Public Disclosure Authorized

Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 08-Dec-2020 | Report No: PIDC29879

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Cambodia	P173368		Health Equity and Quality Improvement Project - Phase 2 (P173368)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	Jul 17, 2021	Aug 31, 2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Kingdom of Cambodia	Ministry of Health	

Proposed Development Objective(s)

To improve equitable access to quality health services, and to provide immediate and effective response in case of an eligible crisis or emergency in the Kingdom of Cambodia.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	140.00
Total Financing	50.00
of which IBRD/IDA	50.00
Financing Gap	90.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Credit	50.00

Environmental and Social Risk Classification	Concept Review Decision

Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Cambodia has experienced robust economic growth and macroeconomic stability over the past decade; however, the ongoing COVID-19 pandemic threatens to reverse the economic gains.** The economy grew at an annual average of 5.4 percent between 2010 and 2019. Per capita income (current prices) more than doubled during the same period – from US$785 in 2010 to US$1,643 in 2019. The economy is driven by the garment, construction, and service (especially tourism) sectors. Although Cambodia has made dramatic progress in reducing poverty, 13.5 percent of the population still live below the national poverty line. Additionally, about 4.5 million near-poor[1] remain vulnerable to small economic shocks, especially in a context of the unprecedented health, social, and economic challenges posed by the COVID-19 pandemic. Growth is projected to be reduced by more than half; from 5.5 percent in 2019 to 2.5 percent in 2020. Government revenues from taxes and other sources are also anticipated to decrease, leaving less fiscal space for Cambodia to invest in social sectors.

2. **About 90% Cambodia's poor live in rural villages where access to services is still lacking, with geographical variations in rural poverty as well**. Non-income dimensions of poverty are significantly higher in rural areas. In 2017, 21 percent of the population (3.4 million people) did not have access to improved water, 34 percent (5.4 million people) did not have access to improved sanitation, and only 57 percent of students completed secondary education. Of concern is that several key indicators are not improving, or not improving quickly enough. Additionally, rural areas of the north eastern provinces have higher levels of poverty. Despite achieving economic growth and improved income, living standards remain low for much of the Cambodian population. Cambodia's institutions are still evolving and there is much evidence that the delivery of basic services lacks quality and accountability.

3. **In Cambodia, women's status continues to be low despite their significant contribution to the economy, and Gender-based violence (GBV) remains a serious issue**. In 2018, the Gender Development Index (GDI) was 0.919 (indicating medium-low equality between women and men) and the Gender Inequality Index (GII) was 0.474 (ranking Cambodia 114 of 162 countries). Social norms hinder women from leadership positions, and many women lack the confidence to demand public services to which they are entitled. While some enabling legislation and policies exist, they are inadequately implemented due to limited governance, transparency and accountability of institutions. Women are underrepresented in management positions, including in the health sector; less than 15% of leadership roles in the Ministry of Health (MOH) are occupied by women. There is also a gender gap in trained health professionals: only 35% of nurses are female and only 20% of MOH leadership positions, including specialists, general doctors, and dentists are female[2].

1 those who live on less than US$2.30 per day

[2] The proportion of females working as specialists, general doctors, and dentists,[2] as well as in MOH leadership positions are approximately 20 percent.

4. **In December 2019, the decentralization and de-concentration (D&D) reform process was accelerated by the launch of Sub-decree 193 on "Decentralization of Health Management Functions and Service Delivery to the Capital and Province Administration"**. These reforms will have a profound impact on the way in which health and other public services are financed, managed, and delivered. Details are not yet clear and are being worked on at central and provincial level, but D&D will involve a shift in responsibility for implementation and management of service delivery to provincial and district-level authorities. This will require a transformation of central ministries, including MOH, to take on more of a stewardship role with a focus on policy making, as well as setting monitoring standards, providing technical support to sub-national planning and budgeting, public financial management (PFM), health service administration, human resource (HR) management, procurement and civil works. Additionally, this reform process is also an opportunity to strengthen community participation and social accountability for health in the country.

5. **With a coastal region on the Gulf of Thailand, Cambodia is one of the more disaster-prone countries in Southeast Asia, affected by floods and droughts on a seasonal basis.** The Mekong River is the most prominent geographical feature of the country, flowing directly from the north to the Mekong Delta of Vietnam in the south. Cambodia's topography includes the low-lying central plains of the Mekong, which are surrounded by mountainous and highland regions. Cambodia's topography includes the low-lying central plains of the Mekong, which are surrounded by mountainous and highland regions; the climate is tropical with a monsoon/rainy season (May-October) and a dry season (November-April) with relatively cooler temperatures. During the 20-year period from 1987 to 2007, a succession of droughts and floods resulted in significant loss of life and considerable economic loss.

Sectoral and Institutional Context

6. **Cambodia's population of 15.3 million has seen steady improvements in health status during the past decades**. Health outcomes have improved dramatically, and Cambodia achieved most of the health-related Millennium Development Goals. Cambodia is also one of the early achievers of the 90-90-90 target for HIV treatment and has reached the goals of 90 per cent HIV diagnosis, treatment and suppression. Maternal mortality ratio decreased from 472 deaths per 100,000 live births in 2005 to 170 in 2014, and under-five mortality rate from 83 deaths per 1,000 live births in 2005 to 35 in 2014[3]. The total fertility rate has also fallen; fertility in 2018 was 2.5 children per woman[4]. Remaining challenges include high neonatal mortality, poor nutrition outcomes[5], a double disease burden of communicable and non-communicable diseases (NCDs), and high rates of adolescent pregnancy. There are also persisting inequalities in health outcomes by socioeconomic status, geographic regions and between urban and rural populations—the agenda of access to basic reproductive, maternal and under-five health services have not been met for all in the country. Quality of care remains a challenge, but MOH's quality improvement effort is beginning to improve service quality in hospitals and health centres.

7. **While health service utilization has increased over the years, access to noncommunicable and/or chronic diseases is particularly limited at the primary care level.** In 2016, 43 percent of Cambodians aged 18–69 had never had their blood pressure checked, while 72 percent of respondents previously diagnosed with high blood pressure were not on medication. Continuity of care for chronic conditions requiring ongoing management barely exists throughout the country.

8. **NCDs account for a large and increasing share of the burden of disease in Cambodia – the share of deaths**

[3] Cambodia Demographic and Health Surveys 2004 and 2014.
[4] World Development Indicators
[5] 32.4 percent of children were stunted in 2019, a measure of chronic malnourishment

attributed to NCDs increased from 33% in 2000 to 64% in 2018[6]. In 2017, NCDs accounted for six of the top 10 causes of combined death and disability[7]. The share of the burden of NCDs increased in 2007-2017 (diabetes by almost 50%), while the share of communicable diseases and injuries decreased. The impact of NCDs on the economy and the financial burden of households is considerable – a household with at least one member with a chronic disease were 3.1 times more likely to incur catastrophic health expenditure compared to other households in 2014. Community structures and networks have been insufficiently utilized in the response to NCDs. Addressing NCDs can serve as a starting point to promote people-centred integrated care based on a strong primary care system with a focus on prevention and integrated disease management pathways to ensure that complicated cases are referred to hospitals.

9. **In Cambodia, prevailing structural barriers and social norms also limit access to health services for girls and women.** Distance and travel time to health facilities make it difficult for girls and women to seek care, while rigid gender norms contribute to widespread tolerance and acceptability of GBV and reduce women's willingness to seek help. 20 percent Cambodian women are reportedly experiencing physical and/or sexual violence by an intimate partner, but only two out of five of them have sought assistance to stop the violence they have experienced. Few public facilities provide services for GBV survivors, partly because training and skills among health professionals on how to respond to GBV are inadequate.

10. **Public financing for health in the country has increased steadily since 2008 and the country has high rates of out-of-pocket (OOP) expenditures for health.** In 2017, current health expenditure (CHE) was approximately US$1.3 billion, corresponding to 6.1 percent of GDP and US$82 per capita. Government spending on health accounts for 23.8 percent of CHE, a slight increase since 2010, but still only 6.1 percent of the total government budget. Donors account for 15.1 percent of CHE which is a slight increase since 2010[8]. OOP spending on health accounts for 60.4 percent of CHE, which is an increase from 51.9 percent in 2010. The high OOP places a considerable financial burden on households—15.3 percent of households experienced catastrophic health expenditure (more than 10 percent of total household expenditure) in 2014[9], and approximately 3.7 percent of households were pushed into poverty due to high health spending in 2017.[10]

11. **The country's health care system is structured by an operational district (OD)-based public health sector and fast-growing private sector**. In the public sector, each OD contains health centres providing first line health services (minimum package of activities - MPA) and a referral hospital providing second-line health services (complementary package of activities - CPA). In 2019, there were 101 ODs with 91 referral hospitals, 1221 health centres, and 127 health posts. Each province (25) and the one municipality have a health department and there are nine national hospitals in the larger cities.

[6] WHO (2018) Noncommunicable diseases country profiles. Geneva: World Health Organization.
[7] IHME (2020) Cambodia country profile. Available at: http://www.healthdata.org/cambodia [accessed on 2 September 2020].
[8] Additionally, there has been a considerable injection of funds to respond to COVID-19 in 2020.
[9] WHO, Global Monitoring Report on Financial Protection in Health 2019.
[10] Using poverty line based on US$ 1.9 per capita per day. Source: World Bank (2020). Cambodia Health Financing Systems Assessment.

12. **The Cambodian public health system has been supported through the multi-donor financed Cambodia Health Equity and Quality Improvement Project (H-EQIP) (P157291) , financing both demand- and supply-side interventions (Box 1)**. Demand-side schemes aim to remove financial barriers to access and increase utilization of health services by the poor through the Health Equity Fund (HEF). Since 2017, approximately 2.6 million poor household members have been covered by HEF. While coverage has increased, there are implementation bottlenecks resulting in poor utilization of HEFs in approximately 40 percent of ODs[11].

BOX 1: H-EQIP supported a move from donor-led systems to RGC-led results-oriented funding approach and leveraged an effective partnership with DPs. It has improved the supply-side by strengthening a nationwide network of health facilities and consolidating social health protection schemes for the poor, i.e., HEF. H-EQIP has strengthened and empowered the QAO to develop the NQEMP and implement quarterly quality assessments in all health facilities, using the SDG to reward improvements in the quality of care. H-EQIP has supported the MEF and MOH in the establishment of PCA, which has become a functional validation agency for HEF and SDGs. H-EQIP has supported the introduction of innovative results-based financing approaches and contributed to strengthening of

13. **An estimated 60-80 percent of health service utilization occur in the private sector**, of which 30 percent are catered for by informal providers including drug sellers, traditional and religious healers, while 70 percent of episodes are catered for by allopathic, formal health care providers (who are often public sector employees). Out-of-pocket (OOP) spending by households accounted for more than 60 percent of current health expenditure in 2017, 40 percent of which is spent on medicines. The remaining 60 percent is spent on fees paid to private sector providers, which accounted for 53 percent of current health expenditure in 2016. The government has recognized that more consistent and stronger regulation of private providers, and a functioning accreditation system are needed, but progress has been slow.

14. **Service delivery Grants (SDGs) are a key Government supply-side financial instrument and are comprised of fixed lump-sum grants and performance-based grants.** The fixed lump-sum grants are Royal Government of Cambodia's (RGC's) health service financing mechanism which have officially been introduced to the health sector since 2016. These grants are allocated to all government health facilities at subnational level throughout the country in fixed amounts for operational expenditures in addition to operational budgets defined in their annual operational plans (AOPs). The performance-based grants are co-financed by RGC, IDA and a Multi Donor Trust Fund (MDTF)[12] provided to all government health facilities at subnational level based on their performance scores as quarterly assessed using a systematic IT-enabled tool. Both fixed lump-sum grant, and performance-based grant payments are made directly to each health facility's bank account.

15. **The Payment Certification Agency (PCA) is a Public Administrative Enterprise governed by a Board chaired by the Ministry of Economy and Finance (MEF), which has made significant improvement in the efficiency of health service delivery and financing in the country**. It acts as a neutral agency to monitor, verify and certify HEF claims and conduct ex-post verification of SDGs—this agency is one of the key achievements of the ongoing H-EQIP. While HEF card holders can access health services at no cost from all public facilities across the country, the facilities make claims to PCA which validates them and then sends to MOH for reimbursements, which are made directly to health facilities' respective bank accounts. However, PCA needs to be fully independent of MOH to become more effective and tougher reviewer of quality of care and performance of public providers. Also, it should strengthen the capacity to perform a purchasing function, beyond payment certification, based on the review and assessment

[11] Note that findings from a study on under-utilization of HEF conducted during the proposed project preparation will inform the project design as well.
[12] Contributed by DFAT, KFW Development Bank and KOICA.

of health care providers.

16. **The Patient Registration and Management System (PMRS) is used to manage a variety of patient and finance tracking functions.**[13] Hospital staff use PMRS to submit invoices related to the HEF claims, and the application is also used as a patient and beneficiary registry, health facility registry, as well as tracking patient admissions, discharges and transfers. PCA uses PMRS to administer and certify HEF payments, and to detect fraud in the transactions by auditing the records manually. However, the PMRS application has some performance issues at scale which is currently being refactored to address them. Additionally, new features, such as automated fraud detection and dynamic reporting are currently being added as part of this process.

17. **Although HEF is an established financing instrument to encourage the poor to access health services in Cambodia, additional efforts are needed to increase its utilization**. In addition to strengthening the role of HEF-Promoters, there is a need to consider multi-stakeholder engagement, including other ministries, subnational administrations (SNAs) and local bodies, to broaden and expand efforts to promote the HEF utilization. While the focus of HEF will remain on the poor in the short-term, HEF could potentially contribute to increased population coverage for UHC (Universal Health Coverage) by expanding coverage to other carefully defined population groups, such as the near-poor, informal sector and the indigenous populations and other vulnerable groups. The anticipated reduced fiscal space due to COVID-19 may make this a medium-term objective but should remain on the policy agenda. Another limitation of HEF is its incompatibility with National Social Security Fund (NSSF)[14]: the providers used, the benefit packages and reimbursement rates are different, and no system exists to move eligible beneficiaries between HEF and NSSF when their status changes. The Social Health Protection (SHP) system would benefit from harmonization of incentives for health providers across schemes to pave the way for a move towards strategic purchasing and leveraging funding to improve service quality. At minimum, HEF and NSSF need to use a common data and IT platform. When providers face the same financial incentive, quality monitoring, and performance assessment by NSSF and HEF, the strategic purchasing can more easily incentivize and support providers to improve quality of care and reduce waste in service delivery.

18. **Quality of care remains as a concern while significant improvements have been achieved in service coverage**. Evidence gathered from H-EQIP suggests that of the various dimensions of quality of care, provider knowledge and clinical practices, some of which are tied to health communication skills, are the most critical gaps. Additionally, physical infrastructure, including health facility buildings and equipment need better planning, management and further investments to improve quality of service delivery. Procurement and maintenance of major medical equipment in provincial and referral hospitals have been recognised as a challenge, and MOH is willing to explore public-private partnership options to procure quality medical equipment along with routine maintenance support.

19. **While H-EQIP has successfully expanded Comprehensive Emergency Obstetric and Neonatal care (CEmONC) services in populated areas, additional measures are needed to expand these services to remote areas.** In addition, the roll out of Basic Emergency Obstetric and Neonatal Care (BEmONC), a primary health care level initiative to reduce maternal and new-born mortality, is still far behind the target and requires immediate improvement. Indeed, the slowed pace of decline in maternal mortality between 2010 and 2014 could be

[13] These include health Facility registration, patient registration, and tracking from admission to discharge, invoice submission and management, non-medical expense management (food, transport, funerals), invoice approval and payment, and reporting on all of these activities

[14] NSSF covers formally employed workers (mainly in the garment and service industries) and civil servants but not their dependents. In April 2019, the scheme had more than 1,712,000 people enrolled. The contribution rate is set at 2.6 per cent of the employee's salary.

attributed to low quality of pregnancy-related care. Currently the emergency medical referral system is available only in Phnom Penh. There is a need to establish a national emergency referral system including a robust ambulance service network with timely transport to hospitals of obstetric and accident emergencies.

20. **Blood transfusion is essential for saving mothers' lives before, during and after delivery and is also very important for treating people involved in serious accidents**. Blood Transfusion system in Cambodia is underdeveloped as there is only a single major Transfusion Centre and Blood Bank at the National level. Only four provinces have a transfusion centre and among the 91 hospitals in the country, only 34 are equipped with a blood bank although almost all have staff capable of collecting, cross-matching and transfusing blood. It will be important to strengthen the blood transfusion system nationwide by upgrading provincial centres to becoming Regional Transfusion Centres, ensuring hospitals have blood banks and developing a system to involve the community in blood donation and expanding the pool of regular blood donors.

21. **RGC through MOH is committed to further improving quality of healthcare services as recommended in the National Social Protection Policy Framework 2016-2025**. MOH is working closely with key stakeholders to establish a national healthcare accreditation system as a way of building public confidence. The National Quality Enhancement Monitoring (NQEM) tools and processes, led by the MOH Quality Assurance Office (QAO), has built a strong foundation for processing further steps to reaching this goal.

22. **Cambodia has successfully contained the local transmission of COVID-19 so far.** However, the capacity of Cambodia to respond to a larger outbreak is a **cause** of concern. While Cambodia has experience in infection prevention and control, healthcare waste management, and communication in emergency situations, its capacity to manage risks associated with a larger outbreak of COVID-19 and to maintain routine services may be limited. If the health system is not strong enough, and if people are not able or willing to adhere to recommended preventive measures, responding to a surge of case may require lockdown measures. This would have an adverse impact on both health and economy, with worse implications for the safety and vulnerability of disadvantaged populations, especially women and people with disabilities.

23. **The COVID-19 pandemic has exposed some weaknesses and insufficiencies in the laboratory system in Cambodia.** Currently, there are two laboratories at the national level, i.e. the National Institute of Public Health Laboratory (NIPHL) and Institut Pasteur du Cambodge (IPC), which have the capacity to perform COVID-19 tests using RT-PCR. The H-EQIP is supporting for enhancement of the capacity of NIPHL and establishment of 14 laboratories in bordering provinces to cope with the increased need for testing COVID-19 when more crossing points and flights from many other parts of the world will be allowed to land in Cambodia. In addition, H-EQIP will also support for upgrading the NHIPL from Biosafety level 2+ to Biosafety level 3. However, the technical capacity and safety issues of the national and provincial laboratories still need to be reviewed prior to their upgradation so that the country can cope with COVID-19 and any future public health emergencies more effectively.

24. **PFM capacity weaknesses particularly at the sub-national level remain a challenge even though H-EQIP has been supporting Provincial Health Departments (PHDs) and ODs to improve PFM capacity and to address accountability weaknesses at health facility level where financial management skills are low**. It is not yet clear to what extent the D&D reforms will impact on H-EQIP II funds flow and related accountability arrangements. In moving forward, it is most likely that funds will continue to flow to MoH administered designated account (DA) and then to health facilities. However, budget preparation and financial reporting arrangements may need to be modified to ensure that Provincial Governments are kept informed of budget allocations and spending. In preparation for H-EQIP 2, it is proposed that MOH Department of Budget and Finance (DBF), with support from the

H-EQIP Pooled Fund Partners, will carry out a joint review of financial management arrangements for SDG performance-based grants, to identify further training needs, to review the training modality, to identify revisions to the SDG financial procedures manual and forms, and to identify any needs for technical assistance.

25. **Cambodia has been on a transition away from internationally funded and implemented social services towards government-funded and implemented services.** As Box 1 above denotes, H-EQIP is one example of such a transition with increased RGC financing for HEFs, introduction of PCA and use of HEF promoters. This strategy is also strongly reflected in the RGC's own strategies—the country's rectangular strategy is clear on the RGC's desire to meet the increasing demands for improved quality of public services, and MEF has been pushing for integrating key services into the RGC budget. However, the pace of this transition will likely be slowed by the COVID-19 induced reduced government fiscal space.

Relationship to CPF

26. **H-EQIP II is aligned with and will contribute to the realization of the vision and objectives of the National Strategic Development Plan (NSDP) 2019-2023, health sector strategies and policies, and the social health protection framework to support the achievement of UHC**. NSDP sets out a vision for implementing the fourth phase of the Rectangular Strategy for Growth, Employment, Equity and Efficiency[15]. One of the key policy priorities of the NSDP is to "enhance public health and nutrition of the people to support sustainable human resource development, economic growth, and social development."

27. **The proposed project will contribute achieving goals, objectives and targets of the Strategic Plan of MOH,** which guides health sector stakeholders to effectively and efficiently use their available resources to translate health strategies into action to accelerate progress towards UHC. The Fourth Health Strategic Plan (HSP-4) 2021-2025 is currently undergoing stakeholder discussions in its draft form and is expected to be finalized by first quarter of 2021. Also, it supports the National Social Protection Policy Framework 2016-2025 (NSPPF) which is a long-term roadmap to "build an efficient and financially sustainable social protection system serving as a policy tool for reducing and preventing poverty, vulnerability and inequality." The policy framework also contributes to the strengthening and broadening of human resource development as well as stimulating national economic growth. The NSPPF includes a strong focus on SHP, including human capital development, welfare for vulnerable people, and health insurance.

28. **The proposed project is aligned with the World Bank Group's Country Partnership Framework (CPF) for the Period FY2019-FY2023 Focus Area 2: Foster Human Development**, and also closely linked with its Twin Goals: reduce extreme poverty and enhance shared prosperity, as well as with the Bank's Health, Nutrition and Population Global Practice's focus to assist clients accelerate progress toward UHC.

C. Proposed Development Objective(s)

29. **To improve equitable access to quality health services, and to provide immediate and effective response in case of an eligible crisis or emergency in the Kingdom of Cambodia.**

[15] Royal Government of Cambodia (2019) Rectangular Strategy for Growth, Employment, Equity and Efficiency. Fourth Phase. Phnom Penh: Royal Government of Cambodia.

Key Results (From PCN)

30. **The two expected key results are: (i) improved financial protection; and (ii) enhanced quality of health services.** PDO indicators proposed for the project are listed below. Final options will be based on: (i) alignment with the indicators listed in the proposed HSP-4 Monitoring and Evaluation (M&E) framework; and (ii) availability and reliability of the data. Proposed indicators may be refined/modified during project preparation as the HSP-4 and its M&E framework are still being developed. While the PDO indicators will focus on the two results of improving financial protection and quality of health services, intermediate results indicators will include those related to health systems strengthening in line with Component 3.

31. **RESULT 1: Improved financial protection of the poor**
    - Number of households that experienced impoverishing health spending reduced.
    - Utilization of health services by HEF beneficiaries increased.

32. **RESULT 2: Improved quality of health services**
    - Average score on the internal quality assessment of health facilities improved.
    - Number of health facilities accredited.

D. Concept Description

33. **H-EQIP II will build on lessons learned from the current phase of H-EQIP to support the RGC in advancing UHC through improving equitable access to quality health services and financial protection for the poor and vulnerable; and improving the performance, sustainability, and equity of national institutions**. The proposed project will also improve digital health information system to support the planning, provision, and monitoring of the decentralized health services; maintain a focus on SDGs; support a move towards accreditation of health facilities; strengthen the independence, capacity and authority of the PCA to take on an expanded role including a move towards strategic purchasing; and institutionalize a functioning system to recognize and reward public health facilities for providing quality care. Furthermore, the project will: (i) strengthen the health system in the context of the RGC's decentralization agenda and will increase resilience to shocks such as COVID-19; (ii) support UHC policy agenda as outlined in the forthcoming Health Strategic Plan (HSP 4) and National Social Protection Policy Framework to improve equity through financial protection; and (iii) increase HEF utilization and gender equality by establishing better linkages between supply side and demand-side activities, including increasing support to local government for improving community engagement, and by addressing barriers to social inclusion.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

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APPROVAL

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