



A Legal and Regulatory Assessment of Private Healthcare Provision in Cambodia

Private Providers' Perceptions

HP+ POLICY *Brief*

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Background

The Royal Government of Cambodia has committed to improving equitable and sustainable access to high-quality healthcare and aims to achieve universal health coverage (UHC) as envisioned in the National Social Protection Policy Framework 2016–2025. Reaching UHC will require a coordinated approach that leverages both public and private providers to deliver high-quality health services that meet the needs of the population. Cambodia, like other countries that have made significant progress toward UHC, must consider how to effectively engage private providers to expand access to healthcare, while ensuring that appropriate regulations are in place to promote quality of care (see Box 1).

Cambodia's private sector is already a significant provider of healthcare services and must play a major role in achieving UHC. Yet, the current policy and regulatory environment is oriented more toward the public sector. Cambodia's private sector is the first point of contact with the health system for most Cambodians (67–78 percent in urban areas and 65 percent in rural areas) (WHO, 2015). While the public sector provides most preventive and inpatient services, the private sector dominates the provision of outpatient curative consultations. Yet, Cambodia's main health financing schemes are oriented toward the public sector. Both the Health Equity Fund, which focuses on reducing financial barriers to accessing care for poor and vulnerable populations, and the National Social Security Fund, which manages social health insurance schemes for private sector employees and civil servants, provide services almost exclusively through public sector providers—although, in

Box 1. Dimensions of Quality Healthcare

- **Effective:** evidence-based care that results in improved outcomes and is based on need
- **Efficient:** care that maximizes resource use and avoids waste
- **Accessible:** care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
- **Acceptable/Patient-Centered:** care that accounts for the preferences and aspirations of patients and the cultures of their communities
- **Equitable:** care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
- **Safe:** care that minimizes risks and harm to patients

Source: WHO, 2006

2018, the National Social Security Fund did begin contracting with a handful of private providers in and around Phnom Penh.

The Ministry of Health (MOH) has committed to improving equitable and sustainable access to high-quality healthcare. Recognizing that quality of care in both public and private facilities remains inadequate, under the *Health Strategic Plan 2016–2020*, the MOH aims to strengthen regulatory mechanisms to enhance continuous quality improvement efforts (MOH, 2016). Improving quality of care requires a comprehensive legal and regulatory framework together with appropriate engagement and

enforcement mechanisms to ensure that laws and regulations are implemented. However, a 2018 assessment conducted by the U.S. Agency for International Development (USAID) Applying Science to Strengthen and Improve Systems (ASSIST) project concluded that regulation of healthcare professions in Cambodia is hindered by limited understanding and lack of enforcement of professional councils' regulatory authority. Recently, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) collaborated with the MOH to draft a law on the management of healthcare facilities and services, pharmacies, dentists, para-clinics, and supporting medical services.

Given the private healthcare sector's role in increasing access to health services, the Health Policy Plus (HP+) project, funded by USAID and the U.S. President's Emergency Fund for AIDS Relief (PEPFAR), conducted a comprehensive legal and regulatory assessment of private healthcare provision. The assessment sought to gain insight into how existing laws and regulations are implemented and perceived in the private health sector. HP+ interviewed managers and owners of private health facilities to understand, from their perspective, what laws and regulations currently govern the private health sector, how these measures are being implemented, what gaps exist, and how regulatory mechanisms can be strengthened. HP+ sought to understand their level of awareness of government requirements related to owning and operating private health facilities, as well as their perceptions of how these requirements are being implemented. The analysis explored laws and regulations pertaining to opening, operating, or transferring ownership of a private health facility, including accreditation, facility management, and quality assurance, as well as interaction between private facilities and government entities. These insights can be used by policy-makers to identify opportunities to improve engagement with private sector providers and strengthen the whole health system.

Table 1. Health Facility Levels in Cambodia

Facility Type	Facility Level	Oversight Entity	No. of Private Facilities*	Available Services	No. of Beds
Hospital	Large-side	Ministry of Health	16	Inpatient and outpatient services; lab; pharmacy	80+
Polyclinic			56	Inpatient and outpatient services; lab; pharmacy	20–80
Clinic			349	Medical specialties; lab; radiology; pharmacy	10–20
Lab	Large- and small-side	Ministry of Health and provincial health departments	88	Laboratory services	1
Cabinet	Small-side	Provincial health departments	9,675	Consultative services	Less than 2

Source: MOH, 2011 (Prakas 034); * MOH, 2017 (Annual Progress Report)

Methodology

HP+ collected data for this assessment through (1) a desk review of government policies, regulations, guidance documents, and publicly available MOH data, and (2) key informant interviews. The desk review provided an understanding of the current legal and regulatory framework, while key informant interviews offered insight into informants' understanding and perceptions of the legal and regulatory environment.

Two sets of key informant interviews were held. Thirteen key informant interviews were conducted to gather information about the level of engagement with the private sector

and informants' understanding of the legal and regulatory environment in Cambodia. Informants included five representatives from provincial health departments (PHDs), one Operational District (OD) representative, three directors of the Dental Council of Cambodia, a representative from the National Social Security Fund, and five representatives of donor and multilateral organizations (GIZ, Marie Stopes International, USAID ASSIST project, the World Bank, and the World Health Organization).

In addition, 28 private facility managers and owners were interviewed at their facilities. Informants represented hospitals, polyclinics, clinics, cabinets, and labs across the six USAID-priority provinces: Battambang, Kampong Cham, Kampong Chhnang, Pailin, Phnom Penh, and Thbong Khmum. Large-side facilities (hospitals, polyclinics, and clinics) were purposively sampled from an MOH list of all large-side facilities, proportional to the total number of facilities in each province. Since small-side facilities are not under MOH oversight, there is no master list, therefore, chain referral sampling was used based on recommendations from PHDs. Respondents were asked about their knowledge and perceptions regarding regulations related to opening, operating, and licensing private health facilities; providers' relationships with professional associations and councils; monitoring quality; and reporting to government health offices.

Findings of this analysis cannot be generalized across the entire private sector as the sample size was relatively small and did not include all levels of health facilities. Regardless, collected insights can help decision-makers better understand how regulations around licensing, inspection, reporting, and accreditation are perceived to be implemented and enforced. This analysis can help identify policy levers that can be used to ensure a minimum standard of care in the private health sector and identify opportunities for improved engagement with private sector providers.

Results

Ownership and Licensing

Requirements regarding the ownership and licensing of private healthcare facilities are detailed in MOH regulation (Prakas) 034 (MOH, 2011). Prakas 034 outlines who is eligible to operate a private health facility; licensing application processes; and guidelines for opening, closing, renewing, or transferring ownership of a private health facility. According to respondents, implementation of Prakas 034 is determined by local administrators and subject to their discretion. Box 2 provides a summary of license application requirements.

Eligibility and dual practice. Cambodia's legal framework appears to allow dual practice (e.g., providers are permitted to work in both public and private sector facilities).

According to Prakas 034, civil servants, including public health facility staff, are permitted to own small-side private health facilities, but are not authorized to own large-side facilities. The 1994 Law on the Common Statute of Civil Servants of the Kingdom of Cambodia bars civil servants from undertaking work for personal purposes during working hours. Sub-decrees 21 (Kingdom of Cambodia, 1996) and 56 (Kingdom of Cambodia, 2016) state that civil servants must work eight hours per day, five days per week, although these hours are flexible depending on the specific ministry or

Box 2. License Application Requirements

- Application form
- Brief biography and contact information of applicant
- Health certificate issued by the Ministry of Health or state-run hospital
- Facility layout
- Education diploma (or certificate recognized by the Ministry of Health or Ministry of Education)
- Confirmation letter of registration with a professional council
- Current photo of applicant

institution. Generally, private facility owners and managers interviewed were familiar with this law and 54 percent were currently also working in the public sector, either at provincial health offices or public health facilities. A few noted that dual practice is necessary to supplement household income.

Licensing procedures. Licensing procedures for private health facilities, including fees, processing times, and where to apply, are further detailed in Interministerial Prakas 14342 for small-side facilities (Ministry of Interior and Ministry of Economy and Finance, 2016) and Joint Prakas 1356 for large-side facilities (MOH and Ministry of Economy and Finance, 2016). Large-side facilities are licensed directly by the MOH, while small-side facilities apply for licensing through provincial or municipal health departments. Cambodia introduced One Window Service Offices to make administrative services more transparent and efficient by combining the services of different line ministries into a single office (GIZ, 2017). In 2017, the government began scaling up One Window Service Offices, however, they still require support from PHDs to process licensing applications, as One Window Service Office officers are not well versed in licensing requirements.

Licensing requirements and processes were well understood by the private facility owners and managers interviewed by HP+. All those interviewed had valid licenses, which were acquired through the offices indicated in Figure 1. The majority knew the necessary materials and steps for licensing applications, which health office to submit application materials to, and that licensing applications for small-side facilities would be processed by the One Window Service Office—although few had experienced the “One Window Service” during the licensing process. Eighty-five percent of respondents were aware of the need to apply for license renewal and when they would need to apply. The licensing process took an average of three months (responses ranged from less than one month up to four months)—considerably longer than specified in licensing regulations (see Table 2). Sixty-eight percent of providers reported that they leveraged personal connections with MOH, PHD, or OD officers for assistance with the licensing process.

Figure 1. Where Facility Licenses Were Acquired

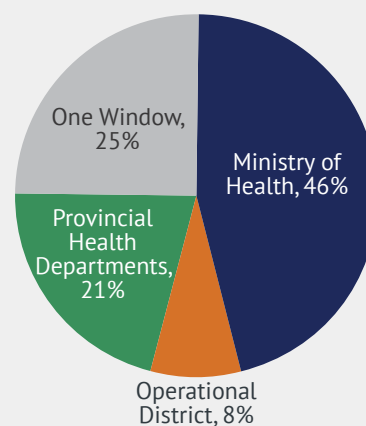


Table 2. Licensing Fees

Facility Level/Type	Opening Fee (Riel)	Renewal Fee (Riel)	Relocation Fee (Riel)	Validation Period (Riel)	Duration of Licensure Process
Small-side	200,000	140,000	0	3 years	7 days
Large-side (clinic)	4,000,000	2,800,000	3,000,000	4 years	20 days
Large-side (polyclinic)	4,600,000	3,200,000	3,000,000	4 years	20 days
Large-side (hospital)	6,000,000	4,200,000	4,000,000	4 years	20 days

Source: MOH and Ministry of Economy and Finance, 2016 (Prakas 1356); Ministry of Interior and Ministry of Economy and Finance, 2016 (Prakas 1432)

Inspection. The MOH has the authority to penalize or close facilities that operate without a valid license. Penalties for operating without a license are outlined in Joint Prakas 1356 (MOH and Ministry of Economy and Finance, 2016) and Interministerial Prakas 14342 (Ministry of Interior and Ministry of Economy and Finance, 2016). Prakas 0211 (MOH, 2011) designates roles and responsibilities for the inspection of the health facilities. Taken together with Prakas 034 (MOH, 2011), these regulations stipulate that the Health Technical Department General, the Department of Hospital Services, and PHDs (or municipal health departments) are responsible for inspecting the validity of facility licenses and drug expiration dates on an annual basis. At the subnational level, PHDs (or municipal health departments) are responsible for inspecting facilities every three months. The regulations state that inspections should follow a standardized checklist. Although the regulations are clear, most facility owners/managers, both large- and small-side, were unfamiliar with the standardized checklist and reported having had inspections, at most, twice per year. These results suggest that inspections are happening less frequently than required and without the standardized checklist. Implementation or enforcement of inspection regulations appears to be inconsistent, possibly resulting from a lack of clarity around the roles and responsibilities of different governing agencies.

Quality of Services

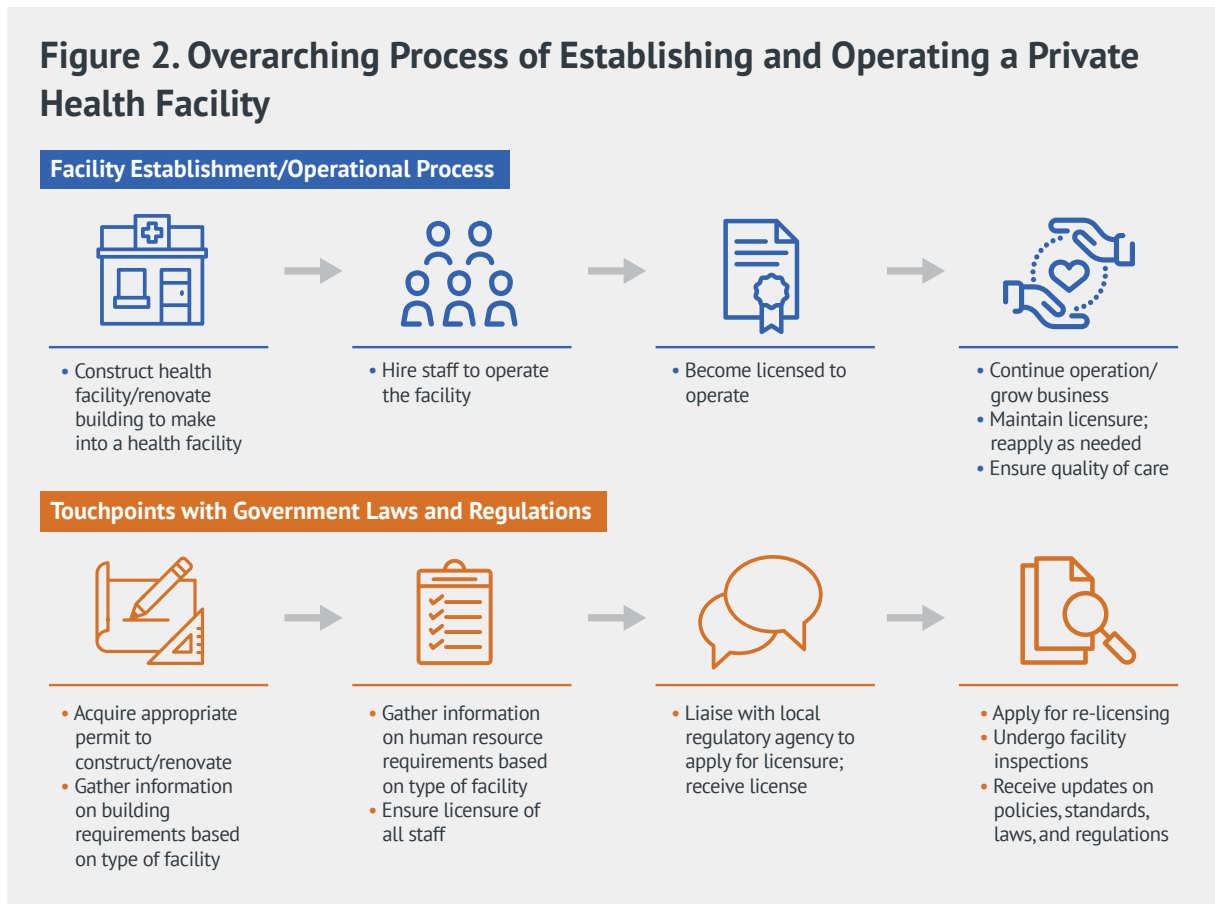
As described previously, the quality of services remains a challenge for both public and private health facilities. In 2006, to help achieve the goals of the National Health Strategic Plan, the MOH created guidelines on a complementary package of activities for public hospitals. The guidelines detail clinical and non-clinical standards of care, equipment, human resources, fees, and hospital management for different types of referral hospitals. However, the guidelines do not apply to private facilities. Eighty percent of providers interviewed said they are not familiar with any quality standards for private facilities. Instead, providers reported that they relied on their experiences in public facilities to determine quality standards for their private facilities. A few providers reported using Phnom Penh facilities as a benchmark and one facility owner reported that, at their facility, quality improvements are made in response to client feedback. Only four providers said that they follow the public facility complementary package of activities guidelines in their private facilities.

Accreditation. In addition to licensing, accreditation is a governance mechanism that can be used to ensure the quality of health service delivery through the monitoring and promotion of consistent quality and safety standards. As a member of the Association of Southeast Asian Nations (ASEAN), Cambodia is required to establish accreditation and conformity standards. The *ASEAN Guidelines for Accreditation and Conformity Assessment* provide a common basis for the operations of accreditation and conformity assessment bodies in member states. However, legislation and regulation on accreditation processes remain nascent in Cambodia. Although the Ministry of Industry and Handicrafts is responsible for oversight and monitoring of the ASEAN guidelines, the ministry's accreditation responsibilities do not apply to health specifically. In 2018, GIZ worked with Sithisak Law Office and the MOH to produce a draft law on health services management. The draft law, which was in review as of July 2018, would establish an accreditation body to ensure that predefined standards are universally applied to public and private health facilities.

Reporting. Health facilities are required to submit regular reports to government offices. Small-side facilities report to ODs, while large-side facilities report to PHDs. Most providers reported that their facilities submit monthly reports in hardcopy, as few have received training from PHDs on the use of electronic health management information systems. The standardized health management information system template includes cases by disease type; inpatient department discharges by disease type; average length of stay; bed occupancy rate; antenatal care, delivery, and postnatal consultations; family planning services provided; and surgeries. However, respondents reported that they do not receive feedback on these reports, nor do they know how the reports are used.

Government Engagement of the Private Healthcare Sector

Although PHD and OD respondents perceived there to be open communication between PHDs, ODs, and facilities, few providers felt well informed about laws, regulations, and standards beyond licensing. Figure 2 illustrates the process, based on HP+’s findings, for establishing and operating a private health facility, as well as the points at which private facilities interact with government institutions.



Professional councils. All healthcare providers, individually, are required to establish and maintain membership with one of five professional councils (see Box 2, bullet 6)—the Council of Nurses, Dental Council, Medical Council, Midwives Council, or Pharmacy Council (Kingdom of Cambodia, 2000). These professional councils have two primary roles: (1) to regulate health professionals in the interest of public safety, and (2) to represent the interests of their professional members. The councils maintain registries of members, ensure ethics and standards are observed, and provide support when a complaint is made against one of their members. Professional councils are one of the main avenues through which laws and regulations are communicated to healthcare providers in both the public and private sectors. Respondents reported having regular, informal communications with the councils via Telegram Messenger and Facebook. They also reported feeling that professional councils do not set standards of practice, provide technical trainings, or sufficiently support members when complaints are filed against them. Only 14 percent of providers reported having attended at least one training per year facilitated by a professional council. Further, most respondents did not have a clear understanding of the distinction in roles and responsibilities of professional councils or other governing agencies. Some of this confusion, as well as councils’ perceived failure to meet members’ expectations, may be rooted in the fact that councils represent individual providers, not networks of providers at the facility level (e.g., hospitals, clinics, cabinets) or sector level (e.g., private providers). This leaves councils poorly positioned to support and advocate for institutions at a broader level, as professional councils

do in many other countries. For example, the private hospital association in Indonesia, ARSSI, organizes trainings, disseminates information about quality service provision, helps mediate conflicts between private hospitals, and champions private hospitals' interests.

Conclusions and Recommendations

Insights from the owners and managers of private health facilities suggest that licensing processes are well documented, communicated, and fairly well understood and implemented. However, laws and regulations about facility management, quality standards, and monitoring are not uniformly implemented or enforced. As the private sector is key to improving equitable and sustainable access to high-quality healthcare, the MOH should improve dissemination, implementation, and enforcement of regulations. Based on the findings from this assessment, the following recommendations were identified to strengthen engagement with the private sector and improve quality of services through the private sector.

- Build upon the USAID ASSIST project's 2018 report to further clarify and disseminate roles and responsibilities of entities and health levels. Although regulations regarding hospital management and clinical care exist, providers are not clear about the roles and responsibilities of different government agencies or professional councils. Better dissemination and engagement of the private sector is necessary to improve implementation of these regulations.
- The MOH should extend or modify the complementary package of activities to include private health facilities. Public and private facilities should be subject to the same clinical practices and standards of care. Where guidelines on the complementary package of activities are not applicable, standard guidelines for public and private facilities should be developed in collaboration with providers. Guidelines, whether existing or new, should be well communicated to providers, including details on how implementation will be monitored and enforced.
- Improve the licensing process to reduce the time needed to secure a license. The "One Window Service," which few providers had experienced during the application process, may yield efficiencies in licensing. Other process improvements should be implemented to make the application process easier and quicker.
- Results suggest that facility monitoring is inconsistent, with inspections happening less frequently than required and not in accordance with a standardized inspection checklist. Lack of standardized tools and requirements for monitoring and inspection compromises their perceived objectivity and benefits. To improve quality of care, there is a need to improve dissemination and implementation of the existing checklist. Prior to doing so, the checklist should be reviewed to ensure that it is relevant and tailored to specific facility types. There is also a need to further clarify which agencies are responsible for monitoring and inspection and to strengthen these agencies' enforcement capacity. To avoid conflict of interest, an independent department for inspection within the MOH should be established.
- Clarify reporting requirements and enhance data use. Facility data provide an opportunity for the MOH to monitor the quality of service provision. However, results from this assessment suggest that the health management information system is not well utilized among the private facilities sampled. In addition to greater use of the electronic system, further development of review, analytical, and feedback processes for routine reports can be focused to monitor quality. For instance, data collected can be used to ensure that clinical activities align with service delivery standards and service guidelines for each facility level. Routine reports can also be used to monitor whether facilities have unusual levels of morbidity or mortality.

References

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). "Inauguration of One Window Service Offices at District Level in Kampong Speu Province." March, 31, 2017. Available at: <http://giz-cambodia.com/inauguration-of-one-window-service-offices-at-district-level-in-kampong-speu-province/>.

Ministry of Health (MOH). 2006. *National Guidelines of Complementary Package of Activities for Referral Hospital Development from 2006 to 2010*. Phnom Penh: Kingdom of Cambodia.

Ministry of Health (MOH). 2016. *Health Strategic Plan 2016–2020*. Phnom Penh: Department of Planning and Health Information, Kingdom of Cambodia.

Ministry of Health (MOH). 2017. *Annual Progress Report*. Phnom Penh: Department of Planning and Health Information.

Ministry of Health (MOH). *Prakas 0211 (March 30, 2011): On Roles and Responsibilities of the Food and Drug Administration, Pharmaceutical and Cosmetic and Medical Services, Paramedical and Medical Assistance of Private Sector of the Ministry of Health*.

Ministry of Health (MOH). *Prakas 034 ABS/AP (July 4, 2011): On The Modification of Procedures and Technical Conditions of the Request to Open or Close, Transform or Relocate Private Medical, Paramedical, and Medical Aide Services*.

Ministry of Health (MOH) and Ministry of Economy and Finance. *Joint Prakas 1356 (November 18, 2016): On Public Service Provision and Transition Penalty in Cash*.

Ministry of Interior and Ministry of Economy and Finance. *Interministerial Prakas 14342 (December 29, 2016): On Administrative Services of Sub-National Administrative (One-Window Service Office)*.

Kingdom of Cambodia. *Ankuret 21 (April 30, 1996): Sub-Decree on the Duration of the Work Week of Civil Servants of the Kingdom of Cambodia*.

Kingdom of Cambodia. *Ankuret 56 (April 1, 2016): Sub-Decree on Management of Presence of Civil Servants and Contract Staff*.

Kingdom of Cambodia. *Royal Kram 1094 (NS/RKM/1094/006, October 26, 1994). Law on the Common Statute of Civil Servants*.

Kingdom of Cambodia. *Royal Kram 1100 (NS/RKM/1100/10, November 3, 2000). Law on the Management of Private Medical, Paramedical, Medical Aide Profession*.

Kingdom of Cambodia. *Royal Kram 1116 (NS/RKM/1116/014, November 19, 2016). Law on Regulation of Health Practitioners*.

USAID Apply Science to Strengthen and Improve Systems (ASSIST) project. 2018. *Cambodia Country Report FY18*. Bethesda, MD: University Research Company, LLC, USAID ASSIST Project.

World Health Organization (WHO). 2006. *Quality of Care: A Process for Making Strategic Choices in Health Systems*. Geneva: WHO.

World Health Organization (WHO). 2015. *The Kingdom of Cambodia Health System Review, 2015*. Geneva: WHO.

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