UHC IN CAMBODIA: CURRENT ACHIEVEMENT AND FUTURE CHALLENGES

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OUTLINE OF THE PRESENTATION

- Cambodia at a glance
- Brief health system context
- How to measure UHC progress
- UHC progress in Cambodia
- Remaining challenges

CAMBODIA

80%

A lower-middle income country

GNI per capita = USD1,070 (2015)

A PLURALISTIC HEALTH SYSTEM

- A geo-demographic based **public sector**: the health district-based model
- A fast growing & loosely regulated **private sector**:
  - Private for-profit &
  - Private non-for-profit

- Policies, legislations, strategic planning
- Resource mobilization and allocation
- Monitoring, evaluation, research, HIS
- Training, support to provinces/districts
- Multisectoral coordination, external aid

- Link MoH and ODs
- Implement health policies, HSP via AOP
- Ensure equitable distribution and effective use of resources availabe
- Support development of OD (M&E, in-service training, coordination)

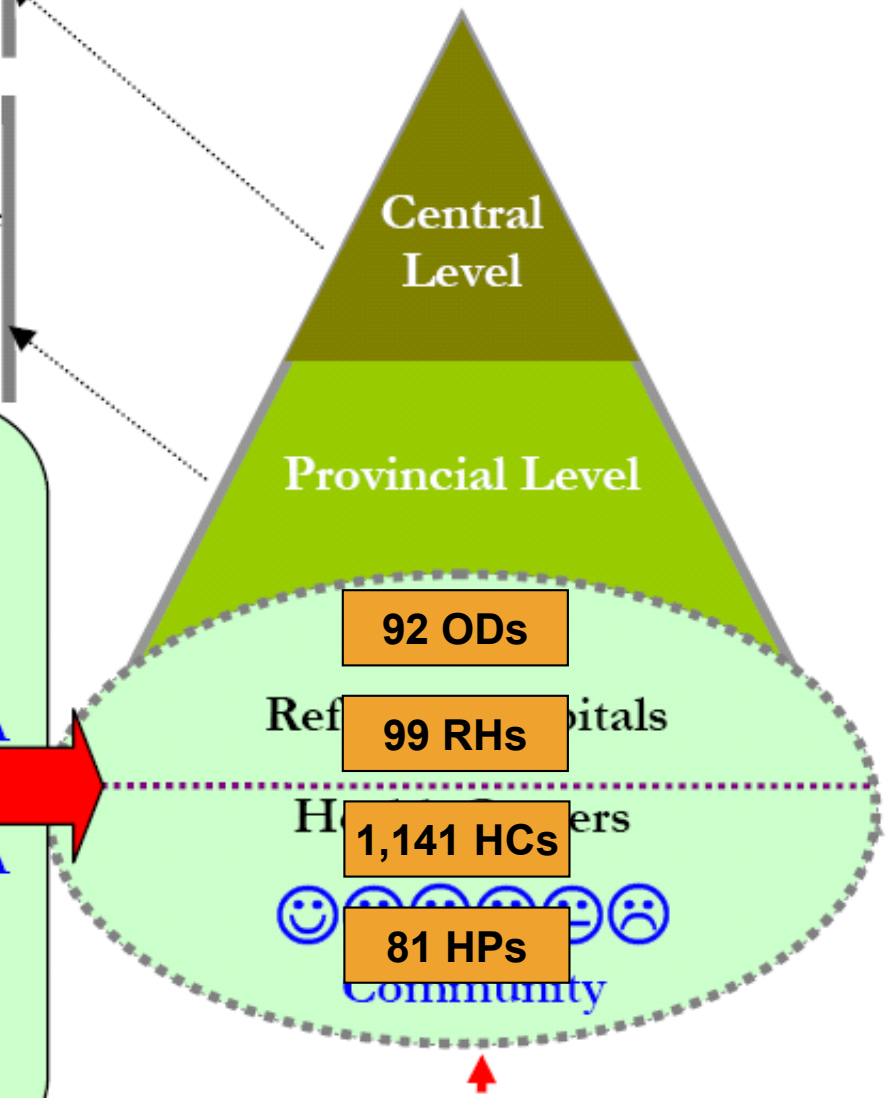
- Distinct and complementary to HC care
- Specialized services
- Treatment for complex health problems
- Follow-up/continuing care
- Support HC in clinical training & supervision

CPA

Health Services and Management

MPA

- Encourage community participation
- Have close contact with the population
- Be efficient and affordable
- Provide integrated high quality
- Ensure accessibility: financial, geographically and culturally appropriate



Operational District Health System

Health Centers providing Minimum Package of Activities (MPA) to about 10,000 people:

- curative consultations for common health problems,
- emergency care and minor surgery (dressing);
- treatment & follow-up of tuberculosis & leprosy; care for under-five children;
- care for pregnant women and normal delivery; family planning

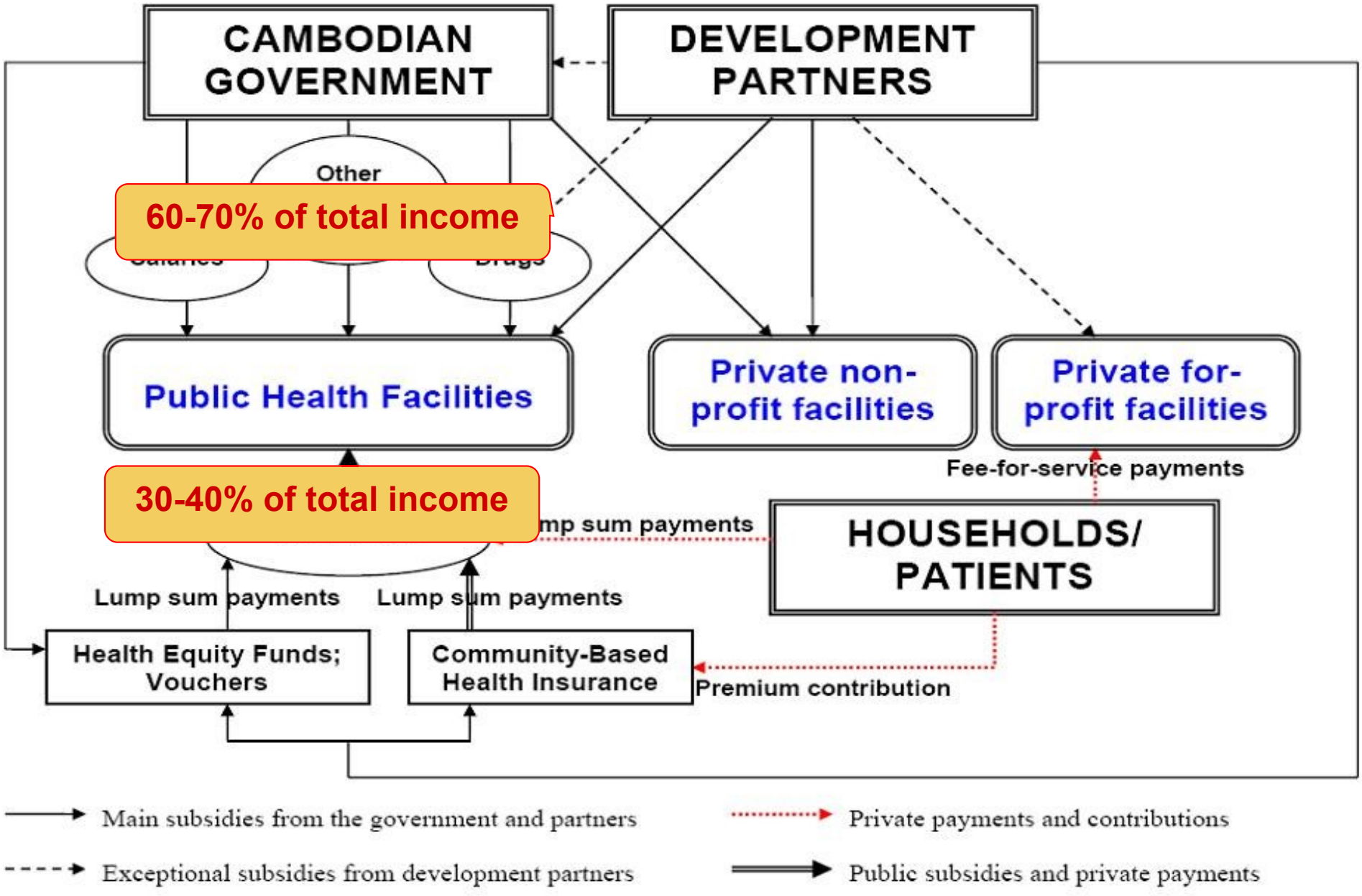
Referral Hospitals providing Complementary Package of Activities (CPA) to about 100,000 people:

CPA1: referral consultations; general hospitalization for adults and pediatrics; medical and surgical emergencies, including complicated delivery & tuberculosis cases; and laboratory, ultrasound and x-ray

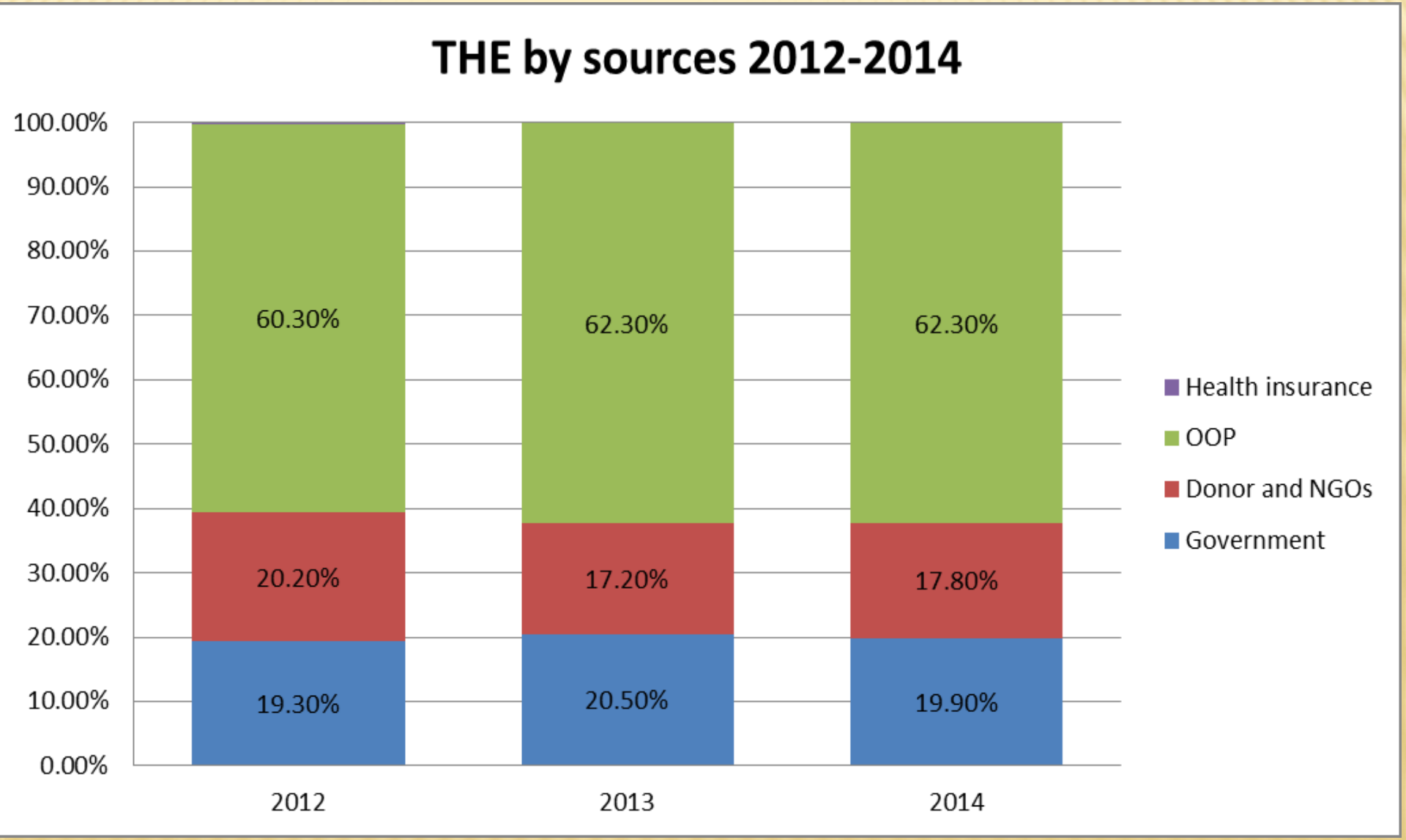
CPA2: above + operation theater for emergency surgical interventions, e.g. C-section, appendectomy

CPA3: above + all kinds of surgical interventions and specialized services (provincial hospitals)

HEALTH CARE FINANCING

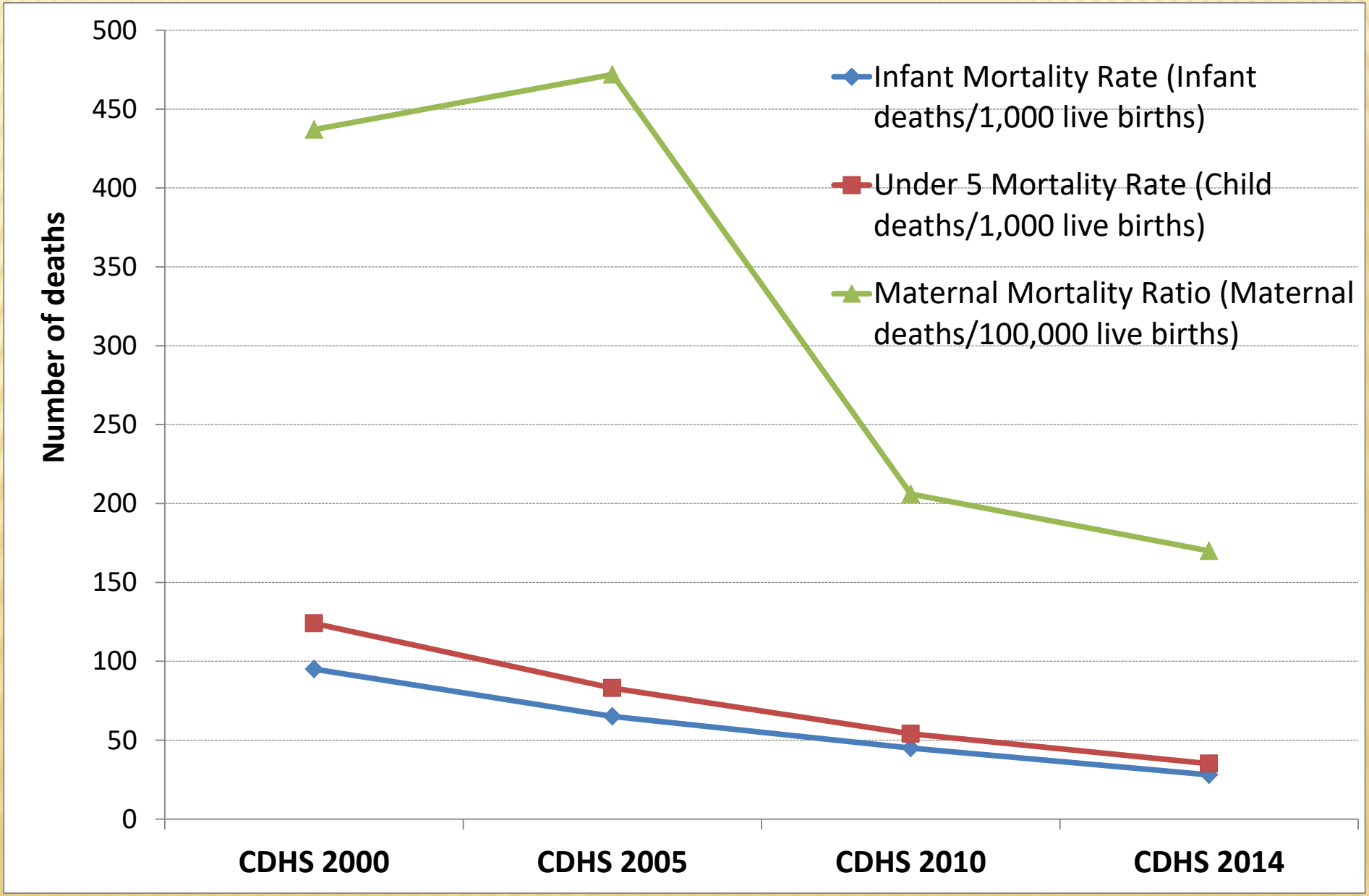


HEALTH EXPENDITURES IN CAMBODIA

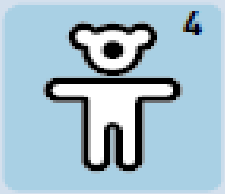
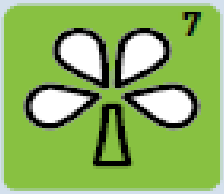


Source: Cambodia MOH's NHA Report 2016

IMPRESSIVE REDUCTION IN MORTALITY RATES



MOST HEALTH MDG TARGETS ACHIEVED

		Achievements	CMDG Targets
 Reduce child mortality	**Infant mortality rate** *per 1000 live births (2014)*	**28**	50
	Under-5 mortality rate *per 1000 live births (2014)*	**35**	65
	Measles immunization *% coverage (2014)*	**79**	90
 Improve maternal health	**Maternal mortality ratio** *per 100 000 live births (2014)*	**170**	250
	Skilled birth attendant *% births (2014)*	**89**	87
	Contraceptive use *% married women aged 15-49 (2014)*	**56**	60
 Combat HIV/AIDS,malaria and other diseases	**HIV prevalence** *% adults aged 15 to 49 years*	**0.6**	0.4
	Malaria mortality rate *per 100 000 population (2013)*	**0.08**	0.8
	Notified cases of TB *new and relapse (2014)*	**43 738**	40 000
 Ensure environmental sustainability	**Water (rural)** *% using improved drinking-water sources (2014)*	**59**	50
	Sanitation (rural) *% using improved sanitation facilities (2014)*	**41**	33

CMDG = Cambodian Millennium Development Goals; TB= tuberculosis.

Source: Cambodia Demographic and Health Survey 2014; Cambodian Millennium Development Goals Report 2013; WHO Tuberculosis Report; UNAIDS Cambodia; WHO Malaria Report.

UNIVERSAL HEALTH COVERAGE (UHC)

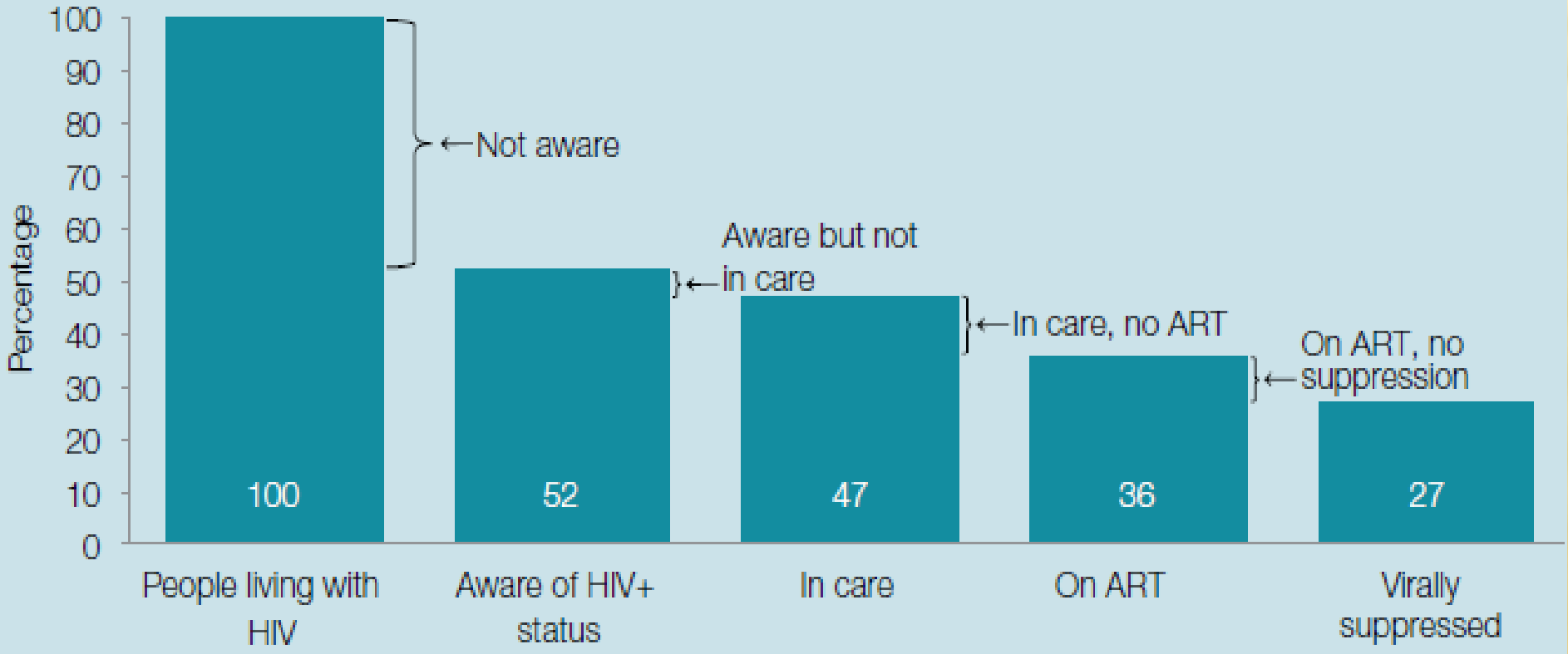
- SDG3: Ensure healthy lives and promoting well-being for all at all ages
- UHC one of the 9 targets in SDG3 is reflected in the Cambodia HSP3: 2016-2020

Source: Dr Lo Veasnakiry's presentation on Dec 05, 2016

HOW TO MONITOR UHC PROGRESS

- Two key components of UHC:
  - Coverage of the population with quality, essential health services: health promotion, prevention, treatment, rehabilitation and palliative care
  - Coverage of the population with financial protection
- Coverage for the whole population (average) & by population groups: richest-poorest, urban-rural (equity)
- 'Effective' coverage, taking into account: need, use and outcome

Figure 1.2. Effective ART coverage cascade: percentage of people living with HIV on ART with viral load suppression (less than 1000 copies/ml), Kenya, 2012

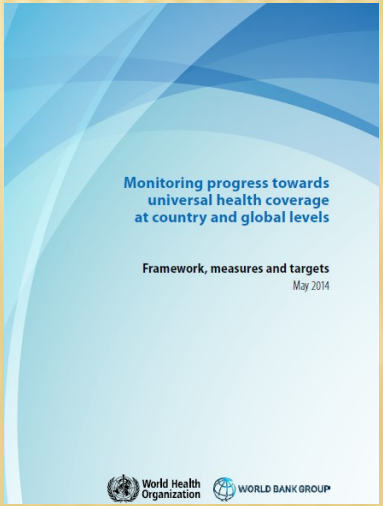


Similar for Diabetes, Hypertension, TB…
How about C-section, General Hospitalization?

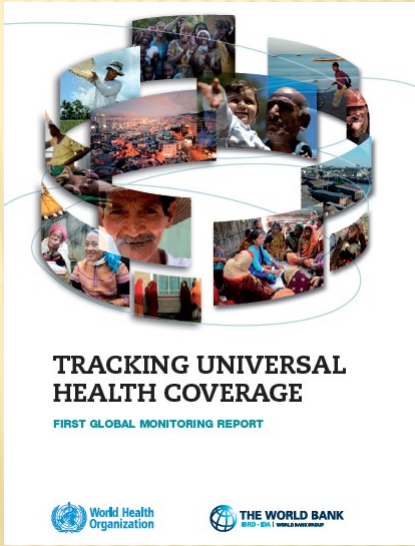
Source: WHO & WB (2015) Tracking Universal Health Coverage: First Global Monitoring Report

HOW TO MONITOR UHC PROGRESS

- Many ways to monitor the UHC progress, depending on the country context, policy choice and availability of data
- The best is to do it as an integral part of the whole health system performance assessment
- WHO & WB Group developed a UHC monitoring framework for measuring UHC progress at country and global levels



HOW TO MONITOR UHC PROGRESS



- The first attempt to apply the UHC monitoring framework
- Coverage of the population with quality, essential health services:
  - Prevention: FP, ANC4, SBA, DTP3, Tobacco use…
  - Treatment: HIV-ART, TB treatment, Hypertension & Diabetes treatment
- Coverage of the population with financial protection
  - % of the population that does not experience CHE
  - % of the population that is not impoverished by OOP

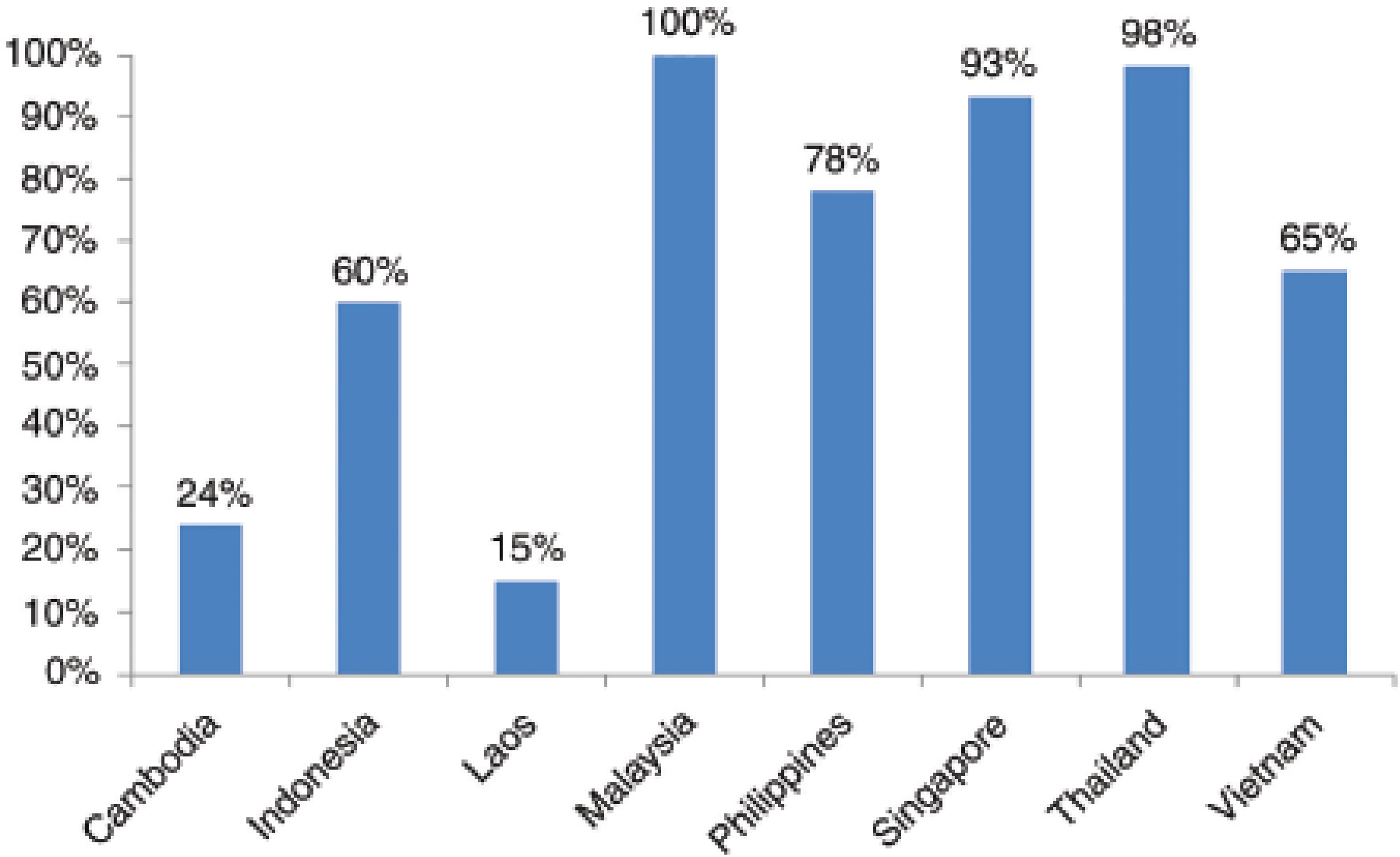
  Alternatively: % of population covered by SHP mechanisms & non-OOP/prepayment as % of THE?

THE FIRST ATTEMPT TO MEASURE UHC IN CAMBODIA AND OTHER ASEAN COUNTRIES

Pop. coverage		Service coverage	OOP
Malaysia	100%	Free PHC, esp. MCH, but rationed by waiting time & # family physicians in HCs => private services	41%
Thailand	98%	Comprehensive benefit package, free at point of service for all three public insurance schemes	19%
Philippines	76%	Benefit package covers IPD only except for the sponsored program (+OPD); high level of co-payment for all PhilHealth components (average reimbursement: 54%)	55%
Indonesia	48%	Inadequate benefit package although policy intention is to provide comprehensive services (OPD+IPD) because of low per capita government subsidy for the poor (US$6/y)=> low levels of financial protection.	30%
Viet Nam	55%	Benefit package is comprehensive but has a substantial level of co-payment: 5–20% of medical bills.	55%
Lao PDR	8%	SHI for the formal sector (& limited CBHI/HEF for the informal and poor), but low coverage & small service package.	62%
Cambodia	23%	HEF for the poor with a comprehensive package, including transport cost and food allowance, but the scope and quality of care provided at government health facilities are restricted.	61%

Source: Tangcharoensathien et al. 2011

ANOTHER ATTEMPT A FEW YEARS LATER
BASED ON INSURANCE & INSURANCE-LIKE SCHEMES

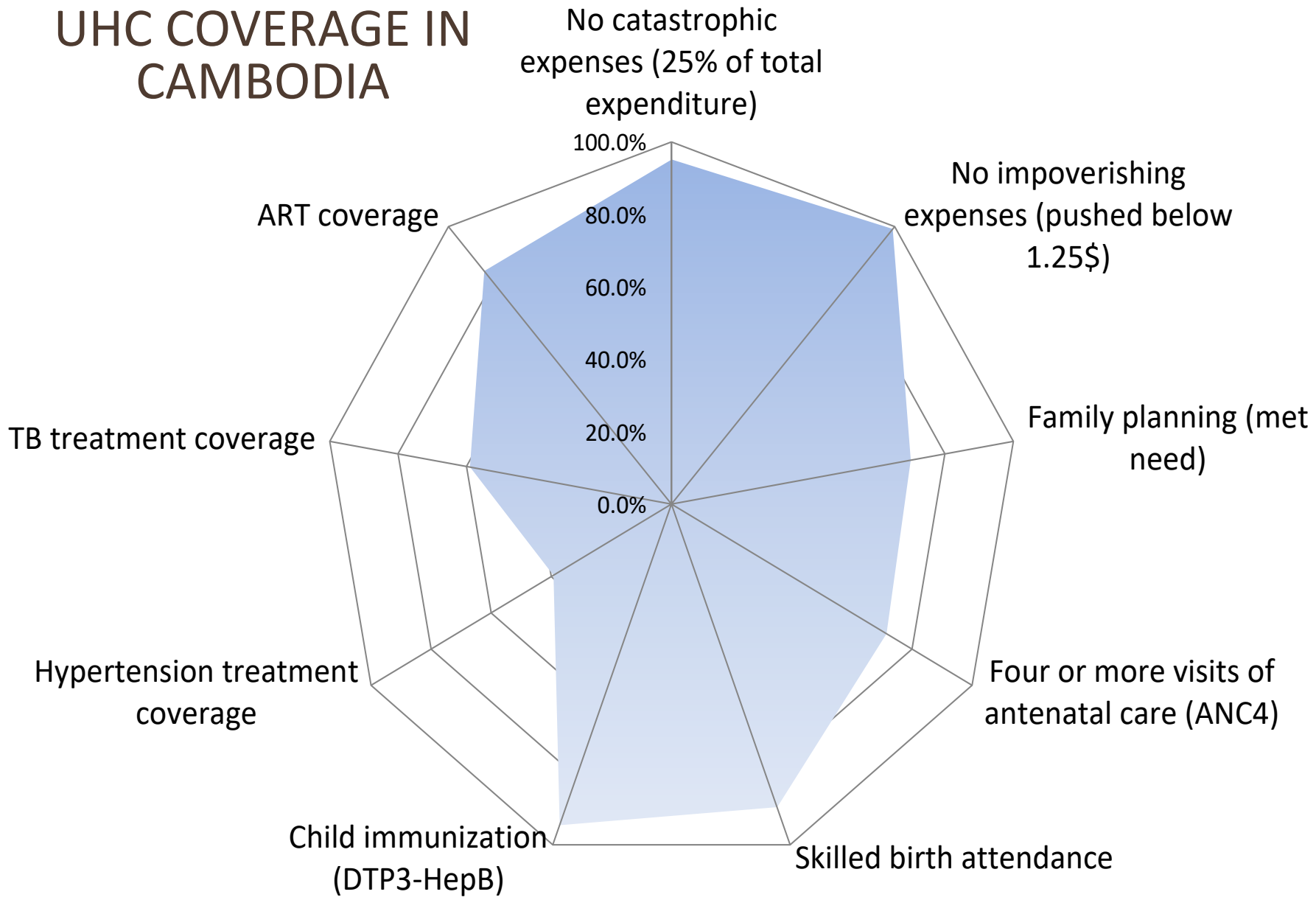


Source: Van Minh et al. 2014

FRAGMENTED COVERAGE BY SHP MECHANISMS

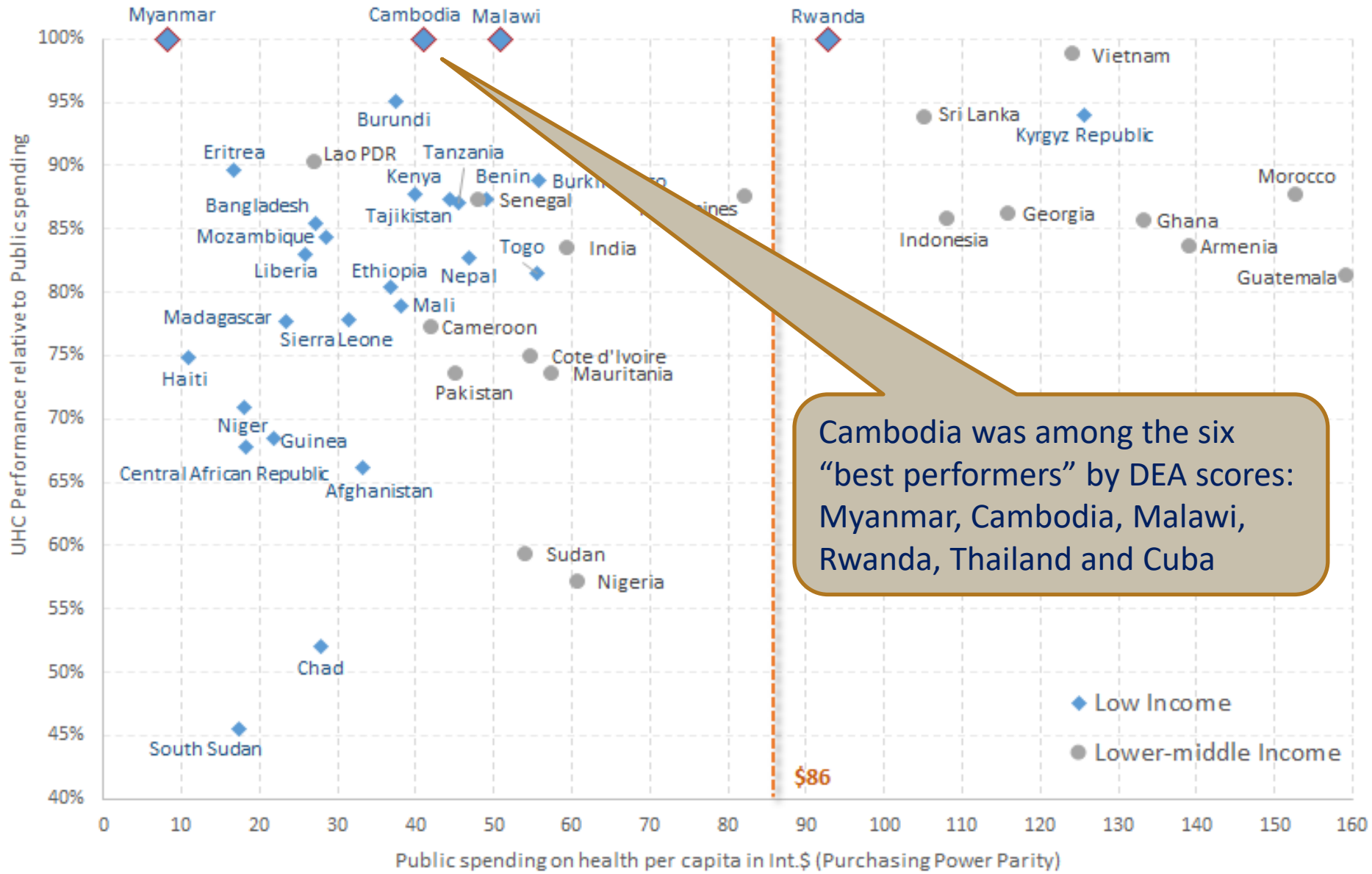
SHP schemes	Population coverage	Service coverage	Financial contribution
Direct government/ donor subsidies	All service users	EPI, TB, HIV/AIDS Other MPA/CPA	Free services Subsidized (Pay user fees only)
Health Equity Funds	Over 3 million poor	MPA, CPA services + Transport, food	Free services + Support for transport, food
Reproductive Health Vouchers	Reproductive age/Pregnant Women	Reproductive & SMH Services + transport + CCT	Free services + support for transport + CCT
Social Health Insurance/Work Inury: NSSF	1 million salaried workers	MPA, CPA, transport maternity, disability benefits	Free services + ambulance support + other benefits
Community-Based Health Insurance	118,000 voluntary members	MPA, CPA services + Transport	Free services + transport support
Private Health Insurance	<5% of the population	Limited benefit package (risk rated)	Reimbursement with ceiling?

UHC COVERAGE IN CAMBODIA



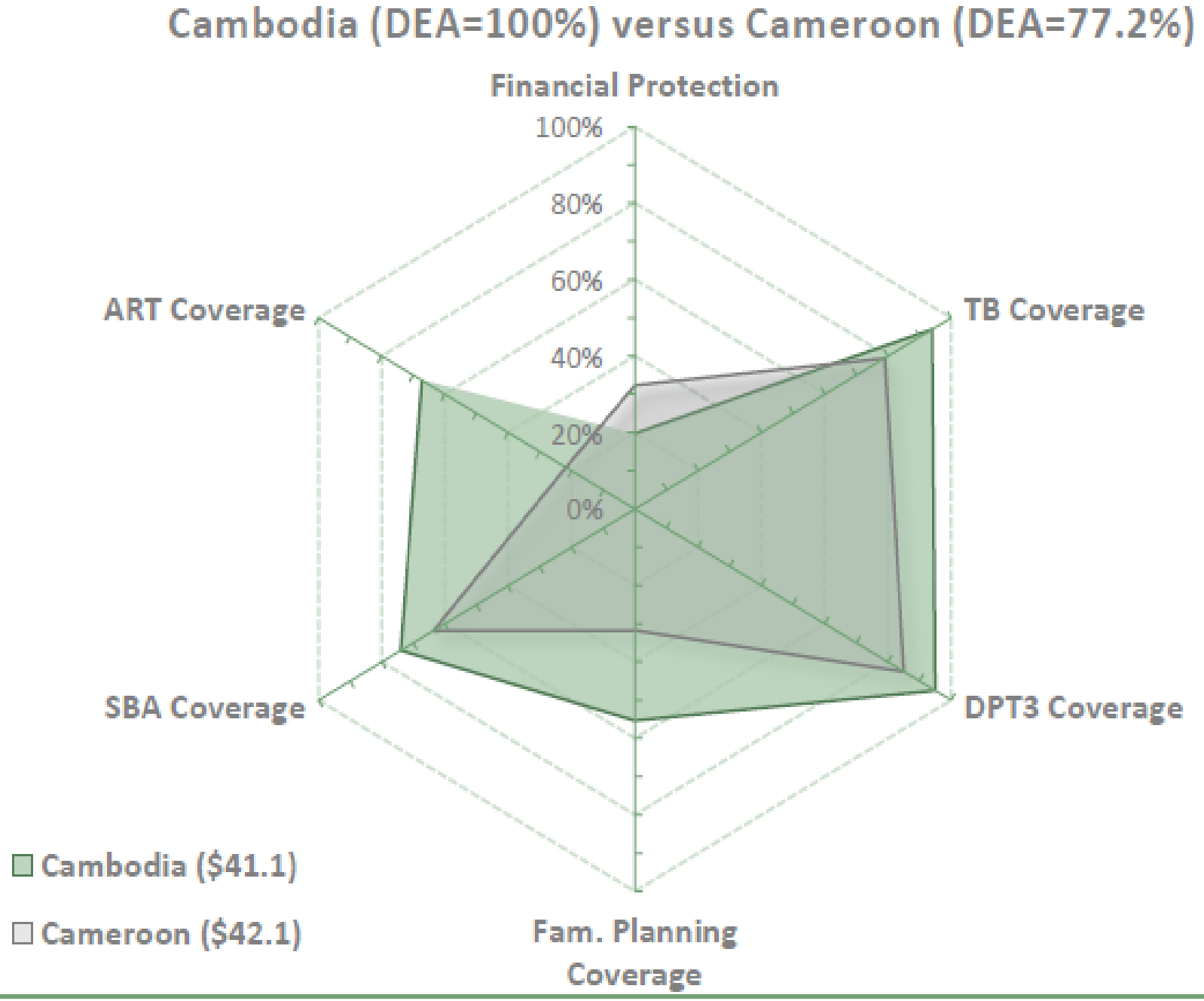
Source: Author, 2016

USING GGHE DATA TO MONITOR PROGRESS TOWARD UHC



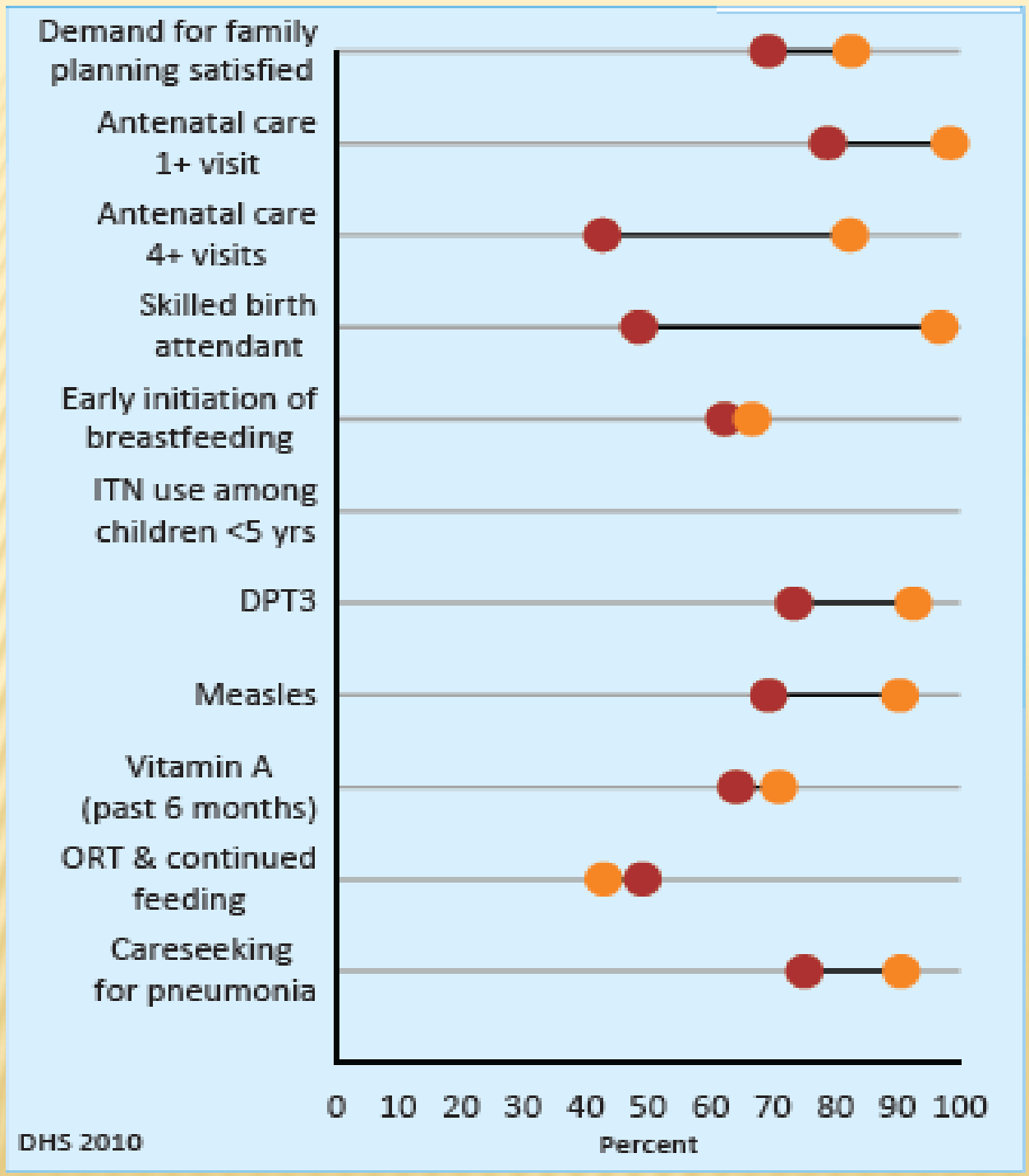
Cambodia was among the six "best performers" by DEA scores: Myanmar, Cambodia, Malawi, Rwanda, Thailand and Cuba

Source: Jowett et al. 2016 WHO Health Financing Working Paper No 1



Source: Jowett et al. 2016 WHO Health Financing Working Paper No 1

SOCIO-ECONOMIC INEQUITY IN COVERAGE:

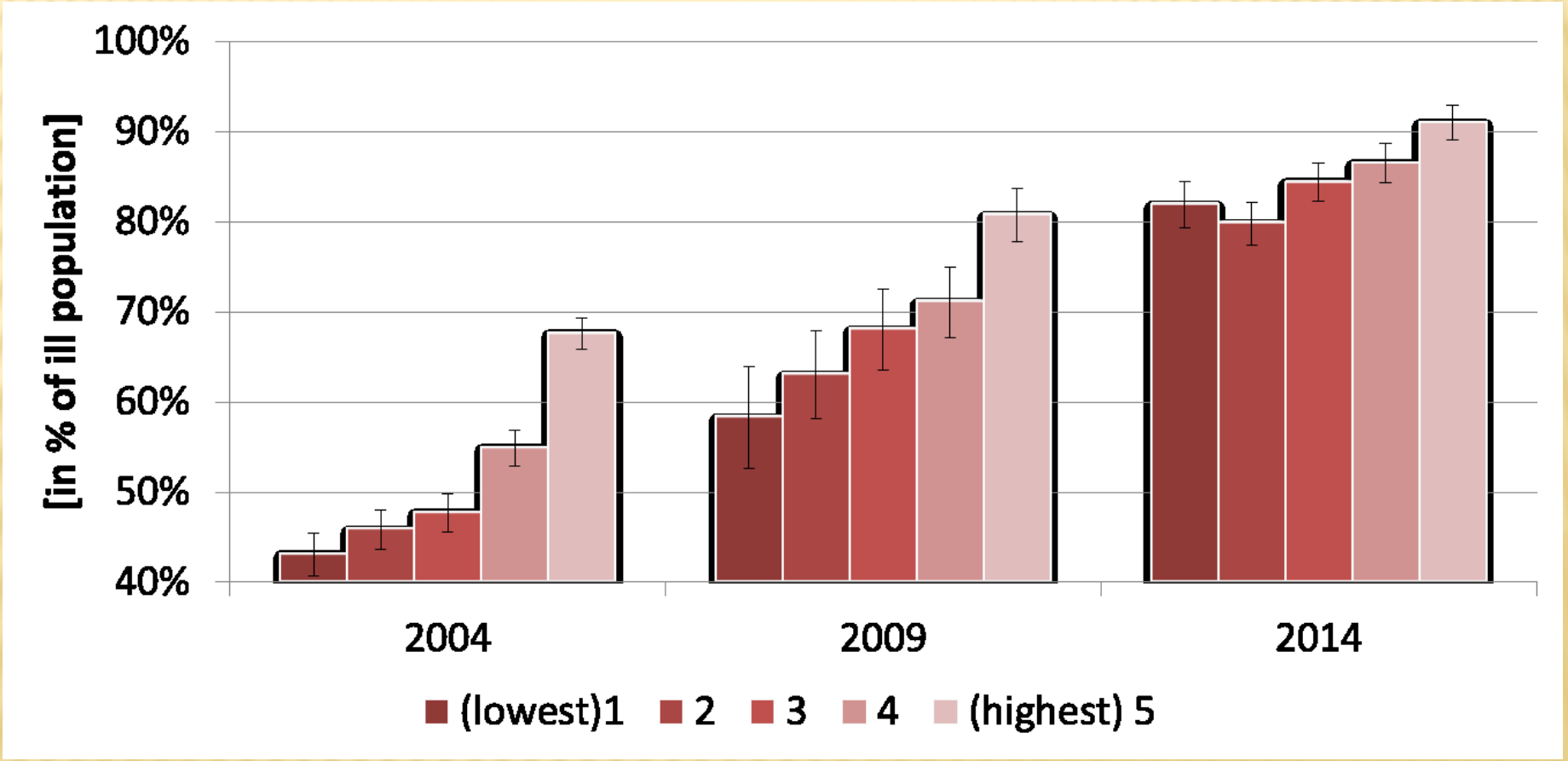


Poorest 20%

Richest 20%

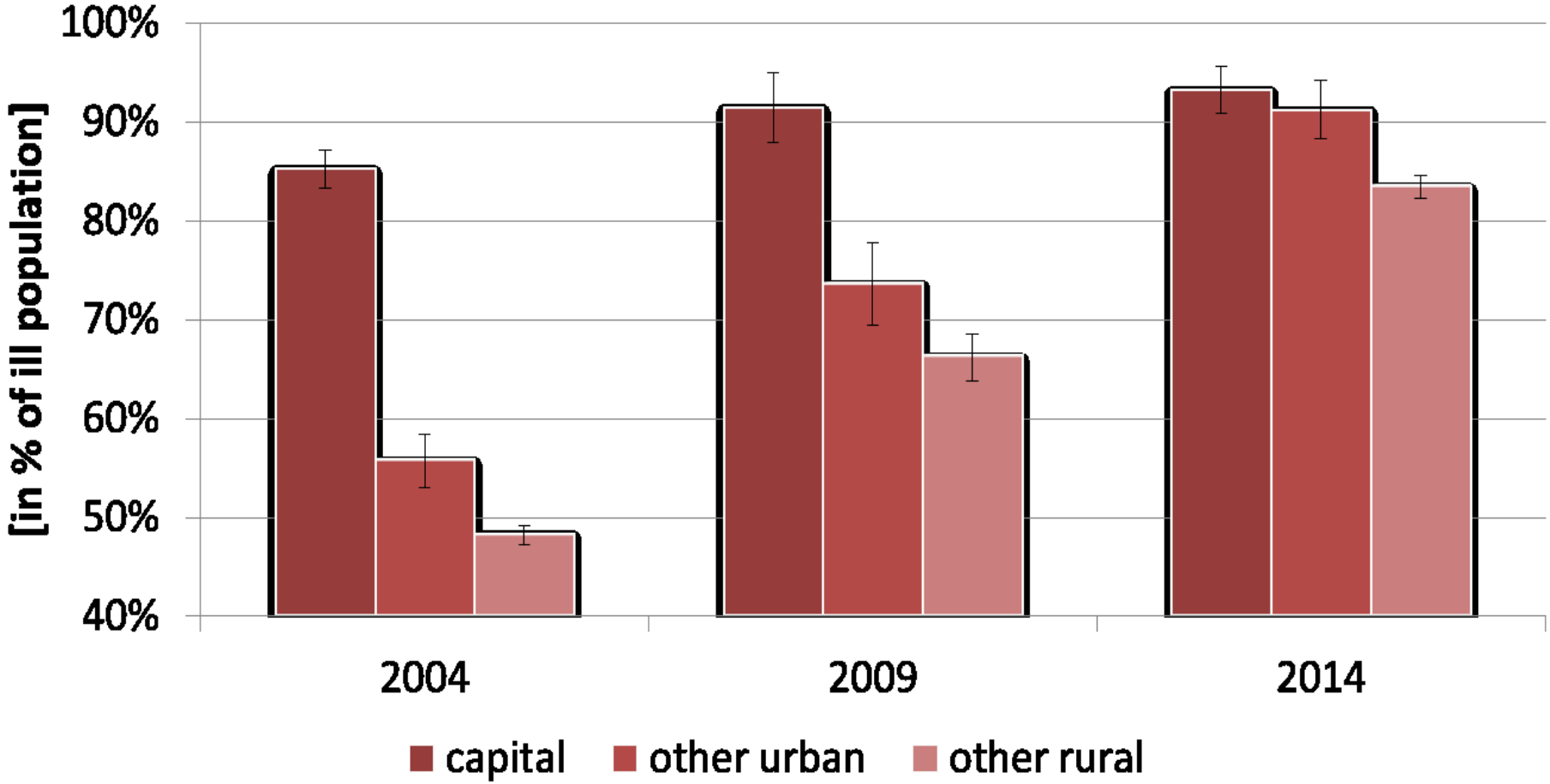
Source: Countdown to 2015 report

ACCESS TO MEDICAL CARE WHEN ILL: SUBSTANTIALLY INCREASED, AND MORE EQUITABLE



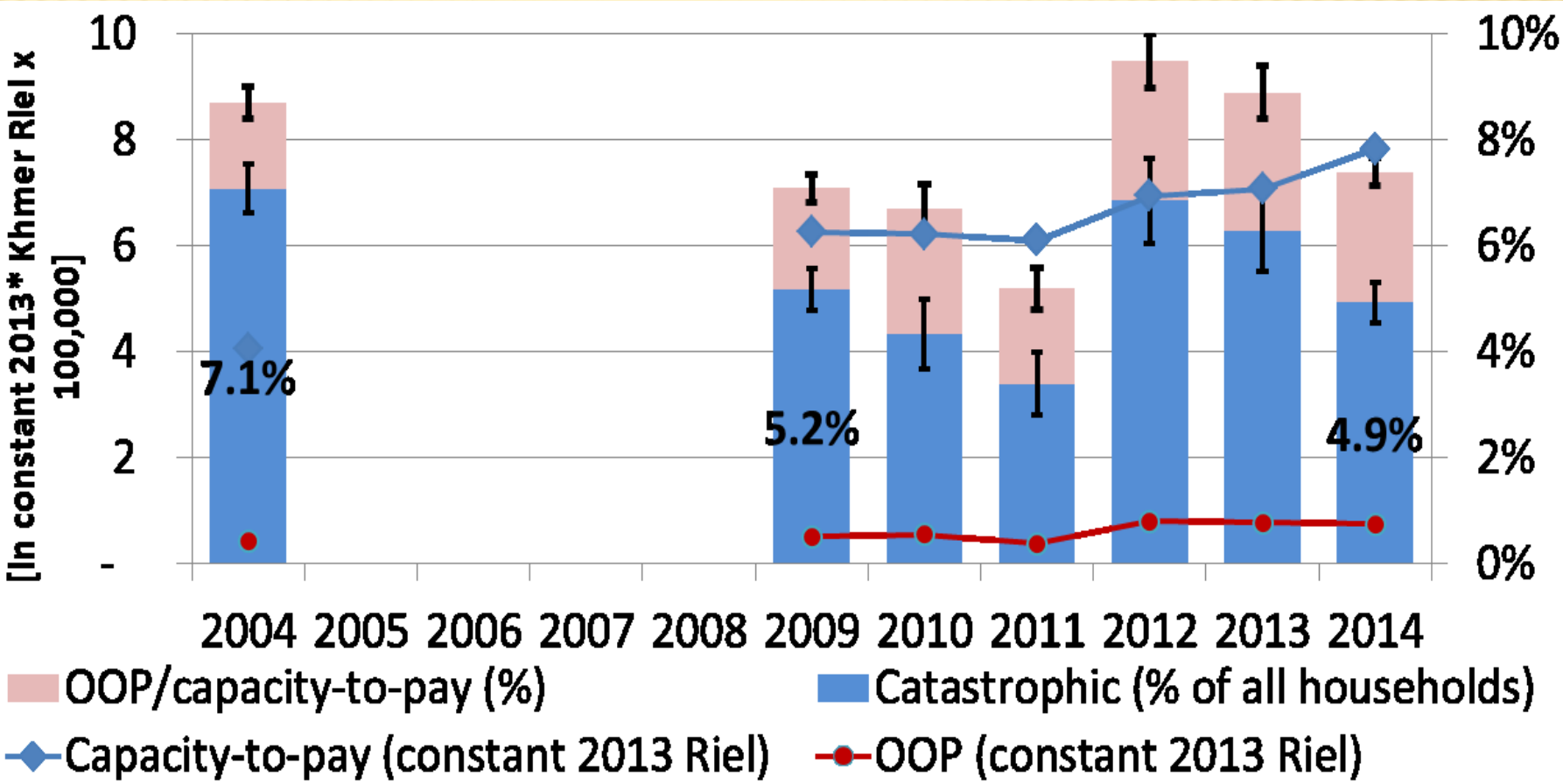
Sources: Second data analysis of Cambodia Socio-economic Survey (2004-2014), MoH, GIZ, WHO

ACCESS TO MEDICAL CARE WHEN ILL: ALMOST DOUBLED IN RURAL AREAS



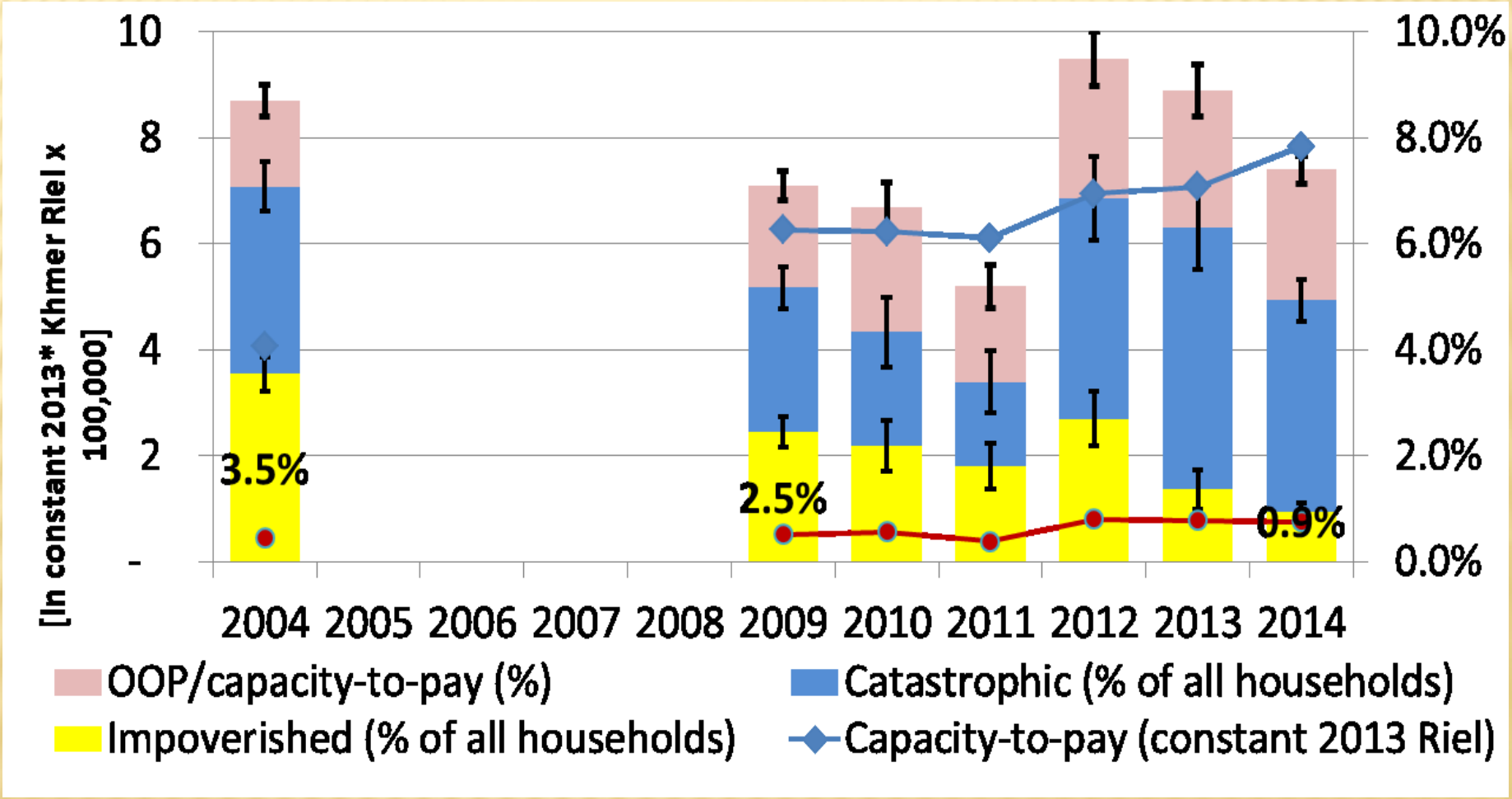
Sources: Second data analysis of Cambodia Socio-economic Survey (2004-2014), MoH, GIZ, WHO

INCIDENCE OF CATASTROPHIC EXPENDITURE



Sources: Second data analysis of Cambodia Socio-economic Survey (2004-2014), MoH, GIZ, WHO

INCIDENCE OF IMPOVERISHMENT FROM HEALTH EXPENDITURE



Sources: Second data analysis of Cambodia Socio-economic Survey (2004-2014), MoH, GIZ, WHO

REMAINING CHALLENGES

- Population coverage:
  - The poor already covered and soon the formal sector
  - But the near-poor and non-poor informal sector "the missing middle"?
  - Many of those covered:
    - About 2/3 of the sick Cambodians seek non-medical and private sector care (CDHS reports)
    - A large % of the poor holding a HEF card and sought care , did not use their entitlement

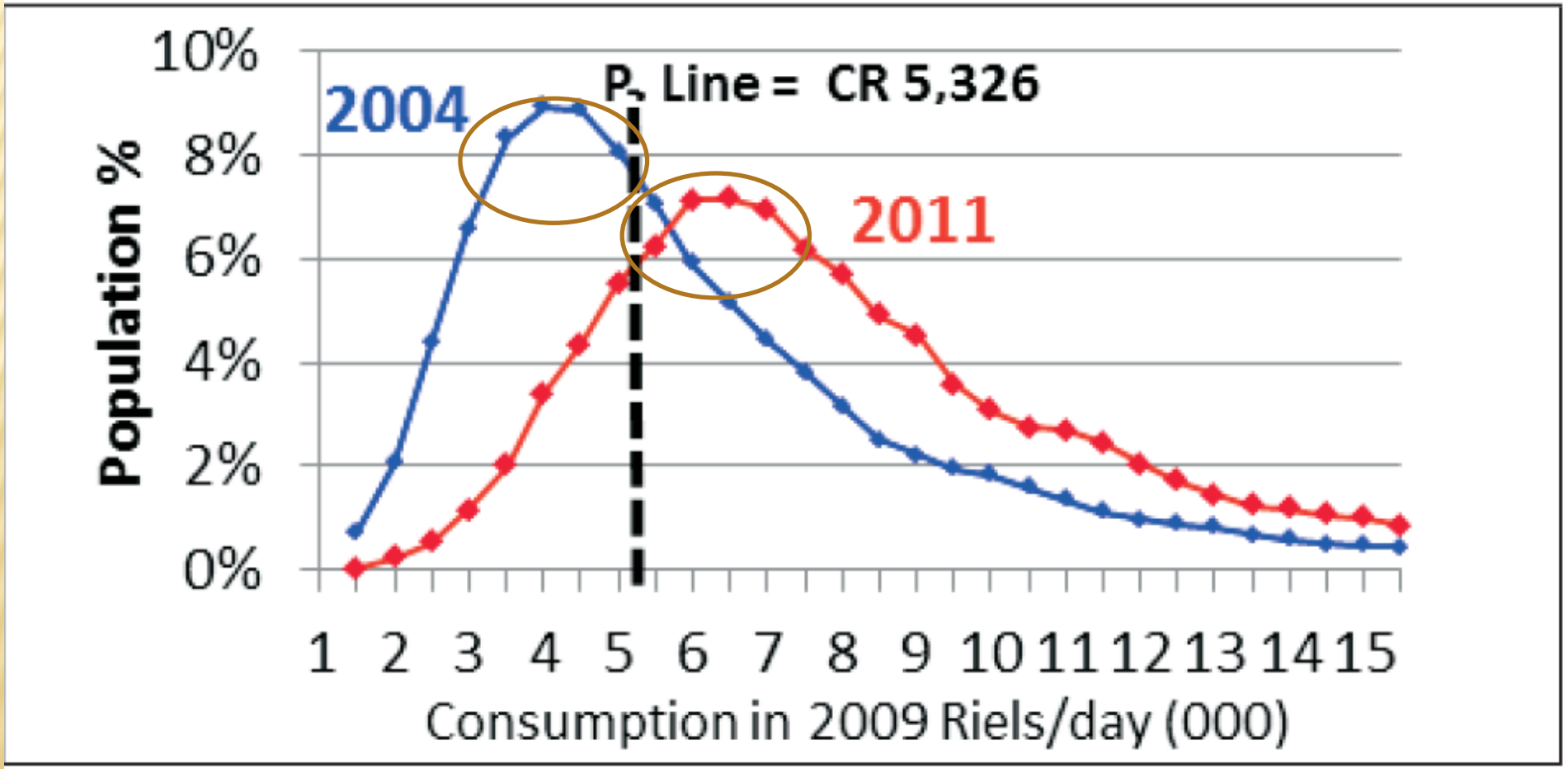
REMAINING CHALLENGES

- Service quantity and quality:
  - Increasing NCDs, but no reliable supply yet
  - Quality of care: a major concern in both public and private sector.
  - A recent country-wide quality of care assessment in pubic health facilities => below the average of standard care

REMAINING CHALLENGES

- Financial protection:
  - Relatively low % of GGHE, but large % of OOP (60%) and significant % of external funding
  - Despite economic growth & poverty reduction, still those escaped the poverty remains very vulnerable "the near-poor"

Population Shares By Consumption, Cambodia



Source: Where have all the poor gone? Cambodia Poverty Assessment 2013

REMAINING CHALLENGES

- Institutional arrangements
  - Fragmentation and harmonization
  - Attention to ‘insurance’ approach may undermine the already well performing “Universal Entitlement” for priority health services
- Data and research
  - Despite many relatively good data sources, still lack of data to compute key UHC indicators
  - Further progress to UHC requires research, in particular health system and economic research to inform policies

THANK YOU FOR YOUR ATTENTION!