CHAPTER 3

THE RESOURCE ENVELOPE

Analysis of health spending in Cambodia

Health financing in Cambodia is dominated by private out of pocket expenditures (US$ 24 per capita annually) that make up roughly 73% of spending. Of the remainder, external sources account for around two-thirds of spending although this figure has at times been significantly higher.

Table 1. Public sector spending by source for 1996-2001 (Millions US$)

Source	1996	1997	1998	1999	2000	2001
Government	16.2	17.4	12.0	32.7	26.8	32.9
Multilateral	NA	NA	NA	NA	NA	21.0
Bilateral	NA	NA	NA	NA	NA	30.2
NGOs	NA	NA	NA	NA	NA	14.1
Total external aid	39.8	24.2	59.0	68.0	65.1	65.3
Total public sector spend	56.0	41.6	71.0	100.9	91.9	98.2
Dollars per capita	5.2	3.8	6.3	8.7	7.7	8.1
% Government	29	42	17	32	29	33
% External	71	58	83	68	71	67

Sources: Ministry of Health expenditure report 2000; Ministry of Economy and Finance statement to fiscal working group by Minister of Health, 23rd April 2002; Cambodia Development Council (CDC) estimates of external aid, April 2002.

Note: Does not include government capital spending - in the health sector this rarely exceeds more than about 3% of total Government of Cambodia and donor funding.

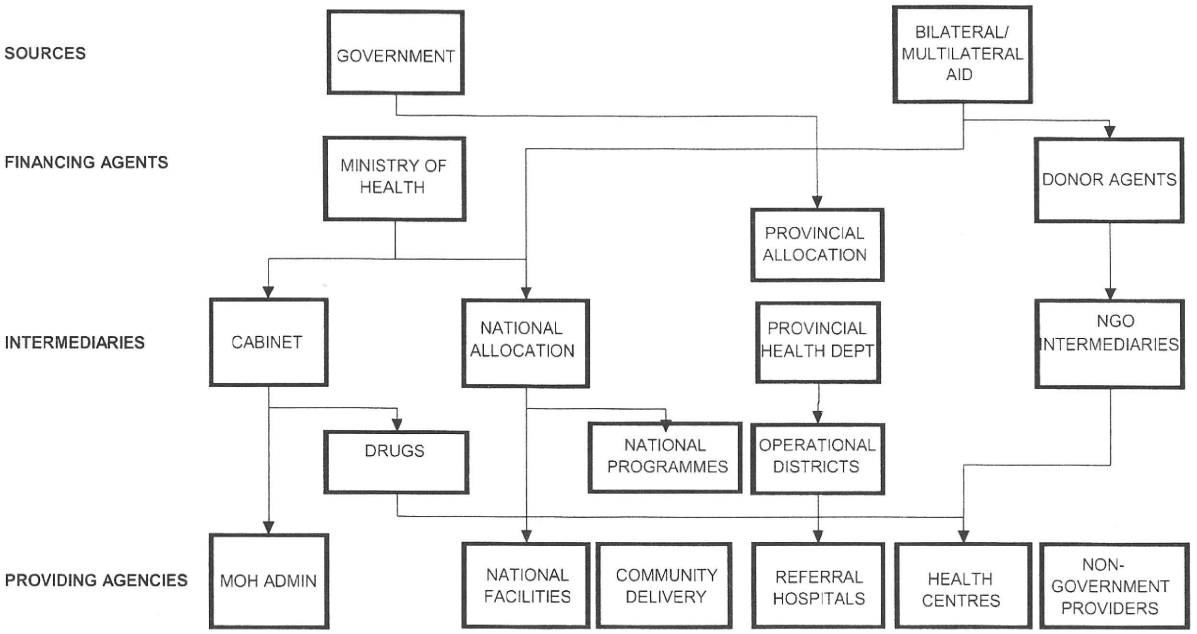
In 2001 bilateral funding accounted for around 46% of external aid, while multilateral and non-governmental organisation funding (core funding only) accounted for 32% and 22% respectively. The way in which external funds are disbursed is illustrated in figure 2. Approximately 47% of external aid is allocated to national programmes, national facilities and projects and the Ministry of Health. The remainder is distributed through project aid to provinces and non-government providers. (See table 2 and figure 2)

Table 2: Public Sector Health Spending 2001

	Government		Donors		Total	
	Thousands US$	%	Thousands US$	%	Thousands US$	%
Cabinet (central MOH departments)	4,141.93	4%	3,136.92	3%	7,278.84	7%
National Programmes	4,977.99	5%	11,131.37	11%	16,109.36	16%
National Hospitals and Institutes	5,781.72	6%	16,934.72	17%	22,716.44	23%
Sub-total Central MOH	**14,901.64**	**15%**	**31,203.00**	**32%**	**46,104.64**	**47%**
Provincial Health Departments	**18,084.19**	**19%**	**34,141.81**	**34%**	**52,225.99**	**53%**
Total	**32,985.83**	**34%**	**65,344.81**	**67%**	**98,330.64**	**100%**

Source: T Ensor, 2002, and MOH 2001 Expenditure Book

Figure 2. Main funding flows in the health sector



Note. Distributions based on the 2001 budget and Cambodia Development Council external funding figures. Information on distribution by external partners is incomplete.

The 4% allocation from the national budget held by the Ministry of Health is mainly for national level administration. The remainder (3% of external spending) is accounted for by projects administered by the ministry such as a health management project. National programmes account for around 16% of spending, incorporating both donor and government resources.

Currently, there is very little information on how these resources are distributed between national and province level facilities. National facilities, which account for 23% of spending, include organisations such as national hospitals and the National Institute of Public Health.

Around 55% of government spending, just less than 19% of the total, is allocated to provinces. The drugs budget, which accounts for around 12% of total public spending is centralised at the cabinet (ministry) level and supplies are then distributed to facilities, out of which 82% is allocated to provincial health departments and 18% to national level facilities.

It is currently difficult to separate out how donor funds get to facilities. Some go to national level programmes. Other funds go to provincial offices or direct to health facilities.

Resources: availability and funding flow

Ideally, three main sources of funding should be reflected in the MTEF: government, donor and private household finances through official user charges. Inevitably it will be some time before the MTEF can capture funding in a comprehensive way and accurately reflect their flow through the system. A number of systems are in place to develop this information base. The current configuration focuses on funding from government, development banks and donors.

Government health spending

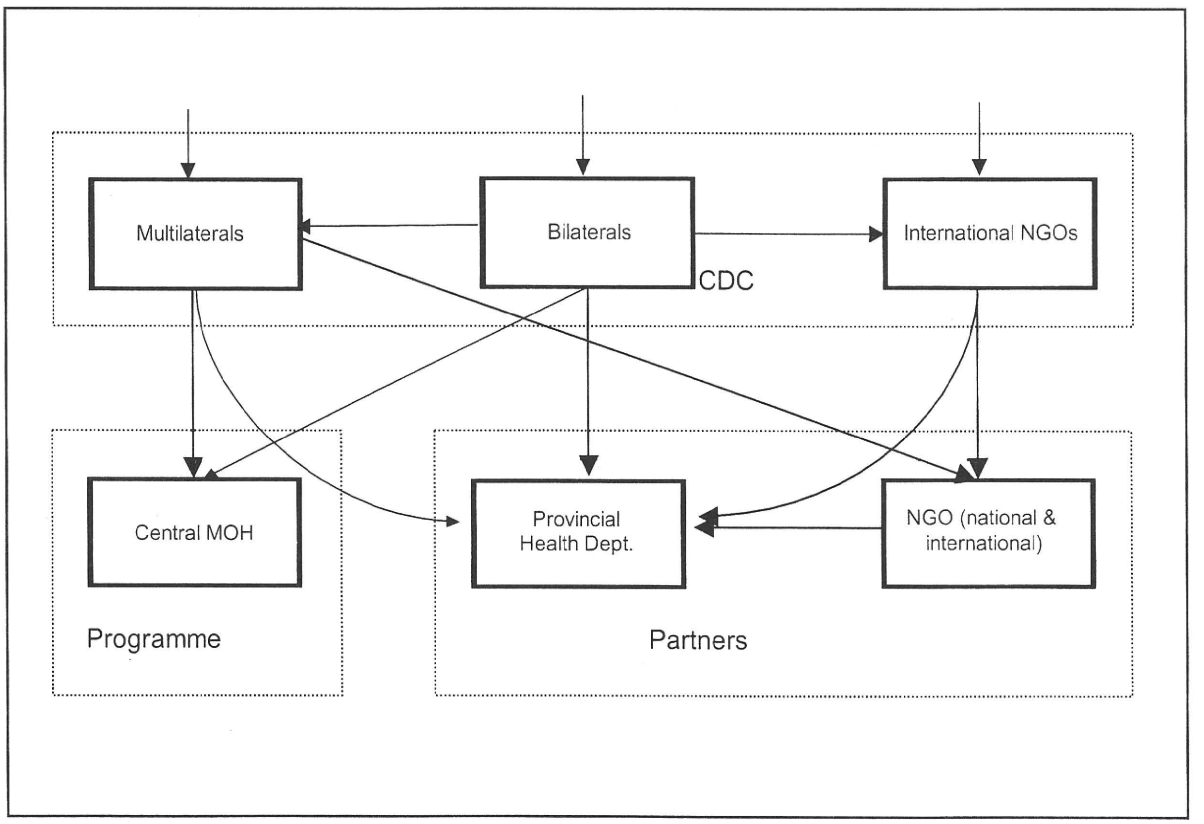
This is mostly captured through the budget for the Ministry of Health. Indicative projections for resources available are based on macro-economic and fiscal projections of the MEF and assuming a certain proportion that is allocated to health. The assumed proportion is likely to remain stable or rise slightly. A stable proportion is reflected in the present analyses.

Other government resources include capital funding and funding for health care through other ministries. Given that the MTEF is implemented on a line ministry basis it does not include health spending by other ministries. Capital spending by government is incorporated in Chapter 50 - as public investment.

Donor funding

The database developed by Cambodian Development Council (CDC) holds data on multilateral, bilateral and non-governmental organisation funding. Presently, it provides the most comprehensive picture of donor aid for health and all other sectors. The council's database only has a record of spending in the previous year and limited information on the current budget year. No forward estimates are obtained and it is doubtful whether most donors are able or willing to provide such information. The information from the council is complemented by information collected by the Ministry of Health through requests to external partners. The following figure outlines financing flows from donors and external agencies to the health sector.

Figure 3. Donor funding flows and sources of data



CHAPTER 4

KEY COMPONENTS

This chapter outlines areas to be financed for the Cambodian health sector, and provides financial information based on existing plans and commitments. It is emphasised that these figures are preliminary and will need to be revised later in the year on account of the following factors:

- The estimation of costs based on annual operational plans of budget management centres based on sector priorities
- The updating of contributions of external partners based on the new strategic plan by the end of 2002

Steps in developing the MTEF in the Ministry of Health, Cambodia

The preparation of the MTEF is based on the following elements:

- Forward projections of government spending
- Compiling and updating information on donor funding
- Review of income by programme sub-sectors, i.e. national programmes, central ministry departments
- Estimation of costs based on strategic activities
- Integrating available resources into the planning process
- Monitoring and updating expenditures throughout the plan period.

The first step of the MTEF is to indicate resources available in the health sector. Although the aim is to obtain a comprehensive picture of both government and donor resources and spending, this will take time to develop an accurate picture. The following steps were taken to produce this first MTEF.

Step I: Forward projections of government spending

Projected government spending is divided into two parts:

- First, baseline adjustments based on inflation, population growth and wage adjustments
- Second, above baseline adjustments for individual programmes

Provincial allocations were further adjusted based on unit cost estimates of essential services delivery and expected increases in planned activities.

Step II: Compiling and updating information on donor funding

a) Incorporating the contributions of donors

The list of projects financed by donors developed by the Cambodian Development Council was used to cross check the information held by the Ministry of Health through their partnership database. A request was sent out in mid 2002 to external agencies asking for forward indicative estimates on planned spending within the sector (see Annex C for the request form).

b) Reflect spending in programmatic categories

A sector approach calls for all public resources to be reflected in plans for the sector that, in turn, reflect the sector strategic plan. In the initial stages the easiest donor support to reflect in programme plans are the national programmes. These are already outlined in the public investment programme, which is a three-year description of donor and government investment.

The second stage is to reflect donor spending in operational plans. Over time, efforts will be taken to incorporate funding information into a programme framework.

Step III: Estimation of costs based on strategic activities

a) Estimation of costs by programme sub-sectors

A bottom-up costing study conducted in 2002 with support from WHO and co-financed by DfID, WB and USAID provides unit cost estimates of service delivery at district and provincial level, construction and also programme supervisory and technical support from central level MOH institutions. These costs are further projected to reflect changes in inflation, population growth and utilisation rates.

b) Estimation of costs by strategic priorities

The strategic plan highlights a series of priorities that will be reflected in operational plans (see volume 4 of the strategic plan). These plans will be developed both for national programmes and services provided through provincial health systems. The MTEF will then be used to plan and monitor broad allocations, starting first with rough estimates of the cost to implement some of the eight priority core strategies (see Box 2).

Overall, the present MTEF is pragmatic and is largely based on the current institutional structure of the Ministry of Health. Starting from the end of 2002 and in the beginning of 2003 the revisions to this edition will include forecasts of expenditures for priorities based on the sector strategic plan.

Step IV: Integrating resources into the planning process

The MTEF provides an opportunity to integrate a number of planning processes including the preparation of the annual budget and the public investment programme. The first version of the MTEF does not indicate allocations by individual budget management centres[1] . Later this year, as well as in the next 1-2 years, when operational plans are more definite and details regarding donor funds become available the MTEF can be presented by different levels, i.e. sectoral, sub-sectoral, provincial and below following the configurations of MOH budget management centres.

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[1] Budget management centers: Cost centres with responsibility to manage and spend an allocated budget from the government specific to their activities. The configuration is as follows:

- The central Ministry of Health as Central Budget Management Centre Level 1, national institutes and national programmes - Central Budget Management Centre, Level 2;
- The provincial health departments - Provincial budget management centers level 1 and operational district offices Provincial Budget Management Centre, Level 2.

Step V: Monitoring and updating expenditures

To support the MTEF and operational planning process, the Ministry of Health will conduct a standardised review of health expenditures at the end of each year. This will indicate how funding was allocated to different programmes and levels of facility. The review will focus on national budget expenditures and include donor funding. Later, there will be efforts to further disaggregate spending on national programmes by level of facility and population group that benefit from the expenditures.

The review of spending could be used to monitor the progress of operational plans, and the outputs and outcomes achieved through the strategic plan. This would inform the development of the annual budget, public investment programme and rolling planned expenditures through the MTEF in one consolidated resource planning process.

CHAPTER 5

PROJECTING HEALTH SPENDING 2003-2007

Cost and expenditure projections

Projections of government spending and external financing over the next five years are likely to become more refined as the sector planning process develops. The initial projections are somewhat crude and reflect broad objectives across the sector. The following steps were taken.

Baseline adjustments

The first stage of projections is to make broad adjustments based on expected inflation, population growth and wage increases across the public sector. The latter parameter is itself an important policy variable given the very low wages paid to public sector employees. Table 3 indicates average staff payments by type of facility and projections of wages with no increase other than 3% inflation rate.

Table 3. Average staff payments by type of service facility, 2003-2007

Category	Estimated staff costs (US$)				
	2003	2004	2005	2006	2007
Health centre	58	60	62	64	66
Health centre with beds	46	47	48	49	51
District hospital	70	72	74	76	78
Provincial hospital	49	51	53	55	57

Source: MOH/WHO/DfID/WB/USAID Costing Study 2002

Note: The payments in the table are official remuneration figures including staff salaries as well as payments from national programmes, NGOs, etc. The figures reflect distortions that exist currently in the health sector due to the concentration of alternative financing systems such as contracting and other NGO supported projects at health centre and district hospitals.

Above-baseline adjustments to plan priorities

The second level of adjustment is to develop forward estimates of budget for each operational plan. During the period of 2003-2007 this information will be requested from the various national programmes and departments at the same time that budget proposals are developed. Some forward estimates are already developed for use in the public investment programme. These will be further refined so that individual plans would indicate subcomponents and activities that will be financed over the next five years by the expected source of funding.

At the provincial level the key to the projections is how spending on health centres and hospitals is expected to increase. The 2002 MOH/WHO/DfID/WB/USAID costing study provides estimates of the current costs of health centres and hospitals at the current level of activity. The estimations in the study provide a basis for projecting costs as activities increase. The cost of a representative province is worked out using these estimates based on current and desired activity. This gives an indication of recurrent and annualised capital costs of providing services in a province. The following table indicates the unit and total costs of delivering the minimum and complementary package of activities for one 'average' province. The budget allocation to OD and PHD administration is used as proxy for their management costs. The estimations are based on assuming that 70% of OD management costs are allocated to health centres and 30% to district hospitals. Likewise, 25% of PHDs' administrative costs are factored into the cost of the provincial hospital and 75% to supervising the delivery of MPA.

In the scenario for 2003-2007, provincial utilisation (numbers of clients) is assumed to increase at 20% per year. Activity increases are assumed to affect non-staff costs in health centres and hospitals while costs in operational districts and provincial health departments increase only in line with inflation.

Table 4. Unit cost of MPA and CPA service delivery in provinces and operational districts for 2003-2007 (monthly average costs including depreciation)

Category	Estimated unit cost (US$)					
	Current	2003	2004	2005	2006	2007
Health centre (including outreach costs)	1,260	1,389	1,544	1,730	1,952	2,220
Health centre with beds	2,418	2,635	2,895	3,207	3,582	4,031
District hospital (without surgery)	7,822	9,044	10,511	12,271	14,383	16,917
District hospital (with surgery)	15,377	16,724	18,340	20,279	22,607	25,399
Provincial hospital	30,763	34,628	39,266	44,832	51,510	59,525
OD management	855	1,026	1,231	1,477	1,773	2,128
PHD management	8,505	9,356	10,291	11,320	12,452	13,697
Sub-total – one OD without surgery	23,695	26,595	30,077	34,255	39,258	45,276
Sub-total – one OD with surgery	31,250	34,275	37,906	42,263	47,482	53,758
Total province	117,908	131,449	147,618	166,926	189,960	217,531
With 3% inflation	-	135,392	152,046	171,934	195,659	224,057
Average population per province	545,811	558,910	572,324	586,060	600,126	614,529
Per capita costs (per year)	2.6	2.9	3.2	3.5	3.9	4.4

Source: MOH/WHO/DfID/WB/USAID Costing Study 2002

Relevant assumptions

Average population per province (2001): 545,811
Average population per operational district (2001): 181,937
Average number of health centres (without beds) per OD: 10, with beds per OD: 1
Average number of district hospitals without surgery per province: 2, with surgery: 2
Average number of operational districts per province: 3
Annual increase in utilisation rates: 20%, Annual population growth rate: 2.4%, Inflation: 3%

The costs in table 4 do not include support costs from central level, i.e. the ministry's technical departments as well as the various national programmes. Further estimations including these additional costs would significantly increase annual per capita costs.

In addition to these indicative estimates, provinces will develop their own plans for the annual budgeting process. These could be developed further to include forward estimates of spending.

The next table presents unit costs for construction of health centres and referral hospitals that the ministry would consider when deciding on the allocations for the revised health coverage plan.

Table 5. Unit cost for civil works

Category	Estimated unit cost (US$)				
	2003	2004	2005	2006	2007
Health centre	24,350	25,081	25,833	26,608	27,406
District hospital (without surgery)	156,956	161,665	166,515	171,511	176,656
District hospital (with surgery)	256,956	264,665	272,605	280,783	289,207
Provincial hospital	358,750	369,513	380,598	392,016	403,777

Inflation: 3% **Source:** MOH/WB/ADB Project Coordination Unit

As mentioned earlier, the technical and supervisory support from central level, particularly the national programmes comprise an important factor that influences financing needs. The estimations for this category are based on total costs for the following items:

a) Programme support, including staff payments, training, other operational costs
b) Capital expenditures at each national institution, including both construction and equipment
c) Technical assistance, largely reflecting externally financed advisory services.

The source of data for this category of costs is the most recent (2002) public investment programme (PIP) for the Ministry of Health where both investment and recurrent operational costs are estimated.

The data in the PIP may not be too accurate and the costs are likely to be overestimated. There is very little information on programme costs, especially with regards to externally financed activities that constitute a large portion of their expenditures. These costs will be revised in 2003 when operational plans are more definite.

Table 6. Total support costs from central ministry and national level institutions

CATEGORY	ESTIMATED TOTAL COST (THOUSAND US$)				
	2003	2004	2005	2006	2007
Tuberculosis and leprosy	**1,825.30**	**2,565.74**	**3,096.54**	**4,044.91**	**5,284**
-Programme support	1,255.30	1,853.24	2,222.30	2,972.85	3,976.89
-Technical assistance	486.00	607.50	745.40	923.18	1,143.36
-Capital	84.00	105.00	128.84	148.17	170.40
Malaria, dengue and schistosomiasis	**2,797.30**	**3,296.59**	**3,853.62**	**4,554.47**	**5,404.72**
-Programme support	1,390.30	1,700.39	2,042.64	2,476.00	3,001.30
-Technical assistance	644.80	805.95	988.90	1,224.71	1,516.76
-Capital	762.20	790.25	822.08	853.76	886.66
Maternal and child health	**6,154.27**	**6,710.50**	**7,548.58**	**8,480.03**	**9,597.03**
-Programme support	4,117.23	4,857.95	5,663.24	6,642.06	7,790.06
-Technical assistance	574.00	592.50	684.44	748.57	818.71
-Capital	1,463.04	1,260.05	1,200.90	1,089.40	988.26
HIV/AIDS and STIs	**11,935.74**	**13,318.60**	**12,901.54**	**13,498.32**	**14,133.76**
-Programme support	5,551.85	5,600.57	5,717.36	5,802.06	5,888.01
-Technical assistance	569.70	568.00	608.49	629.27	650.76
-Capital	5,814.19	7,150.03	6,575.69	7,066.99	7,594.99
Mental health and prevention of blindness	**1,554.72**	**1,751.16**	**2,002.74**	**2,352.11**	**2,806.03**
-Programme support	753.12	941.40	1,155.10	1,430.59	1,771.79
-Technical assistance	345.60	432.00	530.06	656.48	813.05
-Capital	456.00	377.76	317.58	265.04	221.19
Ear, nose, throat and oral health	**1,216.08**	**1,184.70**	**1,259.52**	**1,398.75**	**1,615.71**
-Programme support	363.24	454.05	557.13	690.01	854.58
-Technical assistance	253.80	317.25	389.27	482.11	597.10
-Capital	599.04	413.40	313.12	226.63	164.03
Blood transfusion programme	**1,471.98**	**1,542.13**	**1,705.15**	**1,948.81**	**2,279.95**
-Programme support	863.58	1,054.63	1,264.99	1,531.08	1,853.14
-Technical assistance	129.60	162.00	198.77	246.17	304.88
-Capital	478.80	325.50	241.39	171.56	121.93
Health education	**2,910.97**	**3,308.80**	**3,908.43**	**4,585.04**	**5,409.01**
-Programme support	2,024.97	2,463.80	2,944.31	3,550.45	4,281.38
-Technical assistance	250.00	312.50	383.44	474.89	588.15
-Capital	636.00	532.50	580.68	559.70	539.48
MOH support to basic health services	**69,792.15**	**64,817.61**	**87,559.60**	**92,285.68**	**97,294.73**
-Programme support	58,360.10	57,646.60	64,704.74	68,270.37	72,032.49
-Technical assistance	5,638.34	4,676.45	5,362.61	5,298.60	5,235.36
-Capital	5,793.71	2,494.56	17,492.25	18,716.71	20,026.88
Others	**19,727.43**	**23,510.09**	**28,244.49**	**28,250.31**	**31,019.48**
-Programme support	12,569.34	15,274.45	17,349.21	17,352.26	17,352.26
-Technical assistance	2,600.90	2,359.09	2,760.42	2,760.45	2,788.05
-Capital	4,557.19	5,876.55	8,134.86	8,137.60	10,879.17
Sub-total programme support cost (minus external technical assistance and capital)	**87,249.03**	**91,847.08**	**103,621.02**	**110,717.73**	**118,801.90**
Total (including technical assistance)	**119,385.94**	**122,005.92**	**152,080.21**	**161,398.43**	**174,844.15**

Source: Public investment programme 2002, Ministry of Health Cambodia

The next step is to obtain preliminary costs of the core strategies in the sector-wide plan of 2003-2007 to forecast funding requirements for implementation of strategic priorities. The estimations for provision of minimum and complementary packages of activities are based on the costing study, the central level support costs are from the PIP and the financing requirements for midwifery pre-service and refreshers' training are based on the Ministry's safe motherhood strategic plan 2001-2005. Costing for the remaining strategies will be done later whenoperational plans are developed and activities are more clearly defined and quantified.

Table 7: Indicative Costs of Eight Core Strategies in the Health Sector Strategic Plan (2003-2007)

STRATEGIES	COSTS (THOUSANDS US$)				
	2003	2004	2005	2006	2007
Revise Health Coverage Plan and complete construction of facilities					
☐ Revision of HCP					
☐ Civil works					
Provision of MPA					
☐ With OD and PHD support costs	15,771.32	17,558.20	19,702.45	22,265.13	25,354.01
Provision of CPA					
☐ With OD and PHD support costs	21,566.40	24,416.10	27,828.61	31,916.10	36,812.17
Central level support to MPA and CPA delivery at provincial level	119,385.94	122,005.92	152,080.21	161,398.43	174,844.15
Behaviour change of consumers					
☐ Attitudinal change of providers					
☐ Improving interpersonal skills					
Quality improvement					
☐ Develop culture of quality through the use of standards					
Human Resources Development					
☐ Increase number of midwives (MWs)	131	110	110	110	110
☐ Strengthen skills of trained midwives	74	74	74	74	74
☐ through continuing education					
Increase financing and strengthen financial management skills					
☐ Advocacy to increase financing					
☐ Strengthening management skills					
Organisational and management reform of MOH					
☐ Organisational reform					
Total:	**156,928.66**	**164,164.22**	**199,795.27**	**215,763.66**	**237,194.33**

Planned expenditures

At present, resources available from the national budget are indicated as an envelope that the Ministry of Health programmes into allocations based on institutional structure. By and large, donor contributions are actually pre-programmed expenditures i.e. earmarked in advance as technical assistance or expenditures for operational costs. Thus, the first configuration of the MTEF reflects very little distinction between available income and planned expenditures. As MOH's capacity for sector-wide management improves with stronger commitment among donors to participate within a coordinated process for resource planning, the MTEF would be able to separate out income from expenditures.

Categories for allocating expenditures

At present, priorities established by the health strategic plan fall into four main groups:

a) Provision of basic services:

- Strengthening basic health services
- Provision of essential drugs and consumables
- Provincial health plans
- Provincial level management
- Minimum service package
- Complementary service package
- Locally funded priority health programmes
- Other programmes

b) Nationally implemented priority public health programmes

- Tuberculosis & Leprosy Control Programme
- Control of malaria, dengue & schistosomiasis
- Maternal and child health
- National AIDS/STI programme
- Prevention of blindness and mental health
- Development of health education & and promotion
- Other programmes

c) Provision of essential specialised services

- Strengthening and rehabilitation of national hospitals
- Strengthening the National Laboratory for Drug Quality Control
- Development of medical specialties for ENT, oral, mental care
- Blood transfusion programme
- Development of National Institute of Public Health
- Development of traditional medicine
- Other programmes

d) Sector wide management

- Sector management (central level Ministry of Health, provincial level departments and operational districts)
- Strengthening health management and planning
- Human resource development
- Others

It is anticipated that total planned spending may well exceed predictions of the available resource envelope. The Ministry of Health will then decide how individual plans should be cut in order to fit in with broad sector objectives. Then provincial allocation, i.e. basic health services, would increase as a proportion of total government spending.

A number of these financial targets will be generated by the priorities outlined in the strategic plan. As information on spending limits improve, the planned expenditures in the MTEF can be properly linked to the various major activities of the strategic plan.

The national budget figures are based on assumptions that there will be an increase in health spending from public sources by 20% increase every year. The drug budget is allocated by 82% to basic health services (provincial allocation) and 18% to national facilities (essential specialised services). The total funding available in the sector is shown in the next table with a note of caution that information on donor funds is incomplete and the figures do not fully capture the total amount of resources available in the sector. (See table 8.)

Table 8. Planned expenditures in the health sector 2003-2007 by source of financing

Category	Planned Expenditures (Thousands US$)																	
	2002			2003			2004			2005			2006			2007		
	RGC	External	Total	RGC	External	Total	RGC	External	Total	RGC	External	Total	RGC	External	Total	RGC	External	Total
Basic health services	25,810	12,678	38,488	30,550	5,802	36,352	39,880	6,678	46,558	46,420	6,555	52,975	54,100	NA	54,100	63,710	NA	**63,710**
Priority programmes	7,200	51,499	58,699	8,530	18,230	26,760	10,320	13,656	23,976	12,170	NA	12,170	15,580	NA	15,580	19,320	NA	**19,320**
Specialised services	5,870	3,759	9,629	7,250	913	8,163	8,510	1,027	9,537	9,730	NA	9,730	11,870	NA	11,870	14,470	NA	**14,470**
Sector management	4,590	2,987	7,577	4,170	5,306	9,476	5,040	6,255	11,295	5,930	NA	5,930	7,550	NA	7,550	9,420	NA	**9,420**
Civil works	-	1,880	1,880	-	2,459	2,459	-	5,587	5,587	-	5,587	5,587	-	NA	NA	-	NA	**NA**
Total	**43,470**	**72,803**	**116,273**	**50,500**	**32,710**	**83,210**	**63,750**	**33,202**	**96,952**	**74,250**	**12,142**	**86,392**	**89,100**	**NA**	**89,100**	**106,920**	**NA**	**106,920**

Note: Incomplete data on donor spending - to be updated in August and December 2002

The last table compares projected costs of implementing the eight priority strategies in the sector-wide plan for 2003-2007 against funds available within those sub-sectors.

Table 9. Comparison of costs against income for core strategies in the health sector strategic plan 2003-2007 (Thousands US$)

CATEGORY	THOUSANDS US$									
	2003		2004		2005		2006		2007	
	Income	Costs	Income	Costs	Income	Costs	Income	Costs	Income	Costs
Basic Health Services	36,352	37,338	46,558	41,974	52,975	47,531	54,100	54,181	63,710	62,166
Priority Public Health Programmes	26,760	119,386	23,976	122,006	12,170	152,080	15,580	161,398	19,320	174,844
Essential specialised services	8,163	NA	9,537	NA	9,730	NA	11,870	NA	14,470	NA
Civil Works	9,476	NA	11,295	NA	5,930	NA	7,550	NA	9,420	NA
Sector wide Management	2,459	NA	5,587	NA	5,587	NA	NA	NA	NA	NA
MW training	NA	205	NA	184	NA	184	NA	184	NA	184
TOTAL	**83,210**	**156,929**	**96,952**	**164,164**	**86,392**	**199,795**	**89,100**	**215,763**	**106,920**	**237,194**

Note: Incomplete data on donor funding

Institutional issues

It is important that the priorities of the strategic plan are represented in the MTEF. The MTEF should also indicate where resources are insufficient to meet financing needs of strategic priorities necessitating a process for prioritising commitments. Correspondingly, the annual MTEF process will have to be closely connected to the development of operational plans that are produced at the provincial or facility level.

To ensure that resource allocation decisions are consistent, the ministry will link the processes that currently produce the public investment programme and annual (government) action plans and budgets to the MTEF.

On a regular annual basis, a more formal review of health sector expenditures will be conducted to assess the achievement of outputs and outcomes against disbursements expenditures.

The findings of these reviews will inform subsequent planning and resource allocation decisions leading to joint discussions between Ministry of Health and Ministry of Economy and Finance, and between the Ministry of Health and external partners on reduction of shortfalls and duplications.

CHAPTER 6

EVALUATION

Assessing the MTEF

The MTEF process aims to help the Ministry of Health develop a 5 year budget that:

- Reflects the strategies and priorities identified in the health sector strategic plan
- Takes into account sector wide local and external sources of funding (including income from user fees)
- Is developed jointly with all partners and other relevant stakeholders

When writing new editions of this volume the Department of Finance, Ministry of Health will assess the financial information sent in by, and provide feedback to, central and provincial levels, and to partners.

Evaluating the medium-term expenditure framework

The ministry will regularly evaluate whether the framework is relevant, easily understood by implementers and partners and useful. If changes are needed to the framework process new editions of this volume will be produced. The following are examples of a few of the management criteria that will be used to evaluate the framework:

- Is the MTEF process user-friendly?
- Is the process efficient and effective?

The current MTEF is at best, an outline for preparing a fuller, more accurate framework of planned expenditures against priorities for the next five years. The timing and the inadequacy of information for this version especially with regards to external spending indicate the need for further continuous work on costing and allocating expenditures. The success and failure of the MTEF as a joint planning tool would be contingent on two factors:

- Whether the ministry and its external partners participate in a clear and transparent process to table inputs and discuss on ways to improve efficiency, including financial flows to national programmes, and
- Whether there is capacity within the MOH to gather and analyse information adequately to enable subsequent discussions among decision-makers.

In this regard the MTEF institutional process would need to factor in measures for advocacy and strengthening capacity to effectively manage these risks.

ANNEX A.
TABLES FOR PREPARATION AND UPDATE OF MTEF

Section 1
Resource allocation for health sector strategic plan period 2003-2007

Table 1(a). Recurrent expenditures for basic health services at provincial and operational district level 2003-2007

CATEGORY	PLANNED EXPENDITURES (MILLIONS US$)				
	2003	2004	2005	2006	2007
Strengthening basic health services					
Provision of drugs and consumables					
Other basic services					
Total					

Table 1(b). Recurrent expenditures for priority public sector health programmes 2003-2007

CATEGORY	PLANNED EXPENDITURES (MILLIONS US$)				
	2003	2004	2005	2006	2007
Tuberculosis and leprosy					
Malaria, dengue and schistosomiasis					
Maternal and child health					
HIV/AIDS and STIs					
Mental health					
Prevention of blindness					
Oral health					
Total					

Table 1(c). Recurrent expenditures for essential specialised services 2003-2007

CATEGORY	PLANNED EXPENDITURES (MILLIONS US$)				
	2003	2004	2005	2006	2007
National hospitals					
National laboratory for drug and food quality control					
National Blood Transfusion Programme					
National Institute of Public Health					
Traditional medicine					
National Centre for Health Promotion					
Others					
Total					

Table 1(d). Estimated expenditures for civil works 2003-2007

CATEGORY	PLANNED EXPENDITURES (MILLIONS US$)				
	2003	2004	2005	2006	2007
Health centres					
Referral hospitals					
Other capital items					
Total					

Table 1(e). Recurrent expenditures for sector wide management and other cross cutting issues 2003-2007

CATEGORY	PLANNED EXPENDITURES (MILLIONS US$)				
	2003	2004	2005	2006	2007
Sector management (MOH, PHDs and ODs)					
Strengthening health management and planning					
Human resource development					
Others					
Total					

ANNEX B: External financing by sub-sectors

Table 1: Provision of basic health services

Agency	BHS				Drugs				Others	Total	Total	Total	Total
	2,002	2,003	2,004	2,005	2,002	2,003	2,004	2,005	2,002	2,002	2,003	2,004	2,005
Multilateral	**5,175,329**	**4,735,146**	**5,902,460**	**5,879,603**	**985,000**	**416,000**	**150,000**	**125,000**	**330,818**	**6,491,147**	**5,151,146**	**6,052,460**	**6,004,603**
UNICEF	602,000	760,000	760,000	760,000	985,000	416,000	150,000	125,000		1,587,000	1,176,000	910,000	885,000
WHO									330,818	330,818	0	0	0
AUSAID	296,478	193,986								296,478	193,986	0	
EU										0	0	0	0
ADB	2,267,815	2,320,160	2,104,960	1,457,103						2,267,815	2,320,160	2,104,960	1,457,103
WB	2,009,036	1,461,000	3,037,500	3,662,500						2,009,036	1,461,000	3,037,500	3,662,500
Bilateral	**0**	**0**	**0**	**0**	**1,700,000**	**0**	**0**	**0**	**3,871,000**	**5,571,000**	**0**	**0**	**0**
Belgium										0	0	0	0
GTZ										0	0	0	0
Germany					1,700,000					1,700,000	0	0	0
Norway									451,000	451,000	0	0	0
France									3,420,000	3,420,000	0	0	0
NGOs	**814,050**	**650,773**	**625,930**	**550,344**	**0**	**0**	**0**	**0**	**0**	**814,050**	**650,773**	**625,930**	**550,344**
Assembly of God	25,870	12,820	28,025							25,870	12,820	28,025	0
World Relief Cambodia	78,561	134,445	88,663	87,428						78,561	134,445	88,663	87,428
Catolic Relief service	644,351	503,508	509,242	462,916						644,351	503,508	509,242	462,916
Health Unlimited										0	0	0	0
JOCS										0	0	0	0
Aids medical International										0	0	0	0
MSF	65,268									65,268	0	0	0
Medicine sans France										0	0	0	0
Total	**5,989,379**	**5,385,919**	**6,528,390**	**6,429,947**	**2,685,000**	**416,000**	**150,000**	**125,000**	**4,201,818**	**12,876,197**	**5,801,919**	**6,678,390**	**6,554,947**

Table 2: Priority Public Health Programs 2002

Agency	TB	Malaria	MCH	HIV/AIDs	B & M*	H Promotion	Others	Total
Multilateral	**861,430**	**3,651,707**	**5,653,745**	**5,371,423**	**0**	**395,270**	**0**	**15,933,575**
UNDP								0
UNICEF			2,030,000	2,030,000		170,000		4,230,000
UNESCO				6,000				6,000
WHO		603,636	558,372	131,679		225,270		1,518,957
EU		1,903,201						1,903,201
ADB				1,522,664				1,522,664
WB	861,430	1,144,870		1,681,080				3,687,380
UNFPA			3,065,373					3,065,373
Bilateral	**3,236,000**	**800,000**	**11,021,120**	**18,008,138**	**0**	**897,285**	**0**	**33,962,543**
USAID	2,200,000	800,000	7,000,000	12,000,000				22,000,000
AUSAID			402,000			751,000		1,153,000
CANADA				750,000				750,000
German			700,000					700,000
Japan-JICA	1,036,000		1,693,000	70,000				2,799,000
UK			1,226,120	5,041,138		146,285		6,413,543
FRANCE				147,000				147,000
NGOs	**0**	**0**	**765,126**	**122,526**	**0**	**715,418**	**0**	**1,603,070**
Assembly of God	0		25,870					25,870
World Relief Cambodia	0		78,561					78,561
Catholic Relief Services	0							0
Health Unlimited			488,145			715,418		1,203,563
JOCS			4,430					4,430
Pharmacien Sans Frontieres			67,814					67,814
Aids Medical Internationale								0
MSF	0		100,306	122,526				222,832
Medicine Sans France								
Total	**4,097,430**	**4,451,707**	**17,439,991**	**23,502,087**	**0**	**2,007,973**	**0**	**51,499,188**