Kingdom of Cambodia
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Ministry of Health

Health Equity Fund
Operation Manual

September 2016

Acknowledgement

The Health Equity Fund Operation Manual is a joint product of the Ministry of Health in collaboration with Health Development Partners, the Technical Working Group of the Department of Planning and Health Information with technical and financial support from H-EQIP and USAID.

The Technical Working Group consists of;

1. Dr Lo Veasna Kiry, Director of DPHI, Team Leader
2. Dr Sok Kanha, Deputy Director of DPHI
3. Mr Ros Chhun Eang, Chief of Bureau Health Economics and Financing
4. Dr Bun Samnang, Vice Chief Bureau Health Economics and Financing
5. Ms Thor Bony, Vice Chief Bureau Health Economics and Financing
6. Dr Im Sothearum, Officer of Bureau Health Economics and Financing
7. Ms Chea Chanthou, Officer of Bureau Health Economics and Financing
8. Dr Ly Nareth, World Bank Cambodia Office
9. Dr. Chantha Chak, Health Systems Strengthening Team Leader, USAID
10. Dr. Bart Jacobs, GIZ Social Health Protection Policy Advisor
11. Mr. Pemprey Suos, Department of Foreign Affairs and Trade, Australian Embassy
12. Mr. Tapley Jordanwood, Chief of Party, USAID Social Health Protection Project
13. Dr. David Griffiths, Consultant, World Bank

We highly appreciate all of the above people who contributed in the development of this document. We strongly hope that this document will be a good guidance for planning and implementation of the Health Equity Fund scheme.

Contents

List of Abbreviations

BHEF	Bureau of Health Economics and Financing
CENAT	National Center for Tuberculosis and Leprosy Control
CNM	National Malaria Center
CPA	Complementary Package of Activities
DBF	Department of Budget and Finance
DHFSC	District Health Financing Steering Committee
DPHI	Department of Planning and Health Information
H-EQIP	Health Equity and Quality Improvement Program
HEF	Health Equity Fund
HEFB	Health Equity Fund Beneficiary
HEFI	Health Equity Fund Implementer
HEFO	Health Equity Fund Operator
HEFP	Health Equity Fund Promotor
HFTO	Health Financing Technical Officer
HIS	Cambodian Health Information System
HSSP2	Second Health Sector Support Program
IDPoor	Identification of Poor Households Program
IPD	In-Patient Department
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MoH MG	Ministry of Health Monitoring Group
MoP	Ministry of Planning
MPA	Minimum Package of Activities
NCHADS	National Center for HIV/AIDS, Dermatology and Sexually-transmitted Diseases
NGO	Non-Governmental Organisation
NHID	National Health Identification number
NMCHC	National Maternal Child Health Center
NSSF	National Social Security Fund
OD	Operational District
OPD	Out-Patient Department
PCA	Payment Certification Agency
PHD	Provincial Health Department
PHFSC	Provincial Health Financing Steering Committee
PMRS	Patient Management and Registration System
RH	Referral Hospital

1 INTRODUCTION

1.1 Health financing situation in Cambodia

Together with the start of health sector reforms in the mid-1990s user fees were gradually introduced at public health facilities. The shift from free, but underfunded, public health care provision towards paid care aimed to raise additional revenues to invest in quality improvements as well as motivating staff. The money raised through user fees was retained at the health facilities and a certain proportion was to be used to purchase supplies and commodities while the remainder was divided among staff members. The rules for establishing a user fee system at a health facility or within the Operational District were set out in the Health Financing Charter.

Contrary to observations from other countries, the introduction of user fees was accompanied by an increase in public health service utilisation. The poor, however, were deterred from accessing public health facilities, as staff– especially in hospitals- tended to be reluctant to grant fee-waivers, as this would reduce available resources for which replenishment was not certain. Thus in order to safeguard the positive effects of user fees on public health service delivery and utilisation while enabling the poor access to health care, several Non-Governmental Organisations (NGOs) started with the simple concept of paying public health providers for the services rendered for free to poor people. These initiatives were termed Health Equity Funds (HEFs) and were managed by a third party independent of the health providers. Many such interventions sprang up all over the country, each with different criteria and means to identify the poor within the community or when presenting at the health facility, as well as kind of health facilities to be included.

A variety of asset based interview tools were developed to interview and screen potential beneficiaries in a process known as post-identification. Several HEFs began to experiment with the use of these poverty interview tools to identify poor households in advance and provide them with knowledge about the benefits available from HEFs. This pre-identification process proved very successful at raising utilization rates by the identified poor of public health services.

Because of the positive results obtained with the HEFs in terms of: facilitating access to much needed health care; targeting of resources; and income generation, including motivation of staff members; the initiative gained increasing attention from development partners and the government. This led to the formulation and, in 2005, the adoption of the *National Equity Fund Implementation and Monitoring Framework* by the Ministry of Health which streamlined arrangements. It also defined the roles of the third parties managing the HEFs – the Health Equity Fund Operators (HEFOs) who manage day-to-day operations at the Operational District level - and the Health Equity Fund Implementer (HEFI), an umbrella organisation that managed contracting, financing, monitoring and auditing activities of the former. In 2006 Ministry of Planning refined, streamlined, and institutionalized a nation-wide system for the pre-identification selection criteria and processes used to identify poor households eligible for benefiting from the HEFs and social support mechanisms in other sectors.

In 2009 the MOH published the *Implementation of Health Equity Funds Guideline* with objective of adjusting them to the current situation, especially harmonizing the implementation arrangements of different schemes, more specifically their organization, administration, management, reporting and monitoring. This was followed by concerted efforts to harmonize the many HEFs into a single system which included development of a common information system, standard benefit package, standard post-identification tools, contracting of health facilities, billing and verification procedures and an output based contracting mechanism for HEFOs. This standardization facilitated expansion of the geographic coverage of the scheme with portable benefits that allowed the beneficiaries to access care in any facility contracted to provide services to the HEF. Over the years HEFs also became prominent in several strategies, including the social assistance for poor and vulnerable, in the health strategic plan, and in the Government's Rectangular Strategy.

By mid-2015, the HEF had expanded nationwide to cover all Operational Districts and health centers, thereby enabling financial access to public health services for nearly 3 million poor people. Other notable developments included the establishment of an Occupational Risk Insurance scheme for employees of the formal private sector by the National Social Security Fund (NSSF) that became operational in 2008 and is being extended to a full social health insurance from mid-2016 onwards. There are discussions to establish a similar social health insurance scheme for civil servants operated by the same agency.

The Ministry of Economy and Finance (MEF) is discussing its approach for the development of the Cambodian social protection system and the following key areas are being considered:

- 2016-18: the introduction of health insurance for employees and public servants to be managed by NSSF; implementation of an accreditation system to improve quality; implementation of an independent control mechanism on claims and payment as well as improvements in staffing and infrastructure
- 2018-20: full government funding of the HEF and the creation of a single operator to manage all social health insurance scheme including the HEF; review to consider the inclusion of new vulnerable populations (i.e. people living with disabilities, old age people and children under five years) if affordable; and increasing participation of the private sector.
- 2020-25: feasibility study of launching a (initially voluntary and later mandatory) social health insurance for people working in the informal sector economy if technically feasible and affordable.

With the initiation of the H-EQIP Project a number of important structural changes have been made to the HEF system that include:

- Moving the responsibility of HEF administrative issues at the hospital level from HEFOs to the hospital staff, thereby integrating HEF processes into the normal duties of the hospital.
- Increased responsibility of Health Center Chiefs and Operational District management to report HEF invoices of services delivered to HEF beneficiaries at the health center level.
- Previously HEFOs were responsible for the HEF related contracting and paying of public health facilities. Under H-EQIP this has become a

registration process whereby facilities apply to be a provider to the HEF system and are then paid on a monthly basis through bank-to-bank transfers directly from the MOH.

- A new role of HEF Promoter (HEFP) has been developed to provide 'patient concierge' services for HEF beneficiaries seeking care at hospitals, application of the post-identification process, and the coordination of HEF promotion activities designed to improve utilization by the poor of the HEF system.

1.2 Objective of the Operation Manual

This operation manual serves to clarify:

- Management of Health Equity Fund at all levels and roles of all institutions involved regarding organization, administration, financing, reporting, and monitoring;
- Description of beneficiaries, the benefits package and payment mechanisms;
- Verification of delivered services, triggers of payments and flows of money;
- Functions of the Health Equity Fund Promoter

1.3 Terminology

Health Equity Fund	A demand-side social health protection scheme that pays contracted or approved health care providers for services rendered to eligible populations and provides social assistance to clients in the form of transport reimbursement, food stipends and funeral grants.
Health Equity Fund Operator	A third party agency that managed the HEF day-to-day operations at the Operational District and hospital level prior to H-EQIP.
Health Equity Fund Promoter	The successor to the HEF Operator with a much more focussed and sustainable set of responsibilities around supporting HEF beneficiaries in hospital and post-identification of the poor.
Health Equity Fund Implementer	A private firm paid by a development partner to verify delivery and documentation of HEF benefits; certify monthly invoices from public health facilities; manage HEF information systems; and participate in HEF governance.
Payment and Certification Agency	Successor to the HEF Implementer that will operate as a semi-autonomous institute with the same role as the HEF Implementer and will become fully operational from mid-2018 onwards.
National Social Security Council	Regulatory body, chaired by the Ministry of Economy and Finance to overlook the harmonious development of social health insurance, including the Health Equity Fund.

Health Financing Steering Committee	Committees established at the operational district and provincial level, chaired by the respective Deputy Governor for Social Affairs and comprised of representatives of relevant departments, including health, and non-governmental organisations, and community representatives.
IDPoor	A programme by the Ministry of Planning that pre-identifies poor households nationwide through standardised community proxy-means testing process.
Pre-identification	Process by which poor households are identified through by the IDPoor programme and the household is provided with an "Equity Card".
Post-identification:	Process by which poor people, missed during the IDPoor process, are identified at the hospital when presenting for care. Each household of which a member is identified through the post-identification process is provided with a "Priority Access Card".

2 GUIDING PRINCIPLES

The following are the guiding principles for implementing the Health Equity Funds:

- *Universality*: poor people will have equitable access to essential curative, preventive, promotive and rehabilitative health care services
- *Poor and vulnerable*: health financing system developments will ensure inclusion of the poor and vulnerable as a means of socioeconomic development.
- *Financial protection*: access will be guaranteed, irrespective of available money.
- *Health care services*: will be effective, provided in an efficient way and acceptable.
- *Good governance*: the health financing system follows the rule of law and is responsive to the present and future needs of society.
- *Accountability and client oriented*: health providers are accountable for the quality of their services, which must be patient-centred.
- *Sustainability*: the inclusion of beneficiaries and the benefits they are entitled to are decided to ensure that the costs involved can be paid for within the budget and that institutional capacity exists to manage the whole system from identifying beneficiaries to verifying activities and payments.

3 THE HEALTH EQUITY FUND

The Health Equity Fund supports access to health services free at the point of use to the eligible population across the whole of Cambodia. The medical services and non-medical benefits to be provided to targeted eligible populations are defined in the MOH *National Guidelines for the Benefit Package and Provider Payment Mechanism of the Health Equity Fund*. This document may be updated from time-to-time and eventually replaced by a successor manual that will automatically be reflected in the services, beneficiaries and systems described in this manual.

3.1 Vision of the Health Equity Fund

"To enable active social and economic participation of poor and vulnerable residents of Cambodian society through universal access to an essential package of quality health interventions thereby providing financial protection against the consequences of ill health."

3.2 Future development of the Health Equity Fund

The HEF has developed, and will continue to develop, over time to conform with national policies on the development of the Cambodian social protection system. Attention is being, and will be, paid to ensure harmonious development with the other social health protection schemes, namely the social health insurance schemes for formal private sector employees and civil servants under the National Social Security Fund.

While poverty incidence will decline due to further economic growth and improved social services, the difference between poor people and those just above the poverty line is small: thus any economic shocks such as health expenses are likely to push many into poverty, or deeper. Therefore, the HEF should be used as a vehicle to include vulnerable population groups over time.

This 2016 manual is a continuation and an updated replacement of the 2009 MOH *Implementation of the Health Equity Funds Guideline,* which was formulated to guide the implementation of the HEF system financed under HSSP2 arrangements.

3.3 Beneficiaries of the Health Equity Fund

3.3.1 Target Population Groups

The HEF provides support for medical services and non-medical benefits to specific target population groups as detailed in the MOH *National Guidelines for the Benefit Package and Provider Payment Mechanism of the Health Equity Fund*. All members of a targeted population group are eligible for the full set of HEF benefits unless otherwise specified in this current document.

Beneficiaries of the HEF are currently all people belonging to households that have been classified as poor under the IDPoor Programme of the Ministry of Planning and those identified as poor at a public hospital through a post-identification interview.

3.3.1.1 Pre Identification

Pre-identification is the process of identifying poor households before they seek social assistance from mechanisms such as the HEF. Funded by the Royal Government of Cambodia, the national Identification of Poor Households Program (IDPoor) of the Ministry of Planning conducts the pre-identification process in annual rounds that each cover one third of the country. Pre-Identified poor households are identified using standardized processes at the village and commune levels that result in the classification into two levels of poverty status that include Poor Level 1 ("very poor") and Poor Level 2 households ("poor").

Each poor household identified receives an "Equity Card" that includes a household number, a picture of household members, their address, and the name of the head of household. "Equity Cards" are valid for three years or until the next round of pre-identification in a given area. The Ministry of Planning provides the MoH with a complete data set of all households identified during each annual round, covering a third of the country, of the IDPoor process that is incorporated into the MoH Patient Management and Registration System (PMRS) and available to public health facilities to check the validity of the "Equity Cards".

3.3.1.2 Post Identification

Post-identification will be conducted by the staff of HEFPs during working hours in the morning from 7:30 to 11:30 am and in the afternoon from 2:00 to 5:30 pm on weekdays. During weekends, holidays, emergencies, or in the absence of HEFP staff members, hospital staff members may conduct post-identification but review of eligibility will happen by HEFP once staff members are at the hospital.

Post-identification interviews are conducted at each public hospital amongst in-patients only (see Annex 1 for the questionnaire). The interview process takes about 15 minutes and based on the results, eligibility for HEF benefits can be provided immediately to the patient and includes all members of his/her entire household. Like the pre-identification process it classifies households into Poor Level 1 and Level 2 and provides them with a uniquely numbered "Priority Access Card" that is valid until the next anticipated round of pre-identification and card distribution by the IDPoor Program.

It is also the role of the HEFP to conduct community verification visits at the home of patients recently post-identified as poor in a sufficient numbers, particularly when interview results are close to the cut off line between Poor Level 2 and non-poor status (see Annex 2 for the report form).

Both "Equity Cards" and "Priority Access Cards" can be used throughout the country to access HEF supported health services at public health centers and hospitals nationwide. Additionally, the MOH PMRS provides every client registered into the system with a unique national health identification number (NHID) that is associated with their health records and printed on a card provided to the client. A HEF beneficiary can use their NHID instead of the household "Equity Card" or "Priority Access Card" to access their benefits.

3.4 Benefit Package for the Health Equity Fund

The MoH *National Guidelines for the Benefit Package and Provider Payment Mechanism of the Health Equity Fund* provides the necessary details for health

facilities and the institutions associated with the HEF to provide services and non-medical benefits to HEF targeted Beneficiaries and receive payment for the delivery of these benefits. This document is updated from time-to-time by the MoH to ensure efficiency of the HEF system and in response to public health priorities.

3.4.1 Clinical Practice Guidelines

The MoH has established diagnostic and treatment guidelines and protocols for clinical practice that stipulate the treatment to be given for a specified condition. These must be adhered to by providers when treating HEF Beneficiaries, and all required treatment records must be completed in line with MoH instructions. Failure to do so may result in non-payment by the HEF.

The key clinical practice guidelines finalized by MoH include:

- Clinical Practice Guidelines for Medicine at CPA 1, 2, & 3 and MPA;
- Safe Motherhood Guidelines for Hospitals and Health Centers;
- Emergency Obstetric and Neonatal Care Guidelines;
- Clinical Practice Guidelines for Postpartum Haemorrhage;
- Clinical Practice Guidelines for Neonatal Sepsis;
- Clinical Practice Guidelines for Paediatrics;
- NCHADS HIV Prevention, Counselling, Testing, Anti Retroviral Therapy and other treatment Guidelines and Standard Operating Procedures;
- Infection Control Guidelines.

3.4.2 Medical Benefits

Health services for HEF Benefits are purchased from health facilities and include the full range of services defined in the Clinical Practice Guidelines, according to level of facility. These services are provided at no cost to HEF beneficiaries.

3.4.3 Non-Medical Benefits

In addition to medical benefits, HEF Beneficiaries and their caretakers are entitled to the non-medical benefits as defined by the MoH *National Guidelines for the Benefit Package and Provider Payment Mechanism of the Health Equity Fund:*

- Transportation reimbursements for institutional deliveries at health centers, for specialized out-patient services at hospitals with an appointment or referral letter, and for in-patient care;
- Caretaker food allowances for in-patients; and
- A funeral allowance to the caretakers of HEF Beneficiaries who die while in hospital.

3.4.4 HEF Complaint Mechanism

The HEF system has established a formalized complaint mechanism to allow for the reporting of complaints through the HEFP during daily ward visits, through client satisfaction surveys, by health providers, and by the HEFI/PCA during household visits, beside interviews, or key information interviews. In general complaints are recorded anonymously without disclosing the identity of the

concerned beneficiary or aggrieved party unless they specifically agree to be identified and participate in subsequent discussions and potential solutions.

Complaints will be recorded in the MOH PMRS and then reported to the relevant Provincial or District Health Financing Steering Committee for consideration.

3.5 National Health Programs

The Ministry of Health currently includes national programs that address particular diseases or conditions with a mandate to achieve relevant clear objectives. The most notable national programs in Cambodia are the National Center for Tuberculosis and Leprosy Control (CENAT), the National Center for HIV/AIDS, Dermatology and Sexually-transmitted Diseases (NCHADS), the National Maternal Child Health Center (NMCHC) and the National Malaria Center (CNM). These vertical national programs are meant to work in coordination with the general horizontal health service delivery of the public health system.

Each of these national programs provides direct support (budgetary and/or in-kind) to the delivery of respective services. The MOH *National Guidelines for the Benefit Package and Provider Payment Mechanism of the Health Equity Fund* provides guidance as to how the support provided by national programs is coordinated with support provided by the HEF to avoid confusion at the service delivery level and overlaps and/or gaps in the support provided to HEF Beneficiaries.

4 INSTITUTIONAL ARRANGEMENTS

4.1 Key players

A series of institutions are involved with the management and operations of the HEF at all administrative levels. These including the following with corresponding responsibilities provided below:

- Ministry of Economy and Finance
- Ministry of Health
    - Department of Budget and Finance
    - Department of Planning and Health Information
    - Health System Managers (Annex 4)
        - Provincial Health Department
        - Operation District Management Team
    - Health Care Providers
        - National Hospitals
        - Referral Hospitals
        - Health Centers
- Payment Certification Agency and Health Equity Fund Implementer
- Health Equity Fund Promoters
- Health Financing Steering Committees
    - At Operational District level
    - At Provincial level

4.1.1 Ministry of Economy and Finance

The Ministry of Economy and Finance coordinated the development of the Strategy for Development of the Cambodian Social Protection System which includes social health insurance that encompasses the HEF. The strategy also foresees the establishment of an accreditation system to ensure minimum standards of quality of care. This Ministry chairs the National Social Security Council that oversees the harmonious development of social health protection schemes for the different population groups. By 2020 the entire HEF budget will be provided by the Ministry of Economy and Finance.

4.1.2 Ministry of Health

4.1.2.1 Department of Planning and Health Information

This department leads technical developments on health financing and associated functions such as provider payment levels and methods, benefit package composition, and vulnerable population groups to consider for inclusion as HEF beneficiaries. It informs the Ministry of Economy and Finance and other stakeholders on the feasibility to include certain health services through sound cost-effectiveness and cost-benefit assessments. They ensure economies of scale and efficiencies as the department ensures linkage with, and integration of, specific health financing interventions such as vouchers and voluntary insurance schemes for the informal sector population with the HEF operations.

4.1.2.2 Department of Budget and Finance

The Department of Budget and Finance will ensure adequate financial management capacity at all contracted health facilities through training and monitoring.

The department will produce quarterly and annual financial management reports on disbursement rates of government and pooled donor funds for the HEF to the health facilities.

The Ministry will transfer payments directly to health facilities' bank accounts for services rendered to the target populations following notification by HEF Implementer (HEFI/PCA).

4.1.2.3 Health care providers

Individual health facilities are required to register within the PMRS system as stipulated in the Health Equity Fund Terms and Conditions for Hospitals (Annex 3) as providers of health services to the system. This is done by entering the following information into the MOH PMRS:

- Basic facility information including:
  - Location
  - Facility level
  - Start date of the HEF
  - Population coverage
  - Registration date
- Director, Vice Director, Chief Accountant and Chief Nurse – name, title, phone number
- Professional council representative
- List of wards with Chief of Ward names
- Bank Information – Bank name, account name, account type, account number, bank address.

Following entry of the above details by the facility director, they must agree to the standard terms and conditions of the HEF system by clicking "I Agree" and re-entering their username and password. The registration of each health facility must be approved by the corresponding Operational District, for health center and referral hospitals under their direct supervision, or by the Provincial Health Department for provincial referral hospitals under their direct supervision. Only registered health facilities are eligible to receive payments from the HEF system for services delivered to HEF beneficiaries.

Referral hospitals

Many of the administrative activities previously performed by the Health Equity Fund Operator have been delegated to the hospital administration. As such a Cashier and Clerk are involved in the day-to-day operations of the HEF at their facility, more specifically:

- Providing hospitalised HEF Beneficiaries with transportation reimbursements for travel from their home to the hospital as well as daily caretaker food allowances
- Verifying monthly HEF Beneficiary utilization in the Patient Management Registration System for submission to the HEFI/PCA
- Update the records of poor households eligible for HEF benefits.

- Conduct concierge tasks of the HEF Promoter outside working hours, more specifically verification of IDPoor status – subject to endorsement by HEFP staff members - and initiation of Summary of Treatment Form.
- Responsibility for maintenance of computer equipment necessary to access and use the MOH PMRS and HMIS.

Health Centers

- Verify identification of HEF Beneficiaries
- Properly record utilization of HEF Beneficiaries including name and code number
- Payment transport allowance for HEF eligible women who give birth at the Health Center
- Submission of a monthly invoice for services rendered to HEF Beneficiaries.
- Responsibility for maintenance of computer equipment necessary to access and use the MOH PMRS and HMIS

4.1.3 Health Financing Steering Committees

A critical level of governance within the HEF system are the Health Financing Steering Committees (HFSC). There is a HFSC in Phnom Penh that is responsible for the oversight of HEF related activities at the national hospitals as well as all of the Operational Districts located within the city. There are also HFSCs established through a provincial or district level decree that includes designation of the deputy governor responsible for the health sector as the chair of the committee. A District HFSC has the purview of HEF related activities and issues within the catchment area of its respective Operational District. A Provincial HFSC is primarily concerned with the issues and activities of the catchment area of the Operational District in which the Provincial Referral Hospital resides but also is a referral point for issues that District HFSCs within the province cannot by themselves completely resolve. In the Operational District where the Provincial Referral Hospital resides there shall not be a separate District HSFC which would only duplicate the functions of the Provincial HFSC. Details on the HFSC are provided in Annex 4.

The Phnom Penh HFSC is the final referral point for any problems which cannot be solved at a lower level HFSC.

All HFSCs meet quarterly to perform the following tasks:

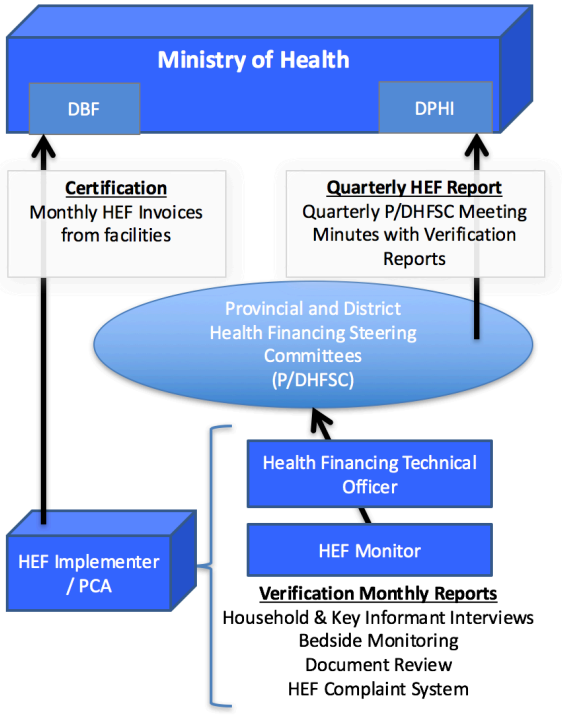
- Review all HEF monitoring findings, utilization reports, finance summaries and other information related to the previous quarter.
- Review of any pre- and/or post-identification issues encountered;
- Review and ensure transparent monitoring of scheme activities;
- Ensures adequate access and utilization of health services by the poor and non-poor by looking for appropriate solutions to address access barriers.
- Analyse effectiveness, equity and efficiency of the HEF operations and stimulate eventual integration with other social health protection schemes and health financing interventions.

4.1.4 Health Equity Fund Implementer/Payment Certification Agency

The Payment Certification Agency (PCA) will become fully operational from mid-2018 onwards. Until then the Health Equity Fund Implementer (HEFI) will

conduct the independent monitoring and invoice certification process and support capacity building within the PCA with support of other institutions under supervision of the Ministry of Health and gradually hand over responsibilities to the PCA.

The HEF system includes an independent monitoring process that verifies that services are delivered and accurately reported by health facilities. Based on the verification of services provided to HEF Beneficiaries by participating health facilities, the HEFI/PCA provides a written certification of the invoices submitted by health facilities to the MoH as a requirement before reimbursements are made to facilities through bank-to-bank transfers.



At the field level the independent monitoring process is conducted by a team of dedicated Monitors who have responsibility for one to three Operational Districts each. On average the HEF Monitor will spend 10 days per month interviewing between 30 and 40 households based on the sample generated by the PMRS. They will spend an additional 10 days conducting a detailed document review whereby they sample 10-20% of the documentation generated by health facilities to ensure that proper records are being kept. Monitors also stay in touch with facility directors, Operational District and Provincial Health Department managers who are key informants that provide insight into staff behaviour, unusual utilization patterns, and progress on the resolution of previously uncovered issues.

The independent monitoring process is based on the patient level data entered on a day-by-day basis by referral hospitals and health centers level using the PMRS and by health centers into the standard MoH registers. In order to investigate the utilization by HEF beneficiaries in the previous month, the HEF monitor uses the PMRS to generate a sample of between 30 and 80 households (depending on the number of Operational Districts they cover), which are clustered in three to four

randomly selected Health Center catchment areas. The selection of households is done through a "Red Flag" process which identifies specific patterns of utilization that are more likely two have encountered problems accessing care and randomly selected households. The HEF Monitor also regularly visits the Referral Hospitals to conduct bedside monitoring of HEF beneficiaries and can augment their sample to investigate issues that are reported or observed.

At the Health Center level, individual patient utilization is recorded using the PMRS in some facilities and in others using the standard MoH patient registers. Following generation of the sample using the PMRS or through a HEF monitor review of the relevant Health Center register to select the appropriate number of households to be interviewed within the selected catchment area. The results of all household interviews (both Referral Hospital and Health Center level) are entered chronologically answer-by-answer into the PMRS.

At the end of every month the HEF monitor writes a concise but detailed verification report of all of their findings that is sent to their supervisor. Health Financing Technical Officers (HFTO) are based at the HEFI/PCA office in Phnom Penh. The HFTO conducts a detailed review of the report to identify any key issues and removes all personal identifiers. This written report is then distributed by the HFTO to each member of the Provincial and/or District Health Financing Steering Committee (P/DHFSC). These reports generate significant discussion. It is important to note that one of the strengths of the verification system is its ability to identify problems within HEF systems and to respond, in collaboration with government, appropriately and unequivocally.

4.1.5 Health Equity Fund Promoters

As part of the move towards using Government systems, the HEFOs, who have made a very important contribution to the whole HEF System have been replaced by the Health Equity Fund Promoter (HEFP). The HEFP is planned to be more focussed and sustainable as they will concentrate on supporting HEF Beneficiaries and carrying out post-identification of the poor in hospitals.

Specific tasks and associated procedures of The Health Equity Fund Promoters are given in Annex 5, *Guidelines for the HEF Promoter*. In summary, the overall purpose of the HEFP is to ensure HEF Beneficiaries are treated with due courtesy, care and respect in the Referral Hospitals and help them receive all their entitlements. The HEFP will have 3 main responsibilities and will:

- provide information and guide / support the HEF Beneficiaries to obtain the appropriate services in the Hospitals (to act as the 'Patient Concierge');
- conduct post-identification interviews of the poor in the hospitals and undertake home verification visits for a sample of post-identified poor; and
- work with community structures to increase uptake of the HEF benefits through use of health facilities, especially primary health care facilities and preventive health services, promote institutional delivery among the rural and underserved populations

5 FINANCIAL MANAGEMENT

5.1 Overview

The financial management section describes the internal controls in the process of payment of non-medical benefits, imprest advance system, invoicing of medical and non-medical benefits and the monitoring of the timeline of HEFI/PCA certification and payment transfer by MOH.

The financial management for HEF incorporates the use of PMRS in the control of invoices issued by health facilities, HEF invoice processing from data entry by health facilities to certification by HEFI/PCA, and the control of advances for non-medical benefits. To help secure the integrity of the financial data entered into PMRS and segregation of roles, the following staff positions have been delegated with different responsibilities and roles in PMRS:

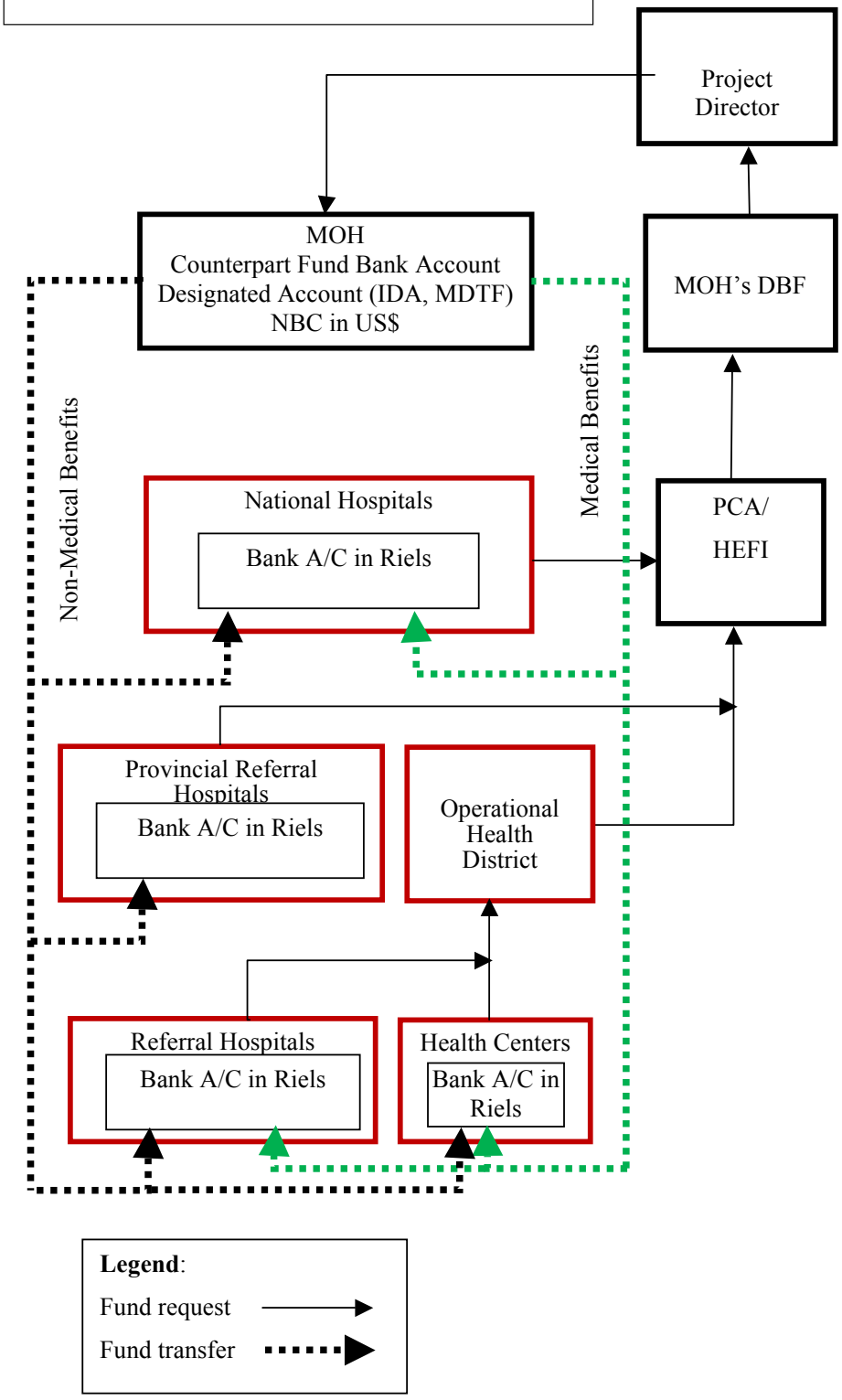
Position/Role	Main Responsibilities	Access Rights in PMRS
Clerk	Responsible for registering all patients into PMRS.	Has 'Add' access right and cannot make any edit or changes once information has been entered.
Cashier in charge of cash collection	Responsible for (i) issuing hospital invoices (for normal patients and HEF patients) from PMRS and collecting cash, (ii) recording fee information in Summary Treatment Form into PMRS and (iii) issuing an official receipt (Official Receipt from MEF) to patients	Has 'Add' access right and cannot make any edit or changes once information has been entered.
Cashier for non-medical benefits	Responsible to making payments of non-medical benefits such as costs for foods, transportation etc. to HEF patients	Has 'Add' access right and cannot make any edit or changes once information has been entered.
Reviewing staff member	Chief Accountant or senior management staff who is responsible for overseeing data entry in PMRS and reviewing data against hard copy documents before Health Facilities' Director approval	Has 'Edit' access right, can make any edit or changes before clicking 'Submit to HEFI/PCA'.
Approving staff member	Director of health facility or a designated person responsible for approving HEF invoices for submission to HEFI/PCA for certification	Has 'Add' access right and cannot make any edit or changes once information has been entered.
Payment processing	Designated staff in MOH's DBF responsible for processing	Has 'Read only' access right and able to

staff member	payment to health facilities.	view/extract all information and reports.

5.2 HEF Process Flow Chart

Funds for medical and non-medical benefits are transferred directly from bank accounts administered by MOH at the National Bank of Cambodia to the health facilities' bank account in Riels based on the amount certified by HEFI/PCA on a monthly basis. All health facilities submit their invoices for the reimbursement of medical benefits and expenses paid for non-medical benefits electronically via PMRS. All original hard copy supporting documents are kept by respective health facilities and OD for their records, post verification, review and audit.

Fund Flow Diagram for HEF



5.3 Payment of Non-medical Benefits

5.3.1 Reimbursement

Health facilities may use their own funds to pay for non-medical benefits to HEF as defined in the HEF Benefit Package and be reimbursed by MOH. Reimbursement for non-medical benefits requires:

- Health Centers to collect information on the non-medical benefits from the manual Central Patient Registration Book and complete the HEF Invoice for HC data entry.
- Referral Hospitals to enter information on the non-medical benefits into PMRS on a daily basis in order to get a monthly invoice ready in time for reimbursement.

5.3.2 Cash Advance from MOH's Department of Budget and Finance

The MOH may provide a cash advance to health facilities (mainly for Referral Hospitals) to be exclusively used for payment of non-medical benefits to HEF beneficiaries. The amount of this cash advance is fixed throughout the year and is based on an average of the estimated non-medical benefits of each health facilities for three months. The advance will be reconciled with the outstanding amount reported in DBF's financial report on a monthly basis. DBF will check the balance of the advance reported in PMRS, before providing any additional advance or replenishment to health facilities. To request a Cash Advance for non-medical benefits, the Accountant of RH, with assistance from HEFI/PCA, computes the average estimated costs of non-medical benefits for three months based on the forecasted utilization of HEF and completes a Cash Advance Request for Non-medical Benefits (Annex 7). The Request and the estimated amount are submitted to the Director of DBF for review before endorsement by the Director General for Administration and Finance and subsequent approval by the Project Director.

Once a cash advance for non-medical benefits (initial advance or subsequent replenishment) is received from MOH's DBF, the Chief Accountant of the Referral Hospital records the details of receipts such as date, description and the amount received in the PMRS for controlling the outstanding cash advance and the slow draw down of the balance over one year towards a pure reimbursement-based system.

On a daily basis, the Cashier in charge of non-medical benefits records payments made to HEF beneficiaries in the PMRS, recording thumbprints on a Non-medical Benefit Receipt (Annex 8). Replenishment of the cash advance occurs together with the reimbursement of medical benefits.

The Director of the Referral Hospital shall be accountable for the balance of cash advance (total cash advance receipts less the total amount of the certified non-medical benefits and subsequent deductions after post verification) by HEFI/PCA which can be generated from the PMRS and found in Annex 9. Referral Hospitals shall bear all risks associated with lost or misuse of cash advance received.

5.3.3 Advance to Cashier and Payment Procedures of Non-Medical Benefits to HEF Beneficiaries

Responsibility and Advance to Cashier for Daily Payment

Each Referral Hospital assigns one staff member to perform the role of Cashier for paying non-medical benefits to HEF beneficiaries. This Cashier should be a different staff member from the Cashier whose role it is to collect cash from patients.

The Cashier in charge of non-medical benefits gets a cash advance from the Referral Hospital for daily payment to HEF beneficiaries. The balance of this cash advance at any time shall not exceed Riel 8 million. Referral Hospitals shall ensure that the Cashier has a locked safe box in which to keep the cash after office hours.

To request an advance, the Cashier prepares and signs the Advance Request form (Annex 10). The advance request is reviewed by the Chief Accountant who checks the information in the Request with the information in PMRS. Finally, the Request is approved by the Director of RH and a cheque in the name of the Cashier in charge of non-medical benefits is issued. After issuing this cheque, the Chief Accountant records details of the advance made (date, description, amount) to the Cashier in charge of non-medical benefits in the PMRS.

Procedures for Daily Non-Medical Benefit Payment to HEF Beneficiaries

Non-medical benefits shall be paid at the Cashier's post where there is access to PMRS. Payments shall take place at a regular time. The Cashier shall make an announcement via the hospital audio facility or other means as to when the payments shall be made and remind the HEF beneficiaries to bring a document to identify themselves (such as IDPoor "Equity Card"; Health Card etc.). A signboard shall be put in front of the Cashier's office illustrating the rates of non-medical benefits to be provided to HEF Beneficiaries.

The steps in making payment are as follows:

- On behalf of HEF beneficiaries, their caretaker will present a IDPoor "Equity Card", Health Card or other similar document to the Cashier to identify the name of the patient;
- The Cashier takes a Non-medical Benefit Receipt having the patient's name and then scans the barcode using PMRS. The details of the patient appears on the screen in PMRS.
- The Cashier writes the date on the Non-medical Benefit Receipt and asks the caretaker for their thumbprint. On verifying the thump print, the Cashier records the name of the caretaker on the Receipt and then issues the correct amount written on the Receipt.
- Soon after issuing the cash, Cashier records in the PMRS the amount of payment in relation for the patient.

Before the close of the day, the Cashier will count the remainder of the cash advance under his/her responsibility and check it against the amount shown in

the Daily Expense Report (Annex 11) in PMRS. If there is any difference, this should be investigated and explained.

5.4 Recording of Medical and Non-medical Benefits, Invoicing and Payment Processes

To enable payment of medical and non-medical benefits, the corresponding amounts shall be recorded in the PMRS and electronically submitted to HEFI/PCA for certification. All hard copies of HEF invoices, OPD/IPD forms and supporting documents for non-medical benefits are kept at facilities/ODs for their records, post review, verification and monitoring.

After electronically submitting an invoice to HEFI/PCA (as explained below), each OD/health facility prints out a summary invoice (Annex 12) from PMRS, signs the summary invoice and keeps it for their records. There is no need to send any hard copy documents to HEFI/PCA.

5.4.1 Recording of Medical and Non-medical Benefits and Invoicing at Health Centers/Heath Post

Details of fees and HEF beneficiaries are recorded in the manual Central Patient Registration Book when each patient comes to HC/HP for treatment.

Soon after the end of the month, each HC/HP collates the information on eligible HEF beneficiaries from the manual Central Patient Registration Book and completes a HEF Invoice (Annex 13). This invoice is signed as approved by the Chief of HP/HC.

HP shall send its HEF Invoice to HC for consolidation. HC will consolidate information about HEF's medical and non-medical payments in the HEF Invoice. This shall be completed no later than two working days after the end of the month.

Where HCs have access to the PMRS, a designated person logs into PMRS and enters the information (medical and non-medical benefits amounts) from the approved HEF Invoice. Then, the Chief of HC logs into PMRS, and reviews the information recorded. When the information is correct, he/she will submit the invoice by clicking 'Submit to HEFI/PCA' in the PMRS. Submission of this invoice to HEFI/PCA shall be done no later than 4 working days after the end of the month to enable payment of medical and non-medical benefits within the month of submission.

Where HCs do not have an access to PMRS, HCs shall send its approved HEF Invoice to its OD no later than two working days after the end of the month. A designated person in the OD will enter information from the HEF Invoice of each HC into PMRS on behalf of the HCs. The OD Accountant or a designated person logs into the PMRS and reviews the information entered in PMRS by clicking the reviewer option. After reviewing, the OD Director or his/her designated staff member logs into the system and approves the invoice by clicking 'Submit to HEFI/PCA' option. Submission of the invoices to HEFI/PCA shall be done no later than four working days after the month-end to enable payment of medical and non-medical benefits within the month of submission.

Once the information in HEF Invoices for HC is entered into the PMRS, the system will automatically generate a sequential number of HEF Invoice for the HC. This invoice number shall be recorded on the completed manual HEF Invoice for future reference.

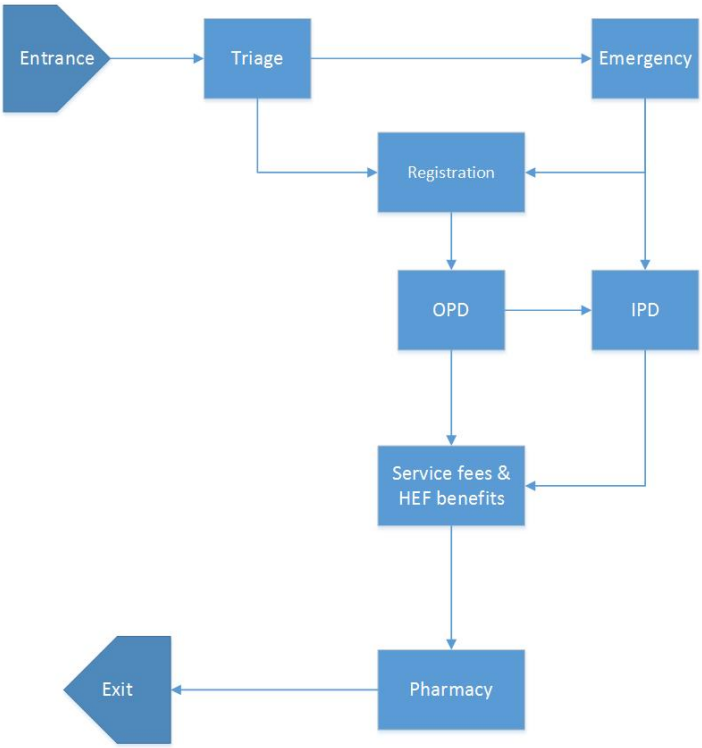
5.4.2 Recording of Fees and Invoicing at RH and National Hospital

All Referral Hospitals and participating National Hospitals have access to the PMRS for daily data entry on medical and non-medical benefits.

Issuance of OPD/IPD for HEF Patient Registration

Upon arrival, patients go to triage for their illness to be assessed. If the patient needs immediate attention they will be sent to the emergency ward and registration will be done later.

Below is standard patient flow at hospitals:



Patients who are not critical are required to register immediately after triage. The Hospital Clerk registers the patient and provides him/her with a patient's MOH Health Card if they are a new patient to the PMRS (or if they have lost their old card). The Clerk determines whether or not the patient is a HEF beneficiary and asks for the Post-ID or Pre-ID card. If the patient's information is already in the system, the Clerk simply swipes the patient's card through a barcode reader to bring up the patient's information. All recorded information for that patient appears on the computer screen. The Clerk then prints out the Summary of Treatment Form for either an OPD (Annex 14) or IPD (Annex 15) case. The Summary of Treatment Form has a sequential number which is used as a reference to check information recorded into the PMRS.

HEF benefits for HEF patients for IPD

After registration, HEF patients who are admitted to the hospital as inpatients will first receive one-way transportation from their home to hospital from the Cashier in charge of non-medical benefits. They also receive money on a daily basis for food for their caretaker (if they have one). HEF patient caretakers receive a fixed amount per day for food from the day of admission to the day of discharge. The payment of this is provided in MOH *Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund*.

Patient Discharge

HEF patients are required to go to the Cashier prior to discharge although they don't have to pay anything. The expenses for HEF patients are charged to the HEF system which is paid by the Government and development partners' funds. The Cashier takes the patient's card to scan the barcode in order to find details of the patient's information and the services fees. Then, the Cashier prints out the HEF invoice (this invoice is based on the HEF standard rates). On the discharge date, the Cashier in charge of non-medical benefits gives HEF patients the remaining transportation costs (from hospital to home) and one day food costs. HEF fees associated with the HEF patients are recorded in the Summary of Treatment Form which is acknowledged by the HEF patient. Fees in this Form are entered into PMRS as soon as patient discharge by the health facilities and the health facilities shall ensure that all supporting documents are complete and accurate once the information is entered into PMRS. Only fees for the HEF patients discharged in the month in question are eligible to claim reimbursement for that month. There is a separate generated report within PMRS for any Patients who remain in hospital beyond the end of the month which is called patients progress expenses. (Annex 16)

Electronically submitting an invoice for reimbursement

The Chief Accountant or a designated staff member at each hospital shall regularly log into PMRS and review information recorded in the system against hard copy documents to ascertain the accuracy and completeness of the information. Shortly after the end of the month, the Chief Accountant or designated person shall review the invoice in the PMRS and digitally sign it.

After review, the Director of health facility or his/her designated person logs into the PMRS and approves the invoice by clicking 'Submit to HEFI/PCA'. The invoice to HEFI/PCA shall be submitted no later than 4 working days after the end of the month to enable payment within the month of submission.

After submission, each hospital is required to print out a financial report (patients discharged) for filing and documentation.

5.4.3 Certifying of Invoices by HEFI/PCA

In the months that follow the submission of any invoice to HEFI/PCA, an independent rigorous monitoring process is conducted to ensure that the service packages provided to HEF Beneficiaries are accurate and complete. Service package Summary of Treatment forms that document the delivery of service packages to HEF Beneficiaries and are kept in chronological files by the Cashier and are monitored for completeness of documentations and clinical quality.

Any discrepancies or lack of documentation found during the monitoring of documentation is used to make deductions from future invoices for any cases found that were deemed neither complete nor accurate. HEFI/PCA will discuss issues identified during the monthly review with the Project Manager for Health and then report to the Project Director and the two Project Managers for actions, including informing health facilities about issues found and the amount of cash to be deducted. If a health facility is found to have created false documents during monitoring, double the amount of the case-based payment is deducted from a future invoice.

When HEFI/PCA identifies any incorrect billing recorded in the PMRS, HEFI/PCA will discuss the issue and the amount to be deducted with relevant health facilities. After agreement, a report is sent to relevant health facilities detailing information on the deduction into PMRS. This shall be done no later than the end of the month. If the health facility fails to enter the agreed amount to be deducted, HEFI/PCA has an authority to apply the agreed deduction in PMRS.

All invoices for HEF payment from all health facilities are certified by HEFI/PCA no later than five working days after submission. The HEFI/PCA reviews each invoice by identifying any irregularities and checking if there are any agreed deductions and if there are, have these been recorded by health facilities into the PMRS. If the agreed deductions have not been recorded, HEFI/PCA records such deductions before certifying. HEFI/PCA confirms the certification by clicking "Certified" in the PMRS.

After certifying, a detailed list of all facilities (Annex 17) is printed by HEFI/PCA for submission to MOH for payment processing. The list contains all necessary information to enable MOH to make a fund transfer to each facility's bank account. HEFI/PCA delivers a hard copy of the certified invoices, together with a cover letter on certification, to MOH's Administration Department. Upon receipt, the MOH's Administration Department will stamp 'Received' with a date and time for monitoring payment processing time.

Upon delivering the certified invoice to MOH, HEFI/PCA records the date of MOH's receipt into the PMRS.

5.4.4 MOH's Department of Budget and Finance Payment Processes

Designated staff at DBF can log into PMRS to view all information about HEF Invoices of HC, Hospital Invoices charged to HEF, and details of non-medical benefits. Upon receipt of certified invoices from HEFI/PCA, MOH's DBF processes payment for reimbursement and/or clear advance for non-medical benefits. The payment in Riels on certified invoices shall be made no later than five working days from the receipt of the certified invoices. The date stamped/printed by the bank on payment instructions/transfer forms is regarded as the payment date.

Upon making payments, a designated staff member enters information about the payment date and value into PMRS to monitor timeliness of payment.

5.5 Internal and External Auditing

Expenses for medical and non-medical benefits on HEF are subject to internal and independent auditing as defined in the FM manual of H-EQIP.

6. REPORTING

The following sections detail the reporting processes within the HEF system from the facility to MOH level.

6.1. Health Centers

As per standard MOH procedures, health centers are required to record all utilization in the appropriate official MOH Register Books that also include a column for recording the "Equity Card" or "Priority Access Card" numbers of any HEF supported patient.

The utilization and financial data entered into the MOH PMRS is used to automatically generate and submit a standard aggregate monthly report to the MOH Social Health Protection module of the HMIS.

6.2. Referral Hospitals

It is required that all hospitals keep organized chronological files of all HEF Summary of Treatment forms related to services provided to HEF Beneficiaries. Each summary of treatment form must be completed with all necessary details and signed (or thumb printed) by the HEF Beneficiary, the attending clinician, and the responsible hospital administrator. Failure to complete each summary of treatment form or keep this documentation well organized could result in non-payment of the hospital. These records must be kept secure and made available for inspection buy hospital management, operational districts, provincial health department, MOH, the HEF implementer, or other authorized authorities.

At the end of every month the hospital must generate an invoice which details the services provided to HEF Beneficiaries that include the total amount of reimbursement due to the referral hospital facility using the standard format. The generation of the invoice is an automated function of the MoH PMRS. When the invoice is generated using the MoH PMRS it is also required that the referral hospital director digitally sign the invoice using his/her username and password for the system. All invoices generated by the MoH PMRS we'll also be printed, signed and kept on file at each facility for inspection.

The utilization and financial data entered into the MOH PMRS is used to automatically generate and submit a standard aggregate monthly report to the MOH Social Health Protection module of the HMIS.

6.3. Operational District

The Operational District's principal responsibility in regard to the HEF system is to provide technical supervision and support to health center and referral hospitals in their delivery of services to have supported patients in accordance with applicable MoH policies and guidelines. For reporting the OD:

- Ensures that each facility within the catchment area of the Operational District submits accurate and timely invoices to the HEF system to ensure timeliness of reimbursement payments; and

- Enters the HEF invoice details into the MoH PMRS as necessary for health centers that do not have the necessary computer equipment and/or access to the internet.

6.4. Health Equity Fund Implementer/ Payment Certification Agency

On a monthly basis each HEF Monitor, as part of the independent monitoring by the HEF Implementer/PCA, generates and distributes to all P/DHFSC members a detailed report of all of their findings from household interviews, document reviews, bedside monitoring and key informant interviews. These reports keep the identity of HEF beneficiaries who report problems anonymous, except in cases where they explicitly agree to be identified and wish to participate in the investigation and solution. In addition to the detailed narrative report each member of the P/DHFSC receives a summary of utilization statistics from the PMRS and an analysis of the types of complaints received through the HEF Complaint Mechanism.

On a quarterly basis the HEFI/PCA will submit to the H-EQIP Project Director a summary report according to MoH quarterly reporting formats.

6.5. HEF Promoter

The HEF Promoter will provide quarterly and annual reports on activities which will be based on their quarterly and annual plans to the Provincial and District Health Financing Steering Committees, the HEFI/PCA, and the MoH. Reporting will follow MoH guidelines. This report should include:

- Issues related to public health services use by the poor, identified access barriers and respective solutions implemented, health service provider behaviour, challenges encountered, informal fee charged, and joint activities and engagement with other organisations operating in the operational district;
- The numbers of post-identification interviews, community spot checks, and an analysis of the results carried out during the quarter; and
- Quarterly report to the District and Provincial Health Financing Steering Committees on issues related to public health services use by the poor, identified access barriers and respective solutions implemented, health service provider behaviour, challenges encountered, informal fee charged, and joint activities with other organisations operating in the operational district.

Table: Reporting by HEF-P according to MoH quarterly reporting format.

Type of Report	Responsible Entity	Sent to for oversight	Frequency
MoH Quarterly Report and Quarterly Claim form	HEF-P Director	MoH MG, DPHI-BHEF PHFSC, DHFSC	Quarterly
Internal Monitoring report results	HEF-P Director	ODO, DHFSC, PHFSC, PHD	Quarterly
External report	Provincial Monitoring Group, PHD	PHFSC and DHFSC members	Quarterly
External Monitoring annual summary report	PHFSC secretariat	PHFSC members, MoH MG, DPHI-BHEF	Annually

Monitoring tools for the functions of the HEF-P and for assessing the results of home visits made by the HEF-P are attached in Annex 6. These tools are for use by higher level Monitoring Groups and other MoH supervisors and are the basis for ensuring the quality of work of the HEF-P and other reports will be done according to MoH quarterly reporting format.

6.6. Provincial and District Health Financing Steering Committees

The minutes generated during the quarterly meetings of the P/DHFSC meetings are finalized, copies of the reports from the HEFI/PCA monitoring and the HEF Promoter are attached and submitted to the HEFI/PCA where they are scanned and consolidated into single quarterly report for submission to the MOH and made available through the MOH Social Health Protection module of the HMIS to users who have been granted access by MOH DPHI.

6.7. The MoH Patient Management and Registration System

The Patient Management and Registration System (PMRS), is an eHealth web-based application used by public health facilities in Cambodia for the longitudinal management of patient and financial data. It is used by the Health Equity Fund system to specifically manage individuals eligible for HEF benefits, their utilization of services, billing and provider payments, and the monitoring and invoice certification process by the HEF Implementer. The PMRS has been developed under the stewardship of the Department of Planning and Health Information (DPHI) of the Ministry of Health as an integrated part of the Cambodian HMIS.

The PMRS is a national system that manages patient profiles that include assignment of unique National Health Identification (NHID) numbers that work at any health facility using the PMRS. These NHIDs are used by each facility to link web-based patient records with hard copy patient dossiers that are kept centrally at each facility and retrieved during each patient visits. Facility level staff that use the PMRS are provided with unique usernames/passwords and assigned customized roles that limit their access to patient information according to the strict requirements of their job and current task as described in the sections below.

All of the poverty identification data collected by the Ministry of Planning Identification of Poor Households Program (IDPoor) is regularly uploaded into the PMRS. Post-identification data collected during interviews is also kept in the PMRS together with the IDPoor data. The data from IDPoor and post-identification interviews includes:

- Household information (IDPoor number, address, poverty level, and date of identification),
- Household member details (name, age, gender)
- Household member picture, which is available for most households but does not always contain pictures of every household member.

At the hospital level the minimum requirement is that PMRS is used by hospital Clerks and Cashiers. Each Clerk and Cashier must have a computer work station (laptop or desktop) with a stable connection to the internet. Each workstation requires a barcode scanner and a connection to a printer.

Health centers can access the PMRS either through a web-browser or an Android application on a tablet. The web-based version requires a constant stable connection to the internet whereas the Android application has been designed for rural health centers with intermittent access to the internet and can be used while offline.

It is the responsibility of each hospital and health center to maintain the computer equipment, internet connection and stock of necessary supplies to support use of the PMRS. The MoH DPHI HIS Bureau provides support to the central hosting, maintenance, and regular upgrades of the PMRS system.

6.8. Generating Reports from the MoH PMRS

The MoH PMRS also includes a host of tools that allow facility managers to generate automated reports or export utilization and financial data that he can be used to monitor the HEF system within their facility. Likewise, these tools can be used at the Operational District and Provincial level to generate reports for export data related to all facilities located within their relevant catchment areas.

6.9. HEF implementation review

The functioning of the HEF system will be reviewed semi-annually as part of the H-EQIP semi-annual implementation review missions. Findings and agreed follow up action will be reported in the aide memoires. Additional reviews may be organized from time to time by MOH and/or H-EQIP partners, in addition to the semi-annual implementation reviews.

Kingdom of Cambodia
Nation Religion King

Annex 1

Ministry of Health
Hospital Name:……

QUESTIONAIRE FOR PATIENT ASSESSMENT

POST-ID Patient……...

Interview Date:……..

Name of Interviewer:……

1. Patients Background

- Name:…….. Age:…….. Sex:…… Nickname:…….. Marital Status:……..
- In case the patient cannot give answers for the interview the relative can answer instead:……..……..
- Admission Date:……..…… Ward:…….. Bed Nº:……. Number of Patient:……
- Patient's Resident Address: Village/Group:……. Community:…….……
  Commune:…….…… District:…..……. Province/City:…… Tel:……
  The name of Phone owner:……

∗∗ Migrating people or people who have two Addresses please given more comment below:

- Patient's Resident Address: Village/Group:……. Community:…….……
  Commune:…….…… District:……..……. Province/City:…… Tel:…….……
  The name of Phone owner:……

☞ Did you know about the policy of government to support the poverty patients before your admission? Yes ☐ No ☐

☞ What did you expect to receive benefited from this policy before your admission?
Yes ☐ No ☐

2- Family Benefits

1. Family Member							
Name	Nickname	Age	Sex	What is position in family?	Occupation	Qualification	Others
01.							
02.							
03.							
04.							
05.							
06.							
07.							
08.							
09.							
10.							

2. House	Description		Scores
a/ Roof	Palm Leaves, Thatch Roof, Plastic Sheet		0
	Roofing Tile, Zinc, Cement		1
b/ Wall	Palm Leaves, Thatch, Bamboo, No Wall		0
	Wood		1
	Brick, Cement		2
c/ Cover	No		0
	Lattice		1
	Plank		2
	Cement, Brick tile		3
d/ Condition	Very old		0
	Medium		1
	Better		2

3. Electronic Tool		Scores
a/ Radio (No)		0
b/ Tape, TV (Black and White)		1
c/ TV (Color)		2
d/ Walkie Talkie / Mobile		3

4. Electricity		Scores
a/ No or Kerosene Lamp		0
b/ Battery (small than 50A)		1
c/ Battery (Over 50A) or Use Electric		2
d/ Own generator		3

5. Transportation		Scores
a/ No		0
b/ Small bicycle or Small boat		1
c/ Horse cart, Ox cart		2
d/ Boat with engine, Motor, Motor cart		3
e/ Car		4
7. Agriculture Tools		
a/ No		0
b/ Blow		1
c/ Cow, Buffalo, Horse		2
d/ Pump Machine		3
e/ Tractor, plow machine		4
9. Daily Income		
a/ less than 2000 Riels		0
b/ 2000 to 4000 Riels		1
c/ 4100 to 8000 Riels		2
d/ 8100 to 16000 Riels		3
e/ More than 16000 Riels		4

6. Farm Land		Scores
6.1 Size		
a/ No		0
b/ Less than 1 hectare		1
c/ 1 to 2 hectares		2
d/ 2 to 5 hectares		3
e/ More than 5hectares		4
6.2 Quality		Scores
a/ Third quality		0
b/ Second quality		1
c/ First quality		2
8. Animal Feeding		
a/ No		0
b/ One big pig or chicken, duck less than 30		1
c/ Two big pig or chicken, duck less than 30		2
d/ Goat, sheep more than two and cow, buffalo, horse more than one		3
e/ Cows, buffaloes, horses 2up		4

10. Marital Status		Scores	11. Last time of getting ill		Scores
a/ Old age, cripple, orphan (2 persons)		0	a/ More than 30days		0
b/ Old age, cripple, orphan (1person)		1	b/ 15 to 30 days		1
c/ No		2	c/ 5 to 15 days		2
			d/ Less than 5days		3
12. Paid for treatment in last one year		Scores	13. Did you ever borrow money from someone to cure your member in last one year /		Scores
a/ More than 500,000 Riel		0	a/ Ever		0
b/ 200,000 to 500,000 Riel		1	b/ Never		1
c/ Less than 200,000 Riel		2			

3- Interviewer Assessment

……...
……...
……...
……...
……...

4- Total Scores

The results of interview are shown that the patient is

Very poor ☐ Poor ☐

Phnom Penh, ……/……../20..
Name of Interviewer

Note:

- Scores 00 to 10: Very poor
- Scores 11 to 18: Poor
-
- Scores over than 19: Reject

I swear that all my statements are true, sufficient and legal. If not, I declare that I will pay back all of supporting from organization.

Patient's thumb print or relative

Operational District:_____ **Province:**_____ **Annex 2**

Date:_____

Household Spot Check Report Form

3

Name of interviewee _____**sex** _____**age** _____**_EC No.** _____

Address: Village _____**Commune** _____

Interviewee's thumbprint

Reasons of Spot check

☐ **Confirmation of poverty status for a pre-identified individual**

☐ **Confirmation of poverty status for a post-identified individual**

Results: _____

MOH Post-Id Score

_____

Very Poor; Poor; Non-Poor

☐ ☐ ☐

Action taken: _____

Interviewer: Name_____**Signature**_____

Annex 3

Kingdom of Cambodia
Nation Religious King

Ministry of Health

Health Equity Fund Terms and Conditions for Hospitals

1. Purpose of the Health Equity Fund

The main purposes of the Health Equity Fund are the following:

1.1. Contribute to poverty reduction through protecting the poor from unnecessary out-of-pocket and catastrophic health expenses.

1.2. Promote and facilitate access to increase utilization by the identified poor of public health facilities at the primary, referral, and tertiary levels of care.

1.3. Contribute to improving the quality of the public health care system by providing health care services that are appropriate, fair, and friendly.

1.4. Assist the poor to overcome barriers to access (financial and others) and increase the confidence of poor patients as users of the public health system. This will be done by actively promoting public health service utilization by the poor (both at primary level and referral levels), actively seeking their opinions and feedback, and listening to the voice of the poor regarding improvements.

2. Recognition and Verification of Health Equity Fund Beneficiary Status

2.1. HEF support is available to any Cambodian citizen, from any province, who has been identified as poor either through a pre-identification or post-identification process and can provide sufficient documentation or evidence of their status.

2.2. Based on the official "Equity Cards" provided to identified poor households under the signature and stamp of the Commune Council or official "Priority Access Cards" provided under the signature and stamp of a Health Equity Fund Operator or Health Equity Fund Promoter, Referral Hospital directors and staff will recognize beneficiaries of the Health Equity Fund and provide them services in accordance with these terms and conditions.

2.3 In order to facilitate positive identity verification of Health Equity Fund beneficiaries, digital photographs are taken during the pre-identification of each poor household. These photos are imported into the Ministry of Health Patient Management and Registration System (PMRS) and used when an individual Health Equity Fund beneficiary accesses care at a Referral Hospital. The pictures of each household are also printed on the cards issued by the Ministry of Planning.

3. Patient Management and Registration System

3.1. The Ministry of Health PMRS database allows for the entry of individual household data including all members and relevant details obtained from the both the post-identification

and pre-identification process. It also allows for the entry of relevant details from the admission/discharge of individual Health Equity Fund beneficiary.

3.2. In order for a Referral Hospital to be paid by the Health Equity Fund for services and benefits provided to a Health Equity Fund supported beneficiary, all required details must be fully entered into the MOH PMRS. Failure to enter all required and relevant information with accuracy about each and every Health Equity Fund supported case could result in non-reimbursement of the Referral Hospital by the Health Equity Fund.

4. Availability and Provision of Health Services

Hospital staff will ensure that standard Referral Hospital services are available to Health Equity Fund beneficiaries 24 hours a day 7 days a week. In addition, Referral Hospital staff will ensure:

4.1. All Referral Hospital services provided to Health Equity Fund beneficiaries must take place in the Referral Hospital facility with the Health Equity Fund beneficiary physically present at the time of treatment. Provision of consultations or drugs to Health Equity Fund beneficiaries outside the Referral Hospital will not be paid for by the Health Equity Fund.

4.2. The Health Equity Fund will reimburse for standard Referral Hospital services according to the "Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund" signed by H.E. Professor Eng Huot on the 29th of August 2014.

4.3. All Health Equity Fund beneficiaries shall be treated in a respectful and professional manner.

4.4. All Health Equity Fund beneficiaries shall be provided with clear descriptions of their treatments.

4.5. It is essential that a strict policy of no informal payments is in place and is clearly understood by all Referral Hospital staff. No informal payments will be accepted by Referral Hospital staff from Health Equity Fund beneficiaries including requested or voluntary offers of money or gifts.

4.6. All treatments available in the Referral Hospital are available to Health Equity Fund beneficiaries and are in compliance with relevant national guidelines, which govern the provision of public health services.

4.7. Provision of available services will be provided equally to Health Equity Fund beneficiaries and non-Health Equity Fund beneficiaries.

4.8. Health Equity Fund beneficiaries shall have access to unlocked toilets which are clean and have water and soap available for use.

4.9. Proper documentation of Health Equity Fund beneficiary utilization using the standard Summary of Treatment Forms for both In-Patient Department and Out-Patient Department services.

4.10. Inclusion of all HEF beneficiary utilization in the standard Ministry of Health patient dossiers and ward registers.

4.11. Health Equity Fund beneficiaries are provided with proper referrals to higher levels of care including complete referral documentation free of charge to the patient. Coordination of referrals to higher levels will be done with respect to the standard referral process.

5. Standard Processing of Health Equity Fund Beneficiaries Seeking Referral Hospital Care:

5.1. Patient Admission

5.1.1. Upon arrival at the Referral Hospital, eligible Health Equity Fund beneficiaries shall be assessed by Referral Hospital medical staff regarding their medical condition to make a determination if admission to the Referral Hospital is required.

5.1.2. If admission to an In-Patient Department or referral to a specialized Out-Patient Department service is deemed appropriate, Health Equity Fund beneficiaries will be

screened for verification of their identity and referral status. If the Health Equity Fund beneficiary medical condition does not require Referral Hospital level services, the Health Equity Fund beneficiary should be referred to the closest Health Center.

5.1.3. The Health Equity Fund beneficiary identity can be verified through use of the PMRS and interviewing the Health Equity Fund beneficiary (or their caretaker). When presented with an "Equity Card" or a "Priority Access Card" the Referral Hospital Clerk shall enter the identification number found on each card to retrieve the poverty identification details from the PMRS. The database contains all of the relevant household details collected from the pre-identification and post-identification process' as well as a digital photo.

5.1.4. Through a combination of the picture and specific questions about the household, the Referral Hospital Clerk can make a determination if the cardholder is an actual member of the identified poor household therefore eligible for Health Equity Fund benefits.

5.1.5. The Referral Hospital Clerk will initiate a Summary of Treatment Form that includes the basic details of the Health Equity Fund beneficiary. This form is provided to the Referral Hospital staff for inclusion in the Health Equity Fund beneficiary patient dossier for completion by appropriate Referral Hospital clinical and administrative staff.

5.1.6. The Referral Hospital Cashier will provide the Health Equity Fund beneficiary (or their caretaker) with a transportation allowance for travel from their home of record to the Referral Hospital in accordance with the HEF standard transport reimbursement rates.

5.1.7. Referral Hospital staff and Health Equity Fund Promoter staff shall provide explanation to the Health Equity Fund beneficiary and/or their caretaker on the support that is provided by the Health Equity Fund, ensuring that they clearly understand their benefits.

5.1.8. Distribute the daily food allowance for Health Equity Fund beneficiary caretakers. It is required that each In-Patient Department Health Equity Fund beneficiary caretaker receive their food allowance every day and that the caretaker sign or thumbprint the food distribution.

5.1.9. Patients admitted to the hospital who are later post-identified before discharge shall receive a reimbursement for all payments with a receipt that they made to the Referral Hospital for services.

5.2. Patient Discharge

5.2.1. The Referral Hospital Cashier or Clerk must take receipt of the completed Summary of Treatment form the Referral Hospital Patient Dossier ensuring that it has been completed and signed as required.

5.2.2. Provide the Health Equity Fund beneficiary with the remainder of their transport reimbursement for travel to their home of record from the Referral Hospital that will complete the food and transport reimbursement form.

5.2.3. Enter all required information from the Summary of Treatment form and the food/transport reimbursement form into the PMRS.

5.2.4. Print the Health Equity Fund Medical Certificate using the PMRS and give it to the Health Equity Fund beneficiary or their caretaker along with an explanation of all details.

5.3. Data entry of Health Equity Fund beneficiary service utilization into the PMRS is required and is primarily done at the time that a Health Equity Fund beneficiary is discharged. It is required that the Referral Hospital team devise daily internal monitoring systems which check and double check the accuracy of the data entry that has been done during the day.

During all monitoring and cross-checking by Ministry of Health and Health Equity Fund Implementer staff, the exports from the PMRS will be used as the primary source of information to be matched with corresponding documentation and field checks.

5.4. It is the responsibility of the Referral Hospital to ensure that facilities invoice for services provided to Health Equity Fund beneficiaries using the correct prices according to the Ministry of Health "Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund" signed by H.E. Professor Eng Huot on August 29th, 2014.

6. Financial Management of Benefits Provided to Health Equity Fund Beneficiaries

6.1. At the end of each calendar month, the Referral Hospital will use the PMRS to generate the invoice of all services and benefits provided to Health Equity Fund beneficiaries during the month.

6.2. The standard monthly invoice period is from the 1st of the month to the last day of the month in line with the standard reporting period for facilities into the Health Management Information System (HMIS) of the Ministry of Health.

6.3. The Referral Hospital invoice should be reviewed by comparison with the Summary of Treatment Forms and the PMRS to ensure that it is accurate and complete. Any discrepancies should be discussed immediately with the Referral Hospital administrative staff and resolved before submission of the invoice.

6.4. All information provided in the submitted invoice should be based on existing Referral Hospital documentation in patient dossiers and ward registers and is subjected to detailed monitoring by Provincial Health Department, Operational District (where appropriate), the Health Equity Fund Implementer, Ministry of Health, or official auditor staff hired by one of these.

6.5. If monitoring by the Health Equity Fund Implementer or Ministry of Health reveals that a Referral Hospital has reported false or ghost cases in an invoice to the Health Equity Fund system, double the amount of money, which was paid for the false or ghost cases will be deducted from the next disbursement from Ministry of Health.

6.6. All completed and signed invoices shall be submitted to the Health Equity Fund Implementer for certification. Following certification by the Health Equity Fund Implementer, invoices will be submitted to the Ministry of Health who will make payments to Referral Hospitals using bank-to-bank transfers.

6.7. The Ministry of Health will make payment for health services and reimbursement for transportation allowances provided to Health Equity Fund beneficiaries within ***5*** working days following receipt of certification from HEFI/PCA. The ability of the Ministry of Health to make this payment is based on the availability of funds that may from time to time encounter delays. All payments will be made through bank-to-bank transfers in Cambodian Riels.

6.8. The hospital staff is required to keep all documentation of the Direct Benefits provided in a safe, dry and secure location at the Referral Hospital as these records will be periodically checked for accuracy and completeness by Ministry of Health and Health Equity Fund Implementer staff.

7. Monitoring and Governance of the Health Equity Fund System

7.1. The Health Equity Fund Implementer will conduct invoice verification of services provided by Referral Hospitals to Health Equity Fund beneficiaries on a regular retrospective basis to ensure that invoices submitted by Referral Hospital are correct. Key to this monitoring will be confirmation of Health Equity Fund services with individual patients and corresponding entries in the PMRS and standard ward registers.

7.2. On a monthly basis the Health Equity Fund Implementer will document all findings from the monitoring process which will be shared with all members of the Provincial and/or

District Health Financing Steering Committee (P/DHFSC).

7.3. In coordination with local authorities, the Provincial Department of Health and the Operational District Office, the Referral Hospital shall participate in the quarterly Provincial and/or District Health Finance Steering Committee (P/DHFSC) meetings.

7.4. On a monthly basis the Health Equity Fund Implementer will document all findings from the monitoring process which will be shared with all members of the Provincial and/or District Health Financing Steering Committee (P/DHFSC).

8. The Directors and Staff of the [Province name] Provincial Health Department have the following Roles and Responsibilities

8.1. Coordinate with the Ministry of Health Quality Assurance Office and development partners to support the bi-annual (every 2 years) Level 2 Quality Assessments are conducted in accordance with Ministry of Health policy and tools.

8.2. Support resolution of any conflicts or issues resulting from the implementation of the Health Equity Fund.

8.3. Facilitate and organize the quarterly meeting of the P/DHFSC in a timely manner.

8.4. Ensure that adequate representation of local authorities, Operational Districts, Referral Hospitals and Health Centers participate in each P/DHFSC meeting.

9. The Directors and Staff of the [Operational District name] Operational District Office have the following Roles and Responsibilities

9.1. Facilitate and organize the quarterly meeting of the DHFSC meeting in accordance with the Implementation of the Health Equity Fund Guideline.

9.2. Ensure that adequate representation of local authorities, Operational District representatives, Referral Hospitals, Health Centers participate in each DHFSC meeting.

9.3. Working with DHFSC secretariat staff, finalize the minutes of each DHFSC meeting which will serve as the official report of Health Equity Fund activities.

9.4. With support from the Ministry of Health Quality Assurance Office and development partners, organize the bi-annual Level 2 Quality Assessments for all Referral Hospitals.

10. The Directors and Staff of the Referral Hospital have the following Roles and Responsibilities

10.1. To facilitate the monitoring by the Health Equity Fund Implementer and provision of Health Equity Fund beneficiary support by the Health Equity Fund Promoter, the Referral Hospital shall provide office space with sufficient security for these activities. Office space will be close to the cashier's office of the Referral Hospital to ensure good cooperation between the Hospital staff, the Health Equity Fund Implementer, and the Health Equity Fund Promoter.

10.2. To facilitate the monitoring activities by the Ministry of Health and the Health Equity Fund Implementer the Referral Hospital shall grant access to patient dossiers and ward registers to authorized representatives of these organizations.

10.3. To facilitate monitoring and problem solving the Referral Hospital must participate and contribute openly in any interviews with Ministry of Health or Health Equity Fund Implementer representatives.

11. Supervision and Support of Ministry of Health for the Health Equity Fund

11.1. The Ministry of Health provides stewardship of the Health Equity Fund system in the

country in accordance with the National Implementation and Monitoring Framework for Equity Funds and the Implementation of the Health Equity Fund Guideline.

11.2. The purchase of services for the identified poor under the Health Equity Fund system is guided by the approved Ministry of Health "Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund" which determines the benefits which are to be afforded to members of identified poor households, the payment mechanism by which public health facilities will be paid for providing these services as well as the prices which are paid.

Kingdom of Cambodia

Nation Religious King

Ministry of Health

Health Equity Fund Terms and Conditions

for Health Centers and Health Posts

1. Purposes of the Health Equity Fund

The main purposes of the Health Equity Fund are the following:

- Contribute to poverty reduction through protecting the poor from unnecessary out-of-pocket and catastrophic health expenses.
- Promote and facilitate access to increase utilization by the identified poor of public health facilities at the primary, referral, and tertiary levels of care.
- Contribute to improving the quality of the public health care system by providing health care services that are appropriate, fair, and friendly.
- Assist the poor to overcome barriers to access (financial and others) and increase the confidence of poor patients as users of the public health system. This will be done by actively promoting public health service utilization by the poor (both at primary level and referral levels), actively seeking their opinions and feedback, and listening to the voice of the poor regarding improvements.

2. Recognition of Health Equity Fund Beneficiary Status

- Health Equity Fund support is available to any Cambodian citizen, from any province, who

has been identified as poor either through a pre-identification or post-identification process and can provide sufficient documentation or evidence of their status.

- Based on the official "Equity Cards" provided to identified poor households under the signature and stamp of the Commune Council or official "Priority Access Cards" provided under the signature and stamp of a Health Equity Fund Operator or Health Equity Fund Promoter, health facility directors and staff will recognize beneficiaries of the Health Equity Fund and provide them services in accordance with these terms and conditions.
- The Operational District Offices shall provide each Health Center and Health Post with a printed list of the identified poor households and members within the catchment area of the Health Center and Health Post and their household details by which health facility staff can confirm the identity of most beneficiaries.
- Patients who are members of an identified poor family from outside the catchment area of the facility, Operational District, or the Province are eligible for Health Equity Fund benefits. In order to access benefits at the Health Center or Health Post level a patient is required to have their "Equity Card" or "Priority Access Card" and another form of official identification in order to confirm their identity. Facility staff will make every effort possible to review the patient's documents to confirm the identity of the individual.
- In Health Center facilities that use the Ministry of Health Patient Management and Registration System (PMRS), the system can be used to verify the details of each identified poor household member from anywhere in the country.

3. Availability and Provision of Health Services

Facility staff will ensure that standard Health Center and Health Post services are available to Health Equity Fund beneficiaries 24 hours a day 7 days a week. In addition, facility staff will ensure:

- All preventive and curative services provided to Health Equity Fund beneficiaries must take place in the Health Center or Health Post facility with the Health Equity Fund beneficiary physically present at the time of treatment. Provision of consultations or drugs to Health Equity Fund beneficiaries outside the Health Center or Health Post facility will not be paid for by the Health Equity Fund.
- The Health Equity Fund will reimburse for standard Health Center and Health Post services according to the "Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund" signed by H.E. Professor Eng Huot on the 29th of August 2014.
- All preventive services which take place at the Health Center or Health Post including ANC, PNC, birth spacing, vaccinations, growth monitoring, and lab tests (pregnancy malaria, VCCT, TB, minilab) are reimbursable by the Health Equity Fund.
- Outreach services provided by the Health Center or Health Post including birth spacing, ANC, de-worming, Vitamin A, and immunizations **will not** be paid for by the Health Equity Fund system.
- All Health Equity Fund beneficiaries are to be treated in a respectful and professional manner.
- All Health Equity Fund beneficiaries are to be provided with clear and complete verbal descriptions of their treatments which are also written in a Health Book kept by the patient.
- It is essential that a strict policy of no informal payments is in place and is clearly understood by all Health Center and Health Post staff. No informal payments will be accepted from Health Equity Fund beneficiaries including requested or voluntary offers of money or gifts.
- All treatments available in the Health Center or Health Post are available to Health Equity Fund beneficiaries and are in compliance with relevant national guidelines which govern the provision of public health services at Health Centers.
- Health Equity Fund beneficiaries have access to an unlocked toilet which is clean and has

water and soap available for use.

- Proper documentation of Health Equity Fund beneficiary utilization using standard Ministry of Health registers.
- Health Equity Fund beneficiaries are provided with proper referrals to higher levels of care including complete referral documentation free of charge to the patient.
- It is the responsibility of Health Center and Health Post staff to ensure that the official name of the Health Equity Fund beneficiary and the correct "Equity Card" or "Priority Access Card" number is recorded accurately in the official Health Center or Health Post appropriate standard Ministry of Health register book. Failure to record the correct name or card number could result in non-payment for that case.
- Health Centers and Health Posts are only allowed to claim for one case per Health Equity Fund beneficiary per day. Multiple visits by the same Health Equity Fund beneficiary on the same day will not result multiple payments by the Health Equity Fund.

12. Financial Management Benefits Provided to Health Equity Fund Beneficiaries

12.1. On a monthly basis each Health Center, under the signature of the facility director or designate, will submit an invoice of services provided to Health Equity Fund beneficiaries using the standard invoice format available on the Ministry of Health PMRS or from the Operational District Offices. Health Post invoices for services provided to Health Equity Fund beneficiaries should be separate from the respective Health Center invoice but submitted together with the Health Center invoice under the signature of the Health Center Director. Any discrepancies should be discussed immediately with the Health Center administrative staff and resolved before the invoice is finalized.

12.2. The invoice should be reviewed by the Operational District through comparison with the Health Center Register and the PMRS to ensure that it is accurate and complete.

12.3. The standard monthly invoice period is from the 1st of the month to the last day of the month in line with the standard reporting period for facilities into the Health Management Information System (HMIS) of the Ministry of Health.

12.4. All information provided in the submitted invoice should be based on existing Health Center and Health Post registers and is subjected to detailed monitoring by Operational District, the Health Equity Fund Implementer, Ministry of Health, or official auditor staff hired by one of these.

12.5. Data entry of Health Center invoice into the PMRS is required on a monthly basis at the either by the Health Center or their Operational District Offices. It is recommended that the Operational District team devise internal monitoring systems which check and double check the accuracy of the data entry that has been done for a given Health Center during a given month. During all monitoring and crosschecking by Health Equity Fund Implementer staff, the exports from the PMRS will be used as the primary source of information to be matched with corresponding documentation and field checks.

12.6. If any Health Center/Health Post could not able to assess PMRS, the Operational District Offices are required to do the data entry into the Ministry of Health PMRS based on the hard copy invoice provided by the Health Center.

12.7. If monitoring by the Health Equity Fund Implementer or Ministry of Health reveals that a Health Center or Health Post has reported false or ghost cases in an invoice to the Health Equity Fund system, double the amount of money, which was paid for the false or ghost cases will be deducted from the next disbursement from Ministry of Health.

12.8. Payments for transportation allowances to Health Equity Fund beneficiaries will be made by the Health Center or Health Post from funds collected through user fees and will be reimbursed by the Ministry of Health as part of the monthly invoicing process.

12.9. The Ministry of Health will make payment for health services and reimbursement for transportation allowances provided to Health Equity Fund beneficiaries within 5 working days following receipt of certification from HEFI/PCA. The ability of the Ministry of Health

to make this payment is based on the availability of funds that may from time to time encounter delays. All payments will be made through bank-to-bank transfers in Riels.

13. Monitoring and Governance of the Health Equity Fund System

13.1. The Health Equity Fund Implementer will conduct invoice verification of services provided by Health Centers and Health Posts to Health Equity Fund beneficiaries on a regular retrospective basis to ensure that invoices submitted by Health Centers are correct. Key to this monitoring will be confirmation of Health Equity Fund services with individual patients and corresponding entries in the Standard Health Center Register. It is therefore required of the Health Center to ensure that the Standard Health Center Registration Book is maintained.

13.2. On a monthly basis the Health Equity Fund Implementer will document all findings from the monitoring process which will be shared with all members of the Provincial and/or District Health Financing Steering Committee (P/DHFSC).

13.3. The P/DHFSC will meet on a quarterly basis to review the progress of the Health Equity Fund system and address any issues that were uncovered by the Health Equity Fund monitoring process.

13.4. The Health Center will be provided with an opportunity to submit written feedback to the monthly monitoring report of Health Equity Fund Implementer for consideration by the P/DHFSC.

14. The Directors and Staff of the [Province name] Provincial Health Department have the following Roles and Responsibilities

14.1. Coordinate with the Ministry of Health Quality Assurance Office and development partners to support the bi-annual (every 2 years) Level 2 Quality Assessments are conducted in accordance with Ministry of Health policy and tools.

14.2. Support resolution of any conflicts or issues resulting from the implementation of the Health Equity Fund.

14.3. Facilitate and organize the quarterly meeting of the P/DHFSC in a timely manner.

14.4. Ensure that adequate representation of local authorities, Operational Districts, Referral Hospitals and Health Centers participate in each P/DHFSC meeting

15. The Directors and Staff of the [Operational District name] Operational District Office have the following Roles and Responsibilities

15.1. Facilitate and organize the quarterly meeting of the DHFSC meeting in accordance with the Implementation of the Health Equity Fund Guideline.

15.2. Ensure that adequate representation of Health Centers participates in each DHFSC meeting.

15.3. Working with DHFSC secretariat staff, finalize the minutes of each DHFSC meeting which will serve as the official report of Health Equity Fund activities.

15.4. With support from the Ministry of Health Quality Assurance Office and development partners, organize the bi-annual Level 2 Quality Assessments for all Health Centers.

16. The Directors and Staff of Health Center have the following Roles and Responsibilities

16.1. In support of monitoring activities by Health Equity Fund Implementer, and/or the Ministry of Health, grant access to patient registers and records to authorized representatives of these organizations.

16.2. Participate and contribute openly in any interviews Health Equity Fund Implementer, and/or Ministry of Health monitors.

16.3. In coordination with the Operational District Office, participate in the quarterly DHFSC meetings.

16.4. Provide written or oral response to any findings of the Health Equity Fund Implementer or Ministry of Health monitoring and work towards resolution of any issues found.

16.5. Accept the monitoring of Direct Benefit provision to Health Equity Fund beneficiaries by Health Centers and Health Posts. Monitoring will include review of Health Center and Health Post invoices, patient registers and records, household interviews with Health Equity Fund beneficiaries, interviews with Health Center and Health Post staff and local authorities.

17. Supervision and Support by the Ministry of Health for the Health Equity Fund

17.1. The Ministry of Health provides stewardship of the Health Equity Fund system in the country in accordance with the National Implementation and Monitoring Framework for Equity Funds and the Implementation of the Health Equity Fund Guideline.

17.2. The purchase of services for the identified poor under the Health Equity Fund system is guided by the approved Ministry of Health "Standard Benefit Package and Provider Payment Mechanism for the Health Equity Fund" which determines the benefits which are to be afforded to members of identified poor households, the payment mechanism by which public health facilities will be paid for providing these services as well as the prices which are paid.

Annex 4

Health Financing Steering Committees

Overview

A critical level of governance within the HEF system are the Health Financing Steering Committees (HFSC). There is a HFSC in Phnom Penh that is responsible for the oversight of HEF related activities at the national hospitals as well as all of the Operational Districts located within the city. There are also HFSCs established at the Provincial or Operational District level throughout the country that includes designation of a deputy governor responsible for the health sector as the chair of the committee. A District level HFSC has the purview of HEF related activities and issues within the catchment area of its respective Operational District. A Provincial HFSC is primarily concerned with the issues and activities of the catchment area of the Operational District in which the Provincial Referral Hospital resides but also is a referral point for issues that District HFSCs within the province cannot by themselves completely resolve. In the Operational District where the Provincial Referral Hospital resides there shall not be a separate District HSFC which would only duplicate the functions of the PHFSC. The Phnom Penh HFSC is the final referral point for any problems which cannot be solved at an of the Provincial HFSCs.

All HFSCs meet quarterly to perform the following tasks:

- Review all HEF monitoring findings, utilization reports, finance summaries and other information related to the activities of the HEF during the previous quarter.
- Review of any pre- and/or post-identification issues encountered;
- Review and ensure transparent monitoring of scheme activities;
- Ensures adequate access and utilization of health services by the poor and non-poor by looking for appropriate solutions to address access barriers.
- Analyze effectiveness, equity and efficiency of the health equity funds operations and stimulate eventual integration with other social health protection schemes and health financing interventions.

Membership

Phnom Penh HFSC: The HFSC in Phnom Penh is chaired by the Director of the MOH/H-EQIP, or delegate by official appointment. Other members of the Phnom Penh HFSC include (but are not limited to):

- Directors of national hospitals that have registered with the MOH to provide services financed by the HEF
- Representatives of the Municipal Health Department and Operational District Offices
- Directors of CPA1-3 hospitals within the Operational Districts of Phnom Penh
- A representative of the HEFP and up to two representatives of the HEFI/PCA
- A representative of Phnom Penh Municipal City Hall health department
- By rotating invitation, two directors from provincial or referral hospitals either to address specific issues or provide feedback on referral processes

- By rotating invitation, representatives from Sangkhat or Khan councils within Phnom Penh
- A representative from the MOP IDPoor Program
- Active and dedicated members of the community
- A representative from the National Blood Bank

The official membership of the Phnom Penh HFSC is determined through a letter from the MOH/H-EQIP Director which either names specific individuals or representatives to the committee. In general, each member of the committee should be committed to consistent and active participation in the quarterly meetings where issues related to the HEF in Phnom Penh are discussed.

Provincial and District HFSCs: Each Provincial and District HFSC is chaired by either a Deputy Provincial Governor or Deputy District Governor with responsibility for oversight of the health sector. Membership includes representatives from the following list of possible government departments or categories:

- Representatives of the Provincial Health Department and/or the Operational District
- Hospital and Health Center Directors
- Representatives from provincial and/or district level government departments including (but not limited to) Economy and Finance, Planning, Women's Affairs, Social Affairs, etc.
- Religious leaders
- Local Authorities
- Active and dedicated members of the community
- Representatives of the HEFP and HEFI/PCA
- By rotating invitation, Representatives from Commune/Sangkhat or District/Khan councils
- Representative of the Planning Department involved with the IDPoor process.

The official membership of each Provincial and District HFSC is determined through a Dekha which either names specific individuals or representatives to the committee. In general, each member of the committee should be committed to consistent and active participation in the quarterly meetings where issues related to the HEF are discussed.

Responsibilities

Phnom Penh: It is the responsibility of the HEFP in Phnom Penh to coordinate the location, timing, and invitations to the quarterly meeting of the Phnom Penh HFSC. The quarterly meeting of the HFSC will be held at the MOH central offices, or at a suitable space located within a MOH public health facility that is available and does not require the payment of rent. It is the responsibility of the Phnom Penh HFSC to ensure that the quarterly meeting takes place in a timely manner following each quarter and ensure that minutes are duly recorded by a representative of the HEFP and submitted for inclusion to the standard consolidated HEF report to the MOH compiled by the HEF Implementer. Any questions from the relevant authorities within the MOH about a failure of the Phnom Penh HFSC to meet will be answered by the chair of the committee. Named committee members have the responsibility of reviewing all information received pertaining to the operations of the HEF system in Phnom Penh and participating in the discussions during each quarterly meeting where issues are discussed, solutions agreed upon, and decisions taken in previous meetings are followed-up.

It is a responsibility of all the public health facilities within the Operational Districts of Phnom Penh that provide services to the HEF system to share the cost of the quarterly HFSC meeting. The formula that determines each facilities contribution will be determined by the HFSC members according to a consensus that shares the costs of the committee fairly.

The Directors of the National Hospitals have the role to prepare a standardized summary report using the MOH PMRS system that can be distributed to HFSC members and discussed during the quarterly meeting. Each HEFP also has the responsibility to prepare a very short (maximum 2 pages) report of their activities, achievements, and challenges in their work supporting the HEF.

Provincial and District HFSCs: It is the responsibility of the HEFP to coordinate the location, timing, and invitations to the quarterly meetings of the HFSCs located with the area of their operations as determined by their contract under MOH/H-EQIP. The quarterly meeting of the HFSC will be held at the Provincial Health Department or Operational District offices, or at a suitable space located within a MOH public health facility, that is available without the payment of rent.

It is the responsibility of each HFSC chairperson to ensure that the quarterly meeting takes place in a timely manner following each quarter and ensure that minutes are duly recorded by a representative of the HEFP and submitted for inclusion to the standard consolidated HEF report to the MOH compiled by the HEF Implementer. Any questions from the relevant authorities within the MOH about a failure of the HFSC to meet will be answered by the chair of the committee.

The Directors of the relevant Provincial and Referral Hospitals have the role to prepare a standardized summary report using the MOH PMRS system that can be distributed to HFSC members and discussed during the quarterly meeting. Each HEFP also has the responsibility to prepare a very short (maximum 2 pages) report of their activities, achievements, and challenges in their work supporting the HEF.

Named committee members have the responsibility of reviewing all information received pertaining to the operations of the HEF system in Phnom Penh and participating in the discussions during each quarterly meeting where issues are discussed, solutions agreed upon, and decisions taken in previous meetings are followed-up.

It is a responsibility of all the public health facilities within the Operational Districts that provide services to the HEF system to share the cost of the quarterly HFSC meeting. The formula that determines each facilities contribution will be determined by the HFSC members according to a consensus that shares the costs of the committee fairly.

Sources of Information

On a monthly basis the HEFI/PCA through each HEF Monitor assigned to specific catchment areas, as part of the independent monitoring generates and distributes to the P/DHFSC members a detailed report of all of their findings from household interviews, document reviews, and key informant interviews. These reports keep the identity of HEF beneficiaries who report problems anonymous, except in cases where they explicitly agree to be identified and wish to participate in the investigation and solution.

In addition to the detailed narrative report, a summary of the information received through the official HEF Complaint Mechanism is included along with some basic analysis about the types of complaints received and the number of complaints that have been resolved and those that remain outstanding, and a summary of the information about the bedside monitoring to oversee facility performance of providing the day to day food, and transportation based on the standard benefit package. It is the responsibility of the P/DHFSC chair to co-sign the report submitted by the HEFI/PCA HEF Monitor prior to its submission to individual P/DHFSC members.

It is the right of any HFSC to request specific information or data related to the catchment area of the HEF that they hold responsibility from the MOH, the HEFI, and/or the HEFP. The HFSC can also assign members of the committee or their delegates to collect additional information related to the HEF as it pertains to any issue that comes before the committee. This could include interviews with key informants, review of HEF related documentation, or analysis of data to understand issues of concern.

Reporting

Following each quarter of the year the P/DHFSCs meet to discuss progress of the HEF, discuss new problems encountered during most recent quarter, and review progress to solutions of problems previously addressed. Progress on the resolution of issues/solutions discussed in the last meeting are reviewed, current issues discussed and plans for their resolution decided. It is the responsibility of the HEFP representative to record the minutes of the HFSC meeting and distribute the draft to committee members for comment within 2 days after the meeting. Following receipt of any comments, the minutes are finalized and send by the HEFP HEFI/PCA within 2 weeks after the HFSC meeting where they are scanned and consolidated into single quarterly report for submission to the MOH and made available through the MOH Social Health Protection module of the HMIS to users who have been granted access by MOH DPHI. All reports are required to be in Khmer language only and should be not longer than a maximum of 4 pages.

Funding

P/DHFSCs are funded directly by the relevant referral hospital at the Operational District or Provincial level. It is the responsibility of the HEF Promoter to work in coordination with the chairperson of the P/DHFSC to schedule the quarterly meetings, develop the agenda for discussions, and record the minutes of the meeting. It is the determination of each individual committee to decide if they pay per diems or transportation reimbursements to HFSC committee members or invitees.

Role of Provincial Health Department

The Provincial Health Departments are not directly engaged with the operations of the HEF but have a stake as member of The Provincial Health Financing Steering Committee and by ensuring effective administrative and clinical operations of facilities of the respective Operational Districts through equitable distribution and effective use of available resources. They have the responsibility to address complaints raised at and advises extended by the Provincial Health Financing Steering Committee

Role of Operational District

The Operational District's principal responsibility in regard to the HEF system is to provide technical supervision and support to health centers and referral hospitals in their delivery of services to have patients supported in accordance with MOH policies and guidelines. Apart from administrative and reporting issues, the Operational Districts have to address issues raised at the District Health Financing Steering Committee of which they are member.

In case the Operational District cannot adequately and sufficiently address issues related to healthcare provision to the population and HEF beneficiaries they will have to ask assistance from the Provincial Health Department.

Annex 5

Kingdom Of Cambodia
Nation Religious King

Ministry of Health

Guidelines for the HEF Promotor
Draft

29.05.2016

Contents

I. Background

The H-EQIP will build on the innovations supported in the Second Health Sector Support Program (HSSP2), particularly HEFs and SDGs, and aims to increase the sustainability of these innovations by improving their resourcing and management as envisaged in the RGC's HSP-3. It will further strengthen the results-based focus of both HEFs and SDGs with a specific goal of improving quality of health service delivery and utilization of services by the poor. In addition, the Project will use a multi-pronged approach to strengthening health systems, especially to support improvements in quality of care, by focusing on enhancing provider knowledge through both pre-service and in-service training, improved availability of critical infrastructure in health facilities, and strengthening Public Financial Management (PFM). Using a set disbursement-linked indicators (DLIs), the Project will disburse funds against targets achieved on these health system strengthening measures. Another key strategic shift is to attain institutional sustainability through a transfer of responsibility for third party HEF verification from an internationally recruited firm to an independent Government agency which will be established by June 2018, and extending this responsibility to include verifying SDG results at all levels of the health system.

The Project Components include:

Component 1: Strengthening Health Service Delivery

a. Sub-component 1.1: Service Delivery Grants for HCs
b. Sub-component 1.2: Service Delivery Grants for Hospitals
c. Sub-component 1.3: Service Delivery Grants for Provincial Health Departments (PHDs) and ODs

Component 2: Improving Financial Protection and Equity

Component 3: Ensuring Sustainable and Responsive Health Systems

d. Sub-component 3.1: Health System Strengthening
e. Sub-component 3.2: Health Infrastructure Improvements
f. Sub-component 3.3: Project Management, Monitoring and Evaluation

Component 4: Contingent Emergency Response

II. Introduction to Health Equity Funds

The Health Equity Funds (HEF) was introduced as a demand-side financing mechanism to improve access for the poor. The HEF first covered the user fees related to hospitalization (CPA health services), but soon extended to services at health centres, transportation to and from hospital and food costs for caretakers during hospitalization. Beneficiaries are identified according to eligibility criteria, either through Pre-Identification (Pre-ID) poor process or at the health facilities through Post-Identification (Post-ID) poor process. At public health facilities, HEF eligible poor patients get full support for the cost of user fees, and where applicable transportation reimbursements, caretaker food allowances for inpatients, and funeral support.

III. Improving the Health Equity Fund

H-EQIP will implement a range of reforms to improve the management and structure of the HEFs and to integrate the existing, strongly donor-supported systems into Government systems.

The management of HEF eligibility, utilization, and billing information using the MOH Patient Management and Registration System (PMRS) and the financial management of payments by the HEF are moving from the HEF-Operators (HEFOs) to be direct functions of public health facilities with the payment of facilities through direct bank-to-bank from the Ministry of Economics and Finance (MEF)/Ministry of Health (MOH) to each individual health facility. Verification of claims processing is moving from a donor-supported agency, the HEF Implementer (HEFI), to an autonomous government body in the form of a Public Administrative Enterprise (PAE). As part of the review of the existing HEF system and during the design of the new system, several key challenges were identified and these include:

Supporting HEF Beneficiaries in the Hospitals

To date, The HEFOs have ensured that "meet and greet" services for HEF Beneficiaries (HEFB) seeking care are available at all RHs from 7:00 am to 5:00 pm, seven days a week, 365 days a year. These services include (among others)

- Confirm the identity and eligibility of Pre- and Post-identified HEF beneficiaries by consulting the PMRS
- Validate their referral status
- Provide explanation to the HEFB and / or their caretakers on the support that is provided by the HEFs, and ensure that they clearly understand about HEF benefits.
- Conduct the standard HEFB Patient Exit Interview.

These services are very important function as it provides the HEF Beneficiaries with support in the hospital which is often an intimidating place for a poor person from a rural area.

Post-Identification of the Poor in Hospitals

The targeting of poor for HEF eligibility is done through Pre-identification of poor households in their community and Post-identification of poor patients who attend the hospitals. Experience has shown that for both systems to work well, the actual identification must be carried out by someone who does not have a conflict of interests regarding the result of the identification. Pre-identification solves this issue by using a transparent participatory community process managed by the Ministry of Planning. Post- ID carried out by health staff employed by the health facility would be fraught with conflicts of interest and thus needs to be done by independent persons.

This function has to date been carried out by the HEFOs using staff based in the hospitals and the independence of this function needs to be maintained.

Low Utilization of "Equity Cards"

Recent research has shown that there are many households who do not use the "Equity Cards" provided to the pre-identified poor households when accessing public health services. These studies have shown that the important reasons often relate to misconceptions about their entitlements and these include:

- Low awareness among beneficiaries of their benefits and entitlements when seeking care.

- Issues around service quality and availability
- Perceived discrimination in public health facilities
- Old and disabled people in particular face a range of barriers that are not yet considered when accessing primary care facilities.

A specific agency to promote the use of "Equity Cards" and access HEF benefits does not exist but there are many groups and organisations active in the community that could add this specific activity to their existing functions.

The Health Equity Fund Promoter

As of July 1st 2016, HEFOs will no longer be working in the field and all their functions will also cease. The H-EQIP design process has taken this into account and the re-assessment and re-distribution of HEFO functions has been an important part of the process.

The financial functions of the HEFOs are to be re-organised: payments to health facilities are to be made through direct bank-to-bank transfers by the MEF/MOH, payment to clients for food and transport allowances will be taken over by the hospitals and all payments and claims will be processed and verified by an autonomous Claims Processing Agency, i.e. PAE.

There are no existing institutions in the rural areas to take over the functions that support HEF Patients in the RHs, conduct Post-identification interviews in referral hospitals (RHs), and to support the promotion of HEF benefits in the communities. All are important and so it was agreed that the HEF-Ps will be designed to take over these 3 functions.

IV. Purpose of the HEF-Promotor

1. Provide information and guide / support the HEFB in the RHs through a dedicated HEF-P member ('patient concierge') deployed at kiosks/counters in RHs;
2. Conduct Post-Identification of the poor in the hospital;
3. Work with community structures to increase uptake of the HEF benefits through using public health facilities, especially primary health care facilities and preventive health services, promote institutional delivery especially among the rural and underserved populations;
4. Conduct limited monitoring / verification functions concentrating on patient satisfaction.

V. Roles and Responsibilities of HEF-Ps

Patient Helpdesk / Concierge.

The HEF-Ps will ensure that "meet and greet" services for HEF supported patients seeking care are available at all RHs covered by the HEF in their catchment area from 7:00 am to 5:00 pm, every weekday.

It is the responsibility of the HEF-Ps to negotiate with RH management to ensure that a Help Desk is appropriately placed in the RHs, that patient flow is clear and that all concerned staff are aware of the correct sequence of admission for HEF supported patients. Signage to ensure HEF supported patients and others can easily find the Help Desk

Role of HEF-Ps in Normal Working hours for HEF Supported Patients

Arrival in the Hospital

), the hospital staff will validate HEF eligibility of identified poor patients (either pre- or post-identified) using the MOH Patient Management and Registration System (PMRS) and then refer these HEF supported patients to the Patient Concierge. In case pre-identification was carried out but the Equity Card has not yet been issued, a *referral letter* from the relevant Commune Council which mentions the Pre ID date household number is valid. The letter it must be kept in the patient dossier for monitoring purpose.

Then the Patient Concierge will assure that the RH staff assess medical conditions of HEF eligible patients to determine whether admission to the hospital or referral to a specialized OPD service is required.

If the HEF supported patient's medical condition does not require hospital level services, the Patient Concierge will refer the HEF supported patient the HC located on the grounds of the RHs.

Admission as an in-patient

When admission by RH staff is deemed necessary and following registration by the RH Clerk, the Patient Concierge will complete the following steps:

- Provide a clear explanation to the HEF supported patients (or their caretaker) on the support that is provided by the HEF and ensure that they clearly understand their benefits;
- Inform the HEF supported patient about their transportation reimbursement (as applicable) and food allowances;
- Tell the HEF supported patient that the Patient Concierge will be pleased to answer any questions they have and try to help solve any problems they face.

During Admission:

- The Patient Concierge will conduct daily rounds to speak with HEF supported patients admitted in the hospital to ensure that they are comfortable, have a clear understanding of the treatment that they are receiving, and are being treated with respect by the hospital staff.

Discharge from Hospital

Upon discharge from the hospital, the Patient Concierge will complete the following steps:

- Inform the HEF supported patients or their care takers to collect the remainder of their transport reimbursement for traveling back to their homes;
- Ensure that the HEF supported patients or their care takers collects the HEF Medical Certificate (generated from the PMRS) and that hospital staff gives an explanation of all details to the HEF supported patients and their caretakers.
- Conduct the standard IPD Patient Exit Interview.

Attendance at a Specialized OPD

When attendance at a specialized OPD is deemed necessary, the Patient Concierge will complete the following steps:

- Provide explanation to the HEF supported patient (or their caretaker) on the support that is provided by the HEF, ensuring that they clearly understand their benefits, including travel allowances;

- inform the HEF supported patient that the Patient Concierge will be pleased to answer any questions they have and try to help solve any problems they face.

Role of HEF Promoter in *Outside* Normal Working Hours.

Arrival in the Hospital

Upon arrival at the RH, the on-duty hospital staff will receive "Equity Card" and "Priority Access Card" holders and assess their medical condition to determine if admission to the hospital (or referral to a specialized OPD service) is required.

If the identified poor card holder's medical condition does not require RH level services, the on-duty hospital staff will refer the Card holder to the Health Centre (HC) located on the grounds of the RH.

Admission as an in-patient

When admission is deemed necessary, the on-duty Hospital Staff will complete the following steps:

- Verify identity of pre-identified or post-identified HEF beneficiaries by consulting the PMRS and interviewing the card holder (or their caretaker);
- Initiate a Summary of Treatment Form that includes the basic details of the HEF supported patient. This form is provided to the RH staff for inclusion in the HEF supported patient's dossier for completion by appropriate RH clinical and administrative staff;
- Refer the HEF supported patient to the Patient Concierge the next morning.

Discharge from Hospital

This should not take place outside normal working hours.

VI. Post-Identification of Beneficiaries

Introduction

There are two methods by which individuals are identified as poor and become eligible for HEF benefits:

1. The national Identification of Poor Households Program (IDPoor) implemented by the Ministry of Planning which provides each identified poor household with an "Equity Card" which is valid for three years. This process is known as pre-identification;
2. The post-identification process conducted in public Referral Hospitals by the Ministry of Health which provides each identified poor household with a "Priority Access Card" which is valid for a period of one year.

Pre-identification of poor households is carried out at regular intervals in the community using the established systems of the Ministry of Planning at community level and this process manages to capture most of the eligible poor. However some poor people are missed and these include those whose financial status has declined in the period between the regular assessments, those who move between districts. It has been found necessary to develop a system to identify people in need of the subsidy for health care who come to hospital but do not have an "Equity Card". A Post-identification Poor mechanism was introduced (managed by HEFOs) and is used to identify and provide support to identify poor patients in the hospital.

Post-identification of poor households allows for the identification of "poor" and "very poor" patients when they seek care at the hospitals. Each household identified through the post-identification process is provided with a "Priority Access Card" that has a unique identification number similar in format to the MOP "Equity Card" numbering system. A "Priority Access Card" is a card issued by the HEF Promoter only for the purpose of accessing HEF benefits whereas an "Equity Card" issued by the Commune Council under the MOP pre-identification process is for all social transfer mechanisms available in that area.

All poverty identification data from both pre- and post-identification is entered into the MOH PMRS so that patient identity and eligibility for HEF benefits can be verified by RH staff at the time that they seek care.

The process of using post-identification has proven very useful as an on-going method to correct for deficiencies in the pre-identification process.

Patient Concierge to Conduct Post Identification of the Poor

The HEF-Ps will train their staff for conducting post-identification of potentially poor patients who claim they cannot afford the user fees d do not already have an "Equity Card" from the pre-identification process.

Post-identification interviews should be carried out in a private room of the hospitals, so that the conversations cannot be overheard by other patients. If the patient condition is not allowed to be interviewed in the private room, then the caretaker can be interviewed instead. The assessment is done by 1) carrying out the Post-identification Interview (see Annex 3), and 2) conducting community spot checks on post-identified households where it is deemed necessary. Findings from this community spot checks will be reported to Health Financing Steering Committee meeting. The purpose of this verification activity is to discourage the abuse of the system by the non-poor.

In cases where the pre-identification has been carried out but the "Equity Cards" have not yet been issued, a *referral letter* by the relevant Commune Council attesting to the household poverty status including dates of interview and household number may be used in lieu of the actual card. The letter must be kept in the patient dossier for monitoring purpose.

Post Identification Methodology

Post-Identification is performed by applying pre-defined socio-economic selection criteria on patients presenting at the health facility who are in need of health care and saying that they are unable to pay the fees. To establish whether the patient should be provided with benefits supported by the HEF, the MOH has developed a Post-Identification Questionnaire (see Annex 2). This form distinguishes 3 categories: "very poor" and "poor" (both eligible for full HEF benefits), and "non-poor" (who are not eligible for HEF benefits).

If a patient, who has held Post-identification for less than 12 months, returns to the health facility to be re-admitted, s/he is remains eligible to be supported by HEF. If the patient has been Post-identification more than 12 months, the "Priority Access Card" is expired and if s/he supposedly not able to pay the fees, s/he has to go through a post-identification interview process again.

The HEF-P manager is responsible for organizing a sufficient number (as defined by MOH) of verification visits at the home of HEF beneficiaries who have been post-identified to confirm the answer provided on the MOH Post-Identification Questionnaire for Households (Annex 3). They report their findings to the HEF Promoter Manager. The purpose of this verification activity is to discourage the abuse of the system by the non-poor.

VII. Community and Stakeholder Level Services

Household Spot Checks

The household spot checks will be conducted for confirmation of poverty status for a post-identified patient.

Confirmation of poverty status of Individuals Post-Identified as Poor

Following a successful post-identification interview that awards HEF benefits to a poor household, the HEF-Ps may occasionally suspect that the beneficiary may not actually be poor; in this case the HEF-P and so they should conduct a household visit to confirm the poverty status using the MOH Post-Identification Questionnaire for Households (Annex 3). If the spot check reveals that the individual in question is not poor, then the following actions should be taken.

- If the individual in question is still an in-patient the RH then all benefits being provided should be suspended. User fees will not be paid upon their discharge, the HEF-P staff should try to get the individual to repay any transport costs and food allowances already paid.
- If the individual has already been discharged, funds spent for User Fees, Transport or Food need not be recovered. However, the case must be entered into the PMRS, so the HEF-P should ensure that the RH Clerk deactivates the household in the system.

Promoting the Health Equity Fund

The HEF-Ps are expected to develop a process to work with and through existing community bodies, organizations and networks in the RH catchment areas to promote two key objectives:

1. Increase uptake and use of "Equity Cards" by the poor;
2. Promote utilization of public good services particularly for remote and difficult to access population, including urban poor population.

However working with the poorest and marginalised is a challenging task because the poorest and marginalised are insecure because of chronic financial stress (made worse by unscrupulous exploitation in private clinics), are likely to be illiterate, have a limited understanding of health and health services, and have limited trust in existing administrations and service providers. In addition to financial barriers to health services, poor people will also face access barriers related to provider behaviour.

Therefore there is a need to seek ways to:

- work with grassroots and community-based organisations to identify and reduce access barriers to using health facilities;
- improve their ability to make informed choices regarding matters affecting their health, including health services, practices and care providers;
- promote utilization of "Equity Cards" by emphasizing that the HEF will reimburse treatment and care on behalf of "Equity Card" holders.

The key activities involved in promoting the HEF are:

- In villages / communes with low utilisation[1], assess underlying reasons for low uptake of services with the potential HEFB and working through and with local authorities

[1] Within these areas map all non-governmental -, governmental -, and grassroots organisations involved in community development projects, together with pagodas and mosques, and effectively engage them in encouraging HEFB to use their HEF entitlements.

and grassroots / NGO organisations formulate and implement appropriate solutions. Solutions should include financial literacy sessions to ensure free treatment is understood;
- Report quarterly to the District and Provincial Health Financing Steering Committees on issues related to public health services use by the poor, identified access barriers and respective solutions implemented, health service provider behaviour, challenges encountered, informal fee charged, and joint activities with other organisations operating in the operational district.

Thus the HEF-Ps will not be expected to carry out health promotion activities by itself but will be expected to identify groups working in poor and marginalised communities– whether from existing community network, from local government, from NGOs, from religious orders or from community-based organizations – and to ensure that they include the key messages around the HEF in their health and community promotion plans, events and activities.

VIII. HEF Promoter Management Functions

The HEF-Ps will be required to manage the activities taking place in the hospitals and in their catchment areas.

The HEFPs will:

- Develop and implement SOPs for the Patient Concierge and Post-Identification functions in the hospitals; these are to be based on existing government documents and rules;
- Develop a SOP/approach to provide effective mechanisms and processes to work with and through existing community bodies, organizations and networks in the hospital catchment areas to promote utilization of HEF, public good services, primary care facilities and institutional delivery;
- Select, employ and design and implement an initial and continuing training programme for all the Patient Concierge;
- Select, employ and design and implement an initial and continuing supervision programme and schedule for 2 supervisors in each province to provide support to the Patient Concierges;
- On a day to day basis the consultant will work closely with Director of DPHI and senior staff and with the Provincial Authorities, Referral Hospital Directors, and Operational District Managers in their region. The HEF-P will provide monthly, quarterly and annual reports on activities to the Provincial and District Health Financing Steering Committees, the HEFI/PAE, and the MOH. Reporting will follow MOH guidelines.

IX. Implementing Company

Overall Company Profile

Companies bidding to implement the functions and activities described in these TORS must be:

- appropriate legal entity with at least 2 years of experience working with the community in health sector;

- Demonstrable experience creating / employing existing community networks;
- Working across sectors with local authorities and grassroots organisations;
- Record of mobilising communities / local resources and working with poor people / communities;
- The company should already have management staff based and working at provincial level.

Key Experience requirements

These include:

- Experience in working with the MOH and public health facilities and in and with Community-based and other grassroots organisations will be especially important;
- Experience in health promotion in the health sector would be an added advantage

Key Tasks

The HEF Promotors will be based in one of the 6 Regions[i] (see footnote) and will report to the Program Director/Coordinator for overall guidance and fulfilling contractual obligations.

The HEF-Ps will be required to manage the activities taking place in the hospitals and in their catchment areas. The HEFPs will:

- Manage the HEF-P programme in their Region
- The HEF-P will appoint two staff per hospital and one will be responsible for the Concierge/Post identified functions and one would be responsible for the community and health promotion activities. (Nos of staff need to be discussed – workload and budget needs to be considered)
- Adapt and implement the centrally-designed SOPs for the Patient Concierge and Post-Identification functions in the hospitals; these are to be based on existing government documents and rules;
- Adapt and implement the centrally-designed mechanisms to handle direct complaints and problems identified usig the Client Satisfaction Survey (see Annex 2)
- Adapt and implement the centrally-designed approach to provide effective mechanisms and processes to work with and through existing community bodies, organizations and networks in the hospital catchment areas to promote utilization of HEF, public good services, primary care facilities and institutional delivery;
- Select, employ and implement the initial and continuing centrally-designed training programme for all the Patient Concierge;
- Select, employ and implement the initial and continuing centrally-designed supervision programme and schedule for 2 supervisors in each province to provide support to the Patient Concierges;

[i] Region 1 comprises the provinces of …….., [i] Region 2 comprises the provinces of …….., [i] Region 3 comprises the provinces of …….., [i] Region 4 comprises the provinces of …….., [i] Region 5 comprises the provinces of …….., [i] Region 6 comprises the provinces of ……..

Annex 6

M1 Questionnaire For HEF-P Manager

Name of MG Member responsible for Monitoring Results of this HEF-P

Name of interviewee :

Date of the interview

Facility:

OD

√ tick the box containing the answer

		Yes	≤14 days too late	>14 days late
	MG tells the Manager if DPHI received the Quarterly Report on time:			
1	MG asks the Manager: Will the quarterly report next time be on time ?	yes		probably not
	MG tells the Manager if the Quart Report had been signed and if it was found to be complete:	complete/ incomplete		signed/not signed
2	2a) Will it be signed next time ?	yes		probably not
	2b) Will it be complete next time ?	yes		probably not
3	Did you distribute a leaftlet to ALL Patients about patient rights and obligations and rules?		yes	no
	If yes, take 1 sample for each member of the MG who will do interviews			
4	Do you take feedback from all the HEFB patients when they exit the hospital		yes	no
	Within how much time after admission **SHOULD** the HEF-Ps decide on poverty status ? (during last quarterly report period!)			
5	For POST ID patients	immediately	<48hrs	no time limit
6	Does the HEF-P Manager say there is a policy of Co-payment by HEFB at the Hospital?	Yes		no
7	if such policy, what was the MAXIMUM co-payment paid by THE RECOGNIZED POOR			
8	Do you provide enough rice and food every day for the patients?	Enough	not enough	od provided
9	Were you able as HEF-Ps to make sure that HEFB get the same treatments as non HEFB ?		Yes	no
10	Were you able to make the staff have the same good attitude towards HEFB as non HEFB?		Yes	No
11	Is there a FEEDBACK BOX clearly marked and suitable to collect filled feedback forms from patients?		yes	no
12	Will there be a FEEDBOX clearly marked and suitable in the next quarter ?		yes	no
13	What is % of HEFB patients who gave feedback from the total number of reported HEFB patients in the quarterly report?			%

OBSERVATIONS:

Are all the HEFB patient files over the reported 3 months available ?

14 Total that should be there

15 Total that were there

Check 19 randomized Pre-ID patient files on completeness using the checklist!

16 How many (of 19) are complete?

Check 19 randomized Post ID patient files on completeness using checklist!

17 How many (of 19) are complete?

18 Is there a Khmer sign near the Entrance which gives clear information about Equity Fund ?

yes
unclear sign
no sign

19 Will there be a good and clear Khmer sign next quarter ? yes no

Notes by interviewer to qualify responses by the Respondent:

name of interviewer

HV1 Random number:

before you go out to interview check the patient file at the hospital for Questions 18+2

Questionnaire For Home visits to Patients

Name of MG Member responsible for Monitoring Results of this HEFO/Subs

Name of interviewee:

date of this interview: (dd-mm-yyyy)

HEF-P Group: (circle) I II III IV V VI

this column is for qualitative information

(circle) Pre-ID Post-ID CBHI

& Fill in the ID nr:

Village: Khum/Sangkat: Srok: Province:

						if yes, how ?
1	Did you hear or see what are the Patient rights and obligations when you were at the hospital ?	yes		no		
2	Did you give Feedback after your discharge to HEF-P or Hospital ?	yes		no		reason
3	Do you know how to use the Feedback form ?	yes		No		reason
4	For Post ID: Did you know about HEF before you came to the hospital ?	yes		no		details:
5	How many hours after admission were you given HEFB status by this hospital ?	<48 hours	I cannot remember this		>48hours	
6	Did you pay at that hospital before you got the HEFB status ?	no	YES			if yes, amount
7	Did you borrow money against INTEREST before coming to the Hospital in order to pay for the costs of your stay at the hospital	No		Yes		details:
8	Did you have to pay a part of the medical treatment there after you get HEFB status ?	No	yes			details:
9	Did the staff tell you to go buy medicines outside?	No	yes, but did not	yes, and bought		details:
10	Does the HEFO/Subs have AN AGENT at the Hospital ?	yes	no	Don't know		details
11	Would you hospitalize there again in the future if you have HEFB status?	Yes	no			if no: why (HEFO) or (Hosp)
12	did you get benefit from the Equity fund ?	yes	no			reason
13	Do you feel that the Staff gave you medical treatment as if you are like the other patients who are not HEFB?	yes	almost the same	I think I am not getting what I need		reason
14	Do you feel that the Staff attitude towards you was the same as towards the other patients who are not HEFB	yes	almost the same	I feel discriminated		details
15	What do you think of the Equity Fund/Subsidy system ?	Good	It helps a little bit only	It is NOT Good		reason
16	Who is funding this Equity Fund/Subsidy system ? Please make a guess...	Cambodian Government	Foreign Assistance	no opinion		
17	Did you get enough food to eat every day ?	enough	not enough			details
18	If the patient had to receive money for transport, does the patient confirm that the patient received it?	yes		no		details
19	What do you think about the quality of the Hospital service ?	Good	medium	Bad		details
20	Was the complete address filled in the patient dossier and is it the true address according to the patient ?	yes	wrong address	no address		details
21	Check the Pre ID card and ask when the patient received it?	> 3 months before admission	< 3 months before admission	Patient cannot show Pre-ID card		details
22	Do the other Poor people in this village also have the Pre-ID card ?	yes	some of them	no		
23	Patient appears to meet the Poverty Criteria of the HEF-P?	Yes	I doubt it	clearly not		
24	How many meters is the nearest neighbor house from the HEFB's house ?	<10 meters	10 - 50m	50-100m	>100m	
25	What is that neighbor's nickname ?		man / woman (circle)			

Notes by interviewer to qualify interesting responses by the Respondent, please mention the Question nr

name of interviewer

HV1 SUMMARY FORM

Questionnaire For Home visits to Patients

Health Equity Fund

date of interviews (dd-mm-yyyy)

1 Name of MG Member responsible for Monitoring Results of this HEF-P

Did you hear or see what are the Patient rights and obligations when you were at the hospital ?

2 # Yes

3 # No

Did you give Feedback after your discharge to HEF-P or Hospital ?

4 # Yes

5 # No

Do you know how to use the Feedback form ?

6 # Yes

7 # No

For Post ID: Did you know about HEF before you came to the hospital ?

8 # Yes

9 # No

How many hours after admission were you given HEFB status by this hospital ?

10 # < 48 hrs

11 # cannot remember

12 #>48 hrs

Did you pay at that hospital before you got the HEFB status ?

13 # Yes

14 # No

Did you borrow money against INTEREST before coming to the Hospital in order to pay for the costs of your stay at the hospital?

15 # Yes

16 # No

Did you have to pay a part of the medical treatment there after you get HEFB status ?

17 # Yes

18 # No

Did the staff tell you to go buy medicines outside?

19 # No

20 # Yes, but did not buy

21 # Yes, and bought

Does the HEFO/Subs have AN AGENT at the Hospital ?

22 # Yes

23 # No

24 # Don't Know

Would you hospitalize there again in the future if you have HEFB status?

25 # Yes

26 # No

Did you get benefit from the Equity fund ?

27 # Yes

28 # No

Do you feel that the Staff gave you medical treatment as if you are like the other patients who are not HEFB?

29 # Yes

30 # Almost the Same

31 # Not getting what I need

Do you feel that the Staff attitude towards you was the same as towards the other patients who are not HEFB

32 # Yes

33 # Almost the Same

34 # I feel discriminated

What do you think of the Equity Fund/Subsidy system ?

35 # Good

36 # It helps a little bit only

37 # It is NOT Good

Who is funding this Equity Fund/Subsidy system ? Please make a guess…

38 # Cambodia Govt

39 # Foreign Assistance

40 # No opinion

Did you get enough food to eat every day ?

41 # Enough

42 # Not Enough

If the patient had to receive money for transport, does the patient confirm that the patient received it?

43 # Yes

44 # No

What do you think about the quality of the Hospital service ?

45 # Good

46 # Medium

47 # Bad

Was the complete address filled in the patient dossier and is it the true address according to the patient ?

48 # Yes

49 # Wrong Address

50 # No Address

Check the Pre ID card and ask when the patient received it?

51 # > 3 mo before admission

52 # < 3 mo before admission

53 # Cannot show Pre-ID card

Do the other Poor people in this village also have the Pre-ID card ?

54 # Yes

55 # Some of them

56 # No

Patient appears to meet the Poverty Criteria of the HEF-P?

57 # Yes

58 # I doubt it

59 # Clearly not

	nr	Indicator	Source of information
A	1	Quarterly Report arrived at DPHI on time	Check the DPHI registered dated stamp on the quarterly report in the DPHI File+name receiver
A	2	Quarterly Reports completely filled and signed	Check the DPHI files where the Quarterly reports are kept;
A	3	HEF-P Manager confirming that there is a policy of **No Co-payment** by HEFB	See M1 question number 6
A	4	HEF-P Managers confirming that there is enough food for the patients	See M1 question number 7
A	5	Managers guaranteeing equal levels of treatment for HEFB and non HEFB	See M1 question number 8
A	6	Managers guaranteeing that staff has the same attitude towards HEFB and non HEFB	See M1 question number 9
A	7	Hospitals with FEEDBACK BOX clearly marked and suitable to collect filled feedback forms from patients	See M1 question number 10
A	8	% of HEFB that has given feedback	See M1 question number 11
A	9	Proportion of HEFB patient files of the past 3 months that are available	See M1 question number 12
A	10a	Complete patient files of Pre ID	See M1 question number 13a
A	10b	Complete patient files of Post ID	See M1 question number 13b
A	11	HEFs or Subsidizers with a Khmer sign near the Entrance which gives clear information about Equity Fund	See M1 question number 14

Topic	nr	Indicator	Source of information
B	1	Proportion of HEFB having received information from the HEF-P explaining the Patient rights and obligations at this hospital;	See HV1 question nr 1
B	2	Proportion of HEFB having given feedback upon hospital exit	See HV1 question nr 2
B	3	Proportion of HEFB saying they can fill out the feedback form	See HV1 question nr 3
B	4	Proportion of HEFB saying they knew about the Equity Fund/Subsidy before they decided to go to the hospital	See HV1 question nr 4
B	5	Proportion of HEFB saying that they were given HEFB status within 48hours after admission	See HV1 question nr 5
B	6	Proportion of HEFB reporting they have paid before being awarded HEFB status	See HV1 question nr 6
B	7	Proportion of HEFB reporting they have borrowed money against interest in order to pay for their hospitalization	See HV1 question nr 7
B	8	Proportion of HEFB that reports not to have made co-payments or unofficial payments	See HV1 question nr 8
B	9	Proportion of HEFB that reports not to have been told to buy medicines outside	See HV1 question nr 9
B	10	Proportion of HEFB saying that there is an agent of the Equity Fund(Subsidizer) at the hospital whom they can contact	See HV1 question nr 10
B	11	Proportion of HEFB saying they would use the Equity fund (Subsidy) - system again	See HV1 question nr 11
B	12	Proportion of HEFB saying that the equity fund benefits are enough	See HV1 question nr 12
B	13	Proportion of HEFB saying that they think they get the same treatment as non-HEFB	see HV1 question nr 13
B	14	Proportion of HEFB saying that the hospital staff has the same attitude towards them as towards non-HEFB	See HV1 question nr 14
B	15	Proportion of HEFB saying that the Equity fund system (organization) is good enough	See HV1 question nr 15
B	16	Proportion of HEFB thinking that the funding for equity funds comes from the Cambodian government sources	See HV1 question nr 16
B	17	Proportion of HEFB reporting they had enough to eat while being hospitalized	See HV1 question nr 17
B	18	Equityfunds providing transportation money according to beneficiaries	See HV1 question nr 18
B	19	Proportion of HEFB reporting that the service at the Hospital is good for them	See HV1 question nr 19
B	20	Proportion of HEFB patient files that has correct address	See HV1 question nr 20
B	21	Proportion of Pre ID hospitalizing within 3 months after receiving the Pre ID card	See HV1 question nr 21
C	1	Proportion of Pre-ID saying that the other poor people in their village were also pre-identified	See HV1 question nr 22
C	2	Proportion of HEFB appearing to meet the poverty criteria of the HEF	See HV1 question nr 23

1.1 List of patient dossier items

Tool for Monitoring by MG Social Protection

If the randomized patient dossier is not available for MG, then tick the box "patient dossier unavailable", skip the questions and just date and sign the questionnaire at the bottom: □ " patient dossier unavailable"

List of 18 items in the "patient dossier" to be checked by MG			Tick box		
nr	**description of item**	**requirements**	**yes**	**no**	
1a	**Billet d'entrée/Admission**	has Hospital registration number assigned			1
1b	**Billet d'entrée/Admission**	has name, sex, age of patient			2
1c	**Billet d'entrée/Admission**	If Pre Identified by HEFO or MoP process, has full Pre ID number, if Post ID, has full Post ID form			3
1d	**Billet d'entrée/Admission**	Date of Admission on billet entrée is conform Quarterly Report			4
1e	**Billet d'entrée/Admission**	Assigned ward is mentioned			5
2a	**Feuille d'Hospitalisation / Patient Dossier**	has name, sex, age of patient			6
2b	**Feuille d'Hospitalisation / Patient Dossier**	has full address of patient			7
2c	**Feuille d'Hospitalisation / Patient Dossier**	Observations are written			8
2d	**Feuille d'Hospitalisation / Patient Dossier**	Ordered paraclinical exams correspond with available results in the dossier			9
2e	**Feuille d'Hospitalisation / Patient Dossier**	Treatment description is complete			10
2f	**Feuille d'Hospitalisation / Patient Dossier**	The temperature sheet / Feuille de Temperature is filled in completely			11
2g	**Feuille d'Hospitalisation / Patient Dossier**	Diagnostique de Sortie is written down			12
2h	**Feuille d'Hospitalisation / Patient Dossier**	Reason for Discharge is written in Patient Dossier and dated and signed by Dr			13
3	**Patient Discharge document**	The appropriate discharge form and signed is available in the file			14
4	**Feedback Form**	Feedback form filled by Dr on status of patient on discharge is available in the patient file			15
5a	**INVOICE to HEFO**	Is it clear if the referring HEFO was billed and if so for how much ?			16
5b	**INVOICE to others**	Is it clear of any other institution was billed and if so for how much ?			17
5c	**Record whether charged to Gvt Budget Prakas #809**	is it clear from the Patient Dossier whether this case was charged to the Government Budget as a case based payment or not			18

17 or 18 times YES is a complete do		
< 17 times "Yes" is an INCOMPLETE		
	nr Yes	**nr No**

Date of Check ……..

Facility Checked ……

Random nr ……

filled in during preparation of MG visit

MG member name ……

Annex 7

Date :

H.E Professor Eng Huot
Secretary of State and Project Director of H-EQIP
Ministry of Health
#53, St. 281, Sangkat Boeung Kok1
Khan Toul Kok, Phnom Penh
Kingdom of Cambodia

Attn :

Ref: Letter on hand over of roles and responsibilities from HEFOs to health facilities of 1 July 2016

Subject: Request three months advance for non-medical benefits

Your Excellency

Reference to letter date April 25, 2016, hand over roles and responsibility of HEFs to health facilities on July 1, 2016, I would like to request three month advances for non-medical benefit costs.

The total advance request is ……. (in word: ……)

Please wire the requested amount above to the bank account below:

- Account Name:
- Account Number:
- Bank Name:
- Bank Address:

Your sincerely.

(Signature)

Hospital Name:

Request Cash Advances for Non-medical Benefit Costs

Description	Annual Budgeted Amount	Amount to be requested (Average three months of the budgeted annual amount)
Transportation		
Food		
Funeral		
Grand Total		

Prepared By

_____

Name:
Title:
Date:

Approval By

_____

Name:
Title:
Date:

Certified by

_____

Name: (PCA/HEFI)
Title:
Date:

Annex 8

Food for Caretakers and Transportation Hospital

RH/2016/7-00001

Patients Name...Gender.................Age.............ID#..

Address..Patients Dossier #..

Food for Caretakers (5000៛ Per Day)

Total Amount ___________________________Total amount in word_____________________________

Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date....................... Thumbprint 5000៛	Date....................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛
Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date....................... Thumbprint 5000៛	Date....................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛
Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛	Date..................... Thumbprint 5000៛	Date....................... Thumbprint 5000៛	Date......................... Thumbprint 5000៛

Transportation and Funeral Benefit

1. From Home to RH_____________________Amount____________________Riels

2.From RH to Home______________________Amount_______________ ____Riels

3.Funeral Benefit________________________Amount ___________________ Riels

Date: Thumbprint
Date: Thumbprint
Date: Thumbprint

Total Amount________________________ Total Amount in Word________________________________

Date_________________

Paid By

Name:___________________

Annex 9

Cash Advance Balance Report

Report on Balance of Cash Advance from MOH's DBF

Date	Description	Amount Received from MOH's DBF	Amount Advanced to Staff	Progress Payments	Amount Liquidated	Balance		
						Per Bank	Per staff	Total
1/6/16	Initial advance	10000	5000	2000	500	5000	2500	7500
2/6/16	Payment			300	200	5000	2000	7000
10/6/16	2nd week advance to staff		2000	500		3000	3500	6500
								0
								0
								0
								0

Annex 10

Province:
OD:
Referral Hospital:

Advance Request

(for Payment of Non-Medical Benefits and Its Clearance)

A) <u>Advance Request for payment of non-medical benefits to HEF beneficiaries</u>

Payment period: From: ……./……../……. To: ……./……../……. Expected clearance date:

Estimated amount for the period:

Less: Remaining amount from the previous request, if any:

Requested amount for the period:

I, ……., being the requested person, confirm that I am accountable for the advanced I received and will use this advance solely for payment of non-medical benefits to HEF beneficiaries for the period identified above.

	Requested by:	**Reviewed by:**	**Approved by:**	**Received by:**
Name				
Signature				
Date				

B) <u>Advance Clearance</u>

	Amount in Riel
Amount advanced (see above)	xxxxx
Payments made from _____ to _____ *	xxxxx
Remaining amount to be (1) carried over OR (2) refunded *	xxxxx

***: The payment during the period and the remaining amount should be agreed with the amounts in PMRS.**

	Prepared by:	**Reviewed by:**	**Approved by:**	**Received by**:**
Name				
Signature				
Date				

****: This is applicable when the remaining amount is refunded. The recipient signs as acknowledgement of receipt.**

Daily Expenditures

Annex 11

Hospital ៖Kampong Cham Provincial Hospital
Report Date ៖01 Apr 2016
Last Advance ៖ 800,000
Expenditures as of Date ៖ 609,800
Request amount in this period ៖0
Remaining Advances ៖ 190,200

N0.	ID #	Patients Name	Age	Gende	Admission Date	Transport	Food	Funeral	Total Amount
1	03120514-0127		46	F	3/2/16	0	5,000	0	5,000
2	03040501-0020		36	F	8/3/16	0	5,000	0	5,000
3	03120320-0141		33	M	9/3/16	0	5,000	0	5,000
4	03020604-9085		56	M	9/3/16	0	5,000	0	5,000
5	06011007-9024		44	M	9/3/16	0	5,000	0	5,000
6	03161404-0085		20	F	10/3/16	1,000	5,000	0	6,000
7	03131514-9012		53	F	22/03/2016	0	5,000	0	5,000
8	03010101-9006		27	F	22/03/2016	0	5,000	0	5,000
9	03010106-9104		52	F	23/03/2016	35,000	5,000	0	40,000
10	03040102-0293		81	F	23/03/2016	0	5,000	0	5,000
11	03030707-0190		16	M	24/03/2016	0	5,000	0	5,000
12	03050302-0339		59	M	24/03/2016	0	5,000	0	5,000
13	03060604-0016		34	F	1/4/16	18,000	0	0	18,000
14	03080303-0218		52	F	1/4/16	54,000	0	0	54,000
15	03120217-0204		18	M	1/4/16	2,000	0	0	2,000
16	03130311-0064		50	F	1/4/16	30,000	0	0	30,000
17	03020501-0052		25	M	1/4/16	45,000	0	0	45,000
18	03130312-0108		27	M	1/4/16	30,000	0	0	30,000
19	2008-03130809-0052		43	M	1/4/16	30,000	0	0	30,000
20	2008-03150204-0009		22	M	1/4/16	33,000	0	0	33,000
21	2008-03130809-0052		37	F	1/4/16	30,000	0	0	30,000
22	03060907-9009		51	F	1/4/16	19,800	0	0	19,800
23	03150903-9044		36	F	1/4/16	33,000	0	0	33,000
24	03150902-0172		57	F	1/4/16	33,000	0	0	33,000
25	03020501-0052		24	M	1/4/16	45,000	0	0	45,000
26	03130813-0249		51	F	1/4/16	30,000	0	0	30,000
27	03080302-0156		49	F	1/4/16	55,000	0	0	55,000
28	03061504-0039		38	F	1/4/16	18,000	0	0	18,000
29	03110504-0071		38	F	1/4/16	2,000	0	0	2,000
30	03110815-0103		49	M	1/4/16	1,000	0	0	1,000
31	03060102-0209		11	F	1/4/16	0	5,000	0	5,000
					ទឹកប្រាក់សរុប	544,800	65,000	0	609,800

Annex 12

Verification Report on HEF patienta receiving direct benefits at health facilities IPD

Report Date: **22 Jun 2016**
Report Period: 01 May 2016 to 31 May 16

Kampong Thom Prov. Hosp.

Note: highlight blue means that the records have ambulance fee
Note: highlight yellow means that the records have transport and food fee start from zero since 01 Jun 2016

No.	IN	OUT	Days	PAC	Card Type	PC	Name	Sex	Age	Address (Vil. - Com.)	User Fee	Ambulance	Transport	Food	Other	Total
1	29-Apr-16	1-May-16	3	06010909-9004	Post	2		F	24	តំរពាំងចំរនៀង - ជំរលង	120,000	0	20,000	15,000	0	155,000
2	23-Apr-16	1-May-16	9	13020101-0266	Pre	2		M	28	ឆែបលិច - ឆែបមួយ	400,000	0	43,000	45,000	0	488,000
3	1-May-16	1-May-16	1	06010707-0016	Pre	2		M	55	ឆ្ពេន - ឈូកខ្សាច់	120,000	368,000	10,000	5,000	0	503,000
4	27-Apr-16	2-May-16	6	06050201-0114	Pre	2		M	2	កំពង់ជំរា - គោល	120,000	0	110,000	30,000	0	260,000
5	30-Apr-16	2-May-16	3	06030902-0133	Pre	2		F	37	អាចារ្យបេាក - អាចារ្យរលេាក់	120,000	0	2,000	15,000	0	137,000
6	26-Apr-16	2-May-16	7	06060507-0178	Pre	1		F	35	ជាំផល - មានជំរ	120,000	0	105,000	15,000	0	240,000
7	23-Apr-16	2-May-16	10	06050113-9005	Post	1		M	29	រំលរែង - ឈូក	120,000	0	104,000	50,000	0	274,000
8	27-Apr-16	2-May-16	6	06020501-0272	Pre	1		F	15	នីពេជំរក - នីពេជំរ	120,000	0	70,400	30,000	0	220,400
9	29-Apr-16	2-May-16	4	06020302-0163	Pre	1		F	43	កំពង់គេាក្រេាម - កំពង់គេា	120,000	0	19,000	20,000	0	159,000
10	29-Apr-16	2-May-16	4	06021106-0046	Pre	1		F	15	កំពង់ក្រសី - ពេរែគុយ	120,000	0	29,800	20,000	0	169,800
Total for Kampong Thom Prov. Hosp.							No. Discharges: 10				1,480,000	368,000	513,200	245,000	0	2,606,200

Annex 13

Invoice # : HC Code/2016/7-001

Invoice for Providing Health Services to HEFs beneficiaries

Health Center Name: _____Operation District: _____

Month: _____Start From to

Recent Asessement Score Last Annual or Quarter

If score is greater or equall **≥ 75%** fill out in the below box **4000 Riels**

If score is lower than **< 75%** fill out in the below box **2000 Riels**

1- Total OPD for HEFs (No include with Delivery)		x		=		
2- Total Case long term family planning for HEFs (Implant & IUD)		x	**20000 Riels**	=		
3- Total Case of Delivery for HEFs		x	**60000 Riels**	=		
4- Total attempted delivery cases with referral for HEFs		x	**60000 Riels**	=		
5- Total Case of post abortion care for HEFs		x	**60000 Riels**	=		
6- Ambulance fees for HEFs		x		=		
(I) Total Amount (User Fees and Ambulance)		x		=		
7- Total Transportation (Attempted Delivery, Delivery and Post Abortion Care)		x		=		

(II) Total Amount (User Fees and Transport)

Additional Information:

8- Total Population within HC catchment Areas	
9- Total Referral Case Supported by HEFs	
10- Total Correct Referral for HEFs (Referal Letter)	
11- HC revenue (USD) All Income including HEFs	

Prepared By

_____ _____

Name: **Date:**

Review and Data Entry **Approval By**

_____ _____ _____ _____

Name: **Date:** **Name:** **Date:**

***Health Center have to ensure that all cases above are matched with health center registration book*

Annex 14

ឧបសម្ព័ន្ធ ១៤

RH/2016/7-00001

សន្ធេបការព្យាបាល និង ថ្លៃសេវា
សំរាប់អ្នកជម្ងឺដែលគាំទ្រដោយមូលនិធិសមធម៌

OPD

លេខសំគាល់មូលនិធិសមធម៌:_____	ថ្ងៃទី.....ខែ.....ឆ្នាំ២០១
ឈ្មោះអ្នកជំងឺ: _____ភេទ: _____អាយុ:_____	អ្នកសំរបសំរួល
ខេត្ត:_____ ស្រុក: _____ឃុំ:_____ ភូមិ:_____	
ទីតាំង:_____	

លេខលិខិតបញ្ជូន: .....បញ្ជូនដោយ: មសក☐ មព☐ អសក☐ ខ្លួនឯង☐ ផ្សេងៗ☐

ថ្ងៃចូលពិនិត្យ: .....ម៉ោងចូល:.....លេខសំណុំលិខិត: .....

<u>ចំណាត់ជម្ងឺនៃការធ្វើរោគវិនិច្ឆ័យ</u>

☐ ជម្ងឺរាគរូស	☐ ជម្ងឺសួតផ្សេងៗ	☐ ជម្ងឺផ្លូវចិត្ត	☐ ជម្ងឺស្បែក	☐ សំរាលកូនពិបាក	☐ ទារកមិនធម្មតាពីកំណើត
☐ ជម្ងឺគ្រុនចាញ់	☐ រលាកផ្លូវដង្ហើមស្រួច	☐ មហារីក	☐ ជម្ងឺភ្នែក	☐ កូនកើតស្លាប់	☐ ពន្យាកំណើតអចិន្ត្រៃ
☐ ជម្ងឺគ្រុនឈាម	☐ រលាកស្រោមខួរក្បាល	☐ ទឹមនោមផ្អែម	☐ រលាក	☐ ជម្ងឺក្រចៀក-ច្រមុះ-បំពង់ក	☐ ជាប់ញៀន-ស្រវឹង
☐ ជម្ងឺហ៊ីវ-អេដស៍	☐ ជម្ងឺតម្រងទឹកនោម	☐ ស្វិតដៃជើង	☐ ជម្ងឺលើសឈាម	☐ ក្លាយរោគក្រោយរលូត	☐ គ្រោះថ្នាក់ចរាចរ
☐ របេងក្រៅសួត	☐ ជម្ងឺឆ្អឹង-សាច់ដុំ	☐ ជម្ងឺបេះដូង	☐ ជម្ងឺប្រដាប់បន្តពូជ	☐ សំរាលកូនដោយវះកាត់	☐ របួសផ្សេងៗ
☐ របេងសួត	☐ ជម្ងឺសរសៃប្រសាទ	☐ រលាកថ្លើម	☐ សំរាលកូនធម្មតា	☐ ទារកសំរាលដោយមានជម្ងឺ	☐ ជម្ងឺផ្សេងៗ

☐ របួសដោយធ្លាក់-វាយតប់-សត្វខាំ-បាញ់បោះ

សូមធីកនៅពីមុខសេវាដែលបានប្រើប្រាស់

	សេវាដែលបានប្រើប្រាស់	**ថ្លៃសេវា**		**សេវាដែលបានប្រើប្រាស់**	**ថ្លៃសេវា**
	សេវាសង្គ្រោះបន្ទាន់			សេវាមណ្ឌលវីស៊ីស៊ីធី (VCCT)	
	ការពិគ្រោះព្យាបាល			ជំងឺផ្លូវចិត្ត	
	ការពិគ្រោះ សេវាវះកាត់			ត្រចៀក ច្រមុះ បំពង់ក	
	សេវាពេទ្យធ្មេញ			សេវាជំងឺភ្នែក	
	ថតវិទ្យុសកម្ម			លំហាត់ប្រាណ-ការព្យាបាលដោយចលនា	
	ថតអេកូ			រថយន្តសង្គ្រោះពីមណ្ឌលសុខភាពទៅកាន់មន្ទីពេទ្យបង្អែក	
	ការធ្វើតេស្តវិភាគឈាម			រថយន្តសង្គ្រោះពីមន្ទីពេទ្យបង្អែកទៅកាន់មន្ទីពេទ្យខេត្ត	
	ការពិនិត្យសាកសព			សេវារដ្ឋបាល	
	សេវាគ្លីនីកថ្នាំពន្យាជំងឺអេដស៍				

ថ្លៃសេវាសរុប (ជាលេខ):.....

ថ្លៃសេវាសរុប (ជាអក្សរ):.....

ថ្ងៃទី .....ខែ.....ឆ្នាំ២០១ ស្នាមមេដៃ និងឈ្មោះអ្នកជម្ងឺ ឬសាច់ញាតិ	ថ្ងៃទី.....ខែ.....ឆ្នាំ២០១ ហត្ថលេខាគ្រូពេទ្យ / ឈ្មោះ	ថ្ងៃទី .....ខែ.....ឆ្នាំ២០១ ប្រធានគណៈកម្មាការហិរញ្ញប្បទាន

ឧបសម្ព័ន្ធ ១៥

Annex 15

RH/2016/7-00001

IPD

សន្ធេបការព្យាបាល និង ថ្លៃសេវា
សំរាប់អ្នកជម្ងឺដែលគាំទ្រដោយមូលនិធិសមធម៌

ថ្ងៃទី.....ខែ.....ឆ្នាំ២០១

អ្នកសំរបសំរួល

លេខសំគាល់មូលនិធិសមធម៌ .....

ប្រភេទនៃអ្នកទទួលផល ☐ក្រ១ ☐ក្រ២

ឈ្មោះអ្នកជម្ងឺ: ..... ភេទ: .....អាយុ.....

ខេត្ត:.....ស្រុក:.....ឃុំ:.....ភូមិ:.....

ទីតាំង:.....

លេខលិខិតបញ្ជូន .....បញ្ជូនដោយ: ☐ មសភ ☐ មព ☐ អសភ ☐ខ្លួនឯង ☐ផ្សេង

ថ្ងៃចូលសំរាកពេទ្យ: ..... ម៉ោងចូល.....លេខសំណុំលិខិត.....

ថ្ងៃចេញពីមន្ទីពេទ្យ: ..... ម៉ោងចេញ:.....សរុបចំនួនថ្ងៃសំរាកពេទ្យ: .....ថ្ងៃ

មូលហេតុចេញ: ☐ ជាសះស្បើយ ☐ រត់ ☐ ស្លាប់ ☐ បញ្ជូន ☐ ផ្សេងៗ

រោគវិនិច្ឆ័យចេញ:.....

កិច្ចសន្យារះកាត់	
បានពិនិត្យបញ្ជាក់	មិនចាំបាច់

ចំណាត់ក្រុមជម្ងឺ:

☐ជម្ងឺរាគរូស	☐ជម្ងឺគ្រុនស្វិតដៃជើង	☐ជម្ងឺស្បែក	☐បញ្ឈប់កំណើតអចិន្ត្រៃ (គ្រៀវ)
☐ជម្ងឺគ្រុនចាញ់	☐ជម្ងឺរលាកថ្លើម	☐ជម្ងឺឆ្អឹង-សាច់ដុំ	☐រលាក
☐ជម្ងឺគ្រុនឈាម	☐ជម្ងឺមហារីក	☐ជម្ងឺតម្រងនោម	☐ជម្ងឺទាក់ទងគ្រឿងញៀនគ្រឿងស្រវឹង
☐ជម្ងឺប្រដាប់បន្តពូជ	☐ជម្ងឺទឹកនោមផ្អែម	☐សំរាលកូនធម្មតា	☐គ្រោះថ្នាក់ចរាចរ
☐ជម្ងឺហ៊ីវ-អេដស៍	☐ជម្ងឺផ្លូវចិត្ត	☐សំរាលកូនពិបាក	☐របួសដោយធ្លាក់-វាយតប់-សត្វខាំ-បាញ់បោះ
☐ជម្ងឺរលាកផ្លូវដង្ហើមស្រួច	☐ជម្ងឺសរសៃប្រសាទ	☐សំរាលកូនដោយរះកាត់	☐របួសផ្សេងៗ
☐ជម្ងឺរបេងសួត	☐ជម្ងឺភ្នែក	☐កូនស្លាប់កើត	☐ផ្សេងៗ
☐ជម្ងឺសួតផ្សេងៗ	☐ជម្ងឺត្រចៀក-ច្រមុះ-បំពង់ក	☐ក្លាយរោគក្រោយរលូត	
☐ជម្ងឺរះកាត់	☐ជម្ងឺលើសឈាម	☐ទារកមានជម្ងឺ	
☐ជម្ងឺរលាកស្រោមខួរក្បាល	☐ជម្ងឺបេះដូង	☐ទារកមិនធម្មតាពីកំណើត	

លេខរៀង	រាយមុខសេវាដែលបានផ្តល់	ថ្លៃសេវា
១		
២		
៣		
	សរុប	

តំលៃសរុប (ជាអក្សរ) :.....

ថ្ងៃទី: ..... ខែ .....ឆ្នាំ២០១	ថ្ងៃទី .....ខែ .....ឆ្នាំ២០១	ថ្ងៃទី.....ខែ.....ឆ្នាំ២០១
ស្នាមមេដៃអ្នកជម្ងឺ ឬអ្នកកំដរ	ហត្ថលេខាគ្រូពេទ្យ /ឈ្មោះ	ប្រធានគណៈកម្មាការហិរញ្ញប្បទាន

Outstanding Patients Expenditures Report

Annex 16

Hospital ៖ Kampong Cham Provincial Hospital

Date as of ៖ 25 May 2016

Total Expenditures ៖ 1,409,300

No.	ID #	Patients Name	Age	Gender	Date of Admission	Wards	Referral From	Transport Cost	Food	Total
1	06011007-9024		44	M	9-Mar-16	វិទ្យុសសល្បសាស្ត្រ(វះកាត់គូទ)	មន្ទីរពេទ្យបង្អែកទំការលេទំ RH	0	235,000	235,000
2	03151022-0316		40	M	21-Mar-16	វិទ្យុសជំងឺរេនដស៍		0	180,000	180,000
3	03170210-0185		30	M	28-Mar-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	120,000	120,000
4	03131304-0195		36	F	3-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	40,000	40,000
5	03110119-9013		29	F	4-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	110,000	110,000
6	10030801-0170		41	F	5-Apr-16	វិទ្យុសសុខភាពផ្លូវចិត្ត		0	105,000	105,000
7	10010202-0014		41	F	5-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកខ្លួង - RH	0	100,000	100,000
8	11050102-9061		40	F	5-Apr-16	វិទ្យុសជំងឺរេនដស៍		0	105,000	105,000
9	25070717-9001		50	F	8-Apr-16	វិទ្យុសរោគស្ត្រី	មន្ទីរពេទ្យបង្អែកត្បូងឃ្មុំ - RH	0	85,000	85,000
10	06011107-9003		49	M	11-Apr-16	វិទ្យុសសង្គ្រោះបន្ទាន់		0	75,000	75,000
11	03060203-9015		57	M	12-Apr-16	វិទ្យុសរិនិត្យ ព្យាបាលជំងឺទូទៅ	ហាន់ជ័យ - HC	0	70,000	70,000
12	03150903-0218		26	M	12-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកក្រចេះ - RH	0	70,000	70,000
13	03070106-0001		56	F	12-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		0	70,000	70,000
14	03162113-0124		54	F	13-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកត្បូងឃ្មុំ - RH	0	60,000	60,000
15	03050101-9029		32	M	13-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	65,000	65,000
16	2008-03020801-0123		48	M	13-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	65,000	65,000
17	2008-03161301-0201		25	M	13-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកពញាប៉ក្រក - RH	0	60,000	60,000
18	03150904-9041		5	M	14-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		0	45,000	45,000
19	10050302-9094		19	F	14-Apr-16	វិទ្យុសសម្ភព		1,000	60,000	61,000
20	10010802-0125		36	M	14-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកខ្លួង - RH	0	55,000	55,000
21	14040402-0063		36	M	15-Apr-16	វិទ្យុសសង្គ្រោះបន្ទាន់		0	55,000	55,000
22	03020501-9036		18	M	15-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		0	55,000	55,000
23	03131309-9002		52	M	16-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	50,000	50,000
24	06011303-9005		34	F	16-Apr-16	វិទ្យុសសង្គ្រោះបន្ទាន់		0	50,000	50,000
25	10010805-0207		15	F	16-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	35,000	35,000
26	03161813-0118		2015	M	17-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		0	45,000	45,000
27	06011101-9010		38	F	17-Apr-16	វិទ្យុសសម្ភព		0	45,000	45,000
28	03130801-0103		31	M	17-Apr-16	វិទ្យុសសង្គ្រោះបន្ទាន់	មន្ទីរពេទ្យបង្អែកកំព្រាឈរ - RH	0	40,000	40,000
29	25030512-9024		48	F	17-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)	មន្ទីរពេទ្យបង្អែកមមត់ - RH	0	40,000	40,000
30	06011004-9010		32	M	17-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		0	45,000	45,000
31	22010207-0076		67	F	18-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកជីងប្រៃ - RH	0	35,000	35,000
32	03010805-0155		27	F	18-Apr-16	វិទ្យុសសម្ភព	មន្ទីរពេទ្យបង្អែកបាធាយ - RH	0	35,000	35,000
33	2008-03010403-0144		62	F	18-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	40,000	40,000
34	03091207-9135		57	M	18-Apr-16	វិទ្យុសរិនិត្យ ព្យាបាលជំងឺទូទៅ		0	40,000	40,000
35	03130816-0096		20	M	18-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	40,000	40,000
36	22050405-9068		50	F	18-Apr-16	វិទ្យុសជំងឺទូទៅ-មនុស្សចាស់		0	40,000	40,000
37	03020606-9061		60	F	18-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកទំការលេទំ RH	0	35,000	35,000
38	03061105-9297		33	M	18-Apr-16	វិទ្យុសសល្បសាស្ត្រ(វះកាត់គូទ)		0	40,000	40,000
39	03061101-0106		36	F	18-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	40,000	40,000
40	03130819-0188		0	F	18-Apr-16	វិទ្យុសជំងឺកុមារ		0	40,000	40,000
41	03080603-9012		41	F	18-Apr-16	វិទ្យុសរិនិត្យ ព្យាបាលជំងឺទូទៅ		0	40,000	40,000
42	03030608-0408		39	F	19-Apr-16	វិទ្យុសសម្ភព	មន្ទីរពេទ្យបង្អែកជីងប្រៃ - RH	24,000	5,000	29,000
43	03061404-9015		40	F	19-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)		12,300	35,000	47,300
44	25010106-9003		26	F	19-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	20,000	20,000
45	14120105-9003		27	F	19-Apr-16	វិទ្យុសសម្ភព		1,000	35,000	36,000
46	03162102-0200		64	F	19-Apr-16	វិទ្យុសរោគស្ត្រី		0	35,000	35,000
47	03151305-0236		57	M	19-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)		0	35,000	35,000
48	03151307-0132		0	F	19-Apr-16	វិទ្យុសជំងឺកុមារ		0	35,000	35,000
49	03080106-9014		11	F	19-Apr-16	វិទ្យុសជំងឺកុមារ		0	35,000	35,000
50	25031208-9011		53	F	19-Apr-16	វិទ្យុសរិនិត្យ ព្យាបាលជំងឺទូទៅ	មន្ទីរពេទ្យបង្អែកមមត់ - RH	0	30,000	30,000
51	25040716-9004		6	F	19-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)	មន្ទីរពេទ្យបង្អែកឧត្តរាំងឪ - RH	0	30,000	30,000
52	03120625-10012		30	F	20-Apr-16	វិទ្យុសសង្គ្រោះបន្ទាន់	មន្ទីរពេទ្យបង្អែកពញាប៉ក្រក - RH	0	25,000	25,000
53	03060106-0122		71	M	20-Apr-16	វិទ្យុសជំងឺទូទៅ-មនុស្សចាស់		0	30,000	30,000
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...	...		...	...	...	...	...	...	...	...
99	03160415-0083		23	F	23-Apr-16	វិទ្យុសជំងឺទូទៅ-មនុស្សចាស់	មន្ទីរពេទ្យបង្អែកត្បូងឃ្មុំ - RH	0	10,000	10,000
100	14130805-0056		53	F	23-Apr-16	វិទ្យុសសម្ភព		0	15,000	15,000
101	14050702-0077		19	M	23-Apr-16	វិទ្យុកប្រជាធនកម្ម (ICU)	មន្ទីរពេទ្យបង្អែកហ៊ុនសែនស្ទឹងត្រង់ - RH	0	10,000	10,000
102	03130803-0040		2	M	23-Apr-16	វិទ្យុសជំងឺកុមារ		0	15,000	15,000
103	03011010-9006		26	M	23-Apr-16	សណ្ឋាគារ និងវាក់ថ្នាំសណ្តុំ(វះកាត់ធំ)	មន្ទីរពេទ្យបង្អែកបាធាយ - RH	0	10,000	10,000
							Total	38,300	3,070,000	3,108,300

Annex 17

Health Equity Fund Certification

Invoice for the period of ……..

				Amount Claimed during the period			Deductions			Net Amount			
No.	**Name Facilities**	**Bank Account Name**	**Bank Account Number**	**User Fees**	**non-medical**	**Total**	**User Fees**	**non-medical**	**Total**	**User Fees**	**non-medical**	**Total**	**Amount in word**
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
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Preparedy By

Certified By