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Review

Health system strengthening in Cambodia—A case study of health policy response to social transition

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ABSTRACT

Objectives: Cambodia, following decades of civil conflict and social and economic transition, has in the last 10 years developed health policy innovations in the areas of health contracting, health financing and health planning. This paper aims to outline recent social, epidemiological and demographic health trends in Cambodia, and on the basis of this outline, to analyse and discuss these policy responses to social transition.
Methods: Sources of information included a literature review, participant observation in health planning development in Cambodia between 1993 and 2008, and comparative analysis of demographic health surveys between 2000 and 2005.
Results: In Cambodia there have been sharp but unequal improvements in child mortality, and persisting high maternal mortality rates. Data analysis demonstrates associations between location, education level and access to facility based care, suggesting the dominant role of socio-economic factors in determining access to facility based health care. These events are taking place against a background of rapid social transition in Cambodian history, including processes of decentralization, privatization and the development of open market economic systems. Primary policy responses of the Ministry of Health to social transition and associated health inequities include the establishment of health contracting, hospital health equity funds and public–private collaborations.
Conclusions: Despite the internationally recognized health policy flexibility and innovation demonstrated in Cambodia, policy response still lags well behind the reality of social transition. In order to minimize the delay between transition and response, new policy making tactics are required in order to provide more flexible and timely responses to the ongoing social transition and its impacts on population health needs in the lowest socio-economic quintiles.

Contents

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1. Introduction and background

During the 1975–1979 Khmer Rouge "Democratic Kampuchea" period, up to 1.6 million out of the population of 6.7 million died through execution, starvation or overwork [1]. Due to the targeting of the educated classes by the regime, health services were retained only for a minority of the Khmer Rouge elite, with the rest of the population forced to rely on traditional medicine, care by illiterate or semi-literate "Khmer Rouge doctors" and home based care to survive medical or obstetric conditions [2]. Less than 50 trained medical doctors survived this period. This contrasts with the figure of 431 medical doctors who graduated from the faculty of Medicine 6-year program in 1975 [3]. Many nurses and midwives suffered a similar fate [4].

Following the overthrow of the regime by occupying Vietnamese forces, and the ensuing "People's Republic of Kampuchea" period of 1979–1989, foundations for a socialist health system were rebuilt. This included human resource development programs for medical doctors through national and international training programs. The reconstruction of the health system also included the development of commune clinics which resulted in the placement of a midwife or nurse in each commune to provide basic primary health care to a population of 4000–6000, and the strengthening of district hospitals in each administrative district of Cambodia. In 1986, UNICEF commenced immunization programs through the Ministry of Health, and non-government organizations became active in strengthening maternal and child health care services in more secure regions of the country. HIV AIDS emerged as a public health issue in the mid 1990s, and negotiations commenced with the Ministry of Health in the same period for the establishment of birth spacing programs.

Internal security was still a major concern during the 1980s, with the remnants of the Khmer Rouge forces fighting a protracted low grade civil war in many districts in the country. International negotiations culminated in the signing of the Paris Peace Accords in 1991, which paved the way for the 1993 UN-supervised general elections. During this period, Cambodia was able to establish a rudimentary national health system relying using almost entirely domestic resources with very limited external support but nonetheless made progress in key areas [5].

Since the peaceful settlement of the election process, Cambodia has developed along a sustained path of social and economic recovery. GNI has increased from $280 in 1995 to $430 in 2006 [6]. Stimulated by a flourishing garment industry and tourist trade, cities are undergoing significant periods of growth, with the percentage of population residing in urban areas increasing from 12% in 1990 to 20% in 2006 [7]. Apart from a period of political instability which persisted up to 1997, Cambodia has to a significant degree successfully negotiated democratic transition, decentralization and economic liberalization. This "opening up" of the macroeconomic and policy environment has also facilitated some significant developments in health policy and planning in Cambodia.

It is against this social and historical background that this paper aims to describe health system policy development in Cambodia between 1996 and 2008. The specific objectives of this review are:

1. To outline recent social, epidemiological and demographic health trends in Cambodia.
2. To analyse and discuss the policy response to social transition in Cambodia.

2. Methods and sources of data collection

An international literature review was conducted of the Cambodian health system and health policy developments. National documents were also accessed, including national strategic health plans [8,9] and the most recent health sector reviews [10,11]. Secondary analysis was carried out using data from two successive Cambodian Demographic and Health Surveys in 2000 and 2005. These DHS data were published by the National Institute of Public Health and National Institute of Statistics and are made available publicly through the World Wide Web [12,13]. Data analysis was conducted using online data from Macro International Inc., Measure DHS, STATcompiler, www.measuredhs.com, accessed March 19 2008. Barrier analysis and health strategy information was sourced from sector analyses, plans and proposals [14]. The authors have also drawn on their own extensive observations and experience over the last