Cambodia is no longer a country emerging from conflict. The extended period of relative political stability in the wake of the 1998 election has provided a basis for significant and consistent economic growth. With gross domestic product (GDP) currently growing at more than 7% per annum, Cambodia is about to cross the line between low-income and lower middle-income status. Since the 1980s, the government has pursued a national policy based on strengthening the economy, and under these conditions the health of the population has improved significantly.

Significant gains have also been made in the rebuilding of the health system through an extended process of health reform beginning in the 1990s. Nonetheless, the emphasis placed on economic growth has not been fully reflected in government support to the development of the social sectors, including health care. One consequence has been the rapid growth of a disparate and loosely regulated but extensive sector of private health-care providers which now deliver the majority of curative health services.

The long process of health reform in Cambodia has lessons to offer other developing countries. The national health system was rebuilt anew following the destruction wrought by the Khmer Rouge regime of the 1970s and a decade of international isolation. A number of innovative interventions have been implemented – some successfully, others less so – on both supply and demand sides. Scaling up of successful programmes is now on the agenda. While there have been tremendous improvements in health-system performance, reflected in substantial health gains, in comparison with other countries in the region, there is still much room for improvement. The remaining challenges include the low quality of health services (public and private), and persistent health inequities.

Health system context

A period of demographic and health transition has begun. Located on the Indo-China Peninsula, with a growing population of approximately 14 million people, Cambodia has a young but ageing population, with a
third currently under 15 years of age. Falling fertility rates and increasing life expectancy mean the population structure is slowly ageing. More than 90% are of Khmer ethnicity, with minorities including Chinese, Vietnamese, Cham and highland people. The national literacy rate remains relatively low, with illiteracy concentrated mostly in poor, rural and remote populations. Buddhism is the national religion. A process of urbanization is under way, and the population of the capital, Phnom Penh, has more than doubled since 1980.

**Economically, Cambodia is about to become a lower middle-income country.** GDP per capita reached US$ 944 in 2012 (lower middle-income status is achieved at a level of US$ 1035). GDP has grown at an average of 7% per annum since 1995 (World Bank, 2014a). Within a dual-currency economy the United States dollar and the national currency, the Reil, both circulate freely, leaving the country open to foreign pressures.

**Economic growth has been accompanied by a significant reduction in national poverty rates.** The proportion of people living below the national poverty line fell from 50% in 2004 to 20% in 2011. However, the gains have not been equitably distributed. While incomes in urban areas have grown rapidly, life in rural areas remains largely based on subsistence rice production. The Gini-index increased from 38.3 in 1994 to 44.4 in 2007 and returned to 36.0 in 2009 (World Bank, 2014a).

**Constitutional democracy has been established.** Not long after independence was gained from France in 1953 secret United States of America bombing of the eastern provinces occurred during the United States’ war in Viet Nam to hit supply lines for the Vietcong. A United States-supported coup d’état in 1970 brought down the government of King Norodom Sihanouk and installed an unstable republican regime, which was ousted by the Khmer Rouge. Between 1975 and 1979, cities were abandoned, the economy destroyed, intellectuals killed and the traditional elements of Cambodian life destroyed, resulting in the deaths of 1.7 million people or 21% of the population. International isolation continued until 1989 following the fall of the Khmer Rouge. United Nations-sponsored national elections in 1993 opened the country to international cooperation, producing a flood of development agencies and nongovernmental organizations (NGOs) into Cambodia. Multiparty national elections have followed in 1998, 2003, 2008 and 2013.

**Health status has substantially improved since 1993.** Mortality rates significantly dropped and life expectancy at birth was 62.5 years in 2010,
a 1.6-fold increase from 1980. Noncommunicable diseases (NCDs) are rising and are now estimated to account for an equal number of deaths as infectious diseases. Inequities in health outcomes, such as urban–rural or by socioeconomic status, however, persist and health outcomes are not yet as good as in other countries of the region.

**Organization and governance**

The **Ministry of Health (MOH) is the leading force in health-system planning and development.** Following the 1993 national elections, the government depended largely on official development assistance provided by a wide range of multi- and bilateral donors and channelled mainly through a plethora of international NGOs. Since the start of major structural and organizational reform in the mid-1990s, the MOH has increasingly assumed the leading role in health-system development, in partnership with the development agencies, organizing policy implementation through its three General Directorates for Health (Health, Administration and Finance, and Inspection).

**The MOH is solely responsible for the organization and delivery of government health services.** The Directorate General for Health oversees health service delivery through 24 MOH Provincial Health Departments (PHDs) comprising 81 health Operational Districts (ODs), distributed according to population. Each PHD operates a provincial hospital and governs ODs. Each OD covers 100 000–200 000 people with a Referral Hospital delivering a Complementary Package of Activities (CPA), mainly secondary care, and a number of Health Centres. Health Centres cover 10 000–20 000 people and provide a Minimum Package of Activities (MPA), consisting mainly of preventive and basic curative services. Less formal Health Posts are located in remote areas.

**Reforms in health service management and administration are being implemented.** Administration of the public health system in Cambodia is centralized at the level of the national MOH. Autonomy in management decisions for health-service administrators within the public health system is gaining more policy attention. A first step towards greater autonomy for local health managers is the conversion of almost one third of all Operating Districts (ODs) to the status of Special Operating Agencies (SOAs), which enjoy a greater degree of flexibility in human resource and financial management and receive additional funds through a direct Service Delivery Grant.
The Cambodian health market has a wide variety of health-care providers. Qualified providers include public health facilities, pharmacies, private hospitals, and medical professionals rendering services from their own or at patients’ homes. Two thirds of public health staff also work privately. NGO-run health facilities and charitable hospitals also provide services. Qualified private providers and pharmacies are most prevalent in urban areas. Non-medical health providers include vendors selling drugs from shops or markets, traditional birth attendants, drug peddlers and traditional healers.

Private providers dominate curative health-care delivery but remain insufficiently regulated. The law covering private practitioners mandates that the MOH accredit all medical operations, and the MOH provides a licensing system for medical practitioners and pharmacists. Despite considerable improvements, the regulation of private providers, in particular private for-profit health-care providers, remains a major challenge and deserves more policy attention. While the public sector is dominant in the promotion and prevention activities for essential reproductive, maternal, neonatal and child health care, and major communicable diseases control, private practitioners remain particularly frequented for curative care. In rural areas, only 15% of primary care consultations occur in the public sector, and private non-medical (unqualified) providers account for half of all health-care providers.

There is considerable scope for reinforcing the regulatory mandate of the MOH. Four 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 Management of Private Medical, Paramedical and Medical Aid Services; and (iv) the 2002 Law on Prevention and Control of HIV/AIDS.

Health financing
Reforms in health financing have been at the centre of efforts to rebuild the country’s health system. The national budget for health has almost doubled in real terms since 2007 (to US$ 199 million in 2012). (MOH, 2014c). Foreign donors finance about 50% of government health spending through grants and loans. Total health expenditure (THE) has increased with economic growth, reaching US$ 1033 million in 2012 and remaining at more than 7% of GDP; patient out-of-pocket (OOP) payments accounted for 60% of THE.
Without a significant reduction in OOP health expenditure, universal health coverage will not be achieved. The Ministry of Health is committed to moving towards universal health coverage. Government funding provides the main health infrastructure and staff and delivers subsidized care across a standard package of preventive, primary and curative care. Revenues at government facilities are supplemented by nominal user charges introduced in 1996, with funded exemptions provided widely to the poor. A number of demand-side financing schemes provide social health protection, including Health Equity Funds (HEFs), voucher schemes, voluntary community-based health insurance (CBHI) and (to a small extent) private health insurance.

Private providers consume most health-care expenditures. National data indicate that the overwhelming proportion of OOP expenditure is paid to private providers. While health spending as a proportion of income and catastrophic expenditures have both declined, OOP payments for health care are the largest part of household non-food expenditures and are among the highest in the region. The burden is especially great for poor households. Large inequalities exist in the incidence of OOP expenditures across the population.

Government health services are financed from general revenues, supported by donor funding. A third of tax revenues are from Value Added Tax and there are no earmarked health taxes. Development aid accounted for approximately 20% of THE in 2012 and budget expenditure 20%. External funding for health was US$ 209 million (US$ 14 per capita). Donor harmonization and alignment has improved but remains a pressing issue.

Improvement is needed in efficiency in government expenditures. While national data on the disaggregation of government expenditure on health are limited, the 2011 World Bank Public Expenditure Review reported that expenditures on drugs and medical supplies were substantially higher than international average prices; more than half the total health budget is spent on procurement, and 63% on non-programme activities. Efficiencies in the distribution of budget funding to lower levels of the health service require further improvement.

There is no compulsory health insurance or social health insurance coverage. The government’s National Social Security Fund provides work injury benefits to private-sector employees; and the National Social Security Fund for Civil Servants has yet to commence providing health
benefits. There is a small voluntary health insurance market comprising private for-profit insurance companies and not-for-profit CBHI schemes, which serve rural communities and urban workers, though coverage is low. Both of these target non-poor formal- and informal-sector workers who can afford to pay premiums. Subsidized HEFs for the poor provide coverage and financial protection for a quarter of the national population.

A variety of provider-payment mechanisms is used to compensate health-care professionals for services provided. Strategic purchasing of health services is very limited. The principal methods are line-item budgeting for the normal delivery of government health services and fee-for-service in the private sector. The different health-financing schemes use various payment mechanisms, including performance based incentives for staff as well as capitation and case-based payments to facilities.

Physical and human resources

Government health services provide national coverage of infrastructure and staff. Physical infrastructure has been provided under the Health coverage plan, which determines the number, location and size of health facilities by catchment population and geographical access. Public health facilities include: Health Centres, which provide basic services through the MPA; provincial and district Referral Hospitals, which provide a CPA at three levels (CPA-1, CPA-2, CPA-3) based on number and composition of staff, number of beds, standard drug kit and standard medical equipment, and clinical activities; and National Hospitals, which provide higher-level tertiary care.

Private providers outnumber government facilities but are mostly small scale. The private sector offers a diverse range of health-care facilities providing a specified range of curative services. The public health network comprises more than 1400 health facilities, organized within health ODs. The public health workforce was rebuilt essentially anew from 1980 and now comprises 20 000 professionals (predominantly nurses and midwives). There is a rapidly growing though loosely regulated private sector with more than 5500 licensed providers, which deliver a large proportion of health services (mainly curative care).

The supply of hospital beds remains relatively low and ICT is limited. Overall, the country has a ratio of 0.71 hospital beds per 1000 population, with considerable variation across provinces. This ratio is similar to the
Lao People’s Democratic Republic (0.7), but lower than Thailand (2.1) and Viet Nam (3.1). Availability of state-of-the-art diagnostic medical equipment, such as magnetic resonance imaging (MRI) or computed tomography (CT) scanners, is still very limited and maintenance is an issue; such facilities are most commonly available in the private sector. In 2010, a new web-based National Health Information System database was developed for direct entry by public facilities; the system is limited in remote areas by lack of electricity and equipment, and collecting data from private providers is a major challenge.

The MOH sees a need to increase the public health workforce to 32 000 by 2020. Public health staff are recruited through an annual civil service examination. The MOH employs a relatively small number of civil servants (about 20 000). There have been strategic recruitment efforts to address both the shortage and the skill-mix of government health staff, particularly in maternal health, with a significant increase in the number of midwives and a more modest increase in nurses since 2005. Nurses and midwives together comprise 68% of the public health workforce (comparable to neighbouring countries), reflecting a focus on rural and primary care services. Medical doctors are concentrated mainly at central and provincial health facilities, national hospitals and charitable hospitals.

A number of infrastructure and workforce challenges remain. Among the key issues are the maintenance of a viable rural health workforce with more equal urban–rural distribution, the development of medical and nursing specialities, and widespread dual practice by government staff. Emerging challenges are posed by increasing economic growth and urbanization, including demographic and epidemiological transitions.

Provision of care

Cambodia has a mixed health system comprising numerous service providers and with various funding sources. Only 29% of unwell or injured patients sought care first in the public sector, while 57% sought care for their last episode at private providers, according to the 2010 Cambodian Demographic and Health Survey. Private practitioners and clinics are particularly frequented for curative care, whereas health promotion and prevention activities (such as essential reproductive, maternal, neonatal and child health, tuberculosis, malaria and HIV/AIDS control) are the domain of the public sector. The low utilization of the public health facilities for curative care remains a concern.
Public health services are available through a national network of Health Centres and Referral Hospitals, which follows the district health model promoted by the World Health Organization; in principle, primary care services are available within two hours walk from home for the whole population. The quality of public health care is often limited by the poor condition of facilities, low staff numbers and lack of staff motivation:

- **Health Centres** are designed as the first point of contact and as gatekeepers to higher levels of care; they provide maternal, neonatal and child health services, including immunization, nutritional education, screening for breast and cervical cancer, safe abortion; treatment and prevention of communicable diseases; treatment and prevention of NCDs and injuries; and through outreach activities.

- **District Referral Hospitals** provide outpatient care as well as inpatient treatment for referred cases, complicated tuberculosis cases, medical, surgical and obstetrical emergency cases, some surgery, maternal and child health services, provision of X-ray, ultrasound and laboratory services, and rehabilitation services. However, many patients go straight to hospitals, bypassing the health centres.

- **Provincial and National Hospitals** provide the highest-level CPA package; National Hospitals include both general hospitals and specialist hospitals for paediatrics, maternal and child health, and tuberculosis. Medical specialities, such as haematology and oncology, are still at early stages of development.

**Coordination with private providers is a challenge for government planners and policy-makers.** The growing but loosely regulated private medical sector is the point of first contact for the majority of the sick and injured population. Most private providers are small practices, drug shops or single-person practitioners. Private pharmacists are a common, frequently accessed, yet inadequate source of self-medication for most people. Most private providers with formal training are simultaneously public employees (dual practice). Secondary and tertiary services are provided mainly by public hospitals and some private clinics and hospitals. Access to private hospital care is greatest in urban areas. The registration of all private medical and paramedical facilities was made compulsory under a law adopted in late 2000, though the resources available for effectively monitoring are limited.

**The public health system provides a spectrum of services.** Due to the development of quality care initiatives and reduction of financial barriers to access services, utilization of public health facilities is slowly increasing.
Health Centre, Referral Hospital and National Centre services cover the following.

- **Health promotion**, including services directed at reproductive, maternal, neonatal and child health, malaria, tuberculosis, HIV/AIDS and the activities of the National Centre for Health Promotion.
- **Health prevention**, including family planning, antenatal care and postnatal care, birthing care, the Expanded Program on Immunization managed by the National Immunization Program, HIV counselling and testing services.
- **Communicable disease** services such as diagnostic and treatment for malaria, tuberculosis, HIV/AIDS and common childhood illnesses are mainly provided by Health Centres and Referral Hospitals.
- **Noncommunicable disease** services are at an early stage of development: prevention and control activities are managed by the MOH Department of Preventive Medicine in collaboration with PHDs and ODs.
- **Rehabilitation and mental health services** are at an early stage of development. The Ministry of Social Affairs, Veterans and Youth Rehabilitation is currently managing 12 physical rehabilitation centres in Cambodia.

There are no enforced referrals which constraint patients’ choice of providers. But patients are recommended to follow the referral and counter referral system between the community, Health Centres and Referral Hospitals. However, the referral system rarely works as intended and most patients seek multiple sources of health care. Critically ill or injured patients usually bypass primary health care facilities and seek care directly at public or private hospitals without referral. For lesser illness, most rely first on home remedies (especially in rural areas) or self-prescribed medication from local pharmacies or drug sellers; people commonly choose to consult private providers ahead of public facilities; if the patient’s condition deteriorates, private providers generally refer them to a government hospital.

**Major health reforms**

An ongoing process of national health reform began in the 1990s. Reforms began with the extension of the physical infrastructure, continued through innovations in health financing and access to services, and now incorporate district health-sector management and administration. Building on a strong record in health planning and policy
making over many decades, the MOH now sees moving towards universal health coverage as the framework for the continuation of the health reform process.

**Development partners have helped collectively to shape health policy-making.** The openness of the Cambodian Government to international cooperation has had a significant impact on the development of the public health system. This partnership between development agencies and the government, through the MOH, has provided the opportunity for trialling a range of innovative health reforms. A Sector-Wide Management (SWiM) approach brought together MOH and development partners to address health-system barriers in support of MOH objectives outlined in the Health Strategic Plans for 2003–2007 and 2008–2015.

**Reform has been guided by a long-term process of national health planning.** This process culminated in the adoption of two consecutive Health Strategic Plans for 2003–2007 and 2008–2015. The goals of the first Plan for quality improvement and institutional development were largely achieved. The second Plan is pursuing targets related to five of the six WHO health-system building blocks (service delivery, financing, human resources, system governance and information systems) by focusing on six priority areas: service delivery, behavioural change, quality improvement, human resource development, health financing and institutional development.

The key planning activities have included:

1996 – Commencement of the Basic Health Services Project (funded primarily by the Asian Development Bank) to reconstruct district health facilities.
1999 – Piloting of external contracting in service delivery through international NGOs.
2000 – Initiation of the first pilot projects using HEFs.

2007 – Joint Annual Performance Review to assess the Health Strategic Plan and Health Sector Support Program.

2007 – Introduction of the Midwife Incentive Scheme for facility-based deliveries.

2008 – Adoption of Special Operating Agencies Implementation Guidelines and conversion of some ODs to SOA status.

2008 – Adoption of Health Equity Fund Guidelines to formally institutionalize HEFs with MOH authority over the contracted HEF network.

2008 – Adoption of the Organic Law for decentralization and deconcentration of government administration.


2010 – Adoption of the Fast Track Roadmap for reducing Maternal and Newborn Mortality Initiative.


2013 – Drafting of the national Health Financing Policy.

**Providing access for the poor is at the heart of health reforms.** Health Equity Funds (HEF) have proved to be an effective mechanism for providing access to health services and financial protection for the poor, as well as a regular source of supplementary income for public health facilities. Now approaching national coverage, the MOH and donor partners are working together to create a uniform model and a central administration of the district-based HEFs within the MOH.

**Recent health reforms have focused on strengthening the MOH’s capacity to manage health-service delivery.** The major areas of reform in the public health system, in support of the government’s broader Public Administrative Reform, have focused on expanding the coverage of basic health services, providing improved financial access to quality health services in the public sector, and improving the efficiency and effectiveness of health-service management at district level. Since 2009, the internal contracting of government health services between units within the MOH has been piloted through the conversion of a number of health ODs and Provincial Hospitals
into SOAs to provide greater management autonomy, increased staff incentives and more efficient service delivery.

**The longer-term aim is to move towards universal coverage.** The Strategic Framework for Health Financing 2008-2015 aims to improve health system financing and facilitate a universal risk pooling and prepayment mechanism necessary for achieving universal health coverage. The draft Health Financing Policy proposes a process of harmonizing benefit packages, provider-payment mechanisms, claim processing mechanisms, information management systems and disease classification systems to address immediate concerns about the fragmentation of the existing health financing arrangements and risk pools. In addition, the Policy proposed the establishment of a National Social Health Protection Fund to administer the informal-sector social protection schemes, including HEFs, CBHI and maternal health voucher schemes.

**Health system performance**

**The health system is on track to achieve its broad objectives and Millennium Development Goal targets.** Health status has substantially improved. Life expectancy at birth increased from 64.6 years in 2000 to 71.4 in 2012 (World Bank, 2014a); the maternal mortality ratio decreased from 437 deaths per 100,000 live births in 2000 to 206 in 2010; infant and under-five mortality rates decreased respectively from 95 to 45 and from 124 to 54 deaths per 1000 live births between 2000 and 2010.

**Health outcomes still exhibit urban–rural and rich–poor differentials and are poor in comparison with global and regional averages.** Maternal and child health outcomes vary according to socioeconomic status and geographic location: the fertility rate for women in the poorest quintile is more than double that of the richest quintile; children in the poorest quintile have a three-fold greater 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 in the richest.

**Equity in health financing and access to services has improved.** Access to services has improved partly from targeting public resources on the provision of primary health care services in rural areas (especially reproductive health care) and from the expansion of social protection schemes. Socioeconomic survey data reveal an increase in the proportion of unwell individuals seeking care from medical providers, with a greater increase among the lowest two income quintiles; a rise in the use of
reproductive, maternal and child health services; an increasing capacity-to-pay and a decline in catastrophic health expenditure across all income quintiles; and, in particular, lower levels of OOP spending, catastrophic expenditure, and health-related indebtedness among HEF beneficiaries.

A significant improvement in coverage of health services has not been matched by improved quality of service delivery. Improvements have been made in service coverage, especially in the delivery of maternal and child health care following the implementation of the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality, providing increased coverage of skilled birth attendance and other safe motherhood services. However, quality of care remains a major concern in both public and private sector. Client dissatisfaction is evident in several areas, including attentiveness of health-facility staff, availability of staff at night, cleanliness of facilities, and communication on illness diagnosis and prevention.

While government funding for health care has increased significantly, it remains at only 1.4% of GDP. Greater efficiencies in the allocation and use of health funding are needed. The disbursement rate of MOH budget expenditures has improved, reaching 90% of budgeted allocations expended annually. The national bed occupancy rate increased to 82% by 2011, while the average length of stay remained stable at 5–6 days (cf. 2002). However, more than 70% of the health budget is managed centrally (allocated principally to salaries and the procurement of drugs and medical supplies), there is a preference for vertical programmes over health-system strengthening and an emphasis on the provision of tertiary services; and district health care is underfunded. The decentralization of resources to service-delivery level is gradually improving, with an increasing share of budget disbursed through Health Centres and Referral Hospitals. Shortcomings in government administration, in the procurement and pricing of pharmaceuticals and supplies, the low level of staff salaries, and inadequate regulation in the public and private sectors are all sources of technical inefficiency.

Challenges for the future

Achieving the goal of universal coverage requires increased research allocation and a long-term view. At approximately 7% of GDP in 2012, the level of THE remains high. Government has raised its commitment to health which needs to be maintained. The heavy reliance on OOP spending must decline. The pathway to universal coverage requires the
consolidation, under government control, of the social health-protection schemes for the informal sector – built on the firm foundation of the HEFs – and commencing operations through the two National Social Security Funds. The adoption and effective implementation of the draft Health Financing Policy is the first important step.

**Donor support is essential, but greater alignment of donor programmes to national priorities is needed.** Official development assistance is stable at 15–20% of THE, with increased alignment to national policy. While the MOH and development partners have worked closely together in strengthening the health system, development partners have at times followed their own agendas (albeit generally with the consent of the MOH), causing some sense of fragmentation. Further efforts to ensure full accountability in the use of this funding through the health budget should pave the way for a sector-wide approach to donor funding in support of MOH objectives.

**The period of piloting and experimentation is over.** Development partners together with the MOH have initiated a large number of pilots and experimental interventions in different aspects of health-system strengthening, particularly in the supply of services and health financing. Some have been successful, others much less so. Pilot projects in external contracting using nongovernmental providers were terminated in favour of internal contracting processes within the MOH. A number of pilot CBHI schemes were initiated though without the anticipated benefits in coverage. Voucher schemes have been effective, but often duplicate other social protection mechanisms. The time has come to end the period of experimentation and to scale up those interventions that have proved to be successful, particularly the HEFs.

**Health-system policy needs now to return to strengthening the supply side.** The successful expansion of the health infrastructure, relatively low levels of utilization, and the rapid increase in the number of private providers all focus attention on the limitations of public health-service delivery, in particular the persistently low quality of care. In the health reform cycle, this shortcoming returns planners’ attention to a concern with strengthening the supply side. The health reform process is dynamic and requires a balance between supply and demand initiatives over time. Improving the quality of care is now the most pressing imperative in health-system strengthening. In the public sector this requires attention to funding, management processes and the remuneration of public-sector workers. For the private sector, it poses the immediate need for extended regulation, accreditation and enforcement.