

Increasing equity in health service access and financing: Health strategy, policy achievements and new challenges



Policy
Note

Cambodia Health Systems in Transition



Asia Pacific Observatory
on Health Systems and Policies

WPR/2016/DHS/009

© World Health Organization 2016

(on behalf of the Asia Pacific Observatory on Health Systems and Policies)

All rights reserved.

Photo by Philippe Berry, IFPRI, <http://www.usaid.gov>. Image was modified from original.

Increasing equity in health service access and financing: Health strategy, policy achievements and new challenges

Policy
Note

Cambodia Health Systems in Transition



Asia Pacific Observatory
on Health Systems and Policies

Acknowledgements

This policy note is based on a draft brief presented and discussed at the policy dialogue event in Cambodia on 9 October 2015. The event was sponsored by the Asia Pacific Observatory (APO), the Ministry of Health, the World Health Organization (WHO), the Nossal Institute for Global Health, and the German Development Cooperation through the Deutsche Gesellschaft für Internationale Zusammenarbeit.

The original brief drew on work completed during preparation of the Cambodia Health Systems in Transition (HiT) review (published in 2015 and available on the APO website at http://www.wpro.who.int/asia_pacific_observatory/en/) and the draft Cambodia Health Strategic Plan for 2016–2020. As such, the Cambodia HiT authors' indirect contribution to this Policy Note is acknowledged.

The policy note benefited from comments and suggestions from Dong-il Ahn, WHO representative to Cambodia, and Indrajit Hazarika and Ejiro Murakoshi, WHO Cambodia. Dale Huntington, APO Secretariat, is the managing editor of the Policy Notes.

Author

Peter Leslie Annear, Head of Health Systems Governance and Financing, Nossal Institute for Global Health at the University of Melbourne School of Population and Global Health, Australia

Lo Veasnakiry, Director, Department of Planning and Health Information, Ministry of Health, Cambodia

Momoe Takeuchi, Health Systems Development Advisor, WHO Cambodia



What are the challenges?



Economic and demographic change

With gross domestic product currently growing at more than 7% per annum, Cambodia is about to achieve lower-middle income status, and the health of its population has improved significantly. Since the 1990s, progress has been made in rebuilding the health system through an extended process of health reform. With improved conditions, the challenge is now to ensure the benefits of progress are shared equally by all parts of the population.

Cambodia has a young but ageing population. One third of the population is below 15 years of age, while falling fertility rates and increasing life expectancy mean the population structure is slowly ageing. A process of urbanization is under way, and the population of the capital, Phnom Penh, has more than doubled in the past 15 years.

A mixed public-private health system

The health system includes a mix of public and private providers. The use of private providers is much greater among the wealthy, while the use of informal-sector health providers is greater among the poor. Due to these circumstances there is considerable scope to establish appropriate public-private cooperation and to reinforce the regulatory mandate of the Ministry of Health (MOH).

Private practitioners and clinics are particularly frequented for curative care, while health prevention activities (such as immunization and tuberculosis, malaria and HIV/AIDS control) are the domain of the public sector. Only 23% of ill or injured patients seeking care first go to public sector providers; 64% use private and 13% use self-care, traditional healers and other providers.¹

Managing both public and private health services to meet health needs – including the needs of the poor – is central to health strategy and planning in the coming years. The remaining challenges include lifting the quality of health services (both public and private) and overcoming remaining health inequalities.

¹ Cambodia Socio-Economic Survey, 2014



What do we know?



Health status has improved, and the pattern of disease has changed

Cambodia is on track to achieve its Millennium Development Goal targets: life expectancy at birth reached 71.4 years in 2012; the maternal mortality ratio decreased to 170 deaths per 100 000 live births in 2014;² and infant and under-five mortality rates decreased to 28 deaths and 35 deaths per 1000 live births respectively in 2014.³ Due to demographic and economic change, noncommunicable diseases now account for as many deaths as infectious diseases.

Achieving equity has been a central health goal

Over the past five years, the national budget for health has almost doubled in real terms, and there has been impressive progress in providing financial risk protection for the poor. There is ongoing discussion about the long-term vision of establishing a broad national social security system. The MOH will play an important role in this process, especially in strengthening social health protection, not only for the poor but also for other vulnerable populations.

In recent years, the expansion of Health Equity Fund (HEF) schemes has been rapid. District-based HEFs now cover most public health facilities nationally. Studies suggest that HEFs have led to a significant reduction in out-of-pocket (OOP) health expenditure among the poor. A recent analysis of data from the Cambodia Socio-Economic Survey for the period 2004–2009 revealed that HEFs and vouchers both acted to reduce household health spending.⁴

Nonetheless, patient OOP payments still make up more than 60% of total health expenditure.⁵ With the new Health Strategic Plan for 2016–2020 setting a direction towards the goal of universal health coverage, an opportunity exists to reduce the high burden of OOP health expenditure on households by giving greater attention to sound investment in a sustainable social health protection system for all.

A number of other demand-side financing schemes also provide some degree of social health protection, including voucher schemes and voluntary community-based health insurance. Consolidating these public schemes together with the HEFs, as well as the National Social Security Fund (NSSF) and the NSSF for Civil Servants (NSSF-CS), and expanding the coverage to include

² Cambodia Demographic and Health Survey, 2014

³ *ibid*

⁴ Chhim Chhun et al., Working Paper Series No. 106, September 2015, CDRI and the ReBUILD consortium

⁵ Cambodia National Health Accounts, 2012



the so-called “missing middle”, or non-poor informal sector, will be another step towards universal coverage. This step is key to policy development in the next period.

Despite progress, inequalities remain

Overall, access to health services has improved, as indicated by the following Socio-Economic Survey data:⁶

- The proportion of ill individuals seeking care from health-care providers has increased, with a greater increase among the lowest two income quintiles.
- Use of reproductive and maternal and child health services has increased.
- Capacity to pay has increased, while catastrophic health expenditure across all income quintiles has declined.
- Levels of OOP spending, catastrophic expenditure and health-related indebtedness among HEF beneficiaries have decreased.

While catastrophic expenditure and health spending as a proportion of income have both declined, OOP payments for health care are the largest part of household non-food expenditure, and are among the highest in the Asia Pacific region. Furthermore, poor Cambodians make less use of public- and private-sector services and outpatient treatments than the rich.

⁶ Cambodia Socio-Economic Survey, 2009 (analysis report); also Cambodia Demographic and Health Survey, 2011

Health outcomes still exhibit an urban-rural and rich-poor differential. Maternal and child health outcomes vary according to socioeconomic status and geographic location: the fertility rate for women in the poorest quintile is twice that for the richest quintile; children in the poorest quintile have a more-than-threefold risk of death before their fifth birthday than those in the richest quintile; stunting is more than twice as common among children in the poorest quintile than those in the richest.

Rising demand requires better quality of care

Since the 1990s, health infrastructure has improved through the Health Coverage Plan. HEFs were established in 2000, and have since grown to national coverage. The successful expansion of health facilities, increased demand from HEF beneficiaries and others, and relatively low levels of utilization of public facilities all draw attention to the need to improve quality of care and remove the barriers that remain in accessing health services.

In the public sector, this means giving increased attention to funding, management processes and staff incentives. In the private sector, it poses the immediate need for extended regulation, accreditation and enforcement.



The MOH responded to this concern by establishing a Quality Assurance Office in 2007 (following adoption of the National Policy for Quality in Health in 2005) and commencing facility-based quality assessment processes: level 1 assessment in 2007; level 2 assessment in 2014. Improvements have been made, especially in the delivery of maternal and child health care following implementation of the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality, which provided increased coverage of skilled birth attendance and other safe motherhood services. However, the quality of public health care is often limited by the poor condition of facilities, low numbers of staff and lack of staff motivation.

Recent health reforms have focused further attention on strengthening the MOH's capacity to manage health service delivery. In support of the Government's broader public administrative reform, the major areas of reform include expanding the coverage of basic health services, providing improved financial access in the public sector, and improving the efficiency of health service management at district level. Special Operating Agencies were introduced in 2009, using an internal contracting mechanism between MOH units, to provide greater management flexibility, increased staff incentives and more efficient service delivery. Evaluating the impact of these Special Operating Agencies is a priority.



What needs to be done?



Coordination with private providers

Five laws cover the health sector: (i) the 1996 Law on the Management of Pharmaceuticals; (ii) the 1997 Law on Abortion; (iii) the 2000 Law on the Management of Private Medical, Paramedical and Medical Aid Services; (iv) the 2002 Law on the Prevention and Control of HIV/AIDS; and (v) the 2015 Law on Tobacco Product Control.

For most of the population, the growing but insufficiently regulated private sector is the first point of contact. Private providers are mainly small practices, drug shops and single-person practices. Private pharmacists are a common but sometimes inadequate source of self-medication. Most private providers with formal training are simultaneously public employees (dual practice).

While a licensing system exists for medical practitioners and pharmacists, the capacity to achieve compliance is limited. The registration of all private medical and paramedical facilities was made compulsory under the 2000 law. The key to achieving the best health outcomes from the growing private sector is to improve the MOH's ability to monitor providers and enforce regulations. A new Law on the Regulation of Health Practitioners, which was developed by the MOH in consultation with the health

professional councils in 2015, is expected to further support enforcement of the regulations.

Policy issues and challenges

Achieving greater equity of access and sharing the benefits of an improved health-care system are the MOH's key aims for the coming period, as reflected in the draft Health Strategic Plan for 2016–2020. Meeting these objectives in the new phase of health-system reform means adopting an approach that combines the advances made in providing access to care for the poor with the improvements in quality of care delivered within the broader health system. The MOH is well-placed to improve the quality of service delivery by further strengthening supply-side mechanisms, while also achieving greater equity in the distribution of health services by further strengthening demand-side financing mechanisms.

To achieve these aims, the new Health Strategic Plan for 2016–2020 will focus on:

- consolidating the HEFs and other demand-side financing schemes nationally;
- progressively expanding schemes to provide social health protection to other vulnerable populations, including the informal sector;



-
- cooperating with the NSSF and NSSF-CS to bring about the unification of social health protection mechanisms;
 - continuing to work towards more efficient and effective pre-service education and training of health professionals, and to improve staff motivation through appropriate incentive mechanisms (both fiduciary and non-fiduciary); and
 - strengthening the MOH's capacity to cooperate with private providers and enforce regulations in a way that produces better outcomes across the mixed health system as a whole.

The path to universal health coverage lies in consolidating, under government control, the social health protection schemes for the poor, the non-poor informal sector and the employed, built on the firm foundation of HEFs and other existing schemes. The social health protection system is an integral part of the national social security system, which is being established for both formal- and informal-sector populations, and must be supported by stronger regulation of the health-care market and measures to improve the quality of health care. Combining the current achievements with a renewed effort to improve the quality of service delivery will provide the best pathway to improving health outcomes and equity of access to services.



