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# Insurance as a Means to Improve Overall Healthcare in Cambodia

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***Abstract:*** **Developing countries across the world require the supply of health care that is varied, widely available, easy to access, reasonably priced and also of high quality. This paper provides an overview of health care in Cambodia with focus on health care financing and health insurance. The system of delivery of health care services is described followed by an overview of the types of health centers in Cambodia. Furthermore, health care financing is described, providing details of the stakeholders who pay for health care (government and private) and the mechanisms available for financing. The current status of health insurance in Cambodia is also described. The author conducted a study to assess the awareness and interest of a sample population (50 participants) of Cambodian citizens with regard to health insurance programs/plans. The findings from the study highlighted the influence of cost in choosing health care facilities and deferring treatment. Furthermore, the findings drew attention to the fact that out-of-pocket (OOP) expenditure was significant in Cambodia in spite of government subsidies. Moreover, participants had limited awareness of health care programs and insurance schemes and hence were poorly covered under these. However, participants were willing to participate in insurance schemes if they were expected to pay only a partial component of the insurance fees. The author concludes the paper with a recommendation to widen the reach of health insurance to include the majority of the Cambodian population in order to improve overall health care.**

***Keywords:*** **Cambodia, health care, service delivery, financing, out-of-pocket, insurance.**

## 1. INTRODUCTION

Cambodia is a low-income country in the WHO Western Pacific Region (WPR) and is ranked 136 (Medium Human Development) out of 187 countries on the UN Human Development Index. The total population was approximately 15 million in 2013 and is expected to grow to 19 million by 2030 (Malik, 2014). The majority (~80%) of the population lives in the rural area and is engaged primarily in agriculture for sustenance. The composition of the population is predominantly ethnically Khmer and Buddhist (Annear, Bigdeli, Eang, & Jacobs, 2008). Per capita gross national income (GNI) was US$1010 in 2014 in current USD and 17.7% of the population is severely poor (Malik, 2014; World Bank, 2015). This paper provides an overview of the systems of health care in Cambodia with particular focus on health care financing and health insurance. A study was undertaken to assess the awareness and interest of a sample population of Cambodian citizens with regard to health insurance and the results and findings from the same are discussed.

## 2. HEALTH CARE IN CAMBODIA

The health care system in Cambodia has experienced significant change over the last few decades, specifically after the country gained independence in 1953 and following the downfall of the Khmer Rouge rule in the 1980s.The first Royal Government, which took office in 1993, initiated the development of infrastructure for health services and also created a Ministry of Health (MOH). Health care services are also provided by private providers and international NGOs. The predominant system of medicine in Cambodia is traditional as a high reliance on the Kru Khmer (traditional healers)can be found across the country (WHO & MOH, 2012).

### *A. Health care service delivery model:*

Health care in Cambodia is provided through a mixed system of service delivery. Delivery of public health services is structured into two levels of services which are both delivered in all districts: 1) The Minimum Package of Activity. This package is provided at the health centers; and 2) The Complementary Package of Activity (CPA). This package is offered at referral hospitals. On the other hand, the private sector does not provide these packages as private practitioners, private clinics/hospitals, and international NGOs deliver a limited range of services. Tertiary health care services are provided by 6 National Hospitals which are located in Phnom Penh and are semi-autonomous (WHO & MOH, 2012).

### *B. Health centers:*

The Cambodian government provides a minimum level of primary health care services mainly for the rural population. There are over 1000 facilities each covering an average of 15,000 people. The services provided include preliminary consultation and initial diagnosis, inoculation, emergency first aid, long-term disease care, health education, pre- and post-natal care, birth spacing guidance, and referral. However, there has been slow acceptance and usage of these services. For instance, in 2005, the main services provided by the facilities were birth control, pre-natal care, and tetanus injections. Furthermore, in 2010, <50% of health the centers provided the requisite minimum package of services. The MOH reported limitations such as lack of key personnel, shortage of critical drugs, and non-conformance to other guidelines to functioning. Some level of health promotion and disease prevention programs and activities are delivered by NGOs through health centers. National level programs have also been initiated by the government (WHO & MOH, 2012).

There are referral hospitals at national, provincial, and district levels. These are categorized intone of three levels (i.e., CPA-1, CPA-2, and CPA-3) based on criteria such as number of staff, beds, medicines, etc. For example, a CPA-1 hospital conducts no large-scale surgeries (i.e., no general anesthesia), has no facility for blood collection or storage, but hasa basic obstetric service. A CPA-2 hospital on the other hand provides all the facilities available in a CPA-1 hospital and also emergency care services, ICU facilities, large-scale surgeries (i.e., with general anesthesia), and other expert services such blood transfusion, Ear, Nose, Throat (ENT), ophthalmology, and dental services. CPA-3 hospitals provide all the facilities available in a CPA-2 hospital and some additional specialized services(WHO & MOH, 2012).

The health services provided by the private sector are through three kinds of facilities: (1) Consultation clinics offering services such as clinical diagnosis (with ultrasound), laboratory, emergency treatment, and prescription writing; (2) Clinics (10-20 beds)offering outpatient and inpatient services, several medical specialties, laboratory, radiology, and pharmacy services; and (3) Larger polyclinics (20+ beds) offering more expert services. The Cambodian MOH requires the private services to be licensed and registered to function. Private health care providers can offer only a limited set of services, and are required to conform to requirements with regard to experience of staff, size of the facility and equipment, maintenance of records, and handling and retailing of drugs. Frequently, medical personnel working in the public sector (e.g., doctors, nurses, midwives, pharmacists, etc.) also practice in the private sector. A dominant role in supporting delivery and abortion services is played by private practitioners, including traditional birth attendants (WHO & MOH, 2012).

### *C. Health care financing in Cambodia:*

The financing of health care in Cambodia is split between the government and private out-of-pocket payments. Health care financing is characterized by an unusually high level of total health expenditure, relatively low government spending, and high household out-of-pocket (OOP) spending. The government spend is mainly obtained from general taxation revenues with considerable support from external growth partners. The government expenditure on health grew from US$4 per capita (in 2000) to US$9.36 (in 2009) (WHO & MOH, 2012).

Estimates (WHO, 2012-13; Lane, 2007) of health care financing in Cambodia indicate that (i) Total health expenditure in Cambodia is almost double in comparison to similar developing countries, which was approximately 5.7% of GDP in 2011, (ii) external resources for health provide 15.84% of the total expenditure and OOP spending accounts for approximately 57% of all health expenditure.

OOP payment for health care is predominant in Cambodia. Most (68%) of theOOPspend is directed towards private medical services and includes payments to illegal or unregulated private practitioners, unofficial payments to practitioners in the public sector,and other costs, such as transportation. Common strategies used to pay these health costs include savings (51%), wages/earnings (45%), borrowed money (18%), and disposal of assets (8%), all of which can add to the increase of poverty levels across the country (WHO & MOH, 2012).

The Cambodian government provides subsidies in terms of facilities, equipment, staff salary, and essential medicine to ensure that a minimum level of health services and medicines are made available to the general public. However, health care users are required to pay for consultation and treatment and for drugs which are out-of-stock. The fees to be paid can vary between services even if provided within the same district. Private sector fees, on the other hand, are not supported by any government subsidy and are determined by each private health provider. There is limited regulation in this regard (WHO & MOH, 2012).

Financing mechanisms (WHO & MOH, 2012) available in Cambodia to support access to efficient and reasonably priced health care for the people, in particular the poor and defenseless include:

- Direct tax-funded health services plus user fees for the affluent. Exclusions are available on these for designated "poor" citizens, which includes monks, incapacitated war veterans, elderly, and other poor people who qualify for the exclusion.
- Contracting for services (using public or private providers) to specific groups based on provider performance.
- Voluntary Community-Based Health Insurance. In this scheme, the insurer engages public health facilities to deliver agreed upon health services. Patients pay insurance premiums in advance to the scheme and are then entitled to receive free health care at contracted facilities. The public health facilities either receive an advance monthly capitation payment or reimbursement of user fees.
- Health Equity Funds which reimburse health providers for services provided to eligible poor and meet costs related to patient food, transport, and access to health. The use of these funds has shown an increase in usage of services and a decrease in health-related liabilities for patients. Standardization has also been possible for user fees for services in these schemes.
- Voucher schemes. These allow payment of user fees at designated providers for certain health services using vouchers (WHO & MOH, 2012; Annear et al., 2008).

## 3. HEALTH INSURANCE

The 1998 National Charter on Health Financing of the MOH encouraged the creation of a range of health-financing schemes for assessment and appraisal. This, in turn, led to the creation of a policy of user fees at all levels of the health system, and several pioneering pilots of commissioning health service provision, health equity funds, and community-based health insurance schemes. A master plan for social health insurance was approved in 2003 in support of the Charter. This envisaged compulsory health insurance for formal sector workers, voluntary, community-based insurance and social assistance through equity funds (Lane, 2007).

The Law on Social Security Schemes was approved in 2002 to introduce social insurance benefits such as employment injury benefits, age, invalidity, and survivors' pensions, and other benefits based on the actual situation of the national economy (Royal Government of Cambodia, 2002). Under this law, two types of mandatory health insurance schemes (National Social Security Fund for Civil Servants (NSSFC) and National Social Security Fund for private sector workers (NSSF)) were created and executedat first for public civil servants and private sector workers (Cheng, 2013).

NSSFC(2009) is an autonomous scheme under the supervision of Ministry of Social Affairs, Veterans and Youth Rehabilitation and was created to manage social security benefits (e.g., sickness cash benefit, employment injury benefits, maternity benefits, retirement benefits, etc.) for civil servants and their dependents.

NSSF (2008) was started under the Ministry of Labor's management as a three-way engagement of the government, employer, and employee. This scheme includescoverage for employment injury, medical care, and pension.

In 2008, the Strategic Framework for Health Financing 2008-2015 was developed by MOH. This framework attempts "(1) to prevent poverty linked to ill-health, (2) to improve the level of funding and quality of health care, and (2) to facilitate the process to achieve universal health insurance coverage"(Ministry of Health 2008).

Another scheme launched by the government was the National Social Protection Strategy for the Poor and Vulnerable 2011-2015 to provide a complete, cohesive, and efficient social protection plan for the poor and vulnerable (Royal Government of Cambodia, 2011). Two health finance schemes: Health Equity Fund (HEF) and Community-Based Health

Insurance (CBHI) are currently in successful operation. The MOH plans to extend the operation of HEF for full coverage (Ministry of Health, 2013).

The other two compulsory social insurance schemes NSSS for civil servants and NSSF for private sector employees continue to develop and protect employees. The data in 2009 reported that 175,000 civil servants were enrolled in NSSFC scheme and >20 million USD was distributed (ILO, 2012). In 2012, 4,583 organizations participated in the NSSF scheme and almost 4,000 of them paid contributions for 745,275 employees (Ministry of Health, 2013).

## 4. RESEARCH METHODOLOGY

A study was conducted to assess the awareness and interest of Cambodian citizens with regard to health insurance programs/plans in Cambodia. The study was conducted by collecting data from 50 respondents using a questionnaire. The questionnaire consisted of 29 questions of various types and was designed to gather data about the respondents such as demographic data and their choice of health care center. Respondents were also asked about their health care expenses and the accessibility of health workers. Overall, the questionnaire was intended to assess the general satisfaction of persons who utilize health care services in Cambodia and their awareness and willingness to participate in health insurance programs. The respondents were reassured that the survey participation was voluntary and would be kept confidential. Furthermore, the data gathered would be used only for academic purposes. The study was conducted in Phnom Penh over a total period of four weeks between Jan'2014 to November'2014.

## 5. RESULTS AND DISCUSSION

The majority were observed to be male (84%), in the age group 26 to 40 years (76%) and in private jobs (64%) (Table 1).WHO reports that the majority (61%) of the population in Cambodia is between the ages of 15 and 60 years (WHO, 2015). All the respondents in the study were in the age group of 16-55 years of age, which matches the overall population of Cambodia.

Developing countries faced issues related to gender inequality. As per the UN's 2014 Human Development Report, the Gender Inequality Index (GII) for Cambodia is 0.505 including the country in the Medium Human Development category.The GII assesses deficiency in women's accomplishments due to inequality in gender with particular regard to reproductive wellbeing, emancipation and participation in the workforce(Malik, 2014). The number of male respondents were significantly higher than female respondents which highlights the gender disparity in Cambodia.In general, private sector jobs are consideredto be better paid than government jobs. Accordingly, respondents to the survey were seen to be largely employed in the private sector. The private sector is included in the formal sector of employment in Cambodia.

**Table 1: Participant Demographics**

| Category | Frequency | Percentage |
|---|---|---|
| Gender | | |
| Male | 42 | 84% |
| Female | 8 | 16% |
| Age | | |
| 16 to 25 years | 10 | 20% |
| 26 to 40 years | 38 | 76% |
| 41 – 55 years | 2 | 4% |
| Employment Characteristics | | |
| Self Employed | 6 | 12% |
| Dependent | 12 | 24% |
| Private Job | 32 | 64% |

The majority (36%) of the participants responded that their preferred choice of health care provider was government hospitals, followed by private hospitals (28%) and doctors' private clinics (24%) (Table 2). The health care facilities

provided by the Cambodian government are chiefly focus on the rural population. In the cities, however, the population has the additional option of choosing private facilities as demonstrated by the outcome of the study.

**Table 2: Participant choice of health care provider**

| Choice of health care provider | Frequency | Percentage |
|---|---|---|
| Doctor's private clinic | 12 | 24% |
| Government Hospital | 18 | 36% |
| Private Hospital | 14 | 28% |
| No regular place of care | 4 | 8% |
| Community health center or other public clinic | 2 | 4% |

With regard to frequency of visits to the health care provider of their choice, the majority (60%) reported that they had visited the provider more than three timesin the last two years, while some visited at least once (24%).Participants were also asked to rank the factors that influenced their selection of any particular health care facility on a scale of 1 to 10 (Table 3). Certain factors such as convenient time, medicine availability, medicine cost, qualified staff (knowledge), treatment (including surgery), and availability received low ratings on average (i.e., <5) whereas other factors such as accessibility (location), overall hygiene, staff hospitality, treatment cost (including surgery), and trust/image received ratings >5. Trust/image of the facility, overall hygiene, and presence of qualified staff were the three factors that most influenced the choice of a health care facility.

**Table 3: Factors influencing choice of health care facility**

| Factor | Percentage |
|---|---|
| Acessibility (Location) | 5.04 |
| Convenient Time | 4.88 |
| Medicine Availability | 4.24 |
| Medicine Cost | 4.56 |
| Overall Hygiene | 7.38 |
| Qualified Staff (Knowledge) | 3.36 |
| Staff Hospitality | 7.1 |
| Treatment (incl surgery) Availability | 4.4 |
| Treatment Cost (incl surgery) | 5.48 |
| Trust/ Image | 8.76 |

The majority (68%) of the participants reported that the nearest health care center was within 5 kilometers, while 16% said it was between 6 and 10 kms and and 8% said more than 10 kms. This demonstrates the widespread provision of the different kinds of health care facilities across Cambodia.

The government health care centerwas preferred by most of the participants (56%) during emergencies, while the rest chose the Private hospitals (36%) or were not sure of their choice. This could be attributed to the spread of government hospitals rather than the availability of services.

Cambodia is no different from other countries with regard to delay in seeking medical attention, it is considered as a major unresolved public health issue (Christos et al., 2006). In this study,44% did not seek immediate medical attention but postponed it. Several factors determine an individual's responseto medical when one falls sick. Although these factors could be primarily personal, yet it is influenced by how the individuals viewstheir illness, their attitudes towards illness, availability of health care; economic and cultural factors, a will to seek medical attention, or personal reluctance or lack of awareness about the seriousness of the disease (Comfort, et al., 2009). The perceived severity of the disease, its frequency and intensity of persistence also play a crucial role in forcing the individuals to take steps to get well. In this study, 73% of them postponed the medical treatment due to cost.

Only 18 of the participants reported that they have to visit a specialist in the last two years. Out of these, 12 stated that they could find a specialist in these centers. On the other hand, 48% reported adequate treatment was available, while the rest either said or do not know.

Availability of the treatment facilities motivate individuals to seek medical help. However, only 48% reported that health care center did possess adequate treatment facilities like X ray, Blood test, Sonography, ECG, etc. (Table 4). In general, government health facilities such as CPA-2 and CPA-3 hospitals provide a wide range of treatment facilitiesas do all private sector facilities (WHO& MOH, 2012).

**Table 4: Need to visit a specialist, Specialist and Treatment Availability**

| Description | | Yes | No | Don't Know |
|---|---|---|---|---|
| Needed to see a specialist | Frequency | 18 | 24 | 8 |
| | % | 36 | 48 | 16 |
| Availability of Specialist inside Health Care Center | Frequency | 12 | 6 | 0 |
| | % | 67 | 33 | 0 |
| Availability of adequate treatment facility in Health Care Centre | Frequency | 24 | 20 | 6 |
| | % | 48 | 40 | 12 |

If the treatment facilities are not available in their health care center, 52.7% admitted they would approach private centers, while 40% would go to Government centers and 8% were not sure. However, it was found that prescribed medicine was available only sometimes at the health care center pharmacy. A clear lacunae in the availability of medicines in health care centers is evident. A report jointly published by Ministry of Health, Cambodia, and WHO (2012) suggest that

The MOH distributes drugs to operational districts, referral hospitals and health centers as per the guidelines created by them. Further, drugs are made available at all public facilities and in village outreach services. However, in this study, 48% of the participants highlighted the cost of medication being only partly affordable. This finding indicates that the drugs required by the majority of respondents in this study were probably out-of-stock as the government provides subsidies to obtain essential medicines and OOP payments are required only for drugs which are out-of-stock. Few more problems cited by MOH-WHO (2012) are lack of supplies due to challenge in procurement and distribution, inaccurate quantification, non-adherence to procurement schedules, low regulatory capacity and weak enforcement of the law.

Across the globe, a lot of time is spent by patients waiting to be attended in health centers. Several literature highlights the negative influence of wait time on individuals' perceptions on health care services and on their subsequent behavior(Hill and Joonas, 2005). In this study, a majority of participants (76%) indicated that the average wait time to meet a doctor was less than 20 minutes (Table 5). This indicates that there are adequate medical personnel across the health care facilities in Cambodia.

**Table 5: Average wait time to meet the doctor**

| Average wait time to meet the doctor | Frequency | Percentage |
|---|---|---|
| Less than 10 mins | 12 | 24% |
| Between 10 to 20 mins | 26 | 52% |
| Between 20 to30 mins | 4 | 8% |
| More than 30 mins | 8 | 16% |
| More than an hour | 0 | 0% |

Expenditure related to health care was assessed through family income, monthly spend on health care, and ratio of spend between medicine and treatment. The average income of the participants (84%) was found to be lower than USD 5000which is not surprising as Cambodia is a developing country.With regard to the monthly spend on health care it was observed that the majority of the respondents (68%) spent <10% of their monthly income on health care (Table 6). However, 60% of the respondents were "not sure" about the ratio of spend between medicine and treatment.

**Table 6: Health care spend of income every month and the ratio spend between medicine and treatment**

| Description | Frequency | Percentage |
|---|---|---|
| Average % health care spend of income every month | | |
| Up to 5% | 28 | 56% |
| Between 5 to 10% | 6 | 12% |
| Between 10 to 15% | 6 | 12% |
| More than 15% | 2 | 4% |
| Others | 8 | 16% |
| Ratio of spend between medicine and treatment | | |
| 1:05 | 2 | 4% |
| 2:05 | 2 | 4% |
| 3:05 | 6 | 12% |
| 4:05 | 0 | 0% |
| 5:05 | 10 | 20% |
| Not Sure | 30 | 60% |

With regard to their overall satisfaction with the quality of health care received during the last two years, more than half of the respondents (52%) reported that they were "somewhat satisfied" to "very satisfied" (Table 7).

**Table 18: Overall satisfaction with quality of health care**

| Overall satisfaction with quality of health care | Frequency | Percentage |
|---|---|---|
| Very satisfied | 4 | 8% |
| Somewhat Satisfied | 22 | 44% |
| Somewhat Dissatisfied | 10 | 20% |
| Very Dissatisfied | 2 | 4% |
| Don't know | 12 | 24% |

The survey participants were asked to provide their rating of the current health care systems from the perspectives of Availability, Affordability and Accessibility. As can be seen in Fig. 1, the participants felt that the systems of health care in Cambodia fell short on all three counts.

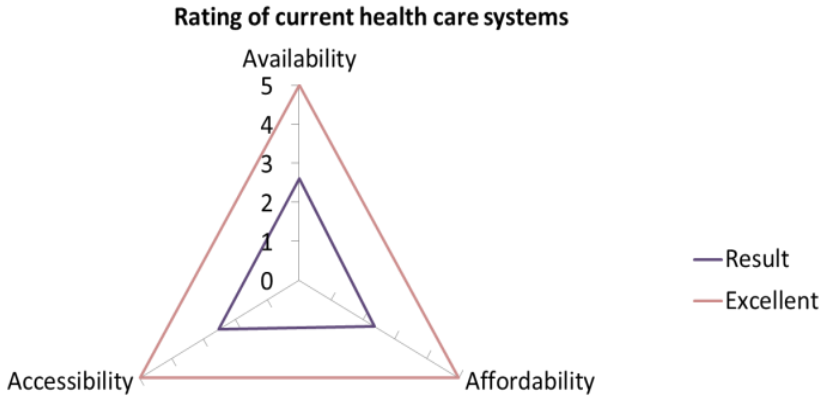


**Fig. 1: Rating of current health care systems**

As per Cheng (2013), very few Cambodians have health insurance and lower than 1% are covered through schemes such as employer-based health insurance or privately purchased commercial health insurance (National Institute of Statistics, 2011). The formal sector protects public civil servants and salaried workers in private establishments through the use of mandatory health insurance. Voluntary health insurance for the informal sector, on the other hand,is available only in selected areas (Ministry of Health, 2010) and hence can be assumed to have limited awareness, scope and coverage.

Accordingly, it was observed that the 64% of the participants were not aware of any special health care programs/ projects offered by the government to help them manage their health problem. Furthermore,56% of the participants reported that they were not aware about health insurance plans either from the government or private sources.Around 60% of the

participants were not covered by health insurance or health plans. On the other hand, the participants (60%) were not only interested in insuring health care needs, but 72% were also willing to invest in insuring health care needs (72%) (Table 23).Willingness does not mean that they would fully fund it, but only partly (52%) in insuring health care needs. We can extrapolate this to conclude that they require the government to make up the shortfall.

## 6. SIGNIFICANT FINDINGS FROM THE STUDY

The following conclusions can be drawn from the study:

a. The cost of treatment is a significant factor in choosing a health care facility.

b. Cost contributes to the delay / postponement in seeking treatment.

c. OOP expenditure is still significant with regard to the purchase of medication, in spite of government subsidies.

d. The average monthly spend on health care is <10% of the monthly income.

e. People in Cambodia are reasonably satisfied with the health care services available in the country; however, the services can be improved from the perspective of Availability, Affordability and Accessibility.

f. The awareness of health care programs and insurance schemes was low.

g. The coverage of Cambodians under health insurance or health plans was low. This could be to some part due to the reliance on traditional systems of medicine.

h. The majority of the participants were willing to partly invest in health care insurance.

## 7. CONCLUSION

Acces to the health care system in Cambodia is safeguarded by law. Health care reforms, e.g., health coverage plan, user-fee implementation, etc. have been implemented to provide country-wise access to services. A variety of health care schemes have also been developed to reduce the health care burden among poor and disadvantaged groups. The past few years have seen a number of wide-ranging schemes such as compulsory insurances for public civil servant and private employees and these are now being expanded to accommodate more members. At present, the health financing strategy in Cambodia uses the mixed system of health delivery and financing that uses public and private resources, development partners, and profits from fee-based service delivery. The government continues to subsidize public health services, while the financial assistance from development partners will be used as per national priority. Achieving universal health coverage in Cambodia may requirethe creationof a single mechanism that combines the different elements of the current health financing system.

Furthermore, the study conducted with 50 participants confirmed the shortcomings in the reach and coverage of health insurance plans across the formal and informal sectors in Cambodia. The government, private sector, and non-government organizations must look into increasing the reach of health insurance to the greater part of the population in both urban and rural parts of Cambodia.

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