

Cambodia's Main Challenges in Improving Health among the Poor

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KEY MESSAGES:

The Royal Cambodian Government (RCG) has achieved remarkable progress in recent years in reducing the poverty rate by more than half. However, the majority of those escaping from poverty only did so marginally and remain largely near-poor and still highly vulnerable to the slightest of shocks. One of the most critical factors in enabling the poor to escape from poverty, and not only remain non-poor but go on to prosper, lies in ensuring higher levels of health welfare in these households. This is especially important in rural areas, where most of Cambodia's poor reside and where health indicators show a stark divergence with those for urban areas. If poverty is to continue to decline apace, and the gap between rich and poor is to continue to narrow, then the RCG will need to ensure that poor and near-poor people's health care is greatly improved such that they can make the most of the new opportunities in education and employment that are now becoming available.

With significant improvements in some health indicators over the past decade, the major challenges in health care going forward are now becoming clearer. These include: making a breakthrough in tackling high levels of child mortality and child malnutrition; addressing equity more effectively in health service provision and health spending, through pro-poor targeted programs and improvements in the coverage and rates of use of Health Equity Funds (HEF); and the improved monitoring of unregulated private providers of medication used by the majority of the poor. In addition, another crucial step forward would be providing adequate financing and ensuring the implementation of Cambodia's first National Social Protection Strategy (NSPS).

Introduction

Despite losing 90 percent of its trained health staff during the Khmer Rouge regime in the late 1970s, Cambodia has made significant progress since then in re-establishing its healthcare system. The Ministry of Health (MoH) now employs 19,700 staff, of which 3,200 are doctors and 4,600 are qualified midwives. Health has become one of the Government's priorities and, partly as a result, Cambodia has made remarkable progress

towards some of its Millennium Development Goals in health.

For instance, in the decade to 2010, Cambodia's maternal mortality rate (MMR) dropped from 437 to 288 (per 100,000 live births); the mortality rate for 0-1 month olds dropped from 30 to 25 (per 1,000 live births); mortality rate for 1-12 month olds decreased from 66 to 45 (per 1,000 live births); mortality rate for 12-60 month olds decreased from 37 to 22 (per 1,000 live births); measles

immunization coverage improved from 79 to 93 percent; DTP immunization coverage improved from 82 to 92 percent; and births attended by skilled health staff rose from 44 to 71 percent.

However, despite this good news, some indicators do not show such promising progress. These include malnutrition in children and mothers, equity issues regarding health services and health spending, and the lack of regulation of private and unlicensed suppliers of medication, from which 55.1 percent of the poor seek medical care (against 17.9 percent of the rich).

The Issues and Challenges

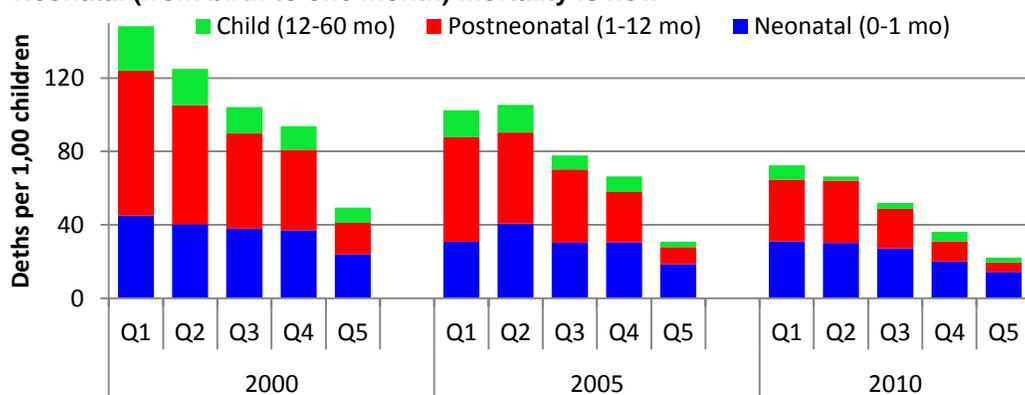
1. INEQUITIES IN CHILD MORTALITY

As in many developing countries, child mortality in Cambodia is closely correlated with wealth, especially for children 1-12 months old. Although the country as a whole is on target to meet the MDG for U5 mortality by 2015, children in the poorest quintile are 3.3 times more likely to die before age five than children in the wealthiest quintile—a ratio that has remained unchanged since 2005. Child mortality for rural children is 3.0 times than for urban children. Education of mothers is also closely correlated with U5 mortality: children born to mothers with no education are twice as likely to die compared with those born to mothers with secondary education or higher. And poor mothers are less likely to be educated: the poorest quintile of girls is twice and five times less likely to attend primary and secondary school, respectively, compared with the wealthiest quintile.

Figure 1. Mortality rates for children aged 0-5 years by year, Cambodia

Source: CDHS 2000, 2005, 2010

Neonatal (from birth to one month) mortality is now



the predominant source of child mortality for both rich and poor. Neonatal mortality has seen the least improvement across all income groups, dropping from 37 (per 1,000 live births) in 2000, to 28 in 2005, and then only to 27 in 2010. It is now the main type of child

mortality in Cambodia. While neonatal mortality declined in urban areas in 2005-10, it showed no improvement either in rural areas or among the poorest quintile. Unlike child mortality (death from 1 to 5 years), which is more influenced by the provision of preventive health services and socio-economic factors, neonatal mortality (death under 28 days) is strongly influenced by the quality of maternal and child care, including prenatal, delivery, and post-delivery care.

Poor coverage and inequities in primary health interventions account for most of Cambodia's child mortality. In 2010, the most prevalent causes of U5 mortality were complications at birth, from diseases that can be prevented by vaccines, and a lack of access to drinking water and good sanitation.

Child deaths increase when births are attended by unskilled personnel. Data analysis suggests that the risk of death increases when births are attended by traditional birth attendants compared with trained personnel; and among trained personnel, the risk of death was higher for births attended by nurses and midwives, compared with qualified doctors. This highlights the need to further increase the percentage of births attended by trained providers at health facilities, and improve the knowledge and skills of midwives and nurses.

2. GROWING BURDEN OF NON-COMMUNICABLE DISEASES (NCDs) IS AFFECTING THE POOR

Cambodia faces the dual burden of both communicable and non-communicable diseases. According to the WHO, even in 2004 NCDs had overtaken CDs as the major source of mortality. This trend towards NCDs is expected to increase going forward, and increasingly affect the poor. Chronic diseases such as hypertension, diabetes and cancer affecting the poor will have major consequences for health outcomes and put many poor and near-poor at risk of impoverishment due to health spending. A focus on primary prevention and treatment will be necessary to reduce the disease burden and reduce the costs, not only for individuals but also for the health system as a whole.

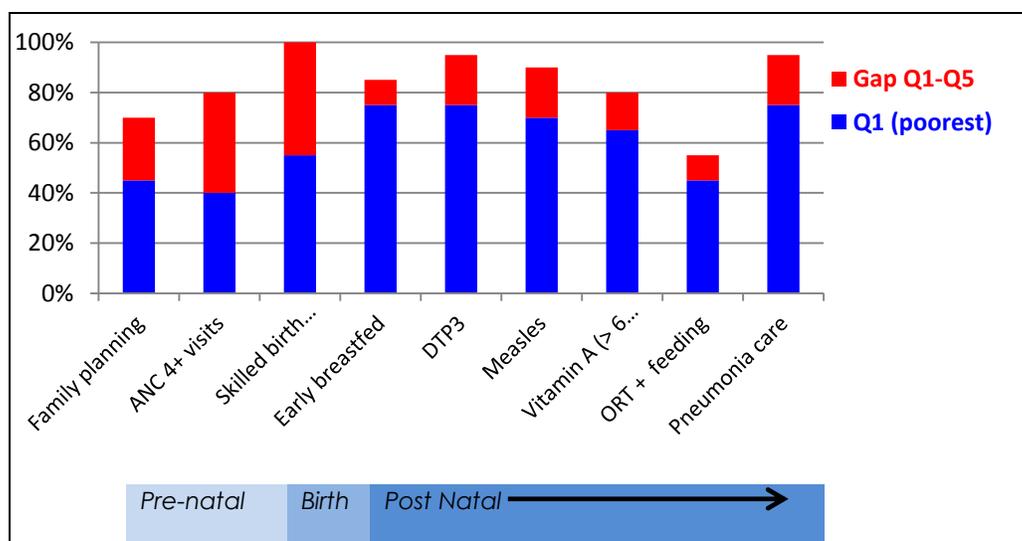
3. INEQUITIES IN THE PROVISION AND USE OF HEALTH SERVICES

Coverage remains highly inequitable for some preventative interventions, especially those that require multiple visits. For example, while 89 percent of the poorest women had at least one antenatal visit in

2010, only 40 percent of poor mothers attended the normal four antenatal care visits compared with 80 percent of the richest mothers. This means that poor mothers fail to obtain essential nutritional support, which affects the quality of the subsequent delivery.

The poorest still suffer from lower immunization rates. Despite a dramatic increase in vaccination rates over the past two decades, only 65 percent of the poor at fully immunized compared with 88 percent in the richest quintile. Ensuring higher vaccination coverage for the poor and remote communities would help to reduce mortality from pneumonia and measles, ranked third and tenth among the top causes of U5 mortality, respectively.

Figure 2. Access to key health interventions, Q1 and gap with Q5, Cambodia 2010



Note: ORT + feeding refer to treatment of diarrhea Source: DHS 2010.

Over 90 percent of the poor seeks medical care when sick, but the majority goes to unlicensed drug shops and markets. This contrasts with the richest quintile of which 75 percent seeks care in private pharmacies, clinics, or hospitals. The problem is that unlicensed drug shops and their products are not monitored or regulated, the shop owners have no medical training, and the medications are prone to counterfeiting.

4. INEQUITIES IN HEALTH SPENDING

Health spending is a major source of debt and impoverishment for the poor and near-poor, and the chronically ill. Despite an overall decline in health spending and catastrophic spending as a percentage of income in recent years due largely to rising incomes, an estimated 2 percent of Cambodians fell into poverty in 2011 due to health costs. Health spending remains a significant burden on the poor, with about 18 percent

incurring debt because of health expenses. Medical expenses are also a major burden for the almost 10 percent of households in Cambodia where at least one family member is chronically ill or injured. Poor families with at least one household member with a long-term illness or injury spend about 25 percent of their per capita income on such illnesses and injuries, while in rural areas the average spending rises to a crippling 125 percent of per capita income.

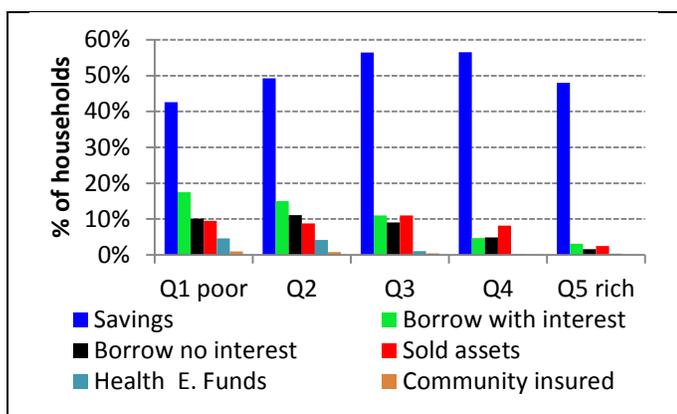
Coverage and use of Health Equity Funds (HEFs) remain low. Despite the introduction of HEFs in the late 1990s, in 2013 they still only operate in 44 out of Cambodia’s 77 operational health districts, leaving about one-third of the poor uncovered. The Government is committed to achieving national coverage of HEFs by 2015. In those districts covered, the poor are identified by a national ID Poor system, but there appear to be gaps in

the system. To illustrate, the 2011 Cambodia Socio-Economic Survey (CSES) found that 80 percent of the poor did not make use of free or subsidized treatment when seeking health care. Only 10 percent of the poor reported using HEF cards to receive free or subsidized treatment, another 10 percent reported using their ID Poor cards, while 4 percent reported having an HEF card but never using it. Meanwhile, about 5 percent of households in the 3rd and 4th wealthiest quintiles reported using the ID Poor or HEF cards to obtain

treatment, suggesting significant inclusion errors in the ID Poor system.

While generally pro-poor, government health spending could be made more equitable and efficient, reducing reliance on out-of-pocket payments. A recent World Bank public expenditure analysis in health found that (i) primary care and preventative spending is pro-poor, while spending on hospitals is not pro-poor; (ii) resource allocation among provinces lacks transparency, and could use poverty as a better criterion for allocation; (iii) too many resources (70 percent) are managed centrally; and (iv) the Ministry of Health spends more than half its budget on pharmaceuticals, and pays more than is necessary for drugs. Savings made here could be used to scale up and deepen coverage of priority equity-enhancing interventions, such as HEFs.

Figure 3. Source of health care financing, 2011



Source: CDHS 2010

5. POOR LEVELS OF MATERNAL AND CHILD NUTRITION

Women continue to suffer high levels of malnutrition and anemia. About 20 percent of all women of childbearing age are underweight on the body mass index (BMI), a prevalence that has failed to improve over the past decade. This has serious implications for their children, starting with low birth weights. While improvements have been seen in levels of anemia, high levels of anemia are still found in mothers with many children, uneducated mothers, and women in poor households and in rural areas.

Maternal support through nutrition and education is crucial for both mothers and their children. One example is iron supplements, which protect both women and infants against anemia. One-fifth of prenatal mortality and one-tenth of maternal mortality are thought to be attributable to iron deficiency worldwide, while anemia is a common cause of premature delivery and low birth weight. Intervention can make a crucial difference. In Cambodia in 2010 only 45 percent of mothers reported receiving a Vitamin A-iron-folic acid supplement in the six weeks post-delivery. Hence there is significant scope for reducing maternal and prenatal mortality by improving the coverage of micronutrient supplements in Cambodia, possibly through cash transfers to poor pregnant women to encourage earlier antenatal and postnatal care.

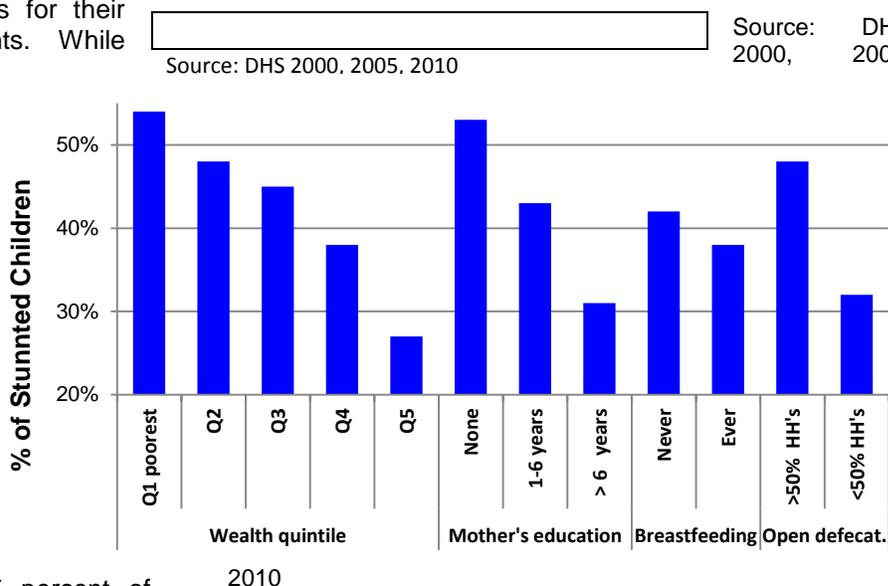
Improvements in child malnutrition have stagnated and wasting has increased since 2005. In 2010, the prevalence of stunting, underweight children and wasting were 40, 28, and 11 percent, respectively, while anemia was at epidemic proportions of 55 percent for children under 5. The long-term consequences of child malnutrition are severe: as adults they die younger and suffer higher rates of chronic disease, while children born

of malnourished women are more likely to die in infancy. While child malnutrition is correlated with socioeconomic status, other key determinants are maternal malnutrition, uneducated mothers, lack of breastfeeding and open defecation in the community. Analysis also shows that stunted women are more likely to have malnourished children, indicating the inter-generational impacts.

Despite progress, more attention is needed to promote breastfeeding and reduce open defecation.

In 2010, 70 percent of communities still defecated in the open and only 50 percent of households in Cambodia had access to drinking water. Thirty percent of mothers did not practice exclusive breast feeding, 20 percent were underweight and 45 percent were anemic. In addition, 76 percent of children did not receive a minimum acceptable diet. These recent statistics highlight how much remains to be done to improve health welfare in Cambodia.

Figure 4. Children stunted by wealth, mother education and breastfeeding and open defecation



Source: DHS 2000, 2005, 2010

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6. THE NEED FOR A NATIONWIDE SOCIAL PROTECTION SYSTEM

The National Social Protection Strategy (NSPS) has still to be implemented. In 2011, the Government approved the first NSPS for Cambodia. However, since then the implementation of the strategy has been slow and there have only been a few new initiatives to date due to inadequate financing and a lack of coordination across the various government agencies involved. With the erosion of traditional family-based safety-net systems due to urbanization, there is an urgent need to adequately finance and implement the NSPS to protect households vulnerable to financial shocks.

Conclusion

Despite some dramatic improvements in health outcomes, significant gaps remain between the poor and better-off, reflecting gaps in coverage and also quality of care. The barrier of social exclusion means that some of the most needy are systematically missed from most interventions. The Government needs to prioritize closing this equity gap in life-saving coverage indicators, including antenatal and postnatal care, ensuring adequate financing for outreach services to remote communities, and improved service coverage in remote areas. Demand-side interventions such as HEFs should be improved, and targeted interventions such as conditional cash transfers (CCTs) further piloted and scaled up.

Recommendations

- **Improve the quality of health care:** Most poor people opt to use the private sector for health care, indicating some level of dissatisfaction with the public sector. Improvements in the effectiveness of the public health sector should be made, such as increasing the availability of drugs, reducing waiting times, and improving the patient-clinician relationship. The training of medical personnel and equipment available should also be improved.
- **Enhance financial protection for the poor:** This should be achieved through improved coverage of ID Poor and HEFs, while maintaining low user-fees in the public sector. Strengthened implementation and monitoring of the ID Poor and HEF systems would help ensure all eligible poor receive HEF cards and are made aware of the benefits. Also consideration should be given to expanding HEFs to the near-poor, urban settings and individuals without a permanent address.
- **Prevention of chronic non-communicable diseases (NCDs):** In the future, the burden of disease will shift towards NCDs. Thus, prevention and promotion programs, such as anti-smoking campaigns and tobacco taxes, should be increased and screening and treatment for NCDs should be integrated into primary health care provision. Extending the coverage for priority chronic diseases into HEFs and social health insurance benefits should also be considered.
- **Multi-sector approach to reduce maternal and child malnutrition:** to be targeted aggressively on the poor and in rural areas. The monitoring of child growth in health centers should be strengthened and should trigger response mechanisms for moderately and severely malnourished children (e.g. micronutrient supplements and feeding practices counseling). Maternal health monitoring should also be strengthened and nutritional status and counseling for pregnant women improved. Community-based programs should be scaled to improve sanitation and eliminate open defecation.

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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