

# Knowledge Brief



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## Cambodia's Rural Health Markets and the Quality of Care

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### KEY MESSAGES:

It is already well known that the main provider of primary health care (PHC) in Cambodia is the private sector and that only 1-in-3 patients visits the public sector for out-patient care. However, data on Cambodia's health market composition, the dynamics of seeking health care, and the quality of health care in the private health sector are scarce. For example, there is almost no information on the differences in the quality of care between the public and private sectors, and between licensed and unlicensed providers. In order to remedy these knowledge gaps, two studies were undertaken early in 2013. The first aimed to look at health markets focusing on: (i) the roll-out of Specialized Operating Agencies (SOAs), and (ii) the roll-out of Health Equity Funds (HEFs). The second study aimed to measure the quality of health care across the sector.

The findings of the two studies suggest that traditional healers, such as Kru Khmer/witch doctors, shops selling pills and traditional birth attendants (TBAs), account for half of total rural health care providers, followed by private and public providers. Health system utilization indicates that 65 percent of all primary health care visits were to the private sector, although 60 percent of hospitalizations took place in public facilities. Possessing an HEF card increases health seeking towards the public sector to 34 percent (up from 15 percent), but only 46 percent of the poor have such cards. Half of women deliver their babies at home, and of those only 11 percent are attended by skilled medical personnel, while 88 percent are assisted by TBAs. Only 54 percent of private providers have formal training. Given the high utilization of the private and non-medical sectors, it seems likely that a large proportion of patients receive inadequate care, in particular from informal non-medical providers.

### Introduction

Cambodia's Rural Health Markets Study and Quality of Care Study were undertaken in eight operational districts (ODs), comprising four Special Operating

Agencies<sup>1</sup> (SOAs) and four non-SOAs. The first study involved: (i) a detailed mapping/survey of all health care providers in 160 sample villages; (ii) household surveys in

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<sup>1</sup> Special Operating Agency: an internal contracting mechanism which delegates greater authority than normal to managers of a health district or hospital, including payments for performance incentives for staff.

those sample villages; and (iii) a facility survey of managers in clinics and referral hospitals to measure governance issues, including staff incentives, resources, financial management, procurement and training. In the second study a combination of three instruments was used: (i) medical vignettes, in which hypothetical medical cases were posed to health providers covering cases of TB, malaria, diarrhea, pre-eclampsia and diabetes, and the diagnoses and recommended treatments recorded on a structured questionnaire; (ii) participant observations, where an enumerator observed real interactions; and (iii) patient exit surveys, where patients were asked about their level of satisfaction with the clinical interaction.

In terms of definitions, non-medical providers were classified as Kru Khmer/witch doctors, shops selling pills, traditional birth attendants (TBA), and monks/religious leaders. Private providers were classified as home/office trained health workers, visits of trained health workers, private clinics, private hospitals and private pharmacies. Public providers were classified as national/provincial/district hospitals, health centers, health posts and public health outreach schemes.

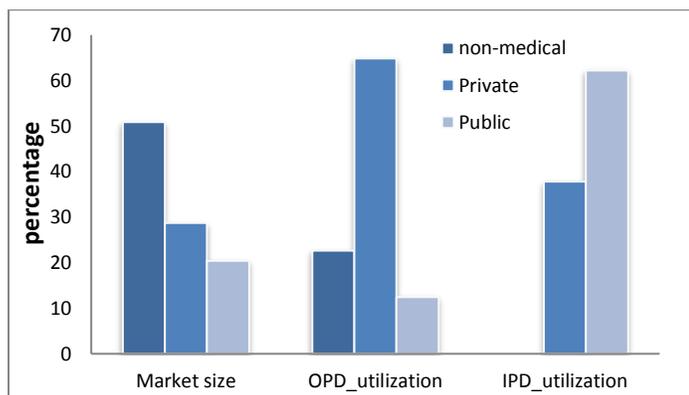
## Key Findings

Some of the key findings of the study are provided below:

### A. Rural Health Markets

- **Non-medical providers are commonest in rural areas, followed by private and then public providers.** Traditional healers, (i.e. non-medical providers) account for 50 percent of the market in rural areas, while the private market accounts for 29 percent, comprising mainly trained health workers receiving patients in their own homes, and trained health workers making home visits. Only 20 percent of total providers work in the public sector.

Figure. The non-medical sector is large, although the private sector is more utilized for outpatients (OPD) while the public sector is preferred for inpatient care (IPD)



- **The private sector dominants in primary health care system utilization.** Sixty-five percent of all primary health care visits occur in the private sector, followed by 20 percent in the non-medical sector, with only 15 percent of visits to public health facilities. However, the situation for in-patient care is different: 60 percent of all hospitalizations are at public health facilities.
- **HEF cards improve public sector utilization, but coverage remains low.** It is already known that HEF card coverage is low, at only 46 percent.<sup>2</sup> However, where patients do have HEF cards this boosts public sector utilization to 34 percent, although possession of HEF cards does not reduce non-medical treatment. Forty-one percent of HEF cardholders use their cards for in-patient care, while only 7 percent use their cards when seeking care at the out-patient level.
- **Half of women deliver babies at home and of those only 11 percent are attended by skilled medical staff.** While only 11 percent are attended by skilled medical staff (a midwife, nurse or doctor), 1 percent give birth totally unassisted. The remaining 88 percent are assisted by traditional birth attendants. High average costs of delivering in a public facility (US\$48) compared with at home (US\$4) probably play a major role in decision-making. If delivering in a public health facility, 89 percent are attended by a midwife or nurse, while 9 percent are assisted by a doctor or medical assistant. Women are more likely to use a public health facility if they live in an operating district under SOA management (45 percent in non-SOAs versus 56 percent in SOAs). Analysis also shows that visiting an antenatal clinic, proximity to a health facility and a higher level of the mother's education and socio-economic status, promote seeking public health facilities when giving birth.
- **Public facilities in SOAs seem to attract higher utilization than non-SOAs.** Utilization of public health facilities for out-patient visits was higher in SOAs (19 percent) than in non-SOAs (9 percent), while the non-medical sector was less used (11 percent vs 20 percent in non-SOAs). Dual practice was also 25 percent lower in SOAs. However, data show that vaccination cover is also lower in SOAs for all vaccines.
- **Only 54 percent of private providers have formal training. Perceptions show that patients view public facilities as being too far and requiring long waiting times.** Despite the low level of formal training by private providers, patients perceived the public and private sectors

<sup>2</sup> See Cambodia Poverty Assessment (CPA, 2013) and the Cambodia Socio-Economic Survey (CSES, 2011).

as being equally qualified. Accessibility seems to play an important role in seeking primary health care (private vs public), with many patients complaining that public health facilities are too far away and the waiting times are too long.

## B. Quality of Health Care

- **Clinical knowledge of health care providers:** As one might expect, clinical knowledge scores using the vignettes are high for doctors, medium for medical assistants, nurses and midwives, and extremely low for non-medically qualified providers. Despite the generally high scores for doctors, only 1 in 3 diagnosed all five basic vignettes correctly, while among those diagnosed correctly in only 82 percent of cases were the correct drugs prescribed. Among non-medical providers, in only 17 percent of cases where the diagnosis was right were the correct drugs prescribed.
- **Levels of knowledge between the public and private sectors:** The vignette test did not reveal a significant difference in providers' knowledge between public and private sectors. However, the knowledge of professionals working in private consultation rooms (i.e. in their own homes) and making home visits was lower. Meanwhile, health providers engaged in dual practice scored higher than those working only in public or private health facilities (i.e. not working in both), indicating more years of practical experience. Also, public providers in SOAs were 30 percent more likely to reach the correct diagnosis compared with those in non-SOAs. Knowledge increases linearly in line with years of medical experience, although there is a significant gap in knowledge of those in their mid-fifties who were trained during the Khmer Rouge era.
- **Private facilities dedicate more time per patient:** Private providers were better at communicating and spent more time with each patient than public providers. However, in terms of the thoroughness of physical examinations, public and private providers were the same, although patients' satisfaction with private providers was slightly lower.
- **Patients are more satisfied with providers who have higher levels of knowledge:** There is a clear correlation between patients' satisfaction and the level of knowledge as measured by the vignettes, regardless of whether the provider works in the public or private sector. Given that the patients were unaware of the results of the vignette tests, it appears that patients accurately value providers' knowledge in their subjective assessment of quality.

## Conclusions

1. Health Equity Fund (HEF) coverage and utilization continues to be too low, and there is little in the way of alternative financial protection.
2. If the currently high levels of neonatal mortality are to be reduced as opposed to stagnating, the costs of skilled delivery at birth need to be reduced and the number of skilled birth attendants need to be raised.
3. The higher utilization of public health facilities for in-patients and births, and the lower use of non-medical remedies in SOAs, are positive findings. However, more robust impact evaluations of the performance of SOAs, with a larger sample and time-series analysis, are warranted.
4. Given that about 20 percent of patients rely on non-medical providers as their main source of primary health care, a large fraction of Cambodians are likely receiving inadequate health care.
5. One third of patients access primary health care from private providers working in private rooms (i.e. at home) and making home visits. Given that their levels of knowledge are relatively lower, monitoring and controlling the quality of private providers may be called for.
6. There appears to be little difference in the thoroughness of physical examinations between the public and private sectors and, despite spending more time per patient in the private sector, patients are less satisfied with private hospitals compared with referral to hospitals.
7. Patients clearly value health providers who have higher levels of knowledge.

## Policy Recommendations

1. **Financial protection for the poor:** Improve coverage of IDPoor<sup>3</sup> and HEFs, while maintaining low user-fees in the public sector. Also, strengthen implementation and monitoring of ID Poor and HEF systems to 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 (homeless mainly).
2. **Reducing the number of unskilled home births:** Given that unskilled home births account for a large fraction of births in rural areas, in order to reduce neonatal mortality, costs in the public sector should be reduced and greater efforts made to ensure that more births are attended by skilled medical personnel and made under

<sup>3</sup> The Identification of Poor Households (IDPoor) Program, which was established in 2006.

hygienic conditions. There also needs to be more pressure to prevent unofficial payments.

- 3. Training for the informal health sector:** In view of the low level of knowledge in the informal sector and the large number of Cambodians who make use of this sector for care, there is a strong case—at least as an interim strategy—for providing training in the recognition of common diseases and severe symptoms. There also needs to be a stronger mechanism to combat the sale of counterfeit drugs.

- 4. Investment in improving the clinical knowledge of skilled health providers:** Given the relatively low level of provider knowledge, there is a case for revising the university curriculum and capacity, and investing in pre-service training as well as in in-service. There may also be a need to provide extra training for health professionals now in their mid-fifties who missed out on important learning during the Khmer Rouge years.

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