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
Pop: 15.58 million

CAMBODIA

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
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

CAMBODIAN GOVERNMENT

- Other

Public Health Facilities

- Lump sum payments

Health Equity Funds; Vouchers

- Main subsidies from the government and partners

PRIVATE NON-PROFIT FACILITIES

PRIVATE FOR-PROFIT FACILITIES

Fee-for-service payments

HOUSEHOLDS/PATIENTS

- Lump sum payments

Community-Based Health Insurance

- Exceptional subsidies from development partners

- Public subsidies and private payments

- Private payments and contributions

30-40% of total income

60-70% of total income
HEALTH EXPENDITURES IN CAMBODIA

THE by sources 2012-2014

Source: Cambodia MOH’s NHA Report 2016
IMPRESSIVE REDUCTION IN MORTALITY RATES

- Infant Mortality Rate (Infant deaths/1,000 live births)
- Under 5 Mortality Rate (Child deaths/1,000 live births)
- Maternal Mortality Ratio (Maternal deaths/100,000 live births)

Number of deaths

CDHS 2000 | CDHS 2005 | CDHS 2010 | CDHS 2014
----------|----------|----------|----------

Infant Mortality Rate
Under 5 Mortality Rate
Maternal Mortality Ratio
## MOST HEALTH MDG TARGETS ACHIEVED

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

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

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Pop. coverage</th>
<th>Service coverage</th>
<th>OOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysia</td>
<td>100%</td>
<td>Free PHC, esp. MCH, but rationed by waiting time &amp; # family physicians in HCs =&gt; private services</td>
<td>41%</td>
</tr>
<tr>
<td>Thailand</td>
<td>98%</td>
<td>Comprehensive benefit package, free at point of service for all three public insurance schemes</td>
<td>19%</td>
</tr>
<tr>
<td>Philippines</td>
<td>76%</td>
<td>Benefit package covers IPD only except for the sponsored program (+OPD); high level of co-payment for all PhilHealth components (average reimbursement: 54%)</td>
<td>55%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>48%</td>
<td>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) =&gt; low levels of financial protection.</td>
<td>30%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>55%</td>
<td>Benefit package is comprehensive but has a substantial level of co-payment: 5–20% of medical bills.</td>
<td>55%</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>8%</td>
<td>SHI for the formal sector (&amp; limited CBHI/HEF for the informal and poor), but low coverage &amp; small service package.</td>
<td>62%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>23%</td>
<td>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.</td>
<td>61%</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>SHP schemes</th>
<th>Population coverage</th>
<th>Service coverage</th>
<th>Financial contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct government/donor subsidies</td>
<td>All service users</td>
<td>EPI, TB, HIV/AIDS Other MPA/CPA</td>
<td>Free services Subsidized (Pay user fees only)</td>
</tr>
<tr>
<td>Health Equity Funds</td>
<td>Over 3 million poor</td>
<td>MPA, CPA services + Transport, food</td>
<td>Free services + Support for transport, food</td>
</tr>
<tr>
<td>Reproductive Health Vouchers</td>
<td>Reproductive age/Pregnant Women</td>
<td>Reproductive &amp; SMH Services + transport + CCT</td>
<td>Free services + support for transport + CCT</td>
</tr>
<tr>
<td>Social Health Insurance/Work Injury: NSSF</td>
<td>1 million salaried workers</td>
<td>MPA, CPA, transport maternity, disability benefits</td>
<td>Free services + ambulance support + other benefits</td>
</tr>
<tr>
<td>Community-Based Health Insurance</td>
<td>118,000 voluntary members</td>
<td>MPA, CPA services + Transport</td>
<td>Free services + transport support</td>
</tr>
<tr>
<td>Private Health Insurance</td>
<td>&lt;5% of the population</td>
<td>Limited benefit package (risk rated)</td>
<td>Reimbursement with ceiling?</td>
</tr>
</tbody>
</table>
No catastrophic expenses (25% of total expenditure)
No impoverishing expenses (pushed below 1.25$)
Family planning (met need)
Four or more visits of antenatal care (ANC4)
Skilled birth attendance
ART coverage
TB treatment coverage
Hypertension treatment coverage
Child immunization (DTP3-HepB)

Source: Author, 2016
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
Cambodia (DEA=100%) versus Cameroon (DEA=77.2%)
SOCIO-ECONOMIC INEQUITY IN COVERAGE:

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 public 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!