

Cambodian Healthcare Policy: Challenge and Development

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Abstract:

This paper is a review of the government healthcare policy for Cambodian people's need. It also described on the government's approach for inclusive growth and sustainable development; wherein people's health identified as one of the priorities for effective human capital. This paper indicated the Second Health Strategic Plan of the government is currently implementing as well; that conducted the 9 priorities of policy on improving equity and accessibility of basic health services, to ensure improved efficiency, affordable costs, and high quality services, and to protect the poor. The 13 strategies of healthcare sector were also explained. These strategies have been defined by Ministry of Health. The healthcare financing and human resource development are vital areas within the healthcare sector. To meet this end, the Ministry of Health is figuring a master plan connecting health sector reform with the broader fiscal and administrative reforms.

Keywords: healthcare policy, Healthcare financing, Human resource, Challenge, Development, Health status

1. Introduction:

The Kingdom of Cambodia is a Southeast Asian country with a surface area of 181,040 km², and a total population of 14.9 million in 2013 (WB, 2013). The nation and its population experienced civil war and genocide in the 1970`s, which decimated a large part of the infrastructure and skilled human resources (PeterLeslie Annear et al., 2015). The health system of Cambodia has suffered from war and chronic under funding and is having a more difficulties to cope with the health needs of the population in the latter half of the twentieth century (David I Levine & Gardner, 2008).

After the period of the Khmer Rouge regime was toppled in 1979, only 25 medical doctors had survived with 1,000 doctors trained in 1975 (Heng & Key, 1995; Theth, 2005). Initially, emphasis on restoring the health system placed on the measure: in 1980-1981, some 11231 medical staff recruited or trained and operated from 1225 health posts; by 1989, there were 1616 health posts (David I Levine & Gardner, 2008). From 1979, the functioning health care system obtained one of the priorities of the governments until now. The 1980s decade was the reconstruction and rehabilitation with many health workers being trained through accelerated training courses of varying quality, however, the services quality provided poor, and only UNICEF was active in Cambodia at that time (Theth, 2005). During the signing of the Paris Peace Agreements in 1991, the government depended largely on external aid to rebuild the health system, mainly channeled through non-governmental organizations (NGO) (Lanjouw, Macrae, & Zwi, 1999). From 1993 general election in Cambodia, authority and responsibility for program development and budgetary control for local health units transferred from the local governors to the Ministry of Health (MOH). From that time, the preparation started on the basic legislation on key organizations in the sector and regulations for the pharmaceuticals management, and these various provisions passed into law between 1995 and 1998 (Godfrey et al., 2002).

Cambodia has observed a noteworthy change in health status of the population because of strong economic growth in the past several years. However, the improvement in neonatal mortality has been greatly slower, and the issues of inequity still persist between rural and urban areas as well as among different socio economic groups including women, the poor, migrant workers, unregistered population and ethnic minorities (WHO, 2014). In spite of the fact that the health status of Cambodia's population stays among the lowest in this region, some recent improvement in morbidity rates has been happening (Theth, 2005). Progress to enhance nutrition has been much slower than anticipated, with under-nutrition contributing to more than 6,400 child deaths annually and 40% of children fewer than 5 are stunting. While, Cambodia has gained a strong progress in communicable diseases control, one of the remaining challenges is developing infectious diseases where Cambodia has the highest numbers of cases of avian influenza H5N1 subtype (47 cases between 2005-2013) globally (WHO, 2014). Government policies are intended to enhance health and the delivery of health services is obviously one approach to accomplish better health and well being.

This paper aimed to review of the government healthcare policy for Cambodian people`s need. It also described on the government`s approach for inclusive growth and sustainable development; wherein people`s health identified as one of the priorities for effective human capital. This paper indicated the Second Health Strategic Plan of the government is currently implementing as well; that conducted the 9 priorities and 13 strategies of policy on improving equity and accessibility of basic health services, to ensure improved efficiency, affordable costs, and high quality services, and to protect the poor.

2. Human Recourse in Healthcare Sector:

A significant success has been achieved in rebuilding the health workforce since 1979, when only 25 doctors survived after the Khmer Rouge. In the early years, the Health Planning has been focused strongly on an increase in staff training and staff numbers. Major planning documents included the 1995 Health Coverage Plan and two Health Workforce Development Plans for 1996-2006 and 2006-2015

(PeterLeslie Annear et al., 2015). The Ministry of Health employs a total of 19,457 civil servants (a relatively small number compared to other ministries), most of whom are nurses (about 46%) and midwives or midwife associates (about 24%); and doctors comprise about 14% of the health workforce, with a greater number of general practitioners than specialists (about 11% and 1%, respectively).

Table 1. Ministry of Health Workforce Projection Plan, 2012-2020

Professional category	Total existing staff	Per 10000 pop.	Total need	Per 10000 pop.	Total gap	Attrition years	Total required
Specialist doctor	259	0.18	367	0.23	108	21	129
Medical doctor	2157	1.51	2679	1.66	522	345	867
Medical assistant	778	0.54	584	0.36	-194	124	0
Dentist	223	0.16	324	0.20	101	18	119
Dental assistant	65	0.05	18	0.01	-47	5	0
Pharmacist	487	0.34	668	0.41	181	78	259
Pharmacist assistant	79	0.06	106	0.07	27	6	33
Secondary nurse	5698	3.99	7577	4.69	1879	912	2791
Primary nurse	3281	2.30	5739	3.55	2458	1050	3508
Secondary midwife	2475	1.73	4495	2.78	2020	396	2416
Primary midwife	2188	1.53	2376	1.47	188	350	538
Secondary laboratory technician	462	0.32	649	0.40	187	37	224
Primary laboratory technician	69	0.05	21	0.01	-48	6	0
Physiotherapist	147	0.10	259	0.16	112	12	124
X-ray technician	22	0.02	230	0.14	208	4	212
Administrative officer	58	0.04	372	0.23	314	0	314
Accountant	137	0.10	226	0.14	89	0	89
Information technology staff	68	0.05	186	0.12	118	0	118
Facility maintenance staff	82	0.06	352	0.22	270	0	270
Driver	56	0.04	153	0.09	97	0	97
Other	666	0.47	4687	2.90	4021	320	4341
Total	19457	13.62	32070	19.86	12613	3683	16448

Source: MOH Health Workforce Projection Plan 2012–2020; Cambodia Health Staff Projection Tool, 2010, 2011; MOH Personnel Department.

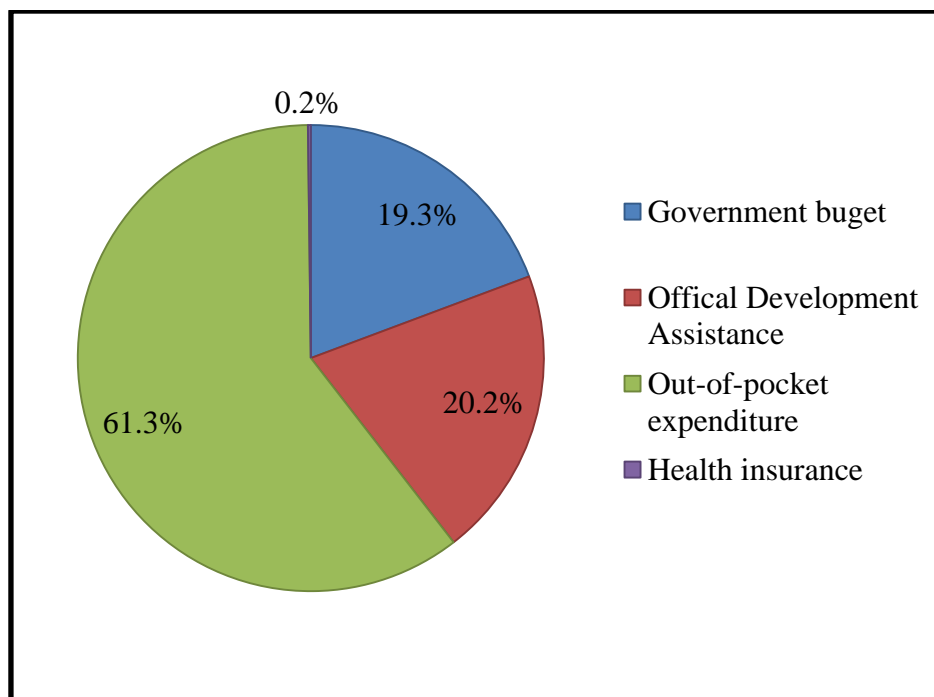
Table 1 showed that to fully implement the Health coverage plan, the Ministry of Health points out that there is a need to expand the total public health workforce to 32,000 by 2020, an increase of 64% from 2012 levels, raising the health worker to population ratio from 13.6 to 19.9 per 10,000 populations.

Health Workforce Strategic Plan 2006-2015 identifies major challenges to be finalized in terms of structure, size and composition of the future workforce, recruitment, employment and deployment, productivity and staff remuneration. All of these elements have the potential impact of the development of the public health system and the effectiveness of health service delivery and health financing strategy (MOH, 2008).

3. Health Financing Reform:

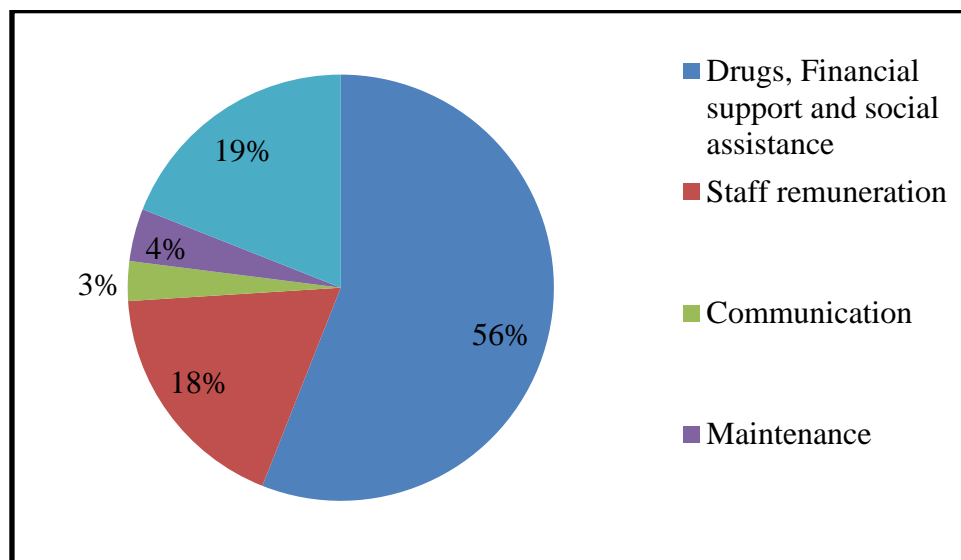
Reforms in health financing have culminated in the focal point of endeavors to rebuild the nation's health system. Total health expenditure (THE) has expanded with steady monetary development, achieving US\$ 1,033 million in 2012 and more than 7% of GDP; without a significant reduction in Out of pocket (OOP) health expenditures, universal health coverage will not reach. Cambodia is under a diversified health financing system with multiple sources of revenue, both public and private (David I Levine & Gardner, 2008). Revenues which ultimately come from individuals, companies or foreign aid are collected via four broad mechanisms: 1) government national budget general taxation revenues (US\$ 199 million in 2012); 2) Official development assistance (ODA) external donors (US\$ 209 million in 2012); 3) Out of pocket (OOP) expenditure households (US\$ 622 million in 2012); and 4) Health insurance public and private (US\$ 2 million in 2012) (MOH, 2014).

Figure 1. Share of total health expenditure by funding source



Source: Source: National Health Accounts; MOH, 2014.

Figure 1 indicated that the household out of pocket (OOP) spending is the main source of financing for health care.

Figure 2. Government health expenditure by Budget Chapter (% of total budget)

Source: Official budget figures provided by the Ministry of Health

Figure 2 showed that more than half of total public health spending goes to drugs and procurement, followed by salaries and operating costs. Government funding for health care has increased substantially, but challenges remain in relation to locative and administrative efficiencies. Seventy per cent of the health budget remains with the central MOH, National Hospitals and national institutes, and only 30% passes to provinces for service delivery (MOH, 2014).

The Government of Cambodia is focused on moving towards universal health coverage; the Health Equity Funds (HEF), a pro-poor health financing mechanism that reimburses the full or partial cost of health services provided to the poor at public health facilities, covered 90% of the identified poor in 2014 (MOH, 2014). The Ministry of Health (MOH) aims to expand HEF to other vulnerable populations and include it under a proposed National Social Health Protection System.

4. Government Healthcare Policy:

The Government of Cambodia is currently implementing the second Health Strategic Plan 2008-2015 (HSP2), the government's approach for inclusive growth and sustainable development, wherein people's health is identified as one of the priorities for effective human capital; and the administration of the public health system in Cambodia is centralized at the national level, as with other government ministries, with responsibilities for implementation and service delivery assigned to Ministry of Health officials at provincial and district levels (WHO, 2014).

4.1 Healthcare System and Service Delivery Model:

Cambodia since 1980 has revised and reformed its health system several times, resulting in the establishment of the current healthcare system in 1996. The current healthcare system introduced a three tier structure with responsibilities allocated at central, province and district levels: 1) Central (top) level: consists of the Ministry of Health, national institutes, national hospitals, national programs and national training institutions, responsible for policies, legislation formulation and strategic planning; 2) Intermediate level: made up of provincial health departments and provincial hospitals, it serves as the linkage between central level and operational districts and is responsible for operationalizing national policies; and 3) Lower level: comprises operational districts (ODs), referral hospitals (RHs), health centers (HCs) and health posts (HPs)

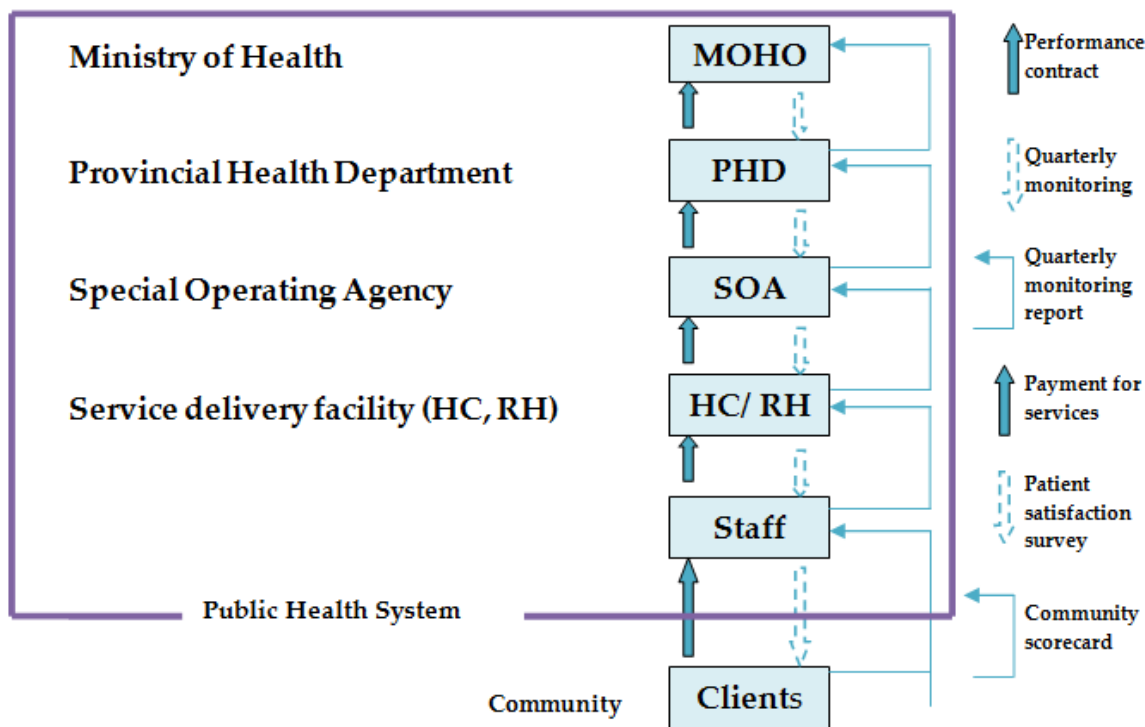
(MOH, 2008). Implemented within the health system are two services delivery models, each providing a package of health services through contracting: 1) Complementary Package of Activities (CPA) provides specialist services and treatment at RHs; and 2) Minimum Package of Activities (MPA) provides primary healthcare at HCs and HPs (MOH, 2008).

The objectives of the health service delivery strategy are decentralized administration delivery, enhanced quality in service delivery and management, advancement of viable public private partnerships in service provision, and greater community engagement. Center information sources seen as important for health service delivery include financial resources competent, healthcare staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines, and operational policies (Leang Supheap & Kannarath, 2014).

4.2 The Ministry of Health's Planning Agenda:

In 2001, the government initiated a process of political decentralization through two laws: the Law on the Administration and Management of Communes and the Law on Commune Elections; in addition, the 'Decentralization and De-concentration' (D&D) agenda is a key area of public policy reform and is expected to increase delegation of administrative functions and the resources from the central to sub national level (PeterLeslie Annear et al., 2015; WHO, 2014). To operationalize the Organic Law, the National Program for Sub-National Democratic Development was developed for the period 2010-2019, under the three tier health system, the MOH activities are administratively decentralized (de-concentrated) but with considerable upward accountability to central level and limited decision-making discretion at provincial and district levels (PeterLeslie Annear et al., 2015).

Figure 3. Contracting arrangements for Special Operating Agencies



Source: Asia Pacific Observatory on Health Systems and Policies

Figure 3 explained about Special Operating Agency (SOA) status was established as one part of the government's 2006 Policy on public service delivery (Council for Administrative Reform, 2006) as a means for providing greater management autonomy to district health and hospital managers through internal contracting arrangements and community monitoring; one implication of the national decentralization process is a possible move away from the health OD model and a return to the management of public healthcare delivery through the government's official Administrative Districts (PeterLeslie Annear et al., 2015). This thusly would require devolution of the obligation regarding health plans and budgets to health officials working at the Administrative District level (replacing the ODs), guaranteeing spread of health data to nearby authorities, and promoting community monitoring of health services.

The Ministry of Health has a strong record in planning and policy making dating back to the 1980s. The Ministry of Health launched the first Health Strategic Plan 2003-2007(HSP1) in collaboration with key stakeholders, including national and local authorities, national and international development partners and civil society organizations (MOH, 2002). Adoption of the second Health Strategic Plan 2008-2015 coincided with the finalization of the Cambodia Millennium Development Goals (MOH, 2008). This planning action has occurred through the Ministry of Health with support from donor partners in a domain of moderately low levels of public funding for healthcare and the lack of satisfactory, and satisfactorily trained, staff, so implementation is infrequently compiled.

4.3 Healthcare Policies:

The supporting objective is to improve equity and accessibility of basic health services, to ensure improved efficiency, affordable costs, and high quality services, to ensure the sustainability of MOH's functions, and to protect the poor. The policies of the government for the health sector hinge upon the following 9 priorities: 1) to provide basic health services, including family planning and reproductive health services, to all people with community participation; 2) to decentralize financial and administrative functions; 3) to develop human resources; 4) to foster competition among public and private sector basic on technology and professional ethics; 5) to promote people's awareness of a healthy lifestyle and the qualifications of health care providers; 6) to promote health legislation; 7) to pay special attention to women's and children' health and nutrition and to the control and prevention of communicable diseases; 8) to take into account specific priority groups such as the elderly and the disabled and specific health issues such as mental health; and 9) to strengthen the Health Information System (MOH, 2008; Theth, 2005).

These priorities are the goal of the Ministry of Health is to promote the health of the people so as to enable them to participate in the socio economic development of the country and to reduce poverty.

4.4 Healthcare Strategies:

In order to attain the objectives listed above. Ministry of Health has defined specific health strategies. These strategies hinge upon the following 13 aims: 1) promote women's and children's health through basic care service delivery for all women, including antenatal care, delivery and postnatal services, reproductive health services such as birth spacing, good nutrition, safe delivery , and personal and family hygiene practice, and through immunization and curative care coverage for children; 2) reduce the incidence of communicable diseases such as malaria, dengue fever, tuberculosis, diarrhea diseases, acute respiratory infection, and sexually transmitted diseases particularly HIV/AIDS; 3) improve coverage of public health service with good quality and efficiency for people; 4) upgrade the professional capacity of government health staff to ensure the effectiveness and efficiency of health system, through planning, revision of basic training, and expansion of continuing training to health staff on clinical technique and management; 5) to ensure supply of drugs, equipment and materials to the public sector, in conformity with actual needs of the system; 6) reinforce the full participation of the private sector in the delivery of health services to people by motivating and controlling the private sector to become a true partner of the Ministry of Health; 7) promote awareness

of the population about good infant and young child feeding and hygienic practices; 8) improve the ability of laws relating to health sector. Develop and strengthen laws and standards of medical services, food safety, cigarettes-drugs, business etc.; 9) upgrade health management through health system reform with a clear defined role at each level, appropriate decentralization, various standards trials of health financing schemes, aid coordination, planning, monitoring and evaluation; 10) upgrade policy development, survey studies and extension of the health information system. Participation of village level committees to identify the poor, who are the issued special exemption cards; 11) subsidized health insurance; 12) demand side financing methods, such as coupons or vouchers; and 13) equity funds, which would finance the cost of providing care to poor persons receiving exemptions, have been suggested as an appropriate solution to the problem of law incentives to provide good quality services for the poor (MOH, 2008; Theth, 2005).

These strategies concentrate on the parts and elements of the health system that must be expected to accomplish by the Ministry of Health, above all it part as steward for the whole health system. The strategy will reinforce MOH's capacity to practice initiative over all activities in the health, and it will enhance planning, accountability mechanisms and effective coordination for better connection assets to enhance health results.

5. The Challenge and Development in Healthcare Sector:

The important challenges related to health systems development are persisting high levels of out of pocket payments which account for more than 60% of the total health expenditures, and poor qualities of cares, particularly in rural and remote facilities. And the human resources for health, the key outstanding issues include health professional registration, the scaling up of the workforce to keep pace with population growth, and developing policies related to private sector service provision (WHO, 2014).

Overall health care system in Cambodia has seen noteworthy developments in all areas due to a great extent to the economic steadiness and proceeded supports from development partners. This relies on upon people's financial ability, service quality and additionally human and financial resources to support health service delivery (Cheng, 2013). As examined before, out of pocket by the family unit is the key source of health care expenditure use in Cambodia, but still around 20% of Cambodian people in total are living below the national poverty line (WHO & WPRO, 2008). Another policy implication in health care development in Cambodia to consider, the all-inclusive health coverage remains a huge assignment for policy-makers and requires multiple approaches. About all Cambodians have no health insurance and less than 1% is secured through employer based health insurance, privately purchased commercial health insurance (MOP, 2011).

In this context, in order to fulfill the crucial health care necessities of people, the Royal Government of Cambodia has to transform below policy missions into concrete achievements: 1) Effective mobilization and allocation of resources; 2) Strengthen the roles and functioning of hospital and health centers, especially among the public practitioners; 3) Restore the confidence and creditability of public health services among the population; and 4) Create facility's catchment zone to guarantee broader coverage for the population (Cheng, 2013; MOH, 2008).

6. Conclusion:

The healthcare system, principally like health coverage plan has been conducted to better provide service to people in public all through the nation. At present, health financing strategy in Cambodia employs mixed model of health financial sources that gathers public budget, restricted revenues from development partners and incomes from fee based service delivery. The government is still funding the public health sector as an appropriate allocation, while the financial supports from development partners will be consistent with national priority. Health Equity Funds is a pro-poor health financing mechanism that reimburses the full or partial cost of health service provided to the poor, and MOH aims to expand HEF to other vulnerable

population as well. To fully implement the Health Coverage plan, MOH makes a plan to expand the public health workforce, and the Health Workforce Strategic plan identifies major challenge be finalized in term of structure, size and composition of the future workforce, recruitment, employment and deployment, productivity and staff remuneration. The Government's objective is to strengthen equity and accessibility of basic health service, to ensure improved efficiency, affordable cost, and high quality service, to guarantee the sustainability of MOH's functions and to protect the poor. In any case, the planning process which in reality has driven with genuine health reforms has been basic to the accomplishments of major improvements in the health sector from the development of physical facilities to expand staffing and to implementation of effective health financing interventions.

References:

- Cheng, B. (2013). Health Care Policy in Cambodia. 1-13.
- David I Levine, & Gardner, R. (2008). Briefing paper: Health care in Cambodia (pp. 2-10). University of California, Berkeley.
- Godfrey, M., Sophal, C., Kato, T., Vou Piseth, L., Dorina, P., Saravy, T., . . . Sovannarith, S. (2002). Technical Assistance and Capacity Development in an Aid-dependent Economy: The Experience of Cambodia. *World Development*, 30(3), 355-373. doi: [http://dx.doi.org/10.1016/S0305-750X\(01\)00121-8](http://dx.doi.org/10.1016/S0305-750X(01)00121-8)
- Heng, M. B., & Key, P. J. (1995). Cambodian health in transition. *BMJ : British Medical Journal*, 311(7002), 435-437.
- Lanjouw, S., Macrae, J., & Zwi, A. B. (1999). Rehabilitating Health Services in Cambodia: The Challenge of Coordination in Chronic Political Emergencies. *Health Policy and Planning*, 14(3), 229-242. doi: 10.1093/heapol/14.3.229
- Leang Supheap, & Kannarath, C. (2014). Addressing the gaps in Health System Service Delivery in Cambodia (Vol. 6, pp. 1-6). Phnom Penh, Cambodia.
- MOH. (2002). *Health Strategic Plan 2003–2007– Accountability, Efficiency, Quality, Equity*. Phnom Penh, Cambodia: Ministry of Health.
- MOH. (2008). *Health Strategic Plan: 2008–2015 – Accountability, Efficiency, Quality, Equity*. Phnom Penh, Cambodia: Ministry of Health.
- MOH. (2014). *Measuring Health Expenditure in Cambodia: National Health Accounts Report 2012*. Phnom Penh, Cambodia: Ministry of Health.
- MOP. (2011). *Cambodia Demographic and Health Survey in 2010*. Phnom Penh, Cambodia: National Institute of Statistics, Ministry of Planning.
- PeterLeslie Annear, John Grundy, Por Ir, Bart Jacobs, Chean Men, Matthias Nachtnebel, . . . Ros, C. E. (2015). *The Kingdom of Cambodia Health System Review* (Vol. 5). Switzerland: World Health Organization.
- Theth, V. B. (2005). *Health Policies for the Poor in Cambodia*. Paper presented at the Healthcare for the poor Asia, Beijing, PRC.

WB. (2013). *Rebuilding Policy Buffers, Reinvigorating Growth*. Washington DC, US: World Bank.

WHO. (2014). *Health Profile: Cambodia*. Phnom Penh, Cambodia: World Health Organization.

WHO, & WPRO. (2008). *Country Health Information Profiles*. Manila, Philippine: World Health Organization: Regional Office for the Western Pacific.