from) the Ministry of Planning (MOP) and is updated annually and published in the beginning of the year. In the PIP, health is classified under the social sector, together with education. PIP indicates a list of projects which is divided into on-going and pipe-line priority projects. Within these two categories, there are further classifications into capital investment and technical assistance projects. It should also be noted that the PIP projects are included in the capital side (Table C and D) of the National Budget.

In relation to budget execution, the MEF, with information from the National Treasury, issues a monthly state budget implementation report known as **TOFE**<sup>3</sup>. The TOFE can be purchased from MEF. It is a good reference on the month by month execution of both the national budget and donor support.

Two other sources of information on the health sector financing should be mentioned here. On donor support, the **CDC ODA Database** proves to be a good, though not perfect, source of

<sup>2</sup> Meeting with Budget Department official of the MEF on January 27, 2009

<sup>3</sup> Tableau des Opérations Financières de l'Etat

data. Regularly updated and publicly available, the database provides information on annual disbursement of funds from various donors. Unfortunately, it is not very user-friendly. Moreover, only information on donor disbursements into projects/ programs is available, but not on the funds disbursed out of each project or program.<sup>4</sup> The CDC ODA database can be accessed via the internet on: <http://cdc.khmer.biz/>

While fairly publicly available, the abovementioned budget documents mainly provide aggregate data. For purposes of monitoring and analyzing budget allocation and execution within a specific sector such as health, detailed data is required. Aggregate information simply does not allow analysts to link what is spent and what has been achieved with the spending nor does it allow more detailed analyses on, say, geographical imbalance in the way budget has been allocated.

More aggregate budget information is produced by the MOH. The most comprehensive and useful of all is the AOPs/3YRPs, a document required to be prepared by all health institutions at all levels. It tells what the needs as proposed by all health institutions are (bottom-up) and how much resources are made available to meet such needs (top-down). According to the health sector calendar, AOPs at individual institutions get prepared as early as March and the sector-wide draft AOPs are finalized in December. The first consolidation of AOPs of RHs, HCs, ODs takes place at the provincial level, and then when sent to the central level, DPHI in MOH puts together provincial and national program/department level plans. In the AOPs one can find very informative annex which include various tables such as expenditure by program, budget management centre, budget code and sub-program, funding sources, and activity classification.

AOPs are prepared jointly between the government and DPs and other health partners. It is also evaluated jointly by these same stakeholders. Annually, around March, there will be National Health Congress which is held at the same as the Joint Annual Performance Review (JAPR) and Joint Review of 3YRPs. These reports cover the achievements and shortcomings of the last year, focusing on a number of key areas such as health service delivery status, behavioural changes and communication, quality improvement, human resource development, health financing, and institutional development. The format of the report from one year to another might change slightly, though<sup>5</sup>.

AOPs, it should be noted again, show funding sources from both the national budget and donors/ NGOs support. On the national budget side, the responsibility for formulation is under the Department of Finance (DOF) of the MOH. There are several steps that this is done. First, it prepares as part of the AOPs the Budget Plan for each year. Partly, the Budget Plan follows the format of the AOPs, except that here, it only focuses on the national budget. In addition to that, the Plan also presents the sector budget following the Chart of Account (COA), meaning by salary (Chapter 64), goods and services (Chapter 60, 61, 62, and 63). Because health has also adopted the PBB, the plan separates between the PBB and the non-PBB. The Budget Plan which is prepared according to the COA is to be submitted to the MEF for budget negotiation and adoption, following the national budget formulation calendar.

The DOF also keeps records of monthly, quarterly and annual budget execution (which in here refers only to the national budget). Against the approved budget plan, the records show the execution by budget lines, between PBB and non-PBB at both central and sub-national levels. The information, according to the interviews with DOF and the DIC, is made available on a quarterly basis to the JTWG and other donor-government forum such as the CDCF. The reporting on the execution of the national budget is the commitment of the MOH to its partners

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<sup>4</sup> Lienert, I., J. Helis, et al. (2008). Cambodia: Improving government accounting. Phnom Penh, IMF.

<sup>5</sup> Beside these annual reports, there might be ad-hoc evaluation reports produced such as those on Cambodia Health Service Contracting Review (February 2007), Sector Wide Management (SWIM) (March 2007), Health Sector Review 2003-07 (August 2007), etc. Expectedly, because health sector is heavily aid-dependent, various evaluations have been made for the interests of those donors.

to show that every year the sector executes at least 95% of the approved national budget. And because an NGO representative (MEDiCAM) also attends the meeting, the NGOs, the MOH officials said, should be regularly informed of the state of MOH budget execution.

Another important source of information is the CMS. CMS produces quarterly and annual reports on the transfer-in and transfer-out of drugs and medical supplies. On the transfer-ins, the report shows the values of transfers from government, World Bank and others donors, while on the transfer-outs, information on which OD received how much of the transfers is provided. Interviews with DOF and DIC officials indicate that the above information is usually presented to the JTWG on a quarterly basis as a commitment of the MOH to its health partners.

As with the capital spending, in health, there are two parts: one domestically financed, and the other externally funded. In the current system, the whole capital spending, which is broken into hundreds of development projects or programs, is managed under the Department of Investment and Cooperation (DIC) of the MEF. Although the DIC does not produce any public documents on planned or executed budgets, it does provide information that is included in the TOFE<sup>6</sup>. All of the domestic financing and part of the foreign funded capital spending gets spent (disbursed) through the National Treasury system, and therefore, their execution is recorded by the National Treasury and sent to the Department of Economic and Public Finance Policy of the MEF for the preparation of monthly TOFE. For the external funding not channelled through the Treasury system, the information on its execution can be obtained from the CDC. However, as discussed earlier, the record on donor supports (some of which are through NGOs) is still not comprehensive both in the case of the CDC ODA database and the newly established database of the DIC within the MOH<sup>7</sup>.

The information contained in the above databases, budget documents and various reports is very rich. Those documents are actually required for both internal sectoral evaluation/ monitoring and for auditing activities usually conducted by MEF and other auditing agencies. These documents and pieces of information – all of them – according to central officials interviewed, can be made available only when there is formal approval from the higher level, which means ministerial level. A letter of request needs to be submitted through the administrative procedures and it might take many weeks before it is known whether approval is granted. With such approval, the bureaucracy is open, and one can get its hand as much on the data. It is therefore a situation of 'ALL OR NOTHING' in asking for such information.

However, it is learned that most of the above pieces of information have been made available to the JTWG as a commitment of the MOH to its health partners. It is confirmed also that most of the information requested by and provided to JTWG can be further shared with other relevant stakeholders. When asked whether the information can be made available to the 'public,' the officials asked which part of the public was being referred to. That implies that in the current situation, the term 'public' in this context should be specified.

### **Health statistics**

More detailed information is produced by MOH, particularly from Department of Planning and Health Information (DPHI), Department of Finance, and Department of International Cooperation. First, the DPHI produces and keeps the annual health statistics which is based on the Health Information System (HIS) sent from the provincial level and which provides a wide range of information including demographic data, health service utilization, by province health indicators, etc. The statistics are supposed to come out annually. However, it might be late for various reasons ranging from capacity to delays in transferring data from various sources. It is

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<sup>6</sup> Meeting with DIC official on February 03, 2009

<sup>7</sup> Based on interviews with National Treasury official (December 08, 2008)

learned from the interviews with MOH officials<sup>8</sup> that the Ministry of Planning is finalizing the so-called “Pre-Identification of Poor Households”, which is like a census. The result from the MOP works will be used for distributing health insurance cards to households identified as being poor.

### **On supports from donors and NGOs**

From the above discussion, quite a fair amount of information is produced on national budget for health. However, in terms of availability, it is very centralized, requiring formal request and approvals from the higher level. For information on donor/ NGO support, a different picture is found: it is fragmented. Officially, the MEF, CDC, MOP and MOH are the ones involved in coordinating donor supports. CDC has produced and regularly updated the ODA Database to keep track of the donor support for the whole government and by sector. The database has been made accessible for those interested in the topic and its quality has been constantly improving.

However, a number of areas still need further improvement. First, the ODA database is still not very user-friendly. Only those with certain knowledge of database and IT management can use it well. Second, the database depends on the information voluntarily sent by the donors. All donors are yet to be fully cooperative in this respect. Third, the database itself is still not comprehensive and accurate enough. There are problems of double-counting and inconsistent classification<sup>9</sup>.

On NGOs, there is a database at the CDC which is managed independently from the donor database. However, as the DIC officials indicated (Nov 28), the information in there still needs further improvement and more importantly, it provides mainly aggregate information, requiring that MOH set up another database to keep more detailing information on these NGOs, their activities and financial status. At the Ministry of Interior, there is also a department responsible for registering the NGOs, but even there, collaboration from the NGOs has been uneven. Another source of information is MEDiCAM who has a database on over 120 NGOs working in the health sector. This interactive database maps the presence by health sub-sector NGOs down to commune level. Only MEDiCAM members are included in the database, although this already represents the majority of health-related NGOs, and include all large NGOs.

Within the MOH, Department of International Cooperation is the one responsible for coordinating and tracking information on aid from donors and NGOs. Since early 2008, DIC, which is a young department itself, has attempted to establish a database using information provided from donors and NGOs. However, according to interviews with DIC official<sup>10</sup>, the database is still not complete as the response rate from donors and NGOs has not been sufficient. The limitation is also made clear in DIC’s Report on External Assistance to Health Sector (2007-2009) dated March 2008. It is also noted that what the MOH has gotten so far on donors/ NGOs support can be quite different from that entered in the CDC database. For instance, expenditure and forecast projections for external support to the health sector indicated in the MOH filled questionnaires and disbursement and projected disbursement collected CDC database for 2007 is very different: MOH questionnaire: USD104 million compared to CDC: USD39.5 million. The database however is expected to improve as the Policy Framework and Operation Guidelines (dated August 2007) for DPs coordination continues to be implemented. The next section will discuss in more detail what can be expected if the Policy Framework is successfully rolling on.

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<sup>8</sup> Meeting with MOH’s DPHI and DIC on November 12 and December 18, 2009

<sup>9</sup> For instance, as revealed during our interviews, how Project Management Unit (PMU) is defined is still not clear-cut. There is a high likelihood of double counting as well given that more than one agency may have reported the existence of the same PMU. These problems have been recognized by the CDC team working on aid coordination issues and they are taking measures to address them.

<sup>10</sup> Meeting on December 18, 2009

## 6.2. Sub-national level

Within the current health service delivery structure, sub-national level includes PHDS, ODs, RHs/HCs and community levels. Information produced at these levels with regards to sectoral performance and budget has been changing over time, reflecting the continuous reforms in the health sector as a whole. PHDS and ODs are reported to hold similar sets of budget documentation. PHDs are the highest level at sub-national level, compiling reports and statistics sent from ODs and lower levels. Those documents include<sup>11</sup>:

- **Provincial AOPs** which consists mostly of the AOPs of various ODs, RHs and HCs. Please see 5.1 on the AOPs and its preparation process. Provincial AOPs indicate the different programs and sub-programs the health sector wishes to achieve in the upcoming years, and the funding sources from (i) national budget and (ii) from already-committed budget from NGOs which have plans to operate in respective provinces in the next budget year.
- AOPs, as its name suggests, assesses the implementation of the plan. The first document representing such implementation is the **Health Information System** which is produced and sent monthly from ODs no later than the 10<sup>th</sup> of the following month. Such information is compiled and sent up to the MOH no later than the 20<sup>th</sup>. There may be minor delays in sending the reports, however. HIS includes rich information about activities of health service provisions as covered under the AOPs.
- The HIS is more like a performance report. As with the budget implementation report, as mentioned several times already, there needs to be a distinction between that of the national budget and that of donors/NGOs. For the **national budget**, there are **monthly and annual reports on budget execution** sent from ODs and further compiled to be sent to MOH. The reports cover all types of (national) budget items ranging from salary, operation and maintenance, user fees, HEF and others. It is noted that only RHs and HCs have user fees reported in their activities because they are the only two levels which are directly involved with health service deliveries. It should also be noted that in health, there is no PBB implemented at provincial level, and hence not applicable in terms of budget information.
- The **reports on drugs and medical supplies** transfers from the national level and their uses are produced quarterly and annually. Field interviews indicate that drugs and medical supplies are all procured and kept at the CMS. They are then transferred directly to various ODs on a quarterly basis. PHDs only keep records on those transfers. ODs are responsible for preparing quarterly reports on how those drugs and medical supplies get used and send them to be compiled and further forwarded to the MOH/CMS by PHDs. Those reports include very detailed lists of each type of drugs and supplies, together with the quantity transferred and consumed.

NGOs are very active at the sub-national level implementing their projects. In the visited provinces, most NGOs are registered with the MOH and mainly work on HIV/AIDS related issues. Given their significant contribution, it is important that NGOs activities are well coordinated and taken into account. For such purposes, a mechanism called Pro-JTWG is established so that every one or two months (depending on time availability and level of urgency), sub-national health officials headed by the PHDs can meet with all the NGOs working in the territory. The agenda is set for each meeting, and usually, a presentation is made from the government side on the execution status of the national budget. NGOs are also asked to share

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11 Based on interviews with a PHD on December 26, 2008 and February 20, 2009; Samples of all the documents list below can be made available.

their activities and budget status. However, as the PHD director indicated, some NGOs are less willing to share their budgetary status.

At the community level, HCs are the most important unit in health service delivery. Each HC is supposed to cover a population of 8,000 to 15,000 people. This means that each HC might cover the territory of more than one administrative commune depending on its population size. For each HC, an HC Support Committee is established, with a membership from 7 to 11 people including relevant commune chiefs. The Committee is supposed to be a mechanism by which commune chiefs can get information (including that on budget) about the HC and make suggestions about how people's health needs are effectively addressed. As stated in the rules, HCs budgetary information needs to be made available to the commune chief when demanded.

As described, so much budgetary information is produced at the sub-national level. Such information however is more to meet auditing and inspection purposes by central agencies (MOH, MEF and auditing agencies) and donors; it is not intended to be shared with the so-called public although it can be made available to the local authority such as the commune chief. When asked whether the information can be made available to the public, the answer is that because the current system is very centralized in many aspects, such sharing can be made only when there is formal approval from either MOH or relevant financial agencies such as MEF. If there is such permission, sub-national level is pleased to share any information needed. In another words, it is a situation of 'ALL OR NOTHING'.

## **7. Budget information availability in health: Expected changes in the short and medium term**

A budgeting system in health and overall is still weak in many aspects and it is constantly changing through various reforms. Some reforms are internal to the sector, while some others are the result of wider reforms, of which the two most prominent are PFM and D&D. NGOs working on budgets in health need to keep track of these in- and outside reforms. The following are the key reforms which will have short and medium term implications on access to budget information in health.

### **7.1. Within health sector reforms**

**AOPs and 3YRPs:** Section 5.1 above already describes AOPs and 3YRPs. AOPs have been in implementation since 2005. However, interviews with central level indicates that AOPs still need improvement to have more comprehensive coverage of all potential funding sources. With commitments from the ministry and DPs, the AOPs/ 3YRPs have potential to become very informative sources of information, which if not made available from the National Assembly, can be requested from the MOH. The information will include both government and donors/ NGOs supports, and how they are linked to certain performance indicators. And because AOPs involve both bottom-up and top-down elements, national AOPs might become a comprehensive (including government and donors/ NGOs) source of performance and budget information for other lower levels of health operation. And although currently, the AOPs have yet to become comprehensive, they are already a resourceful document especially when used along with various monitoring and evaluation reports or forum such as the JAPR and Annual Health Congress.

**A move toward PBB and SOA:** Health sector has been selected along with education and the other five sectors to run PBB. Although PBB has been applied only to non-wage operation spending at the central level, and has only accounted for 6% in 2007 and 9.6% in 2008 (Budget Law 2007/8), it is where the Cambodian health budget is heading. Another parallel move is the introduction of SOA. In a nutshell, the SOA is a performance-based service delivery agency

whose performance is under a management contract with parent ministries. It will develop its own budget and receive financing from national budget, donors, NGOs and user fee budgets. SOA is provided by Royal Decree, therefore has a strong legal status to move forward (Royal Decree No.346 dated March 2008). The implications of the PBB and SOA are as follows. One, it will produce information which can link the input and output, an interesting topic for CSOs and the people who receive public services. Another is that PBB and SOA bring about a more decentralized budget system, unlike the current centralized one. With more decentralization, the accountability of the SOA, for instance, will not be comprised of just the vertical upward lines but also to the provincial, districts and commune councils and the people (see more below on provincial and district councils under the D&D).

**Health Information System:** In August 2008, for the first time MOH adopted the Health Information Strategic Plan (HISSP) for 2008-15. Its vision is “*availability of relevant, timely and high quality health and health-related information, evidence based policy formulation, decision-making, program implementation, and monitoring and evaluation so as to contribute toward the improved health status of Cambodian people.*” It will have 5 main components including that on resources and financing. The strategy was proposed as a response to the current health information that has been limited especially on resource availability. It is not sure when the HIS will be sufficiently developed. But it is its intention to make information systematically gathered, available to not only the policymakers, but also the public including NGOs. Updating on the progress of HIS development can be done by consulting key stakeholders including MOH’s DPHI, NIS, and some donors such as WHO and Health Metrics Networks (MOH 2008).

**MOH-DIC’s Initiative and database:** As mentioned earlier, the MOH-DIC is now upgrading the new database, making it as comprehensive as possible. It also has the intention to link this database with that of the CDC. Such database, once improved, will be very useful for NGOs and those interested in donor health financing. It is likely that data will be accessible since the DIC is working closely with NGOs and donors.

## 7.2. From other wider reforms

**PFM Reforms – 2008 Finance Law:** PFM reforms have the most significant implications for budget information accessibility in the health sector and overall. Prior to the adoption of the 2008 Finance Law, the budget system had been following the 1993 Finance Law, which emphasized the centralization of authority and compliance. According to the 1993 Law, budgeting was to be predominantly about internal control of the government, with the MEF and National Treasury serving as the central and dominant actors. The 1993 Law provided no provision on the role of the public in budgeting matters. By contrast, the PFM reform in general and the 2008 Finance Law in particular provide for such public and civil society participation. Article 84 of this new law states the following:

*‘All execution of state revenues and expenditures shall comply with the regulations and instructions of the Minister of Economy and Finance. All records on revenues and expenditures of national and sub-national administrations shall comply with the chart of accounts and budget nomenclature and all accounting and financial reports must be transparent and publicly disclosed.’*

This new legal provision opens up the opportunity for CSOs to make their case and construct a tactic on how to be genuinely involved in the budgeting affairs of the state.

**PFM Reforms – Improving government accounting system:** Despite the introduction of the new Chart of Accounts and the integration of donor funded projects in the Budget Law since 2007, budget information and presentation in Cambodia is still centralized (for national budget information) and fragmented (for information on donor support) and untimely to a large extent. The reform seeks to: (i) apply COA to domestically-financed capital expenditure (so far, it is

applicable only to recurrent spending); (ii) provide information on not just what gets disbursed but what gets spent out of donor project accounts; (iii) reduce delay in the preparation of TOFE; (iv) fully implement computerization within the treasury system; (v) introduce FMIS to some entities by 2011; and (vi) lay down more detailed classification of budgets by province and de-concentrated agencies<sup>12</sup>. Together with the provisions of the 2008 Finance Law, these reforms will effectively grant CSOs greater access to a more comprehensive and disaggregated budget data at the central level and sub-national level.

**D&D Reforms:** D&D reform is government-wide. With the Organic Law adopted (May 2008) and public support from the Prime Minister himself, the reform will go forward. A national program is being drafted for implementation for the next ten years (2010-2019). The reform will affect various sectors including health and the way public services are delivered through more democratic/ participatory elements. In May 2009, provincial, capital, districts and municipal councils will be elected (indirectly by commune councillors). The council will have a unified administration and budget. The budget is required to be available to the public, and covers various de-concentrated agencies, according to the Organic Law and the draft Law on Financial Management of the Sub-National Administration.

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<sup>12</sup> See Lienert, I., J. Helis, et al. (2008). Cambodia: Improving government accounting. Phnom Penh, IMF.

## 8. Conclusion and recommendations

The report concludes that the issue of budget information availability in health is not as straightforward as one might think; it is not just a matter of legal provision, but practice, and not just of the government, but of many donors and NGOs; and it is not static, but changing over time, requiring that interested NGOs keep constant updates and adjustments in the strategy they use to obtain information and influence decisions. But with reforms going on, budget information in health (and government-wide) will be made available, presenting a big opportunity for CSOs working in this area.

The report recommends that interested CSOs need to adopt certain tactics and form necessary partnerships to acquire sufficient data, especially given the fragmented nature of the current system. The tactics need to be designed for immediate, medium and long term, and they need to reflect changes resulting from various reforms.

### 8.1. For immediate term

*Better uses of JTWG and P-TWG mechanisms to access health budget execution data.* Information on sectoral performance and budgets in the health sector have been very detailed, especially if one can access the monthly, quarterly and annual reports produced within health sector itself. As a matter of rule, however, those detailed pieces of information can be made available to NGOs only with formal approval from the high level (e.g. MOH and MEF). That said, with the intention to improve partnership with donors and NGOs, the government has been committed to sharing budget information using the national JTWG and Pro-JTWG mechanism. As part of the wider decentralization, information sharing has also been encouraged with commune authority through the HC Support Committee forum. MEDiCAM is said to have been representing NGOs in the JTWG mechanisms, and hence gaining access to updated information on state budget implementation and others. Also, as the leading NGO in health sector, MEDiCAM is also holding a lot of information on peer NGOs activities. Therefore, for the immediate term, in order to ensure better access to information on national budget and donors/NGOs support, NGOs should be better coordinated and better use the existing JTWG mechanisms.

*Establish formal relationship with MOH:* To compliment the JTWG mechanism, NGOs should coordinate and agree among themselves to formalize their relationships with the MOH in getting budget information on a regular basis. As experience has shown, bureaucratic layers at the MOH might be too long and time consuming if a letter requesting approvals from the Minister or Secretary of State is submitted every time an NGO wishes to get any piece of health budget information. It would be more effective if something like a Memorandum of Understanding (MOU) is established between the NGOs group and the MOH in relation to this budget information accessibility issue.

### 8.2. For medium and long term

Given the ever changing planning and budgeting process in health sector as well as the ongoing PFMRP and D&D, NGOs attempting to be informed and involved with budgeting issues in the health sector need to consider the following:

*Getting regular updates on the progress of key reforms both within health and cross-cutting.* In the next three to five years, relevant NGOs should ensure regular and proper updates on the improvement of AOPs, MTEF and the use of SOA within health. These reforms will bring changes to the ways health services are delivered and hence the way budget is structured and reported. How PBB is

expanded and its management is changed should also be an area to watch. In parallel, PFMRP activity on improving public accounting should be regularly observed. Regular contact with leading donors on the PFM including the World Bank and IMF and membership in the PFMRP Technical Working Group will help.

*Building on 2008 Public Finance Law provision on the need to share budget information publicly.* The 2008 Public Finance Law provides that budget information needs to be made publicly available. This is in contrast to the 1993 Law which was completely silent on the role of the public on budgeting matters. However, a lot more needs to be done to put the 2008 Law into operation. But that is the starting point for NGOs trying to promote access to public information. This topic should be raised in several Government-Donors-NGOs forums such as the JTWG, the Consultative Group (CG)/Cambodia Development Cooperation Forum (CDCF) and others.

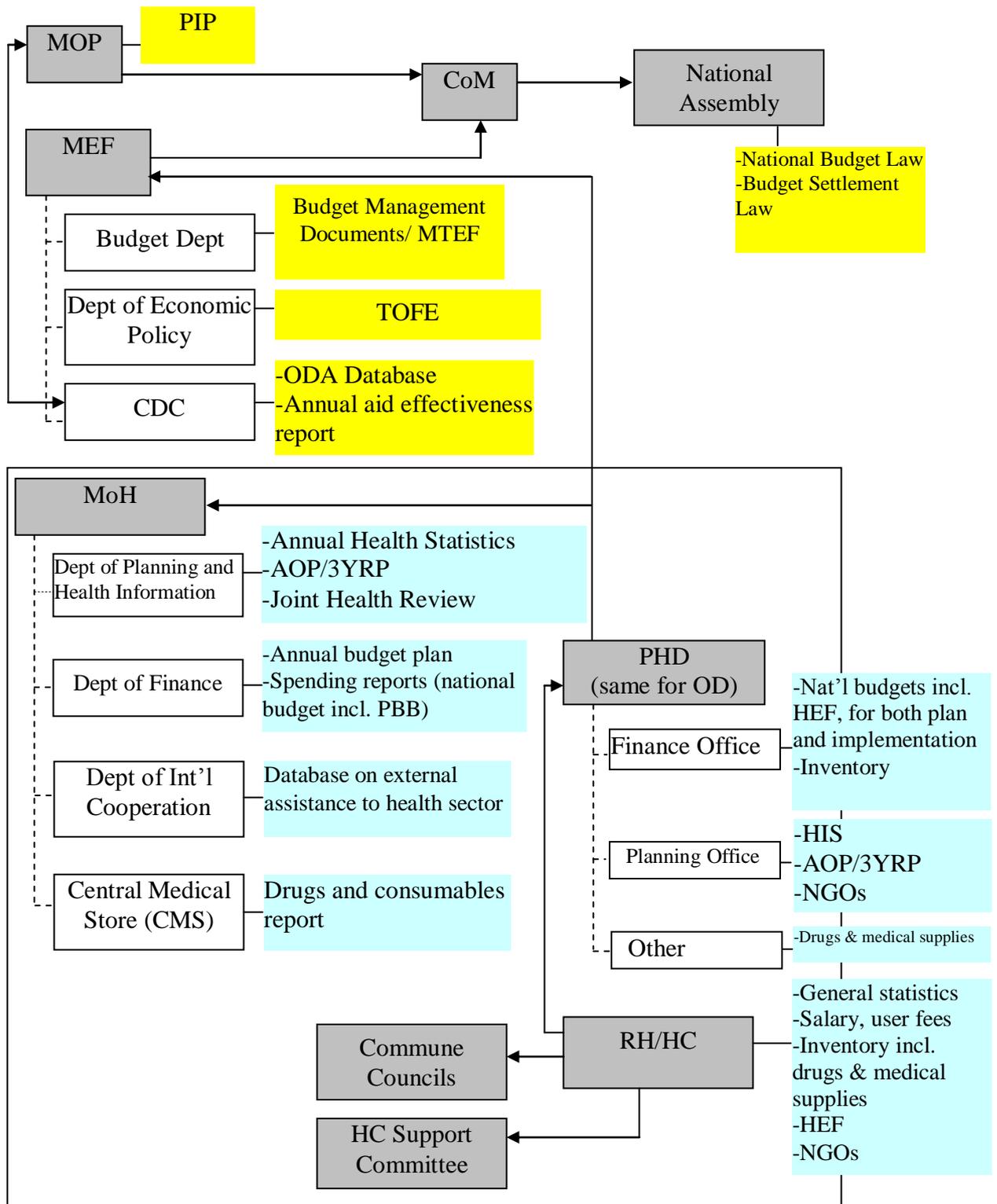
*Paying more attention to the D&D.* With the Organic Law coming out in mid-2008, the D&D is introducing deep but gradual reform on the way public services are provided and resources allocated and managed. There will be provincial and district councils in May 2009. The Council will be a representative of all de-concentrated line departments. Although the budget will only be transferred gradually to the sub-national level, with the reform, the budgeting system will be less and less centralized. The Organic Law and the draft Law on Sub-national Finance provide that the council budget needs to be made publicly available. This might mean that in terms of budget information accessibility, NGOs and people alike need only to deal with each council. This is much more convenient than having to put a formal request through the central ministry hierarchy. The council will also bring various NGOs and donor projects under one umbrella, although this will take time.

Finally, this report has shown that ensuring and promoting access to budget information in health (and also in other sectors) is not something that is limited to the sector alone, nor is it a task which requires action one time only. It is a cross-cutting task, requiring understanding, regular updating and partnership with various agencies and a number of mechanisms. Also, one does not need to re-invent the wheel, e.g. creating new mechanisms, etc; instead, s/he should try to strengthen and compliment what is already in place. Looking into the near future, the prospect for access to budget information in the sector is even better – stronger legal base to push the agenda forward and substantial amount of commitment from the Government and donors/NGOs alike to strive for better cooperation.

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**Annex 1: Flow of information and documents produced by different levels and institutions**



**Legends**

- Information flow
- - - - - Organizational structure
- Producing information/ document

**Annex 2: Budget document availability at national level**

Institutions	Documents and time of publish	Relevant info	Availability
<b>i. On national budget</b>			
RGC	ច្បាប់ស្តីពីហិរញ្ញវត្ថុ National Budget Law: Annually; Available by Dec of previous year	-Rationale supporting the budget -Key budget regulations issued during the year -Approved <u>allocated</u> revenue and spending (recurrent, program, and capital) and by central versus provincial levels	-Available; no formal request needed; not-time consuming; -Contact the National Assembly, the Senate or MEF
	ច្បាប់ទូទាត់ថវិកា Budget Execution Law: Not regularly adopted; can be two years late	-Approved budget <u>execution</u> for all the approved revenue and spending	-Available; no formal request needed; not time-consuming; -Contact the National Assembly, the Senate or MEF
MEF	Four detailed volumes on National Budget Law, including: -Vol 1: The National Budget Law -Vol 2: Budget for central ministries -Vol 3: Budget for provincial LDs -Vol 4: Budget for salakhet Annually	-All information included in the national budget law (above) -Detailed information on ministry budget allocation by economic functions, by province and details on each province	-Available; no formal request needed; not time-consuming but might need to be bought -Contact MEF's Budget Department
	ការអនុវត្តថវិកា State Budget Implementation (TOFE): Monthly and annually; might be late up to more than one month	-Showing budget execution by month, by sectors, and by projects	-Publicly available; no formal request needed; but might need to be purchased from the MEF
MOP	ផែនការអភិវឌ្ឍន៍យុទ្ធសាស្ត្រជាតិ ០៦-១០ National Strategic Development Plan (NSDP) 2006-10	-Indicating sectoral priority, indicators and resource requirement for the period.	-Publicly available from MOP
	កម្មវិធីវិនិយោគសាធារណៈ Public Investment Programmes (PIP) – <i>Annually</i>	-3 year rolling plan of public investment, detailing projects by sectors and years	-Publicly available; no formal request needed; but might need to be purchased
MOH – Dept of Planning	ស្ថិតិសុខាភិបាល Annual Health Statistics <i>Annually</i>	-Detailed information on progress on key indicators in health	-Publicly available; no need for formal approval
	ផែនការប្រតិបត្តិការណ៍ និងផែនការរំកិល ៣ឆ្នាំ AOPs and 3YRPs	-National aggregate information on program and non-programs	-Publicly available; no need for formal approval

	របាយការណ៍វាយតម្លៃរួមលើវិស័យសុខាភិបាល Joint Health Review, <i>Annually</i>	-Annual review against the indicators set forth in the AOPs	-Publicly available; no need for formal approval
MOH – Dept of Finance	សៀវភៅថវិកាប្រចាំឆ្នាំ Annual Budget Plan <i>Annually</i>	-National budgets broken by programs, sub-programs, and then by budget chapters and sub-chapters	-Can be made available to NGOs through JTWG
	របាយការណ៍ស្តីពីស្ថានភាពចំណាយប្រចាំខែ, ប្រចាំត្រីមាស និង ប្រចាំឆ្នាំ Reports on spending <i>Monthly, quarterly, and annually</i>	-Detailed information on national and provincial, HEF, PBB, userfees	
MOH-CMS	តារាងសរុបចំណូល ចំណាយឱសថប្រចាំខែ និង ឆ្នាំ Drugs and consumables report <i>Quarterly and annually</i>	-Detailed on transfers in, outs, types of drugs/supplies, sources of transfers and destinations of transfers	
<b>ii. On financing and supports from donors and NGOs</b>			
CDC	មូលដ្ឋានទិន្នន័យជំនួយបរទេស ODA database No required timeline	-All donor supports by sectors, years and provinces and disbursements into each projects (but not what is spent out of the project)	-Publicly available; no formal request needed; -Information from the database is used to prepare Aid Effectiveness every year
MOH – Dept of International co-operation	មូលដ្ឋានទិន្នន័យស្តីពីជំនួយមកពីខាងក្រៅចំពោះវិស័យសុខាភិបាល (ស្ថិតក្នុងការរៀបចំ) Database on external assistance to health sector ( <i>under development</i> )	-Number of donors and NGOs supports (activities, financing, locations, etc) and expenditure forecast by program areas and broad line items (TA, capital, and recurrent costs) <sup>13</sup>	-Can be made available to NGOs through JTWG

<sup>13</sup> According to MoH's Report on External Assistance to Health Sector (2008)

**Annex 3: Budget document availability at sub-national level**

Types of information	Documents and time of publication	Relevant information	Availability
<b>PHDs and ODs</b>			
Sectoral performance	របាយការណ៍សកម្មភាពប្រចាំខែ និងឆ្នាំ HIS <i>Monthly, annually</i>	-Very detailed on general situation and key health indicators for the provinces broken down by OD	-Can be made available to NGOs through Pro- JTWG-H and sub-national authority
Operational plan and budget	ផែនការប្រតិបត្តិសុខាភិបាល Annual Operation Plans (AOPs) <i>Annually</i>	-General health situation in the province and administrative structure -3YRPs for the province -Activity plan by the four programs and sub-programs together with indicators and implementing agencies, -Detailed budgeting for each program and sub-program, indicating total budget plan in riels, US dollars, national budget share, user fees, and by donors (e.g. HSSP, Global Fund, multilateral, bilateral and NGOs)	
National budget	-Budget plan already included in the AOPs (see above). Also see the MEF's annual budget publication (vol. 3) <i>-Annually</i>	-Detailed budget plan broken down by chapters and sub-chapter of spending, and is intended for programs or non-activities.	
	ស្ថានភាពចំណូលចំណាយថវិកាប្រចាំខែ និងប្រចាំឆ្នាំ Status of monthly and annual spending and revenues <i>Monthly and annually</i>	-Spending in the month -Accumulated amount and percentage of annual budget execution -Break-down by ODs, RHs, and HCs -Break-down by budget chapters including revenue (user fees) and spending by Chapter 60 (both by advance and direct transfers), 61, 62, 63, 64 (including staff number and unit costs and special incentives), 65 and their sub-chapters. <i>-Information on donors and NGOs supports might also be included here depending on its availability from those NGOs</i>	

HEF	របាយការណ៍ប្រចាំត្រីមាសពីការបង់ថ្លៃជួសជុលអ្នកជំងឺក្រីក្រ Quarterly report on HEF <i>Quarterly</i>	-Detailed information on HEF spending broken by ODs, name of patients, their respective HEF payment, date of payment, types of services paid.	
Drug and medical supplies	របាយការណ៍ចំណូលចំណាយឱសថស្ថាន បរិក្ខារពេទ្យ Drugs and consumables consumption report <i>Quarterly and annually</i>	-Detailed information on drugs and medical supplies transferred in and consumed, broken by ODs. For each OD, it is shown by type of drugs/supplies, remaining transfers-in from CMS and locally procured, consumed and balance.	
Donor/ NGOs projects	របាយការណ៍ប្រជុំក្រុមការងាររួមផ្ទៃក្នុងខេត្ត Report on Pro-JTWG <i>Monthly and quarterly</i>	-Number of NGOs attending, their activities, and sometimes on their budgets	
<b>HCs/ RHs</b>			
General statistics	របាយការណ៍សកម្មភាពប្រចាំខែ / ឆ្នាំ Monthly and annual performance report	-Number and types of patients treated or visits	-Can be made available to NGOs through Pro- JTWG-H and sub-national authority including commune councils
General budget information	របាយការណ៍វិភាគចំណូល-ចំណាយ Report on revenue-spending analyses -Monthly and annually	-Revenue from transfers and user fees -Spending on personnel and goods and services -Spending of drugs and medical supplies	
HEF and Insurance scheme	តារាងសំរេងព័ត៌មានបញ្ជីប្រើប្រាស់សុខាភិបាល	-Number and types of visits used as base for calculating HEF and insurance to be paid as fees on behalf of patients to the HDs/RHs	

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