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Theme: The Role of Public Administration in Building a Harmonious Society

WORKSHOP ON HEALTH CARE FOR THE POOR IN ASIA

Health Policies for the Poor in Cambodia

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The public health system of Cambodia is among the poorest in the region and has suffered from war and chronic under funding and is having a more difficulties to meet the health needs of the population. A dangerous communicable diseases result in high mortality rates among poorest children and adults. Progress has been made to revitalize the health system and to break the vicious cycle of ill health, debt, and poverty that economically cripples Cambodian families and retards the country’s development. However in last decades, considerable further effort is needed to improve access to health services of improving quality. To reach this end, the policy of Health Ministry is formulating a master plan linking health sector reform with the broader fiscal and administrative reforms.

1. History of Health Sector Progress

After 1979, only less than 50 doctors survived with 1,000 doctors trained prior to 1975. Medical infrastructures were destroyed also. From 1979, the restoration of a functioning health care system became one of the priorities of the governments until now. In 1980s decade was the reconstruction and rehabilitation with many health workers being trained through accelerated training courses of varying quality. But the quality of the services provided was poor. Only UNICEF was active in Cambodia at that time.

From 1993 general election in Cambodia, authority and responsibility for program development and budgetary control for local health units were transferred from the local governors to the Ministry of Health. From that time, the preparation started on the basic legislation on key organizations in the sector and regulations for the management of pharmaceuticals. These various provisions were passed into law between 1995 and 1998. Also during the 1990s, medical staff needing to complement their government pay of $ 10-20 began opening private practices.

2. Financial Resources and Fiscal Reform

According to the report of Ministry of Health overall health sector expenditure was equivalent to about 12 percent of GDP in 1996-97. Out-of-pocket household expenditures accounted for 82 percent of this expenditure, the government for 4 percent and official donor assistance and direct funding by NGOs for 14 percent. Approximately 90 international and national NGOs are currently working in the health sector some funded by aid donors and some financing their own activities.

In 1999, the government allocated 6.6 percent of its total expenditure to public health services, or just 0.63 percent of GDP. This represents half of Southeast Asia and Pacific regional country overage of 1.3 percent. Although Ministry of Health expenditure has risen in recent years, its contribution per capita remains low at $ 1.70 per person, slightly lower than the $ 1.80 per capita expended in the mid-1990s. In addition, there are wide inter-provincial variations in government budget access, and budget releases remain irregular, under mining the new planning and management structures put in place by the reforms. The cost for a provider to deliver services from an already established health facility, estimated at $ 2.40 per Capita per year, is 30 percent higher than what do the Ministry of health is currently allocating. Increasing health expenditures is imperative.

The report of Ministry of Health analyzes that the burden of health costs weighs heavily on the population, especially the poorest. A 1996 breakdown of funding sources of health expenditures shows that households are by far the greatest contributors to health expenditures, with 82 percent of total. At $ 33 per capita, the level of individual health expenditures is almost 20 times, more than that provided by the public health budget. It is also considerably higher than in other parts of the world, including the Southeast Asian Pacific Region. In relative terms, the poorest strata of society spend the largest proportion of their income on health expenditures (28 percent), making health care expenditure a major source of dept, landlessness and further poverty. On average, a single inpatient visit to a public hospital was estimated to cost 109 percent of non-food expenditures in 1997. Much of this expenditure is not used for improving the quality of care. Medical costs constitute the third largest item of the household’s budgets after food and housing utilities. The rapid uncontrolled growth of the private sector over the last ten years
has frequently diverted patients from public facilities to the staffs' own private practices. The public sector is currently utilized in less than on-fourth of all illness or injury cases.

3. Access and Utilization of Health Services

Since the 1996 Health Coverage Plan the health system has been divided into three levels: central, provincial and operational district. The health infrastructure is still being developed and the reach of the public health system remains limited. In 2000, 55 percent of the population had geographic access to primary-level public health facilities, that is, about half the population lived within a 10kilometer radius or a two-hour walk of a health center. Approximately three-quarters of the primary level facilities receive the drugs necessary to provide a Minimal Package of Activities. Referral services are still in a stage of development and while 92 percent of the provincial Referral Hospitals receive the special package of drugs necessary for performing major surgical procedures, only around 30 percent can provide surgical care. The number of hospital beds per thousand inhabitants (0.96) remains low in comparison to neighboring countries, and their distribution nationwide is uneven.

Utilization of public health services on a national scale is very low as most people first seek care in the private sector when ill. According to the Cambodia Socio-Economic Survey 1999, the percentage of persons with illnesses who had sought treatment from public health institutions was 24 percent nationally, down from 31 percent in 1997. The increase in private health providers during the inter-survey period presumably contributed to the reported decline. In 1998 about 14 percent of all illness or injuries received no treatment with the rate of non-treatment twice as high among rural inhabitants. The poorest segment of the population is more than four times more likely than the most affluent to forgo treatment altogether. The curative care utilization rate also vary widely among provinces. However, an encouraging trend may be seen in the facilities developed in line with Health Coverage plan, which show higher utilization of reproductive health care and immunization activities than other types of primary level public facilities.

Immunization coverage of children under the age of one was 50 percent in 1998, with children in urban areas and whose mother has had secondary or higher education more likely to have completed the vaccination schedule than other children. Also a higher percentage of male children are completely vaccinated than female children. Service coverage for pregnant women was found to be low, with 23 percent of pregnant women receiving services are available from both the public and private health sectors, the contraceptive prevalence rate remains very low (16 percent) compared with other countries in the region.

4. Human Resources

The reform process created the development of human resources within the health sector. At the end of 1998, there were 23,434 health workers employed by Ministry of Health at all level. The population-to-physician ratio is higher in Cambodia, but the nurses to physician ratio is lower and, overall there is a lack of midwives, especially at Health Center level. Health personnel are poorly distributed to meet the health requirements of the population. Fully 63 percent of all the doctors and medical assistants are found in Phnom Penh and provincial towns, leaving remote areas critically under-served. The ratio of population to government doctor, which is 1.280 in Phnom Penh, Varies from 2.545 to 4.777 in the other urban areas, and from 5. 405 to 72, 089 in the provinces. This imbalance is in large part due to inadequate salaries, which make government staff favor urban placements where private practices can be established to supplement a public worker's income. Hardship and supplementary allowances have failed to mitigate this urban bias.

A substantial proportion of the current health staff was trained during the 1980s, when the urgent need to bridge the gap in human resources led to the organization of poor quality crash-course training with a focus on curative care. As a result, the public health services still suffer from inadequate technical and managerial capacity to respond to the recently reformed health care delivery system. In addition, public health workers salaries are totally inadequate to meet the basic cost of living, which causes poor staff motivation, supervision difficulties, and unofficial patient charges. This undermines the overall
efficiency and equity of the system and slows downs progress toward implementation of health sector reforms as a whole.

The first Health Workforce Development Plan provided a framework for the training and employment of health personnel over the period 1996-2005. Current staff numbers are currently deemed sufficient for the implementation of the Health Coverage Plan, with the exception of midwives. The most urgent training program priority is the upgrading of the essential skills of currently employed health workers through in-service training.

5. The Health Status of Cambodian

Although the health status of Cambodia’s population remains among the lowest in this region, some recent improvement in morbidity rates have been occurring. Government policies aim at improving health. The delivery of health services is of course one way to achieve better health and well-being.

5.1 Mother and Child Health

Early childhood mortality was very high during the period of war, dropped considerably during the following 1980-1990 decades. The infant Mortality Rate, a clear indicator of the quality of life for births by the 1998 compare with the average IMR for the Western Pacific Region is 38 per 1000.

The nutritional status of children is not satisfactory. The World Food Program has estimated that the country’s nutritional status remains one of the worst in Asia after Afghanistan and the Democratic Republic of Korea. In 1996, 49 percent of the children aged 0 to 59 months were found to be moderately or severely underweight. Girls are better nourished than boys, but the rural poor experience twice as much malnutrition and mortality as the urban rich. The prevalence of anemia, both among children and pregnant women, is considerably higher than in other countries of the region. Maternal mortality is high, with 473 deaths per 100,000 live births, reflecting the under-development of the health system and the poor access of pregnant women to essential obstetric services. High fertility also contributes to high mortality.

5.2 Infections Diseases

The main health problems of health center outpatient consultations were acute respiratory infection. Among inpatients at public health facilities, major health problems included Tuberculosis (16 percent of all cases), malaria (14 percent) and Acute Respiratory Infection (10 percent). Road accidents came in fourth position, affecting 5 percent of inpatients. Diarrhea disease and Acute Respiratory Infection are the main causes of mortality in children under five years.


6.1 The Ministry of Health’s Planning Agenda

Government health services face the dual challenge of improving both their efficiency and their equity. The Ministry of Health has laid out a broad agenda of activities and designed a sequence of steps to be carried out over the next 18 moths in order to provide a blueprint for the shape and role of Cambodia’s health services in the future. It has laid out the structure of the consultative process that will result in the intended outputs a National Health Sector Strategy and a National Health Master Plan for 2001-2005.

- The National Health Sector Strategy, to be developed in 2001, will set out the sector’s main objectives and the means by which they will be achieved specifying the respective roles to be played by the Ministry of Health and by public and private sector providers.
- The National Health Master Plan for 2001-2005 will be developed during the second half of 2001. It will indicate activities for implementation within the agreed upon time frame of July 2002-June 2006.
The National Health Policy and Strategies and the National Health Master Plan will be informed by Health Sector Expenditure Projections (or medium term expenditure framework), which will assess the financial resources both needed and available for funding priority health services. It will provide indicative budget ceilings for operations.

The overall process involving the three steps described above is planned to be an iterative agenda, with ongoing reviews and analyzes feeding into the different stages of development and refinement throughout 2000-2002.

6.2 Health Policies

The goal of 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. 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 Ministry of Health functions, and to protect the poor. The policies of the government for the health sector hinge upon the following 9 priorities:

- To provide basic health services, including family planning and reproductive health services, to all people with community participation.
- To decentralize financial and administrative functions
- To develop human resources
- To foster competition among public and private sector based on technology and professional ethics.
- To promote people's awareness of a healthy lifestyle and the qualifications of health care providers
- To promote health legislation
- To pay special attention to women's and children's health and nutrition and to the control and prevention of communicable diseases.
- To take into account specific priority groups such as the elderly and the disabled and specific health issues such as mental health.
- To strengthen the Health Information System

6.3 Health Strategies

In order to achieve the objectives listed above, Ministry of Health has defined specific health strategies. These aim to:

- 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.
- Reduce the incidence of communicable diseases such as malaria, dengue fever, tuberculosis, diarrhea diseases, acute respiratory infection, and sexually transmitted diseases particularly HIV/AIDS.
- Improve coverage of public health service with good quality and efficiency for people.
- 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.
- To ensure supply of drugs, equipment and materials to the public sector, in conformity with actual needs of the system.
- 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.
- Promote awareness of the population about good infant and young child feeding and hygienic practices.
- Improve the ability of laws relating to health sector. Develop and strengthen laws and standards of medical services, food safety, cigarettes-drugs, business etc.
- 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.
- 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.
- Subsidized health insurance.
- Demand-side financing methods, such as coupons or vouchers.
- 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. Health insurance for catastrophic medical costs, on the other hand, has been judged as having more potential for poverty prevention than for poverty alleviation.

6.3 Ministry of Health Public Investment Problem

The public Investment Program (PIP) for health sector totals $325.6million for the period 2001-2003, representing 19.7 percent of total PIP allocation. Of this amount, $319.6 million will be administered by Ministry of Health. The largest allocation is for the strengthening of the health services (40 percent of the Ministry total) and the rehabilitation of the national hospitals (almost 20 percent).

A great effort made by Cambodian government on last decade for harmonizing the Health policy development in Cambodia to the poor.