

Financing the Cambodian Public Health Sector

Discussion Paper

for Presentation at the

Cambodian Macroeconomics and Health National Research Symposium

9-10 August, 2005, Hotel Phnom Penh

Phnom Penh, Kingdom of Cambodia

Cambodia Macroeconomics and Health Technical Advisory Group^{*}

^{*} Dr. Lo Veasna Kiry, Ministry of Health (Co-chair); Mr. Ros Seilava, Ministry of Economy and Finance (Co-chair); Mr. Ros Chhun Eang, Ministry of Health, Mr. Tep Phiyorin, Ministry of Economy and Finance, Mr. Hav Ratanak, Ministry of Health; Ms. In Sam Aun, Ministry of Planning; Dr. Sok Kanha, Ministry of Health, Mr. Srey Vuth, Ministry of Economy and Finance, Dr. Ly Vichea Ravuth, Ministry of Health; Mr. Chan Sopheap, Ministry of Economy and Finance, Mr. Long Bore, Ministry of Health; Dr. Benjamin D. Lane, Columbia University/WHO.

Introduction

This discussion paper has been prepared by the Cambodian Macroeconomics and Health Technical Advisory Group (TAG), as part of the Cambodian follow-up activities to the Report of the Commission on Macroeconomics and Health. The TAG was established in November 2004, in order to conduct collaborative policy analysis and research. The TAG membership consists of professionals drawn from the Ministry of Health, Ministry of Economy and Finance, Ministry of Planning, and Supreme National Economic Council. The group was conceived not to have a coordinating or planning role but to provide policy relevant multi-sectoral analysis and technical level knowledge sharing to support coordination at the policy level.

Reflecting the research mandate of the TAG, this discussion paper makes no specific policy recommendations. Rather, its goal is to provide critical analysis of health financing policy and implementation in the Cambodian health system and to identify options and criteria for consideration. It has been prepared as a contribution to ongoing discussions regarding health system financing in Cambodia and, in particular, the upcoming ten-year re-assessment of the 1996 Health Financing Charter.

In this paper, the focus is on funding in the public sector, while recognising the importance of the private sector in the Cambodian health system. Given the make-up of the TAG, this would seem a natural choice. However it is also grounded in the fact that many of the pre-requisites for the private sector to be able to reliably provide good quality and value for money are beyond the power of the institutions involved in the TAG. For example, the private sector must be well regulated, and regulations must be enforced and supported by a strong judicial system that guarantees accountability. People must be well enough educated to be able to make complex choices on health care, and they must be well informed about all the options that are available to them and the quality of service being provided. Achieving this will require substantial long-term investments across Cambodian society.

Macroeconomics and Health in Cambodia

The *Report of the Commission on Macroeconomics and Health (RCMH)* presented evidence linking health to economic performance at the national level. This is supported by the experience of developing countries that have used public health investment as integral parts of their economic development strategies. According to the RCMH, “health status seems to explain an important part of the difference in economic growth rates, even after controlling for standard economic variables” (RCMH p.24). While the international evidence is strong, it is much more difficult to show the causal link between health investment and economic growth for Cambodia, due to the wide variety of factors that simultaneously influence growth and limits on information available concerning these. What can more easily be demonstrated is the importance of health at the level of labour productivity, educational attainment, and poverty alleviation. All of these are of special relevance to Cambodia.

While macroeconomic policies have an immediate focus on GDP and growth rates, the ultimate macroeconomic goal for the Royal Government of Cambodia is poverty alleviation. In the Cambodian context, the importance of a healthy population to achieving economic goals is both direct and indirect. Improving health is a vital element in increasing productivity needed for economic growth, but it is also a fundamental aspect of poverty alleviation in and of itself. Indeed ill health is both a defining aspect of poverty as well as an aggravating factor.

Macroeconomic growth depends upon good management at the top, that is, at the macro level. However it is equally important that resources should be allocated efficiently at all levels of the economy. The RGC’s policies supporting macroeconomic stability have allowed for rapid economic growth over the past ten years. Many of the causes of poverty and means for escaping it will however be located at the household or village level. Successful poverty reduction strategies are therefore also informed by microeconomic considerations as well as a clear understanding of the role of the state and its finances in the national economy. For Cambodia at least, “Macroeconomics and Health” is best understood more broadly, to include all aspects of economic policies relevant to poverty reduction through improved health.

Health has been recognized by the RGC as a priority area in its economic development and poverty alleviation policies. Funds allocated from the national budget to the Ministry of Health have tripled since 1995. The Ministry of Health has been selected as one of the key ministries for public sector reform processes, including the Priority Action Programme, and piloting for the Medium Term Expenditure Framework and Programme Based Budgeting. Cambodia has committed itself to the Cambodian Millennium Development Goals, which will form a central element of the National Strategic Development Plan currently under preparation. Within the health sector, the RGC has been pursuing Sector Wide Management with its partners, as part of broader efforts toward donor harmonization and alignment.

Delivery of health services in Cambodia is subject to severe resource constraints, a heavy disease burden and post-conflict institutional challenges. The health system itself is seriously fragmented. The public health sector divided into numerous national programs, while at the operational level a highly diverse set of non-governmental organisations pursue goals at times parallel to, at times in competition with government priorities. The small formal economy and substantial social development needs mean that national financial resources available for health will be constrained in the near term at least. National health investment is supplemented by international development assistance, however the total public funding available remains well below the levels recommended by the RCMH.

Attention must therefore be given not only to the quantity of funding available for health, but also its quality. With limited financial means, human resources, and political capital available, this means marshalling resources in the most effective and efficient manner possible. It also means paying careful attention to the real economic costs of policies and programs, their realistic prospects for sustainability, and the impacts and synergies they may have with other key development goals.

Financing the Cambodian health system: Quantity vs. Quality of funding

It is estimated that between USD 30 and USD 35 are spent per capita on health in Cambodia. This represents approximately 10% of per capita GDP, the highest percentage among developing

countries in Asia and well over twice the average for ASEAN countries. Of this money, approximately USD 15 flows into the public and NGO sectors, with approximately six dollars coming from International Development Assistance¹, six dollars coming from private expenditure² and three to four dollars coming from the national budget³. Between 17 and 21 USD per capita of private expenditure is spent on private sector health care⁴.

The three main sectors of the health system are each financed differently. The private sector is funded almost exclusively through private expenditure, either out-of-pocket or through payment plans after service. The private sector also receives support from development aid through activities such as training or social marketing. Important subsidies are provided by the public sector in the form of training, facilities use, access to client networks and quality identification for public sector staff with private practices. The non-governmental sector is funded primarily through international development assistance as well as indirect state subsidies, while the public sector is funded from the public purse, development assistance and both formal and informal private expenditure.

The public purse

Funds allocated from the national budget to the Ministry of Health have increased by a factor of 5 since 1995. The 2003 budget of 202 Billion Cambodian Riel (USD 50 Million) for MoH was 11.4% of the national budget, as compared with a 1995 health budget of approximately USD 10 Million⁵. This trend is continuing, with a projected 2006 budget of approximately 260 Billion Riel.

¹ Catherine Michaud. External Resource Flows to the Health Sector in Cambodia. Mimeograph, WHO, Geneva. 2005.

² Cambodia Demographic and Health Survey, 2000. National Institute of Statistics, Ministry of Planning, Phnom Penh.

³ Cambodia Ministry of Health, Phnom Penh.

⁴ Cambodia Demographic and Health Survey, 2000. National Institute of Statistics, Ministry of Planning, Phnom Penh.

⁵ ADB Key Development Indicators 2005

Actual health expenditure for a given year has lagged behind budget allocation, however current expenditures for health made up 9.9% of total recurrent government expenditures in 2003⁶. This is high by international standards and, indeed, the highest percentage of government spending devoted to health by any ASEAN country.⁷

However, as a percentage of GDP, government health expenditures remain very low, staying around 1% for the period 1999-2003⁸. The national budget itself only amounted to 12.5% of GDP in 2003, so the figure for health should not be surprising. As health already accounts for such a large portion of government expenditures, the best way to increase government health expenditure will therefore be to increase revenues into the national treasury.

As a result of Cambodia's success in maintaining macroeconomic stability since 1993, the economy has grown rapidly, averaging 6.6% annual growth in GDP for 1996-2004.⁹ However with over 85% of the labour force still working in the informal sector, the tax base remains extremely weak, and other options for increasing national revenues will be limited for some time.

Budget execution

At the same time, the budgeting process suffers from a number of weaknesses that reduce the effectiveness of the funding that is available. The most serious of these is budget execution, which is incomplete and may be subject to serious delays, with disbursement spread out over two to three years. Thus, simultaneous to disbursement from the budget for a given year, there may be significant outlays to cover arrears from previous years. For example, in the period from January 1st to August 31st, 2005 a total of USD 61.5 Million were disbursed. This is 11 Million Dollars more

⁶ IMF Country Report No. 04/330. Phnom Penh. 2004.

⁷ ADB Key Development Indicators 2005

⁸ IMF Country Report No. 04/330. Phnom Penh. 2004

⁹ Ministry of Economy and Finance

than MEF was able to commit to disburse from the entire 2005 budget and only 2.5 Million short of the health budget approved by the National Assembly. However, 3.5 Million Dollars of this were arrears from the 2003 budget and 16.5 Million were from the 2004 budget.¹⁰ As such, these funds were to pay for activities and procurement that had already been delayed for up to two years.

As a result of these delays, the Ministry of Health cannot predict what funds will actually be available to it at any given point in the year. Without a reliable budget envelope, planning and budgeting within MoH has to be based on best estimates of what might be available, based on trends over the past years. This increases the likelihood that planning at the facility and district levels will be based on incremental rather than needs based budgeting, which makes scaling up of essential services especially difficult. At the facilities level, the unreliable flows of operating funds throughout the system damage staff morale and result in lower quality of service delivery. Delays can also disrupt the procurement of medical supplies, including essential medicines, resulting in stock-outs and shortages. Coping mechanisms such as reliance on money-lenders increase costs to the system and further reduce resources available for health services.

The disbursement problem has two distinct aspects. First there is the difference between the budget for health in the National Budget that is approved by the National Assembly, and the actual amount that the Ministry of Economy and Finance is able to commit to allocate during a given year. The second aspect is the difference between what MEF allocates to MoH and what is actually disbursed over the course of the year. Discussions of disbursement rates tend to lump these two together, thereby obscuring the sources of difficulty.

In 2003, the National Assembly approved a budget of 202 Billion Riel, however the MEF committed allocation for 2003 was 173 Billion Riel. The balance was then paid out by MEF over the course of 2004 and 2005. This difference between approved budget and committed allocation results from the fact that the approved budget does not accurately reflect resources available in the National Treasury. Using the approved National Budget as a guideline, MEF determines the

¹⁰ Ministry of Economy and Finance

committed allocation based on negotiations with individual ministries, once it can estimate the total resource envelope for the government. The ratio of committed allocation to approved budget (85%) may therefore be seen as an indicator of the gap between the approved budget and available resources, as well as the negotiating power of MoH relative to other ministries. It is not an indication of the absorptive capacity of MoH.

The second step in the disbursement process in 2003 began with the 173 Billion Riel committed by MEF to MoH. Of this, 167 Billion Riel were disbursed from the 2003 budget. The ratio of the amount disbursed to the committed budget allocation is an indicator of the technical implementation capacity of MoH and MEF and is therefore a better indication of the absorptive capacity of MoH. This was 96% for 2003 and tends to be much higher than the ratio of committed allocation to approved budget in any given year.

Thus, the low rate of disbursement from the approved National Budget is not so much the result of low absorptive capacity in MoH or weak budget execution capacities in MEF. Instead, it is primarily a reflection of an unrealistic national budgeting system that makes allocation outcomes the result of negotiation between ministries rather than through parliamentary processes. It seems reasonable to suspect that this is not a unique phenomenon. It remains a serious problem for planning and budgeting at all levels, but this could be alleviated through earlier release of the budget envelope to MoH, if only on an informal basis.

Disbursement delays result from a number of compounding factors and constraints that further aggravate the effect of arrears from previous years. The inflow of funds to the National Treasury is uneven, and the timing of major outlays may be beyond the control of MEF. Many ministries submit requests late, overwhelming MEF capacities. These factors may result in a precautionary approach to expenditures on the part of MEF. Throughout the budgeting system in MEF and MoH, budgetary management capacities are still weak. Administrative processes are complex, with unclear lines of authority and accountability. These constraints are aggravated by the simultaneous use of multiple budgetary management systems in MoH and frequent changes in their implementation procedures.

Many other constraints can be eased through closer cooperation and regular, informal information sharing between MEF and MoH, as well as across units within the ministries. The TWGH can play an important role in this regard, as can initiatives such as the TAG. Technical capacities constraints may be eased through improved salaries, focused training, MEF capacities support for MoH, as well as a more strategic approach to technical assistance that strengthens capacities through increased use of national consultants and capacities development as a contractual obligation. Overly complex administrative processes can be simplified through specification of roles and responsibilities for budgeting, control and monitoring. Increased delegation of spending authority can also help, so long as it can be ensured that allocations are dependent upon established priorities and plans of action rather than personal discretion. One of the most important improvements in the disbursement process will be closing the books at the end of each year. MEF is working towards achieving this at the end of 2005 as part of the RGC's Public Financial Management Reform process.

International development assistance

As in many developing countries, International Development Assistance (IDA) plays a key role in funding the Cambodian health system. This aid comes in the form of direct grants from bilateral and multilateral partners as well as philanthropic foundations, preferential loans and technical assistance.

Donor funds represent an exceptionally important contribution to achieving better health for all Cambodians. IDA is estimated to have been USD 83.5 Million, or USD 6.40 per capita for health in 2003¹¹. It is however worth remembering that six dollars per capita falls far short of the amount needed to fill the funding gap identified by the Report on the Commission on Macroeconomics and Health.

The planning problem

¹¹ Catherine Michaud. External Resource Flows to the Health Sector in Cambodia. Mimeograph, WHO, Geneva. 2005

It is critical to efficient use of scarce resources that they be fully reflected in national planning processes, giving government and key partners a comprehensive view in order to better identify key gaps in coverage. For the RGC to ensure that funds are used in a complementary manner, they must have a clear overview of resources flowing into Cambodia and the purposes these are intended to serve. This is difficult to achieve.

For long-term planning the problem is particularly acute. Some degree of certainty regarding future availability of funds is needed for effective health system planning. Yet in Cambodia the negotiation of donor funds through the Consultative Group process has to some degree become a strategic exercise, with donors using uncertainty regarding future funding as a bargaining tool. This has benefits, but it makes the budgeting and planning process all the more uncertain. Donors themselves frequently cannot know what their ability to provide funding will be several years in advance. Multi-year donor commitments such as those made by USAID, DfID, ADB, the WB and the GFATM have therefore been an important step for Cambodia's ability to pursue long-term health priorities. Approximately one quarter of IDA for the health sector is currently covered by such commitments.

Annual planning is subject to informational constraints as well. For example in 2003, only twenty percent donor funds flowed through the national treasury. The other 80% bypassed the national budgeting process and flowed either directly to MoH National Programmes, health facilities, or to the more than 100 NGO's working independently in the health sector. It is therefore extremely difficult to gain an accurate picture of what resources are available to allocate to national health priorities.

The planning problem is reflected in the difficulty of targeting funds to the most pressing needs. Because the source of funding is outside of Cambodia, money may be directed to needs that are perceived from abroad instead of in Cambodia. As a result of global trends, some areas are relatively well funded while others remain seriously underfunded. For example, HIV/AIDS received USD 29.3 Million in 2003 (including USD 15.1 Million from the United States of America). Maternal and Child Health received 13.3 Million in donor funds that year. There are an estimated 123,000 people living with HIV/AIDS in Cambodia, and there are approximately 1.4

Million children under the age of 5. Child mortality is falling, however in 2000 it was estimated that 63,000 children died in Cambodia¹². Clearly HIV/AIDS is a key health concern in Cambodia and globally, and we do not question the need for high levels of funding to fight this disease. Similar attention should however be given to other pressing needs.

IDA and Human Resources Constraints

Human resources capacities pose some of the most important constraints on the effectiveness of IDA in many contexts. Given Cambodia's specific history, long-term investments in the strengthening of capacities throughout the health system are essential. It is not only absorptive capacity that is affected by these constraints. Unless well coordinated with other activities across the health system, new funds may have unintended skewing effects in this context, drawing scarce human resources away from other health priorities.

Civil service salaries in Cambodia do not provide a living wage, and donor-funded salary supplements and per-diems have become important for retaining personnel in the Ministry of Health. However, the differences in funding levels across departments, facilities and National Programmes also result in extreme differentials in salary supplements across the public sector. Thus the incomes of public sector employees are themselves a function of external priorities. At the same time, even the higher supplements do not bring incomes up to the level that the most talented personnel might earn working for NGO's or the donors themselves. The result is a drain on human resources from health priorities that are less favoured by the donors as well as a drain from the public sector as a whole. Without a coherent and transparent system for supporting salaries that is under the control of the Ministry of Health, it will be significantly more difficult for the MoH to manage its human resources effectively to address its priorities.

¹² Based on under-five mortality rate of 135. Robert Black et.al. "Why are 10 Million children dying every year?" The Lancet. Vol.23, June 28, 2003.

Another result of these constraints is the reliance by donors and the RGC on Technical Assistance (TA). While there is no question that the outsourcing of technical expertise is an important management option, there are also limits to its usefulness to any organisation. The World Bank has estimated that TA accounted for 40% of total IDA to Cambodia in 2004.¹³ A valuable exercise would be to determine what percentage of health funds is devoted to long-term TA and national versus international consultants. What can be seen in the Ministry of Health is that international consultants have come to play an important role in the development of products with direct policy relevance. Even though the quality of work provided by international consultants may be high, there is limited hope that a visiting expert can gain the necessary understanding of the system and its particular constraints over the course of a short consultancy. The necessary expertise may in fact be within the ministries themselves, in which case a more effective use of resources would be to focus funding on supporting and strengthening existing capacities rather than importing them on a short term basis.

Transactions costs

Given the high volume of IDA flowing into the Cambodian health sector, it is not surprising that there should be transactions costs for the RGC. Indeed, this has been recognised for some time and has been an important motivation for efforts for Sector Wide Management. Some of most visible costs result from negotiation procedures, reporting requirements, and extremely frequent donor missions. Even donor harmonisation and alignment imposes substantial transactions costs in the short term. Less visible are the heavy costs resulting from the complexity of systems encouraged by donors to support successive reform initiatives within the public sector.

These transactions costs may reflect the institutional capacities and priorities of the donors rather than the RGC. Yet the fact that a donor may have large administrative capacities capable of carrying out complex reporting and application processes does not imply that the same should be expected of an under-resourced public sector in a developing country. A striking example of this is

¹³ World Bank Consultative Group Report 2004

the application process for GFATM support, which demands increasingly large amounts of time from ministry staff and TA over a period of months.

The transactions costs associated with IDA are still small in comparison with the quantity of funding received, however they are not necessarily borne by the same units that benefit from funding. Where these costs fall within the public sector and the impacts that they have on its functioning are therefore an important area for future examination.

Many of the quality issues surrounding IDA are the result of the constraints under which donors must operate. However, even within these constraints, there is significant room for improved donor coordination. Current work to strengthen the Technical Working Group Health and broader harmonisation and alignment with RGC priorities are potentially important contributions in this regard.

Private expenditures in the Public Sector

The 1996 Health Financing Charter was designed to bring transparency to the system of informal payments for “free” services, as well as to address the lack of funding available at the operational levels of the public sector. A fixed scale of user fees for service was introduced, with 50% of revenues from these fees being kept at the facility level to supplement staff salaries and 49% devoted to facilities’ other running costs¹⁴.

To safeguard against negative equity impacts, an exemption system was introduced to guarantee free health care provision to the poor. The current public sector financing therefore relies on out-of-pocket expenditures from those who are deemed able to pay.

An incentive problem that was rapidly identified was that the exemption system called upon extremely low-paid health care workers to subsidize the treatment of the poor through free

¹⁴ New regulations will soon allow 60% to be devoted to incentives.

provision of services for which they would otherwise be paid. While at the Health Center level the exemption system has functioned relatively well, this has not been the case for the Referral Hospital level.

Another problem has been that facilities in areas with particularly high poverty rates must grant more exemptions and receive less user fees. Yet these are the facilities that are most important for poverty alleviation.

The informal payments problem has been alleviated by the use of user fees, however it has not been resolved. Additional charges beyond the listed user fees are also imposed, for services ranging from hospital bedding, food, and release of information. Additional travel and opportunity costs for waiting time and work lost also significantly increase the economic burden on the client. Thus, even though the official user fees are lower than fees charged in the private sector, it is not clear that the actual costs for publicly provided services are lower than those of privately provided services.

The Equity Fund (EF) system offers an innovative solution to these problems. It has been piloted in several forms in health districts around the country and is now due to be scaled up with funding from the Asian Development Bank. EF's complement the user-fee system by providing payment of user-fees for those people who would otherwise qualify for exemptions. This provides financial incentives for facilities to provide the same care to all clients, while at the same time increasing funds available at the operational level.

A goal of EF's is to keep large medical expenses from pushing the poor deeper into poverty. The focus of the system is therefore on the RH level, where the exemption system has performed less well. However, this also means that Health Centers must continue to bear more of the financial burden of treating the poor, while those who are not granted exemptions at this level (or fear they will not) may put off treatment or preventive care, waiting instead until their condition requires hospitalisation at increased costs to the system and risk to the patient.

An important question for EF's is how to identify those who should qualify for coverage. As has been noted, at the RH level, the social networks needed for easy identification of the poor are weaker. Determining who should qualify, especially in advance, can create substantial additional administrative costs for EF's. It could be argued that the purpose of EF's is to prevent health-related poverty as well as alleviate the situation of those already in poverty. If so, then the pool would need to be expanded to include the near poor as well as the already poor. At what point does it then become economically more efficient to simply cover the cost of user fees for all clients?

EF's are currently funded through international development assistance. Scaling up will initially be covered by the ADB, and the long rung sustainability of the system will depend upon either continued foreign assistance or on identification of substantial new state resources. In considering a shift to country-wide use of EF's the following questions bear consideration:

- How do the *economic* costs (financial, human resources, opportunity costs to system etc.) of EF's compare with alternate systems that provide the same degree of support for equity and quality within the public system?
- High administrative costs are to be expected for project implementation, especially at the piloting stage. However once a program is implemented at the national level through the state, what is an acceptable level of administrative costs?
- To what extent is it realistic or appropriate that medical expenses within the public sector be funded by external sources over which the RGC has only limited control? Clearly a scaled up EF system will need to be administered and funded through the state. However, if the original source of these funds is external, how can sustainability be guaranteed for a program upon which large numbers of Cambodians will come to depend?

One response to these may be that Equity Funds should be viewed as a transitional solution, as Cambodia moves towards the development of a Social Health Insurance (SHI) scheme. There is a growing momentum towards SHI. Small pilots are already underway. and MoH is finalising guidelines for the implementation of SHI schemes across the country. Under Ministry of Labor

sponsorship, a set of legislation establishing a Social Insurance legal framework is currently under development. Nevertheless, at a more fundamental level the decision will have to be taken as to whether Cambodia's public health system should move on a path towards self-financing, or whether with the growing economy it may be possible and desirable to return to a state funded system. This question may be expected to be the focus of future policy deliberations.

Conclusion

The Royal Government of Cambodia, together with its Civil Society and international partners, has made significant progress toward a stronger public health system that can serve as a centrepiece for its poverty alleviation efforts. This progress has not always been obvious, however it is clear from Cambodia's dramatic success in addressing challenges ranging from HIV/AIDS to Schistosomiasis, that the capacities and will are at hand. At the same time, wide ranging and deep reforms continue throughout the public sector, which will further strengthen the government's ability to improve the health of all Cambodians.

While the primary focus of this paper has been upon how the public health system may better benefit from resources that are currently available, this should not obscure the fact that significant increases in resources to health will be required. The lion's share of total resources for health in Cambodia are provided by the Cambodians themselves. Even within the public sector, the Cambodian contribution will soon be approaching 50%. Cambodia already devotes a larger share of its national budget to health than any other developing country, and it continues to increase these allocations each year. However, to reach the USD 34 minimum of public health expenditure recommended by the Report of the Commission on Macroeconomics and Health would demand approximately 85%¹⁵ of the entire national budget¹⁶.

¹⁵ The 2003 National Budget was 2,092 Billion Cambodian Riel, or approximately USD 40 per capita.

¹⁶ IMF Country Report No. 04/330. Phnom Penh 2004.

Cambodia has since the early 1990's received a large amount of development assistance, which has been an essential factor in its recovery. It is however not the largest aid recipient within ASEAN, in either absolute or per capita terms.¹⁷ Indeed, 77%¹⁸ of all International Development Assistance provided to Cambodia in 2003 would be required to fill the gap between government funding and the RCMH recommended levels. Despite the success that Cambodia has demonstrated with such limited means, the goal of health for all Cambodians will by necessity depend not only on continued but significantly increased long-term international assistance.

¹⁷ Total aid to Cambodia in 2003 was 506 Million USD, or approximately USD 38 per capita. By comparison, Vietnam received USD 1,982 Million (USD 24 per capita) and Lao PDR received USD 278 Million (USD 48 per capita). Source: ADB Key Development Indicators 2005.

¹⁸ Based on 2003 government health expenditures this gap would be approximately USD 30 per capita, or USD 390 Million.