CHAPTER 1

INTRODUCTION

1.1 BACKGROUND AND RATIONAL

Financing of health services is a concern shared by developed and developing countries although the features and conditions are substantially different. In developing countries, the question is often to introduce key concepts and to initiate systematic approaches in order to lay down the foundations for one or several systems adjusted to the local situation. Such systems should meet the satisfaction of the users regardless of their socio-economic status, the satisfaction of the health personnel as well as the public health authorities with also the support of the political managers. This says that social, professional, economical and political aspects of the society are concerned.

Consequently, the expected changes must be seen as part of a process in which pioneering, experiencing and lesson learning are essential. In 1996, the Kingdom of Cambodia initiated such a process within a wider Health Sector Reform including a plan for increasing of the National Health Budget. A number of innovations have occurred with respect to health financing reform. Some of which a have taken place or in the process of being developed. A key constraint in the implementation of health system reform is the unpredictable and irregular supply of government funding to provincial and district health departments. Much effort has been made to rectify this.

The introduction of a direct cash funding system for districts as part of the Accelerated District Development (ADD) to overcome inefficient centralized spending controls providing cash to districts has strengthened moves to decentralized management. Funding for rural health services of this system has improved with full 100% disbursement of the budget in 1999, but decreasing to 78% in 2000. This was partly due to the unavailability of cash in the treasury. Another change is the launching of the priority action program (PAP). The system was introduced in 2000 to address some of the obstacles of current systems and to more closely link expenditure

with service outputs. Seven provinces and eight central institutions are under the program implementation. But, the actual expenditure regarding this new program was so low with only 51% of actual spending according to the MOH 's expenditure report. A number of factors contributed to this low budget access such as difficulties in absorbing the new procedures and also the unavailability of cash in the treasury.

Also, a critical move has been the adoption of the health financing charter and guidelines in 1996, which represent a policy change for the Royal Government of Cambodia, introducing a shift from free public health services to cost sharing. It has guided the piloting of different models of health care financing. Based on the charter the user fee scheme was started in 1997. As of November 2000, 166 health facilities were implementing the user charge system. The objectives include the mechanism used to exempt the poor.

Donors have made considerable contributions to the country's health sector in recent years. It is estimated that the total aid flow to the health sector, including support provided by non-governmental organizations, per year, amounted to twice or even three time the government's health budget.

The Ministry of Health is looking at ways to make best use of donor funds to the health sector. It is now moving to a more 'sector-wide' approach. The ministry in collaboration with development partners is developing an approach called Sector-Wide Management. (SWIM). Certain steps have been identified; and we are now in early stage of the development process.

There were many provinces implemented Health Financing scheme officially and approved by the MOH. Some provinces have been developed and improve with the support from donors in Cambodia such as:

- In Siem Reap, MSF and UNICEF have been supported in one district (Sotnikum District), under the project " Sonikum New Deal" since 2000.

- Kratie Province (Kratie Referral Hospital), have been implemented Health financing scheme since 2000, with the support from MSF.
- Kampot province (Kampong Trach District) with the support from Mamesa.
- Takeo province support from Swiss Read Cross (SRC).

Takeo Referral Hospital is the first health structure in the country to gather the conditions of a systematic approach to its financing, with a transitional support from an NGO (Technical and Financial support) the Swiss Red Cross since September 1997.

In year 2003, Swiss Red Cross (SRC) will finish their mission and withdrawal the support from the hospital. We believe that, after withdraw the support of Swiss Read it may be some problems will happen to the hospital, especially the ability to find the revenue to generate the hospital cost.

However, it's time for the MOH and the government of Cambodia should consider carefully on it's. Ministry of health and the government of Cambodia have to strength more responsibility to the health facilities, allocate more budgets/ or increase user fees of health services?

There are many questions related with the financial performance in Takeo hospital. Concerning with the above problems, we will see in the result of the analysis in the chapter 5.

1. 2. RESEARCH QUESTION

What is the potential cost recovery in Takeo hospital in year 2003?

1. 3. RESEARCH OBJECTIVE

Takeo Referral Hospital was the first health structure introducing Health financing Scheme, under the National charter on health financing, and health policy, and with a support from the Swiss Red Cross during over 4 years since September 1997- 2002.

In year 2003, Swiss Red Cross will withdraw the support to the hospital, for this reason we would like to analyze the capacity of the hospital to generate the revenue especially in 2003 without donors support. Also this hospital has available data and information to studies.

General Objective

To identify the total cost, total revenue, unit cost, and estimate the potential cost recovery of the Takeo hospital in year 2003.

Specific Objectives

To estimate the total revenue from government, and user fees
To estimate the total cost of the hospital
To calculate the unit cost of each patient services
To analyze the potential cost recovery in Takeo hospital.

1. 4. SCOPES OF THE STUDY

The scopes of this study focus on cost; revenue of Takeo hospital in fiscal year 2003 (1^{st} Jan -30 Dec. 2003) from the provider's perspective, and the cost study is examined at the level of cost center.

1. 5. POSSIBLE BENEFITS

This study provides some data and some policy implication for hospital administration in the following:

The hospital administrator can understand hospital financial status in term of total cost, revenue, and the amount of percentage of revenue supported by government, patient fees, and cost recovery. They can use this result to plan for cost

containment, policy setting, new activities implementation and other decision-makings.

This study will show the capacity of the hospital to generate the revenue, to stimulate the hospital administration and accounting management system, which essential for hospital planning, budgeting, and monitoring hospital performance, improvement in relation to efficiency, equity, quality of services, and sustainability.

The hospital administrators can apply this unit cost data of each activity as criteria to justify budget support from provincial or local administrative authorities. The Ministry of Health can apply unit cost data of each activity as criteria to allocate budget to Takeo hospital.

These studies also will show the government, MOH, the financial gaps that the government should considered.