

# Public Expenditure Review: Immunization as a Case Study

**Presentation to Cambodian National Assembly for Third Sub-Regional  
Symposium for Parliamentarians on Sustainable Immunization Financing**

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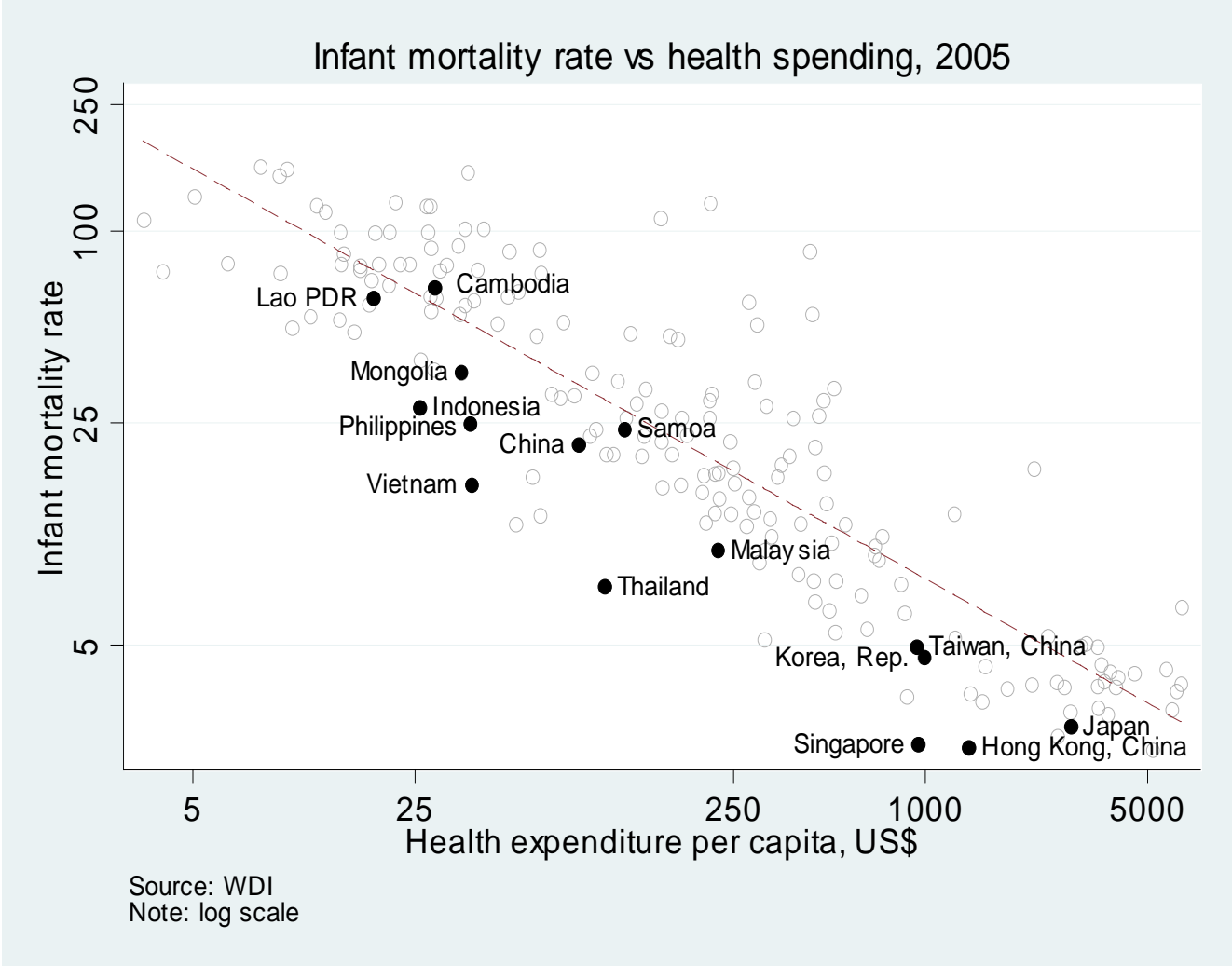
**October 21, 2010**



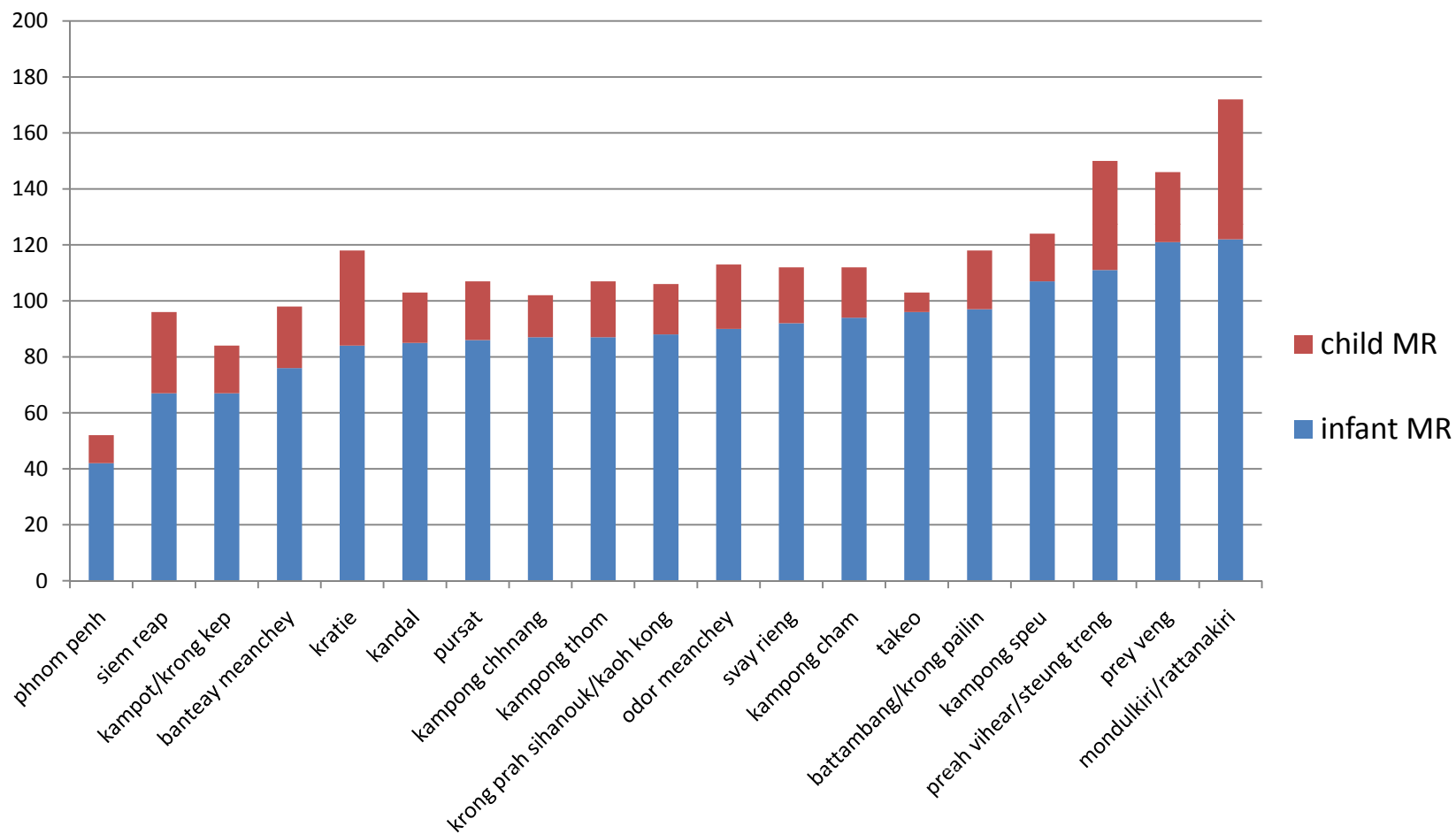
# Outline of Presentation

- Child health outcomes vs. health spending
- Trends in total health spending
- Composition and trends in overall government health spending
- Composition of immunization program spending
- Immunization coverage among the poor
- Innovations in health financing
- “Best Practice” lessons for Cambodia

# Child health outcomes are good relative to total health spending...but could Cambodia do better?

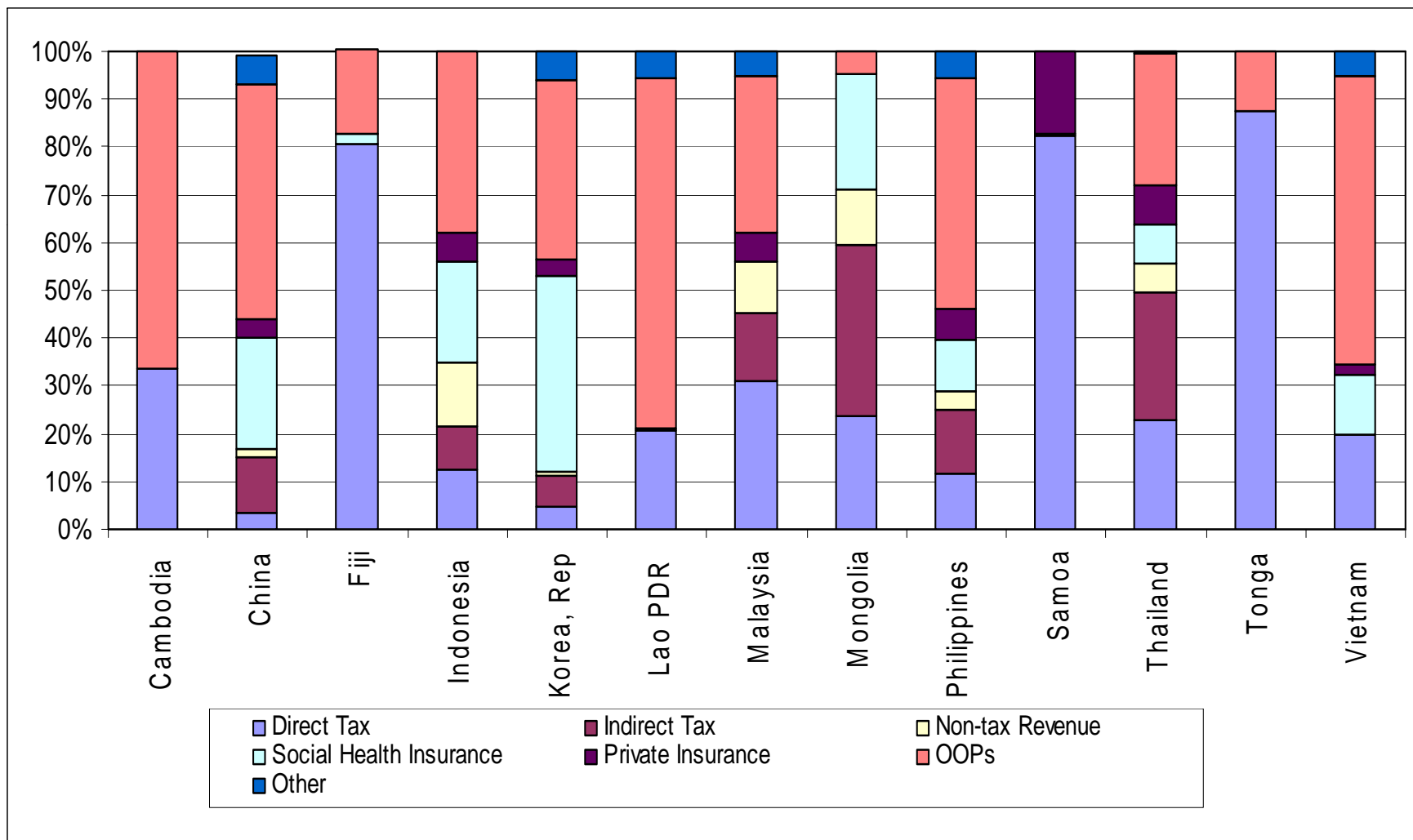


# Continued inequalities in infant and child mortality within Cambodia

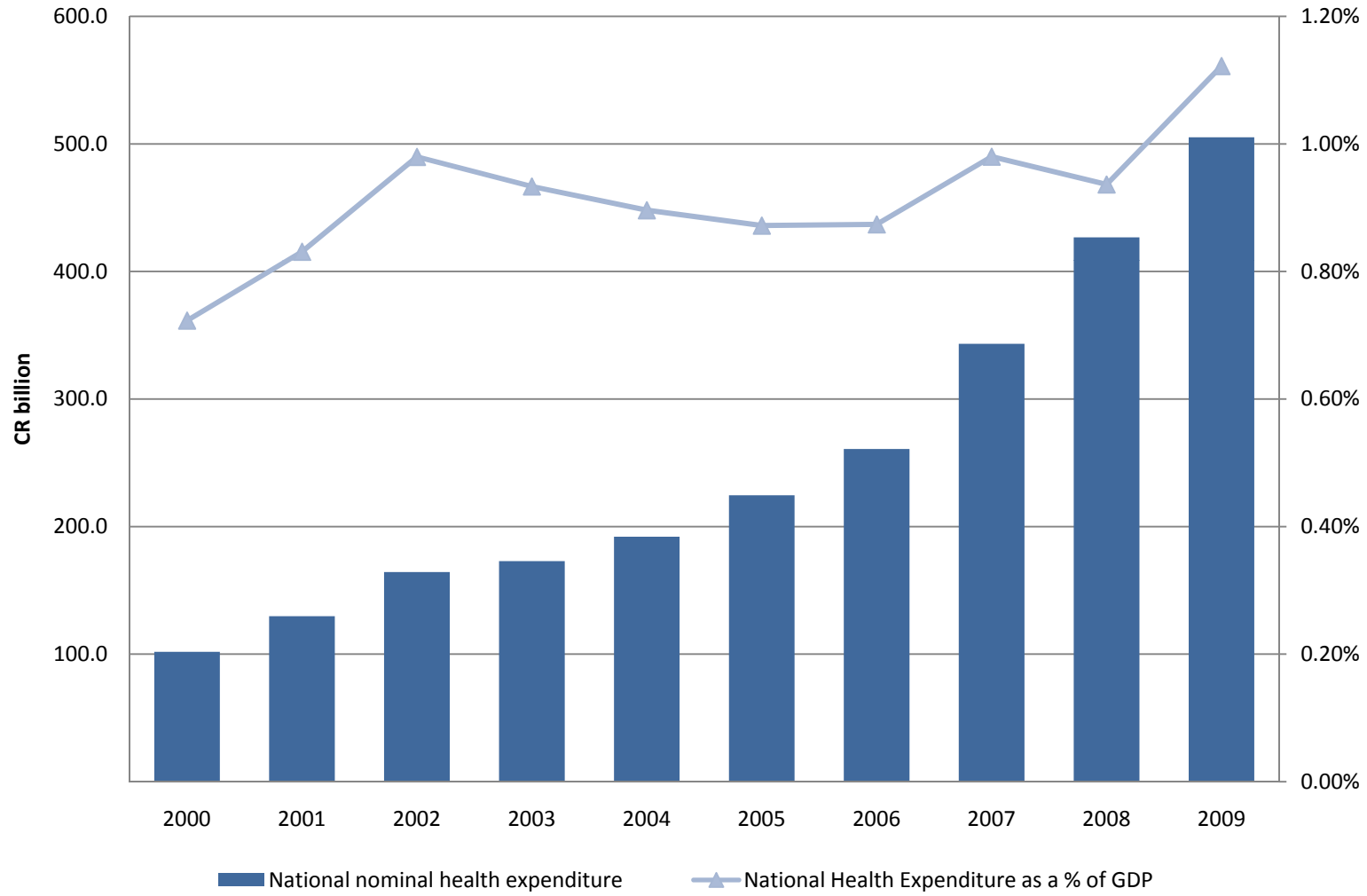


# Most health spending is out-of-pocket

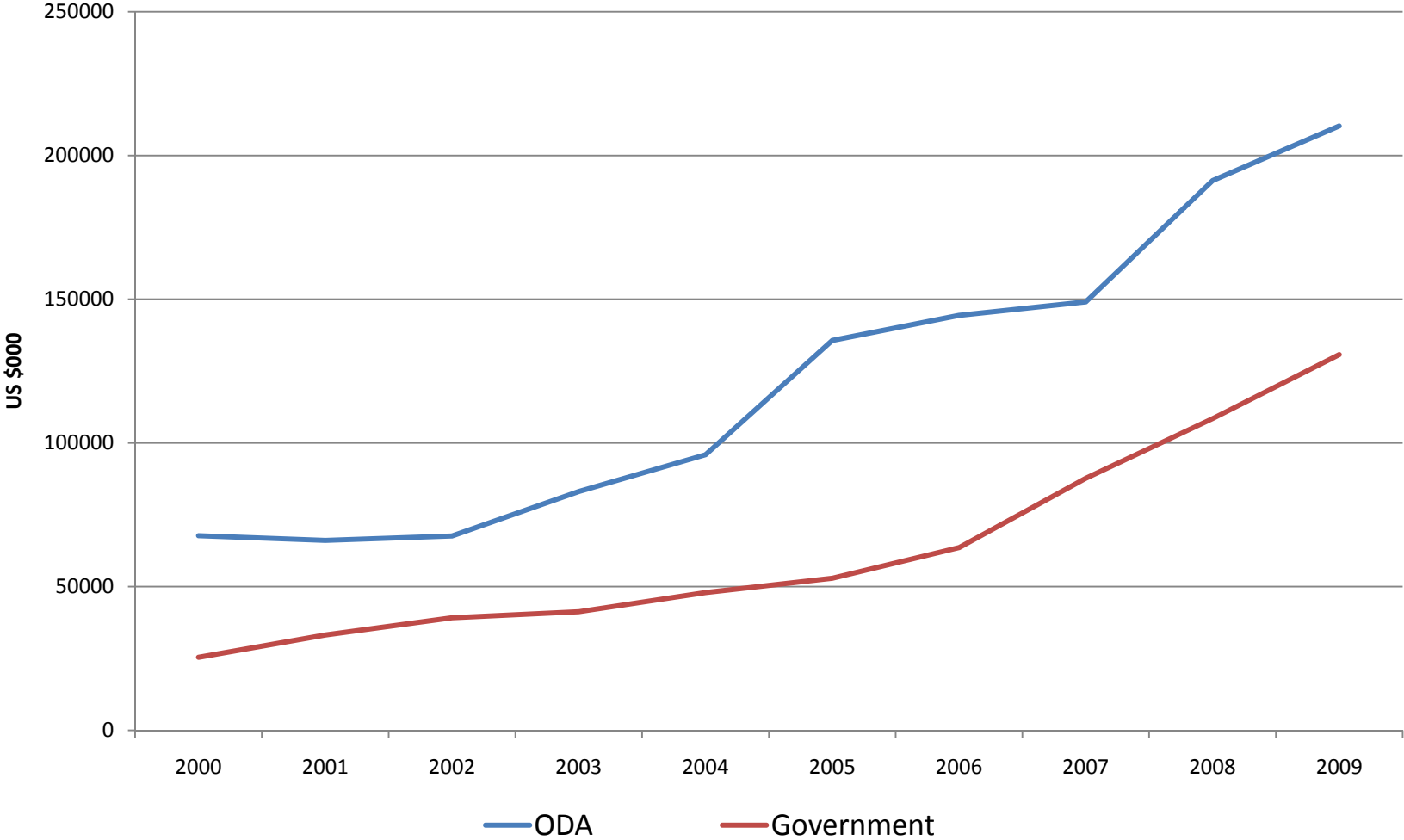
...with limited role of health insurance



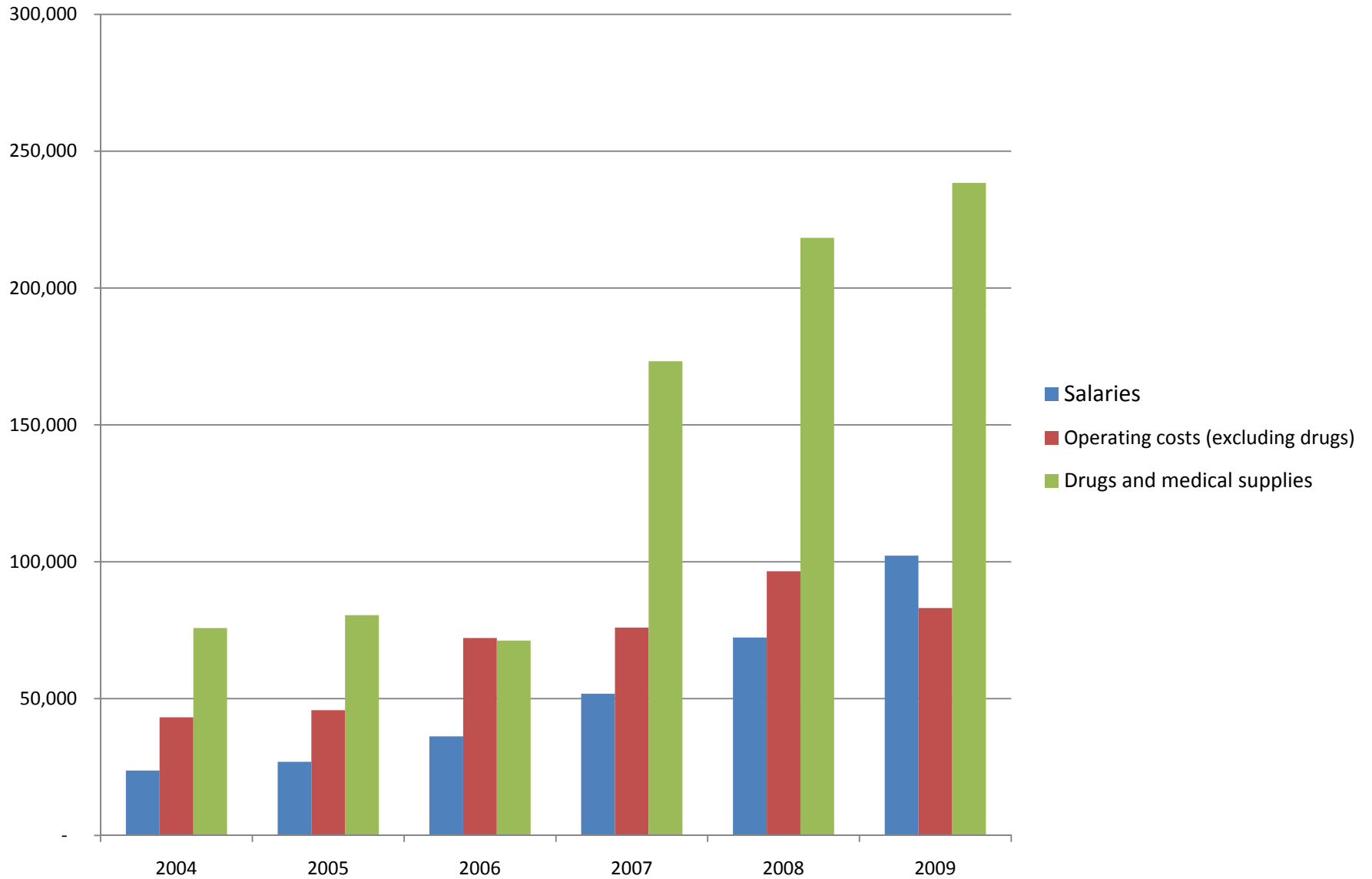
# Total RGC health spending has increased ...but remains about 1% of GDP



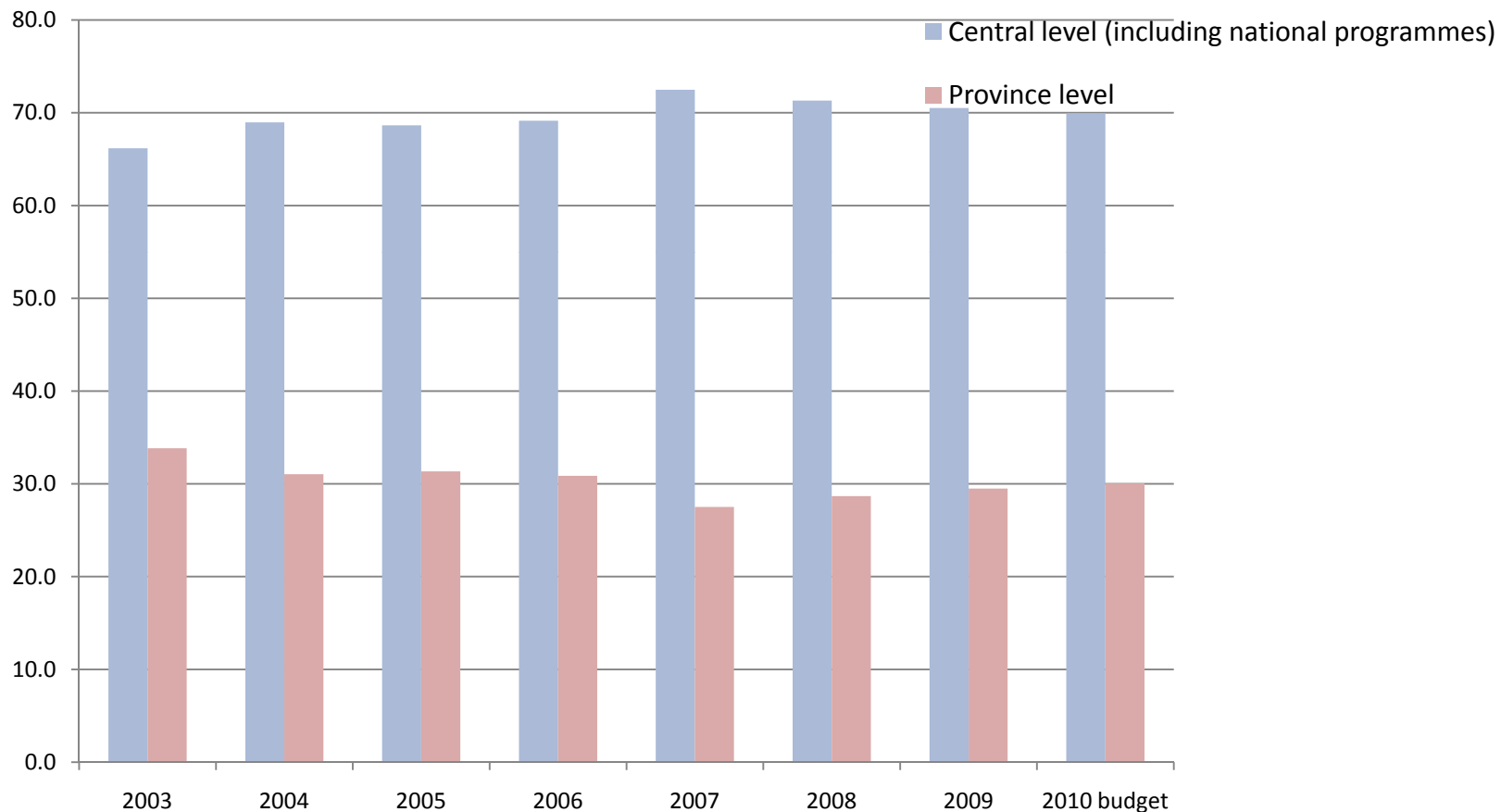
# Increased RGC recurrent spending for health, but donor financing still higher



# Composition of Gov't health spending (CR millions)



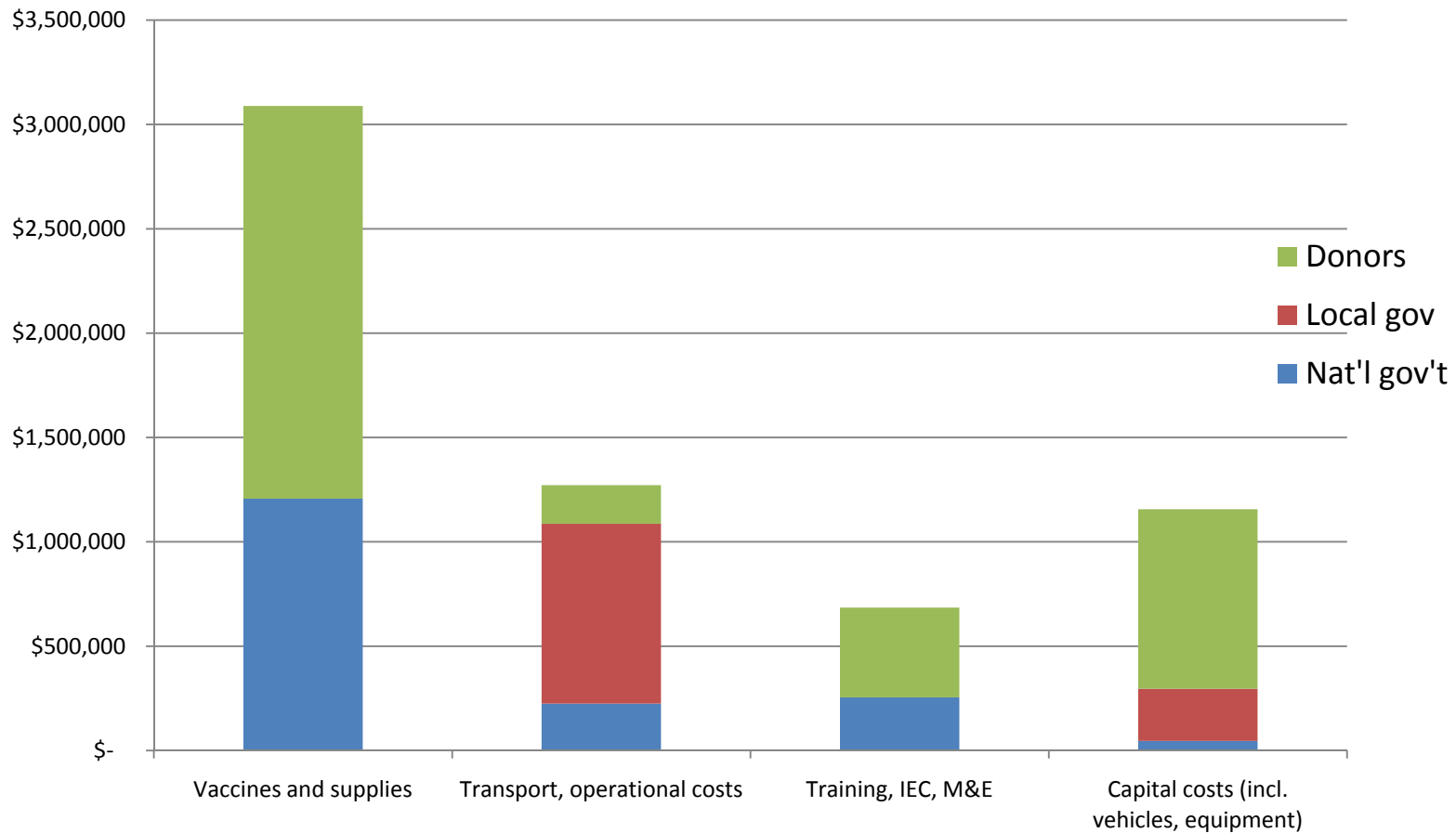
70% of health spending is managed centrally...  
although most drugs and equipment are distributed to provinces



# Efficiency, Equity and Effectiveness of Expenditure – key issues

- Health outcomes could be better relative to spending
- Gov't spending on primary care is pro-poor, but spending on hospitals tends to benefit middle- and upper-income
- Allocation to provinces based on historical norms
- No budgets or expenditure monitoring below province level; insufficient resources reaching health facilities
- Low wages and unequal distribution reduces quality and efficiency of health workers
- Potential cost savings for spending on pharmaceuticals and medical supplies
- Insufficient regulation of private sector

# 2008 National Immunization Program financing (USD)... Future gov't contribution is projected to increase to over \$2.5 million



Source: CAMBODIA National Immunization Program Strategic Plan: 2008 – 2015 (MOH, 2008).

## Coverage of immunization and preventive child health services is relatively equitable

	poorest	next poorest	middle	next richest	richest
child under 5 given vitamin A (%)	90.2	94.0	95.0	91.3	93.5
child under 2 first given breast milk to drink (%)	80.5	79.5	76.5	76.5	76.0
child under 2 has vaccination card (%)	81.2	79.3	86.5	90.6	89.3
child under 2 received 3 DPT doses (%)	72.5	65.7	71.7	74.1	64.2
child under 2 never vaccinated (%)	11.9	11.8	3.6	2.6	1.7

Source: Cambodia Socio-Economic Survey (CSES) 2007

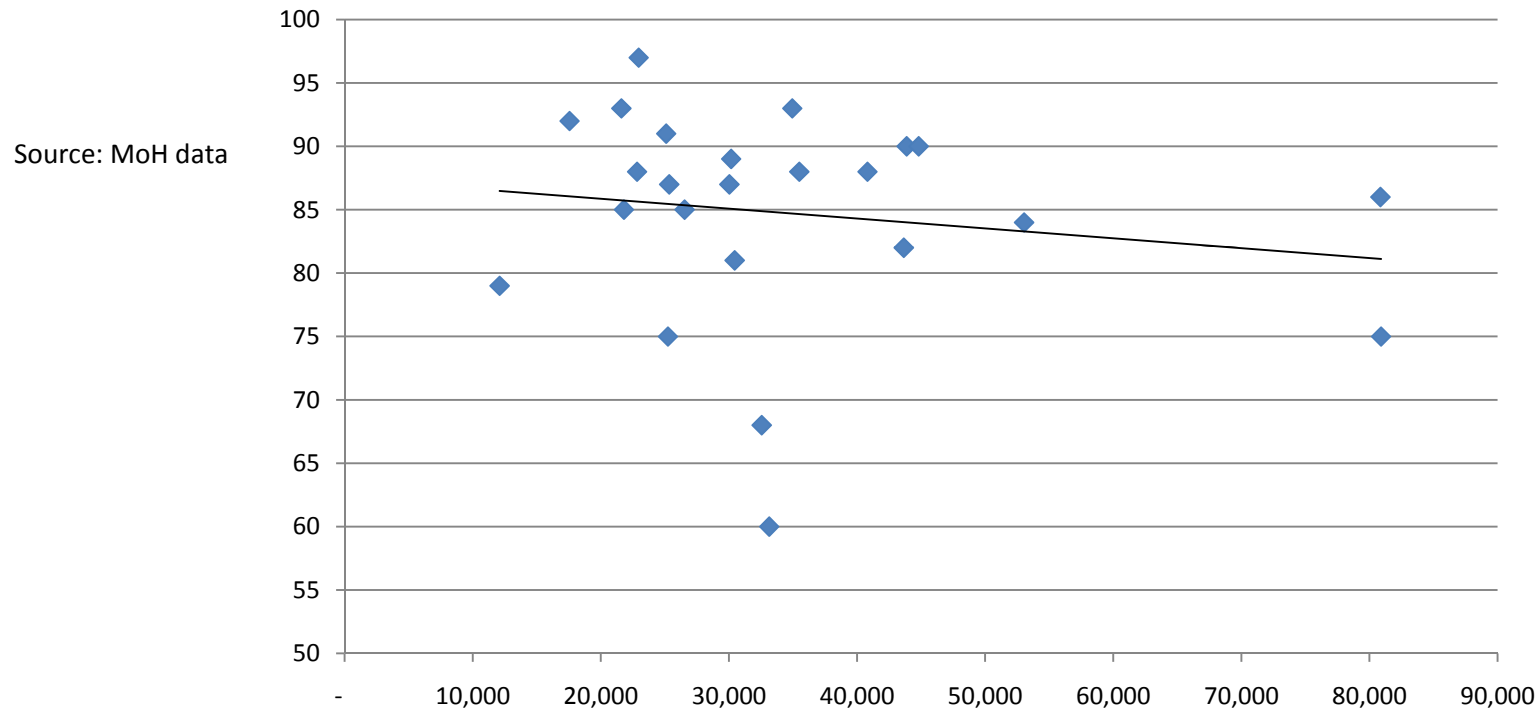
## Coverage of immunization and preventive child health care has improved for the poorest

	poorest quintile			next poorest quintile		
	2004	2007	<i>change (%)</i>	2004	2007	<i>change (%)</i>
child under 5 given vitamin A (%)	77.8	90.2	16%	81.7	94.0	15%
child under 2 first given breast milk to drink	28.7	80.5	180%	30.0	79.5	165%
child under 2 has vaccination card (%)	77.3	81.2	5%	82.0	79.3	-3%
child under 2 received 3 DPT doses (%)	56.8	72.5	28%	61.4	65.7	7%
child under 2 never vaccinated (%)	16.1	11.9	-26%	12.7	11.8	-7%

Source: Cambodia Socio-Economic Survey (CSES), 2004 and 2007

# But...there is no correlation between public per capita health spending per province and DPT3 immunisation (2008)

Lesson : Success with immunisation is not just about spending money



# Cambodia has been a global leader in health financing innovations

- Performance-based contracting for health services
  - Initially through NGOs: significant improvements in immunization and MCH service coverage
  - Now introducing “internal contracting” between MOH and ODs and PRHs (Special Operating Agencies)
  - Performance contracts with health facilities (GAVI-HSS)
- Health Equity Funds (HEFs): finance user fees for poor
  - Over half of ODs covered; plan for nat’l coverage by 2015
  - Most donor-financed, implemented through NGOs;
  - Mostly finance hospital care, but some HCs covered
  - Need to strengthen national institutional framework (Social Health Protection Master Plan)

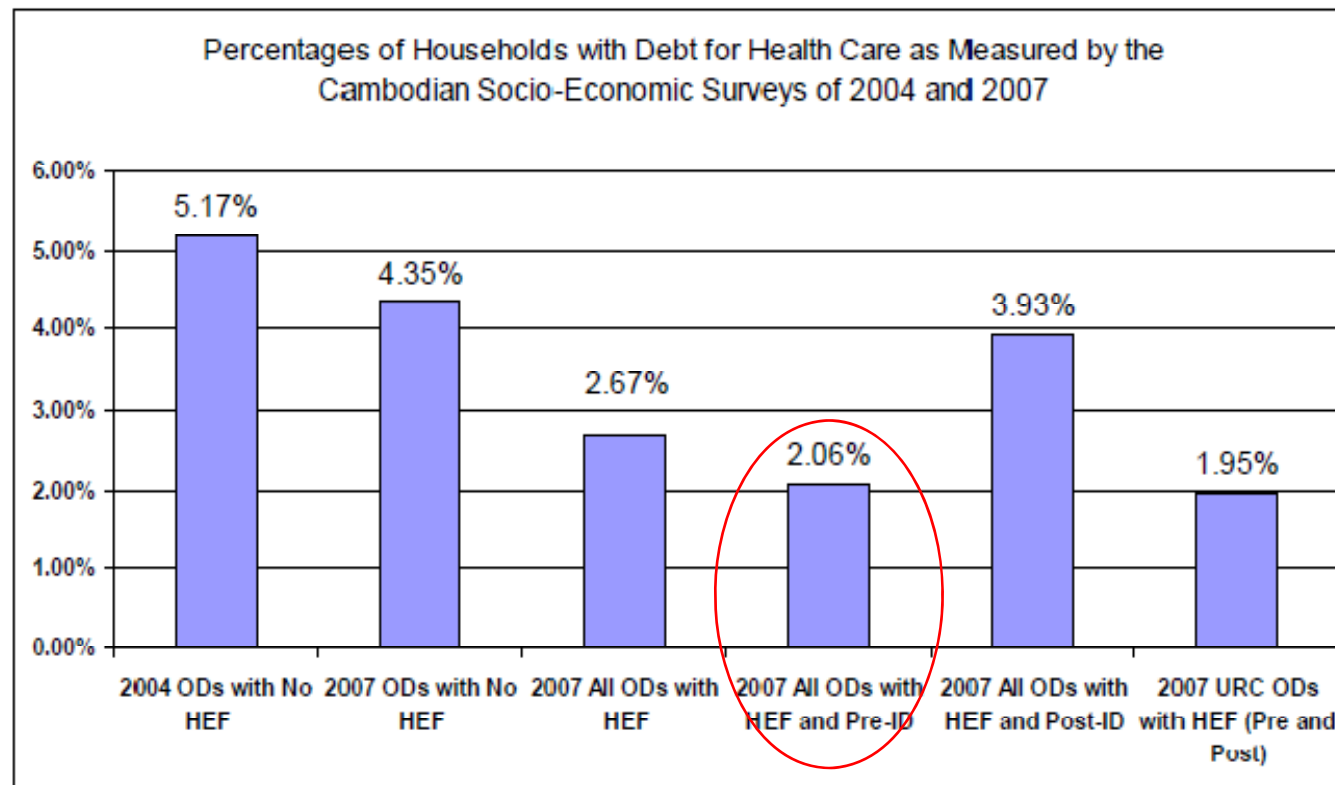
## CONCLUSIVE EVIDENCE ON HEFs

- An effective means of targeting the poor
- Pre-identification is more effective
- Reduce financial and physical barriers
- Provide access for the poor
- Correct facility underutilization
- Reduce but not eliminate debt for health care
- Provide additional revenues and incentives
- Improve opening hours and staff attitudes

(Supply-side strengthening is essential)

## HEFs reduce debt for health care

FIGURE 15: HOUSEHOLDS IN DEBT FOR HEALTH CARE



Jordanwood et al. 2009. Evaluation Report: URC. Using CSES 2007 data.

# “Best Practice” Lessons for health financing in Cambodia

- Shift priority programs to gov’t budget
- Align expenditures with national priorities
- Ensure equity and efficiency of health expenditures
- Increase % of financing reaching ‘front line’ service delivery
- Link financing to performance
  - Including performance-payments for health workers
- Scale up HEFs, insurance, or targeted subsidies to relieve payment burden on the poor

Thank you!



# Child mortality in Cambodia is close to global average for its income level, but is high relative to East Asia region

