



# ADDRESSING THE GAPS IN HEALTH SYSTEM SERVICES DELIVERY IN CAMBODIA



By Leang Supheap and Chheng Kannarath

## 1. Introduction

Cambodia since 1980 has revised and reformed its health system several times, resulting in the establishment of the current healthcare system in 1996. This latest reform 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 programmes 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 operationalising national policies.
- 3. Lower level:** comprises operational districts (ODs), referral hospitals (RHs), health centres (HCs) and health posts (HPs).

Public health services are provided through a national network comprising eight national hospitals, 77 ODs, 79 RHs, 1029 HCs and 77 HPs (Sann and Lo 2006; 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; 2) Minimum Package of Activities (MPA) provides primary healthcare at HCs and HPs.

As one of the five strategic areas of the Health Strategic Plan 2008-15 (HSSP2), health system service delivery “... supports the key output of the public and private health sector and is the means through which the ultimate outcomes of the HSSP2 will be achieved” (MOH 2008: 30). The goals of the health service delivery strategy are decentralised service delivery, improved quality in service delivery and management, promotion of effective public-private partnerships in service provision, and greater community engagement. Core inputs seen as necessary 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.

This paper focuses on current research and suggests future directions for research that can help improve the organisation and quality of health service delivery in Cambodia.

## 2. Overview of Health Service Delivery

All five strategic areas of HSSP2 are designed to support health service delivery through strengthening both the public and private health sectors so that ultimately all communities have access to full MPA and CPA services and to licensed and accredited private sector providers (NIPH 2012).

Since the health system was founded in 1996, several initiatives have been taken to improve access to essential public health services, particularly maternal health services. Health

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financing innovations such as contracting health equity funds (HEFs), vouchers, community-based health insurance (CBHI) and the government midwifery incentive scheme (GMIS) are considered necessary to increase access to maternal health services, thereby improving maternal and infant health.

Contracting has been developed as a supply-side strategy to improve the performance of public health facilities. Two contracting arrangements – outsourcing the management of ODs to international organisations (performance-based contracting), and making better use of the existing government structure (performance-based financing) – were initially implemented in seven ODs in 1999, and then gradually expanded to 19 ODs by the end of 2005. In both arrangements, the contracted health facilities received financial incentives related to certain processes and output indicators. Contracting proved to be effective in tackling the problem of low salaries and poor motivation of public health personnel through performance-based incentives, thus improving the efficiency, quality and use of health facilities (Loevinsohn and Harding 2005; Soeters and Griffiths 2003).

The Health Equity Fund (HEF) is a financing mechanism to promote better access by the poor to essential public health services. The management of the funds is entrusted to a third party, usually a local NGO, which operates independently of the health facility. “HEF beneficiaries are identified according to eligibility criteria either at the community before healthcare demand (pre-identification) or at the health facility through interviews (post-identification). At the health facility, the eligible poor patients get full or partial HEF support for the cost of user fees, transportation cost, food allowance and other costs”. (MOH 2011: 1).

Since the first pilots in 2000, HEFs have been gradually expanded nationwide to 44 ODs in 23 provinces and Phnom Penh municipality (including 42 referral hospitals and 323 health centres), covering about 78 percent of the population living below the poverty line (MOH 2011 cited in Ahmed and Annear 2012:

2-3). Available evidence suggests that HEFs effectively remove financial barriers to accessing public health services, especially for the poor, and reduce out-of-pocket health expenditures (Bigdeli and Annear 2009; Noirhomme et al. 2007). In addition, the government funds its own subsidy scheme (a type of HEF), which is used to reimburse to public health facilities user fees exempted for the poor. As of 2010, the scheme was operating in six national hospitals, 10 referral hospitals and 89 health centres in 10 ODs (MOH 2011). A recent evaluation of the efficacy of such subsidy schemes reveals that they have helped to improve access to health services (Chean et al. 2011).

Vouchers are a demand-side financing mechanism to stimulate demand for under-used services/products through which subsidies go directly to the consumer in the form of a voucher or token that the consumer redeems when demanding the services/products from a provider. (Sandiford et al. 2005 cited in Riggs-Perla et al. 2011: 6). Introduced by Belgium Technical Cooperation (BTC), vouchers have been available since early 2007 in three rural ODs in Kampong Cham province – Cheung Prey, Chamkar Leu and Prey Chhor. These vouchers are “...an extension of HEFs targeting poor pregnant women for delivery and associated services, including support for transport and referral services in case of complications” (Riggs-Perla et al. 2011: 6). A comprehensive assessment of the scheme found that vouchers especially when implemented with HEFs improved access for poor pregnant women to safe delivery (Ir et al. 2010). In addition, another type of voucher, which entitles pregnant women to a package of services (four antenatal care visits, delivery attended by skilled birth attendants, one postnatal check up 24 hours after delivery) can be purchased from health centres at the cost of USD10 per patient regardless of socio-economic status. This voucher does not cover transportation costs and referral fees at the hospital, however. In 2011, vouchers for reproductive and maternal health services, which also target only poor women, were launched in another nine ODs.

Despite the significant increase in the availability of healthcare over the last decade, the utilisation of many public health facilities remains low. The Cambodian Demographic and Health Survey (CDHS 2010) shows that only 26 percent of the total population used public health services, whereas others used formal and informal private sector health services, which often are of unreliable quality and unnecessarily expensive. Such health-seeking behaviour, coupled with the private sector's growing involvement in healthcare provision, is of particular concern and emphasises the need to update and strengthen the current inadequate regulation of pharmaceutical and private health service facilities (NIPH 2012: 23).

## 2.1 Research on Health System Service Delivery

### 2.1.1 Strengths in Current Research

Recent assessment of the barriers afflicting Cambodia's healthcare system highlights the critical need to ensure that strategies to promote health service delivery consider the location-specific factors affecting sustained use of health services and improved health system delivery (Jacobs et al. 2012). Geographical remoteness, access to available and affordable transport, poor quality feeder roads, as well as health service availability, affordability and quality, especially in remote and sparsely populated areas, are the major barriers to accessing healthcare services. Study findings led to the development of an analytical framework for selecting appropriate interventions to improve health service delivery, which was subsequently used for two case studies in Cambodia (Jacobs et al. 2012). The results of those case studies suggest the need for combined interventions and location-specific service delivery planning to tackle specific access barriers: there is "no one size fits all" solution. This analytical framework can be used both to evaluate the effectiveness of healthcare system interventions and to guide research on access to healthcare (Jacobs et al. 2012).

The most significant research so far involves the exploration of health financing including the financial barriers that prevent the poor from

accessing available healthcare services (NIPH 2012:24). The nationwide introduction of the government midwifery incentive scheme (GMIS) together with other efforts to remove supply and demand barriers to essential maternal health services led to a considerable improvement in public health facilities coupled with a steep rise in demand for services in public health facilities and a corresponding substantial increase in institutional and assisted deliveries. After a decade of concerted efforts to strengthen the public health system to supply essential reproductive and maternal healthcare services and address wider social and economic barriers to accessing maternal health services, GMIS resulted in a significant reduction in maternal mortality. Other interventions also contributed to this marked change, including rapid expansion of midwifery clinics and antenatal care at health centres; promotion of the continuum of care across maternal, newborn and child healthcare; improvement of the referral system; provision of "birth waiting rooms" at public health centres in rural areas; and expansion of contracting/special operating agencies, health equity funds, vouchers and community-based health insurance (Ir and Chheng 2012).

### 2.1.2 Gaps in Current Research

Health-seeking behaviour, especially the choice of private or public healthcare providers, is an area that is not well understood. This is of particular importance because the majority are much more likely to seek healthcare in the private sector, where exorbitant medical bills are often the cause of high levels of household indebtedness (NIPH 2012). Informal providers are often the first point of contact for rural people seeking health treatment. The direct relationship between poverty and illness is not just one-way. Not only do issues of affordability and accessibility prevent poor people from accessing services, catastrophic healthcare costs and/or delayed treatment force households into poverty or push impoverished households even deeper into poverty. Healthcare costs are most commonly financed through out-of-pocket payments in both public and private healthcare facilities. In order to fund healthcare

expenditure, people often take out loans or obtain credit from the healthcare provider. “Catastrophic health expenditure is mainly incurred when using unregulated private practices, for the most part for unnecessary treatment” (Van Damme et al. 2001).

Rational use of drugs, i.e. medicines management and delivery, has been increasingly recognised as a significant indicator to monitor the quality and efficiency of healthcare provision. The prescribing behaviour of healthcare providers plays an important role in poverty alleviation policy in developing countries like Cambodia, where out-of-pocket payments share a high proportion of healthcare expenditure. A recent study on the relationship between illness and poverty in Cambodia found a statistically significant difference in the number of drugs per prescription between public and private health facilities ( $p=0.002$ ) (Chheng et al. 2010). In the treatment of pneumonia, for instance, practitioners working in public facilities prescribed an average of 3 different drugs per patient, while those in private facilities prescribed 4.3 drugs. Moreover, although most of the healthcare professionals concerned were working in both public and private health facilities, their practices were inconsistent. This implies considerable variation in practices and standard of care among healthcare professionals. Healthcare practitioners working in public health facilities are bound by policy or guidelines, while those working in private facilities can practice more freely (Chheng et al. 2010).

Financial factors aside, study on decision making when seeking treatment has been very limited (Jalilian and Sen 2011). A study of dengue-related health-seeking behaviours conducted in Siem Reap province found that biomedical and traditional treatments were sought based on both financial accessibility and perceptions of the quality of primary healthcare services (Khun and Manderson 2007). The financial cost is only one of several factors taken into consideration in the decision to seek treatment for suspected dengue infection. The message from medical providers has not replaced traditional knowledge about disease and treatment; people still act based on traditional

understanding. Health promotion and education must be appropriate to the local context and the health issues facing local communities to ensure that such efforts are effective. Research on health-seeking behaviour would produce meaningful understanding of community perspectives, knowledge, attitude and practices to guide the development of easy-to-understand material, which would improve the effectiveness and reach of health education messages (NIPH 2012).

Global health institutions have focused on disease-specific interventions. Evaluation of the appropriateness of health service delivery could be incorporated into a customised holistic approach to healthcare services, making healthcare more responsive to needs (Marchal et al. 2009). Despite the positive contribution of disease-specific programmes to much needed service delivery, they could also have negative consequences for the overall health system. In Cambodia, however, the gradual integration of specific programmes into basic services has helped to improve overall health service delivery. But if these programmes are to succeed, strategic effort must be made to ensure that disease-specific interventions are appropriate to the local context (NIPH 2012: 27).

### 3. Conclusion

Coordination of all service delivery sectors within the MOH would support health system management at all three levels. Even so, significant challenges remain “the slow growth in public service utilisation; the overall low quality of care in both public and private sectors; significant fragmentation of service delivery, funding and administrative authority; ineffective regulation and weak coordination between public and private services; and geographical barriers that include a lack of knowledge about services in remote areas” (Char 2008 cited in NIPH 2012: 23).

In general, there is growing demand for health services in Cambodia, yet there is scant empirical research on how health service delivery can be scaled up to meet that demand. There are several studies on health service delivery, but research to advance knowledge of healthcare-seeking behaviour remains limited. Importantly, such

knowledge is of little value unless local social, economic and geographical contexts are taken into account.

Establishing meaningful research agenda that will translate information and knowledge into policy is crucial to having an effective and well functioning healthcare system. Only with sufficient evidence of the best practices in health policy and programme reform will Cambodia's health system improve. Future research, therefore, must concentrate on knowledge transfer within the social, economic and policy spheres (NIPH 2012: 29-30).

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The DRF vision is of a high capacity, professional and vibrant Cambodian development research community. Its goal is to support and strengthen the capacity of the Cambodian development research community.

The DRF partnership involves the Cambodia Development Resource Institute (CDRI), Cambodian Economic Association (CEA), Learning Institute (LI), National Institute of Public Health (NIPH), Royal University of Agriculture (RUA), Royal University of Phnom Penh (RUPP), Supreme National Economic Council (SNEC) and the International Development Research Centre (IDRC).

In DRF Phase II 2012-15, with financial support from IDRC, the partners intend to work together to build research culture and capacity and to share research knowledge through workshops, policy roundtables and symposiums as well as training and online discussion ([www.drforcambodia.net](http://www.drforcambodia.net)) on six research themes: growth and inclusiveness, governance of natural resources, social policy – education, social policy – health, agricultural development, and Cambodia and its region.

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