**HEALTHCARE PROFILE**

### Healthcare Status

<table>
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<tbody>
<tr>
<td>16M</td>
<td>69</td>
<td>5% LRI</td>
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<tr>
<td></td>
<td></td>
<td>5% Heart Diseases</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4% Stroke</td>
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<td></td>
<td>AVG in East Asia &amp; Pacific</td>
<td>~30% of pop.</td>
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### Total Healthcare Expenditure (2015)

<table>
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<tbody>
<tr>
<td>$1.1 BN (5.9% of GDP)</td>
<td>$65-70</td>
<td>6.1%</td>
<td>22% Foreign Donors</td>
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<tr>
<td></td>
<td>$332</td>
<td></td>
<td>20% Government</td>
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<tr>
<td></td>
<td>AVG in East Asia &amp; Pacific*</td>
<td></td>
<td>1% Private Insurance</td>
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<td>57% Households</td>
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### Financing and Expenses

**Healthcare Status**

- **Population (2017):** 16M
- **Life Expectancy at Birth (2016):** 69 years
- **Top 3 Causes of Death (2015):**
  - LRI (5%)
  - Heart Diseases (5%)
  - Stroke (4%)
- **Health Insurance Coverage:** ~30% of pop.

**Total Healthcare Expenditure (2015):** $1.1 BN (5.9% of GDP)

**Healthcare Budget per Capita:**

**Breakdown of Healthcare Expenditure (2015):**
- 22% Foreign Donors
- 20% Government
- 1% Private Insurance
- 57% Households

### Infrastructure

<table>
<thead>
<tr>
<th>Universal Health Coverage (UHC): Service Coverage Index (2015)</th>
<th>Density of Physicians (per 1,000 pop.)</th>
<th>Density of Nursing &amp; Midwifery (per 1,000 pop.)</th>
<th>Number of Specialized &amp; General Hospitals</th>
<th>Number of Referral Hospitals</th>
<th>Number of Health Center &amp; Posts</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>-0.1</td>
<td>-1</td>
<td>-34</td>
<td>-62</td>
<td>~1,050</td>
</tr>
</tbody>
</table>

**Health in Cambodia is underfinanced by government and relies on international help and household expenditures.**

Note: (*) includes long term care, preventive care, ancillary services and other unclassified health expenditures. Sources: WHO, World Bank, Advention.
The National Malaria Program is organized as follows:

- **The CNM** sits within the MoH along with other disease programmes.
- **Provincial malaria teams** are made of 1 supervisor and 2 assistants per provincial health department (PHD). There are 21 of them in malaria endemic regions providing complete packages of malaria support and 4 in non-malaria endemic regions providing limited packages (i.e. Health staff training, drugs and diagnostics).
- **Operational district malaria teams** are made of 1 supervisor and 1-2 assistants per OD. There are 45 OD malaria teams in endemic regions and 38 in non-malaria endemic regions.
- **Village Malaria Workers (VMWs), Mobile Malaria Workers (MMWs),** and local authorities have been deployed to improve the availability and accessibility of malaria services.

Regarding malaria, the government issued the Malaria Elimination Action Framework (MEAF) 2016-2020 that aims to provide universal access and robust coverage for high quality early diagnosis and effective treatment services, ideally delivered within both public and private facilities.
PRIVATE HEALTHCARE INFRASTRUCTURE

FORMAL PRIVATE HEALTHCARE INFRASTRUCTURE, 2012
MoH issues licenses for private healthcare facilities

- **PRIVATE HOSP.**: 5
- **POLYCLINICS**: 48
- **CLINICS**: 136
- **GPs**: 2,640
- **PMW***: 4
- **PRIVATE PHARMA**: 5

Some private providers offer home-visiting services, including basic medical care and deliveries, especially in rural areas.

INFORMAL PRIVATE HEALTHCARE INFRASTRUCTURE, 2012

- **TRAD. HEALERS**: 5
- **MAGICIANS**: 48
- **UNLICENSED DOCTORS**: ~1,700
- **TRAD. BIRTH ATTENDANTS**: 136
- **UNQUALIFIED DRUG SHOPS**: 4

LEGEND
- [ ] SECONDARY CARE
- [ ] PRIMARY CARE
- [ ] FEVER DIAGNOSIS TESTING

COMMENTS

A substantial share of healthcare services is provided through the private sector, which dominates curative healthcare delivery and has grown rapidly in scope.

A large proportion of the licensed private healthcare providers are small practices or one-person enterprises:
- **GPs** provide clinical consultations and outpatient treatment
- **Clinics** provide outpatient and inpatient services with at least 10 beds providing various medical specialties and diagnostic services
- **Polyclinics** provide outpatient and inpatient services with at least 20 beds providing a wide range of specialized services
- **Private pharmacies** are a frequently accessed and yet inadequate source of treatment

The quality of care of some private providers is questionable and sometimes harmful, and is characterized by improper prescriptions and unnecessary injections and infusions:
- In some cases, such as malaria, tuberculosis or immunization services, public–private partnerships (PPPs) have been developed to standardize quality of care and establish pathways between the public and private sectors, though they remain at an early stage of development

Cambodia’s “National Strategic Plan for Elimination of Malaria 2011-2025” calls for the gradual prohibition of all antimalarials through the private sector outlets. The ban on treatment at private facilities will be prioritized in areas implementing pre-elimination activities:
- Registered private outlets which can assure directly observed therapy (DOT) and establish reliable referral systems will be permitted to continue functioning

The private sector is growing rapidly but remains under-regulated and includes many unlicensed providers

Malaria services are more controlled and standardized thanks to PPP initiatives

Note: (*) Plantation Malaria Workers. Sources: Asia Pacific Observatory on Health Systems and Policies, Advention
MALARIA DIAGNOSIS PROVIDERS’ BUSINESS MODEL

PUBLIC HEALTHCARE FACILITIES

The Government funds the main health infrastructure and staff while also delivering subsidized care across a standard package of preventive, primary and curative care.

Revenues at public facilities are supplemented by nominal user charges, with funded exemptions widely provided to the poor. A number of demand-side financing schemes provide social health protection, including Health Equity Funds (HEFs), voucher schemes, and voluntary community-based health insurance (CBHI).

The services delivered at public facilities are regulated: the MoH has defined a Minimum Package of Activities (MPA) for Health Centers and a Complementary Package of Activities (CPA) for Referral Hospitals.

The MPA consists mainly of preventive and basic curative services, supplemented by specific activities for disease programmes.

The public health sector provides free access to malaria diagnosis and treatment.

PRIVATE HEALTHCARE FACILITIES

Private sector costs are covered by patient out-of-pocket (OOP) payments, as private health insurance is very limited.

Malaria diagnosis and treatment is highly subsidized in the private sector. Since 2003, Population Services International (PSI) Cambodia has managed a nationwide subsidized private sector malaria treatment programme in Cambodia. It reaches >1,500 outlets per month that are given access to unbranded subsidized RDTs (Pf/Pv), in line with the national malaria control programme.

In 2011, the CNM and the Ministry of Health (MoH) established a public-private partnership (PPP) programme to further engage the private sector and provide commodities, training, and supervision to registered public-private mix (PPM) providers.

Since 2013, Population Services Khmer (PSK) and other partners have established a network of plantation malaria workers (PMWs) throughout Cambodia, who are provided with the necessary training and supplies for malaria diagnosis and treatment, including free malaria case management for plantation workers. PMWs are required to report their cases either monthly or quarterly in exchange for new supplies.

The public and private sector is mainly funded through OOP except for certain disease programmes, such as malaria, that are government-sponsored.

Sources: MoH, PSK, interviews, Advention
The health workforce relies strongly on nurses, with 3.5 nurses per doctor. At central and provincial levels, medical doctors are the largest component of the health staff, while in rural areas nurses prevail. >40% of general medical practitioners are located at central-level facilities.

About two thirds of the private providers with formal training, including medical doctors and nurses, are also public employees. Private practice is usually a supplement to inadequate salaries and often involves conflict of interest, which leads to absenteeism in public facilities.

According to a 2016 study, VMWs are usually trusted and appreciated by the community. Nevertheless, they reported that this is often eroded when a patient presenting with fever and other malaria symptoms tests negative for malaria. Protocol dictates that such patients must be referred to the nearest health center, which is often inaccessible. Patients want and sometimes demand treatment from VMWs/MMWs for other illnesses, and workers are frustrated when they cannot provide it.

"VMWs have a major role in malaria elimination but as the malaria burden decreases, they might be useful for other diseases too. Yet, their training is so little, I doubt they will be able to prescribe antibiotics." CNM, Cambodia, Lab expert 1

Sources: Malaria Journal, MoH, interviews, Adventon
Cambodia has one of the lowest rates of physicians per 1,000 population in the world. This is a result of the Khmer Rouge attempt to reboot the society from 1975 to 1979, which led to the genocide of doctors and the shutdown of universities and hospitals, making the country lose an entire generation of caregivers. Since 1990, Cambodia has started to rebuild its medical infrastructure but qualification and resources are still missing to train new doctors, and lack of trust remains an issue.

Hundreds of unlicensed doctors, as well as traditional healers, proliferate and are usually the preferred caregivers for patients, particularly in rural area. After a 2014 HIV outbreak in a village, caused by an unlicensed doctor using tainted needles, the government is working to limit unlicensed medical practice.

Cambodia’s malaria burden continues to be disproportionately borne by ethnic minority groups and mobile, migrant, and cross-border populations, representing a huge challenge for control and elimination of malaria. The current target is to place at least one VMW in every village, including at cross-border sites.

Local populations trust untrained practitioners and some people have never even visited a qualified one. They are perceived as accessible, fast, affordable and also as offering a better, or at least equivalent, level of care as official health centers that are lacking staff and equipment. Health centers are often only staffed with nurses and midwives. Doctors are lacking and so is equipment; that’s why patients tend to go to the private sector.” Head of Laboratory, CNM

A 2014 World Bank survey found only 1/3 of official doctors in rural health centers were able to correctly diagnose a series of illnesses and of those just 17 percent were able to prescribe the relevant drugs.

While the geographic coverage of public hospitals is mostly complete, the costs of transport to facilities, the opportunity cost of time spent at facilities, user fees and ancillary costs all create barriers to access.

Cambodian access to care is quite precarious due to historical reasons and capacity-building needs.

Note: (*) The UHC index is made of 16 indicators such as child treatment, malaria prevention, hospital access, health worker density. Sources: Phnom Penh Post, World Bank, PMI, Advention Cambodian health centre.