

CAMBODIA

STATUS OF HEALTH SERVICE DELIVERY

Results of a Mixed Method Study of Public and Private Health Facilities



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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ASEAN	Association of Southeast Asian Nations
CAPEX	Capital Expenditure
CD	Communicable Diseases
CMS	Central Medical Supply
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease of 2019
CPA	Complementary Package of Activities
CT	Computed Tomography
DALYs	Disability-Adjusted Life Years
ENT	Ear, Nose and Throat
GDP	Gross Domestic Product
HC	Health Center
HDI	Human Development Index
HEF	Health Equity Fund
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDI	In-depth Interview
KHR	Khmer Riel
MCH/FP	Maternal and Child Health and Family Planning
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MPA	Minimum Package of Activities
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NSSF	National Social Security Fund
OD	Operational District
OOP	Out-of-Pocket
OPD	Outpatient Department
PFM	Public Financial Management
PHD	Provincial Health Department
PPP	Public Private Partnerships
RH	Referral Hospital
TB	Tuberculosis
UHC	Universal Health Coverage



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EXECUTIVE SUMMARY

Cambodia has made significant progress in expanding access to health services and improving health outcomes over the past two decades. Life expectancy has risen, and maternal and child mortality has declined sharply. However, the health system faces persistent challenges in service quality, equity, and readiness, especially as the country moves toward universal health coverage (UHC). The current study provides a comprehensive assessment of health service delivery across public and private sectors, highlighting gaps in infrastructure, human resources, medicine, financing, and patient experience.

This mixed-method study combined quantitative surveys and qualitative interviews. Data were collected from 288 health facilities (public and private) across 11 provinces (representing five regions), including health centers (HCs), referral hospitals (RHs), polyclinics, and clinics. The survey was nationally representative for the HC and RH level of the public sector but was not for the private sector. Respondents included facility administrators, health care providers, patients, and government staff. The study assessed facility characteristics, service availability, infrastructure, staffing, financing, and user experience. In total, over 1,300 structured interviews were conducted, supplemented by in-depth interviews (IDIs) with provincial and district health officials, providers, and patients.

Key Findings

Services Delivery Characteristics

Public health facilities demonstrate a strong commitment to continuous service availability. All RHs operate on a daily, 24/7 basis, and the vast majority of HCs (93.8 percent) are also open 24/7 every day. In contrast, few private health facilities open daily.

Despite wide service availability, overall service workload remains relatively low. HCs record fewer than 16 outpatient visits per day, while RHs report fewer than 32 outpatient visits per day. Primary health care services focus largely on maternal and child health and family planning (MCH/FP), with noncommunicable disease (NCD) services remaining limited. This highlights an opportunity to strengthen the role of primary health care in NCD prevention, diagnosis, and long-term management.

Surveyed private facilities primarily focus on outpatient care, with very limited provision of inpatient and surgical services. Outpatient visits account for most of the service volume in private facilities, with substantially higher activity levels compared to inpatient care. Among inpatient services, child admissions exceed adult admissions.

Service completeness remains a challenge, particularly in public facilities. Only 3 percent of HCs provide the full set of required services stated in the minimum package of activities (MPA), although 71 percent deliver more than 75 percent of the required package. RHs show a similar pattern, with just 2 percent offering the package stated in the respective level of comprehensive package of activities (CPA), while most provide between 50 percent and 94 percent of required services. These findings indicate that while many facilities are close to full provision, gaps persist across the system.

In the private sector, offerings are concentrated on general outpatient and basic services. The most commonly available services include outpatient consultations (76 percent), pharmacy services (74 percent), laboratory services (70 percent), minor surgery (69 percent), and general medicine (69 percent). In contrast, specialized and complex services are far less common, with very limited availability of outpatient hemodialysis (3 percent), dentistry (5 percent), ophthalmology (10 percent), and intensive care unit services (16 percent). Overall, surveyed private facilities play an important role in delivering basic outpatient care but contribute less to specialized, emergency, and complex service provision.

Key Inputs to Service Delivery

Key inputs to service delivery remain constrained across the health system, with infrastructure posing one of the most critical challenges. Electricity interruptions are common, affecting more than half of HCs (54 percent) and a substantial share of RHs (43 percent), while nearly one-third (30 percent) of private facilities also report frequent outages. Access to reliable water supply is uneven: piped or standpipe water is available in most RHs (84 percent) but just over half of HCs (54 percent). Water shortages were reported in 2024 by 20 percent of HCs and 18 percent of RHs, further limiting service readiness.

Gaps in the availability of required medicine and functioning equipment persist in both HCs and RHs.

Full availability of functioning equipment is rare, achieved by only 13 percent of HCs and just 2 percent of RHs. Similarly, complete availability of required medicine is uncommon: only 3 percent of both HCs and RHs reported having 100 percent of required medicine in stock. These findings indicate that while partial availability is widespread, critical shortages continue to affect service delivery.

Human resource constraints represent another major bottleneck, particularly in public facilities.

Understaffing is widely reported, affecting 88 percent of RHs and 65 percent of HCs, compared to fewer staffing challenges in private facilities. These shortages limit the capacity of facilities to expand service coverage, improve quality, and address emerging health needs.

Financing patterns differ notably between facility types. HCs are highly dependent on the national budget, while RHs benefit from more diversified revenue streams, including fixed lump-sum grants (23 percent) and user fees (14 percent). Performance-based service delivery grants represent a larger source of revenue among HCs (10 percent) than RHs (5 percent). External funding sources—such as the Health Equity Fund (HEF), the National Social Security Fund (NSSF), and nongovernmental organization (NGO) or donor support—contribute only marginally to both facility types.

Expenditure patterns further reflect these differences. HCs allocate the majority of their budgets to staff salaries and social contributions (63 percent), leaving limited resources for other essential inputs. In contrast, RHs devote a smaller share to salaries (26 percent) and allocate more funding to medications and medical supplies (28 percent). RHs also spend relatively more on equipment purchases (8 percent vs. 3 percent in HCs), maintenance (5 percent vs. 2 percent), and facility renovation (10 percent vs. 7 percent), enabling greater investment in service capacity despite persistent gaps.

Support Systems

Support systems in public health facilities show notable strengths, particularly in management and oversight. All HCs and RHs reported having functional management committees, and quality improvement planning is widely in place, with all RHs and 92 percent of HCs reporting the existence of a quality improvement plan. This indicates strong institutional structures for governance, supervision, and continuous improvement.

Despite these strengths, facilities report limited authority over key operational decisions. Both HCs and RHs have restricted autonomy in budget planning and execution, as well as in human resource management. This constrained decision-making power limits their ability to respond flexibly to local needs, address staffing gaps, or reallocate resources to priority services.

Financial management processes also present challenges. Most HCs and RHs use multiple financial record systems simultaneously, resulting in duplicated reporting requirements and increased administrative and compliance burdens. These inefficiencies can divert staff time away from service delivery and reduce overall system efficiency.

The use of performance-based financing mechanisms remains limited. Only about half of public health facilities reported linking their budgets to performance indicators, suggesting that financial incentives are not yet fully leveraged to improve efficiency, accountability, or service quality.

Notwithstanding these systemic constraints, health care providers report high levels of overall job satisfaction. Satisfaction is particularly strong in areas related to work responsibilities, opportunities for skill development, and workload balance, reflecting a generally positive working environment within public health facilities despite operational and resource limitations.

User Experience

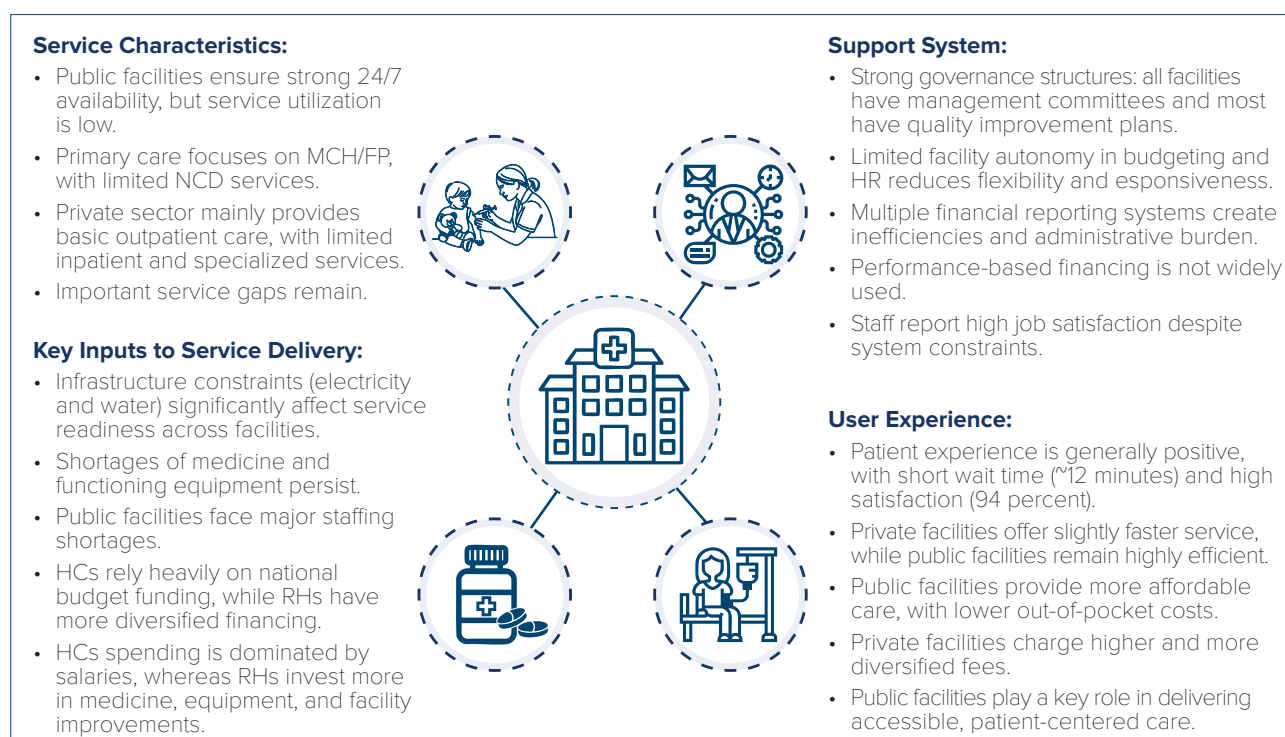
Overall patient experience across health facilities is positive, characterized by short wait time, relatively affordable costs in public facilities, and high levels of satisfaction. Average patient waiting time is low at 12 minutes, indicating generally efficient service delivery. Public facilities report slightly longer waits, averaging 13 minutes, compared to 11 minutes in private facilities. Qualitative data also suggests that private providers generally offer faster service, likely because of having lower patient volumes and streamlined processes.

Patient expenses vary considerably by facility type. Total out-of-pocket costs are significantly lower in public facilities, including both RHs and HCs, reinforcing their role in providing financially accessible care. In HCs, patient spending is largely concentrated on hospital fees, which account for 66 percent of total expenses. In contrast, private facilities impose higher and more diversified costs, with hospital fees accounting for 44 percent of expenses, followed by laboratory tests (32 percent) and medicine (23 percent). This indicates a broader range of chargeable services and inputs in the private sector, contributing to higher overall patient costs.

Despite differences in wait time and expenses, overall patient satisfaction remains high, with 94 percent of patients reporting satisfaction with the care received across facility types.

Figure ES.1 summarizes the findings from the study and table ES.1 provides key recommendations.

Figure ES.1. Summary of Key Findings



Source: Original figure for this publication.

Note: HC = health center; HR = human resources; MCH/FP = maternal and child health and family planning; NCD = noncommunicable disease; RH = referral hospital.

Table ES.1. Key Recommendations

Health service areas	Short-term recommendations (less than 2 years)	Medium-term recommendations (3–5 years)
Service package	Strengthen the NDC program by ensuring the adequate availability of essential medicine and increasing attention to community awareness and engagement.	Enforce service completeness to ensure that the essential services package implemented at the facilities level comply with the facility accreditation standards.
Key inputs to service delivery	- Strengthen supply chain of medicine and equipment to improve the availability and reduce the shortage of essential medicine and functioning equipment. - Address critical staffing shortages in public facilities by revising staffing norms, accelerating recruitment, and redeployment, especially to the rural areas. - Diversify funding sources for HCs by strengthening links to health insurance schemes, health equity funds, and external partners to reduce reliance on the national budget and improve financial resilience.	- Develop a medium-term human resource plan and institutionalize recruitment and redeployment of staff to address structural workforce shortages. - Upgrade health facility infrastructure and equipment. A stocktaking of facility infrastructure and equipment should be conducted to assess readiness gaps and provide inputs for an upgrading plan. - Diversify and stabilize facility-level financing by strengthening integration with insurance schemes, health equity funds, and external financing mechanisms.
Support system	- Expand and better leverage performance-based financing mechanisms to incentivize improvements in service readiness, availability of inputs, and efficient use of resources across facility types. - Clarify and communicate how performance evaluations link to rewards by introducing guidance that connects appraisal results to bonuses and recognition. - Reduce administrative burden by streamlining financial management systems through harmonizing and reducing parallel reporting and budgeting requirements. - Strengthen competency-based training through rapid skills gap assessments and more practical, on-the-job learning.	- Gradually increase facility-level autonomy over budget planning, execution, and human resource management to support more responsive decision-making. - Formalize the linkage between performance evaluations and career progression by connecting appraisal results to promotions and salary adjustments with clear performance thresholds. - Fully align training systems with service delivery needs through routine skills assessments, standardized competency-based curricula, and post-training evaluations.

User experience	• Improve quality of care in public facilities, focusing on upgrading clinical standards, improving management of chronic diseases, maternal and child health services, staff training, and availability of medicine and diagnostics to increase patient trust while maintaining affordable access. • Promote affordable and efficient care across public and private sectors. To address higher out-of-pocket costs in private facilities, policies should expand insurance coverage and encourage strategic partnerships with private providers for acute care. At the same time, expanding or optimizing laboratory staffing and operating hours during peak demand.	• Link quality improvement plans explicitly to patient experience outcomes, not only clinical indicators. • Invest in training on communication, respectful care, and patient engagement to improve patient-centered behaviors of staff, thus enhancing patient trust. • Introduce patient feedback systems and review comments regularly. Link the patient feedback to the quality improvement plans at the facility level. Incorporate user experience indicators (for example, waiting time, respectful care, and continuity) into facility performance-based financing.
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Source: Original for this publication.

CHAPTER 1 INTRODUCTION

1.1. Country and Sector Context

Cambodia has undergone a remarkable economic transformation over the past two decades. Between 2000 and 2019, gross domestic product (GDP) grew at an average annual rate of 7–8 percent, making Cambodia one of the fastest-growing economies in Asia. This growth enabled the country to achieve lower-middle-income status in 2015 and contributed to a sharp decline in poverty—from 33.8 percent in 2009 to 17.8 percent in 2019, lifting nearly two million people out of poverty. However, faced with global and domestic headwinds, Cambodia’s real growth is projected to decelerate to 4.0 percent in 2025 and 4.5 percent in 2026 (World Bank 2025). The economic and social performance is uneven, with domestic investment continuing to face significant challenges and disparities persisting in household welfare improvements after COVID-19. Looking ahead, Cambodia faces the dual challenge of sustaining growth while preparing for its planned graduation from Least Developed Country status by 2029, which will phase out preferential trade benefits (IMF 2025).

In parallel with economic development, Cambodia has achieved substantial health gains. Life expectancy increased from 59 years in 2000 to 70.7 years in 2021. Over the same period, maternal mortality fell from 351 to 154 per 100,000 live births, and under-five mortality dropped from 124 to 16 per 1,000 live births. Immunization coverage and family planning uptake have also improved significantly (World Bank 2023).

Despite progress, Cambodia’s Human Development Index (HDI) of 0.593 remains among the lowest in Southeast Asia. The Human Capital Index indicates that a child born in Cambodia today will achieve only 59 percent of their potential productivity, reflecting persistent gaps in health and education. High out-of-pocket (OOP) health spending—nearly 80 percent of which is directed to private clinics and pharmacies—continues to push vulnerable households into poverty. Catastrophic health expenditure disproportionately affects the poorest quintiles, with inequality in financial burden worsening over the past decade (Antunes et al. 2024). In addition, Cambodia’s UHC index (62 in 2023) lags behind regional peers, reflecting gaps in service coverage and quality (table 1.1).

Table 1.1. Health Financing and UHC Indicators: Cambodia vs. Regional Peers (2021–2023)

	Current health expenditure (% of GDP)***	Out-of-pocket share (%)**	UHC service coverage index (2023)*	Financial hardship (% of population)*
Cambodia	4.71% (2022)	60%	62	22.1% (2023)
Thailand	5.35% (2022)	8.7%	82	11.9% (2017)
Vietnam	4.59% (2022)	43%	71	23.6% (2020)
Philippines	5.11% (2023)	49%	69	31.0% (2023)
Indonesia	2.69% (2022)	35%	67	26.6% (2023)
Malaysia	3.91% (2022)	35%	80	17.8% (2022)
Singapore	4.9% (2022)	30%	88	NA
Lao PDR	2.02% (2022)	42%	64	13.2% (2018)
Myanmar	5.2% (2022)	76%	52	26.7% (2017)

Source: Original for this publication.

Note: * UHC service coverage index scale 0–100 and financial hardship (% of population) based on Sustainable Development Goal indicators of UHCs.

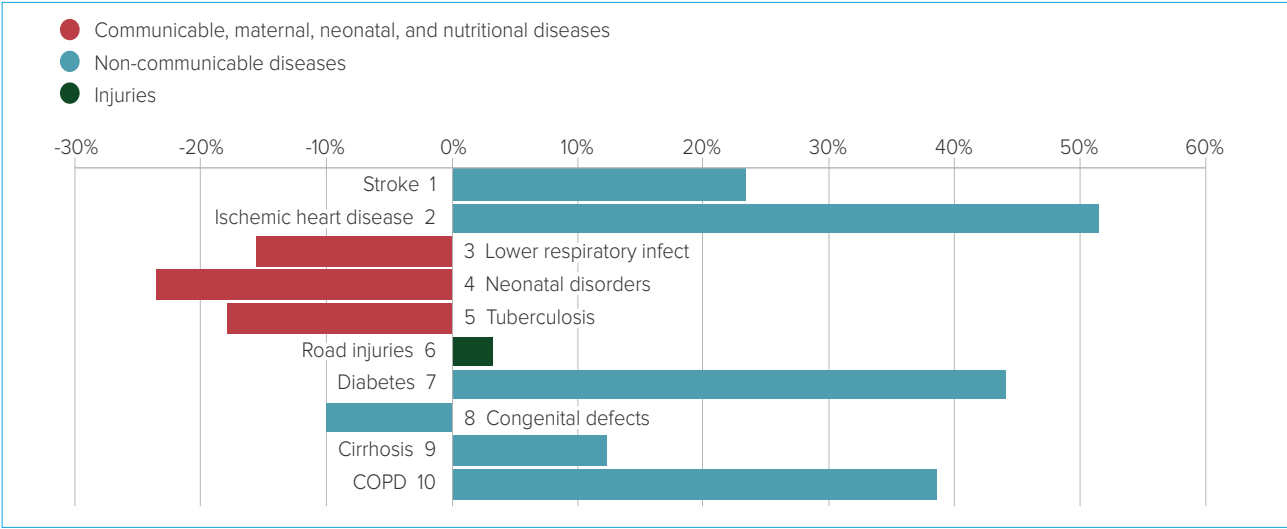
** World Health Organization (WHO) Global Health Expenditure Database, ASEAN Statistical Brief 2024, OECD 2024.

***World Bank Open data – Current health expenditure (% of GDP).¹

¹ See <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?end=2023&start=2014>.

Cambodia has entered the epidemiological transition, evidenced by the rising burden of NCDs while communicable diseases (CDs) and maternal and child health (MCH) remain significant. Between 2013 and 2023, disability-adjusted life years (DALYs) lost due to stroke, ischemic heart disease, diabetes, cirrhosis, and chronic obstructive pulmonary disease (COPD) increased by 23, 52, 44, 12, and 39 percent, respectively (figure 1.1). At the same time, even though the magnitude of DALYs lost due to lower respiratory infection, neonatal disorders, and tuberculosis has decreased, these conditions remain among the top 10 disease burdens in the country. The shift in the disease burden has profound implications for the health system, which is traditionally set up to deal with CDs and MCH. This calls for strengthening the service delivery system with a strong focus on primary health care for effective disease prevention, early diagnosis, and continuous management of NCDs.

Figure 1.1. Top 10 Causes of Death and Disability (DALYs) in 2023 and Percent Change 2013–2023, All Ages Combined



Source: IHME, accessed on December 11, 2025.²

Cambodia operates a pluralistic health service delivery system comprising a nationwide public network alongside a large and diverse private sector. Public health services are organized by defined service package and facility levels. At the primary level, HCs serve catchment populations of approximately 8,000 to 12,000 people and deliver a minimum package of activities (MPA) covering preventive and basic curative services, including MCH, CD and NCD control, and health promotion and outreach. Secondary care is provided through RHs, which deliver complementary package of activities (CPAs) and are classified into three levels. CPA-1 hospitals provide basic inpatient and outpatient services with 40 to 60 beds, without major surgery or blood banking. CPA-2 hospitals expand this scope to include emergency care and major surgery under general anesthesia, with 60 to 100 beds. CPA-3 hospitals represent the highest level of provincial referral care, with 100 to 250 beds, offering specialized services and blood banking. At the apex of the public system, national hospitals provide tertiary and highly specialized care (see table A.1 in appendix A).

The private sector plays a significant and growing role in service delivery and operates in parallel to the public system. As of 2023, Cambodia had 1,212 registered large private facilities, including private hospitals, polyclinics, clinics, laboratories, and specialized facilities, alongside a much larger number of small private providers, estimated at 16,766, though this figure is likely underreported. Private facilities are widely used by the population across income groups and geographic areas, particularly for outpatient and acute care, and represent a major source of health services in both urban and rural areas (table 1.2) (O’Hanlon 2025).

² See <https://www.healthdata.org/research-analysis/health-by-location/profiles/cambodia> on December 11.

Table 1.2. Network of Public and Private Health Facility in Cambodia

	Public	No	Private	No
Large facility	National hospital	12	General hospital	27
	RH (CPA-3)	21	Pediatric hospital	4
	RH (CPA-2)	39	Polyclinic	104
	RH (CPA-1)	61	Clinic	798
			Maternity clinic	14
			Dental clinic	79
			Other clinics	200
			Labs	107
	Subtotal	133	Subtotal	1,212
Small Facility	HCs	1,305	General	
	Health post	132	Maternity	
			Nursing	
			Dental	
			Other	
	Subtotal	1,437	Subtotal	16,776
		1,567	Total	18,095

Source: Ministry of Health 2023, cited in O'Hanlon 2025.

Note: CPA = complementary package of activities; HC = health center; RH = referral hospital.

Shortcomings in service delivery and quality of care constitute critical constraints in Cambodia's progress toward UHC. Recent facility assessments reveal persistent gaps in service readiness, clinical competence, and patient safety, particularly in rural and remote areas. Many public facilities lack essential medicine, functional equipment, and adequate infection prevention measures, while the private sector—though widely utilized—operates with limited regulation and variable standards. Workforce shortages and uneven distribution exacerbate these challenges: Cambodia has only 1.4 health workers per 1,000 population—well below the WHO threshold, with most specialists concentrated in Phnom Penh. Health facility operations have also been impacted by delays in fund disbursement. For example, only 25 percent of health facilities surveyed received timely disbursement of fixed lump-sum grants (Nagpal et al. 2022).

The government of Cambodia has committed to improving population health outcomes and financial protection through successive reforms. With support from international partners, the government introduced the Health Equity Fund (HEF) to provide free health care to the poor and other vulnerable populations. On the supply side, service delivery grants were introduced to directly finance frontline providers with performance-based incentives. These initiatives have improved structural readiness and incentivized better governance, yet process and outcome quality remain weak, signaling the need for stronger accountability, digital health integration, and continuous professional development for frontline providers (Pheakdey et al. 2020).

Government programs to strengthen financial protection in health—mainly the HEF and the National Social Security Fund (NSSF)—have expanded significantly in recent years. Cambodia's main health protection schemes—NSSF and HEF—have expanded rapidly but remain uneven in coverage across

population groups. By 2025, NSSF was expected to cover about 3 million people, primarily formal sector workers, with ongoing efforts to extend voluntary coverage to dependents, the self-employed, and other informal groups. In contrast, HEF reached around 4.7 million people in 2024, making it the largest scheme and a critical safety net for poor and near-poor populations (table 1.3).

Table 1.3. Enrollment in Different Social Health Protection Schemes

Scheme	Year established	Coverage
National Social Security Fund (total enrollments)	2025	3 million people
Health Equity Fund	2024	4.7 million people

Source: National Social Protection Policy Framework 2023-2024.

1.2. Rationale and Objectives of the Study

To effectively strengthen Cambodia’s health system, it is essential to obtain a comprehensive understanding of the status of service delivery. Such knowledge encompasses not only service quality but also the full spectrum of infrastructure, human resources, equipment, medicine availability, support systems, and both provider and patient satisfaction. Furthermore, there is a critical need to understand not only the public sector, but also service delivery provided in the large and increasing private sector. Despite the well-documented magnitude of the private service provision in Cambodia³, the sector remains poorly regulated and largely undocumented, hampering efforts to monitor quality, enforce standards, and integrate these actors into national health strategies. Additionally, the efficiency of facility-level public financial management (PFM) is critical for shaping provider incentives, ensuring accountability, and sustaining health services and quality improvements.

Study Objectives

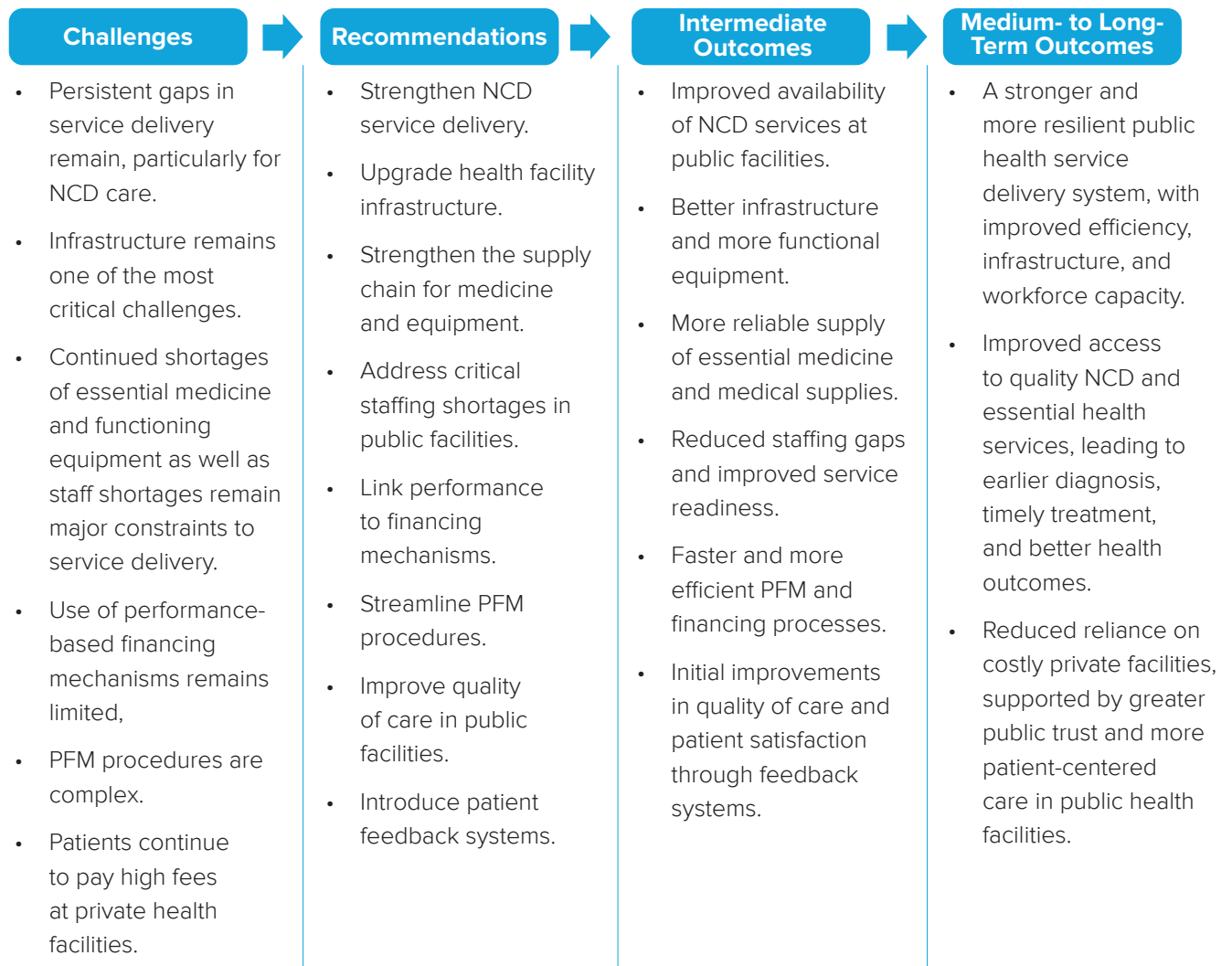
The study aims to capture an overall picture of Cambodia’s health service delivery system, focusing on primary health care and district RHs in the public sector. For the first time, private health facilities are included alongside public ones—an essential step toward understanding the broader landscape and informing policies that promote equitable access, consistent standards, and improved satisfaction across all providers and patients. The study’s main objectives are to

- Provide a snapshot of health service delivery in both the public and private sectors;
- Recommend strategies to strengthen key drivers of service readiness and quality, including health facility management, human resources, financial systems, and patient confidence in care; and
- Provide recommendations on PFM-related aspects within the health sector, based on the scope of the analysis.

Improving health service delivery in the public sector requires tackling key challenges in staffing, infrastructure, medicine, equipment, financing, and patient engagement. Implementing targeted actions—such as strengthening NCD services, upgrading infrastructure, ensuring reliable supply chains, addressing staffing gaps, linking performance to financing, streamlining PFM procedures, improving quality of care, and introducing patient feedback—can produce immediate gains in service readiness, availability, and efficiency. Over the medium to long term, these improvements are expected to build a stronger and more resilient health system, expanding access to quality NCD and essential services, supporting earlier diagnosis and treatment, and reducing reliance on costly private facilities. Combined with efficient resource use and increased public trust, these changes will enable sustained, patient-centered, and equitable care for the population (figure 1.2).

3 WHO (2015) The Kingdom of Cambodia Health System Review

Figure 1.2. Theory of Change



Source: Original for this publication.

This mixed method study relies on a survey of public and private health facilities and a qualitative assessment of key stakeholders. The study included respondents from the following four different types:

- **Health facility administrators**, individually or as a group, who can respond to items related to expenditure, infrastructure, services, inventory, staffing, and so on (for example, facility managers, monitoring and evaluation staff, human resources, and accounting staff)
- **Health care providers working** in targeted health facilities who are directly involved in patient treatment, consisting of doctors, medical officers, nurses (primary or secondary), or midwives (primary or secondary)
- **Patients** seeking treatment at target facilities (inpatient or outpatient service)
- **Government staff**, including staff working at their respective provincial health departments (PHDs) and operational districts (ODs). These categories are subject to IDIs only.

2.1. Facility Survey

The survey used a combination of systematic sampling and probability-based sampling, considering facility size, geographic distribution (by facility type), and budget and time constraints. Because public and private facilities differ significantly in type and distribution, separate sampling and sample size plans were developed for each sector. Field data collection was conducted between April and May 2025. Facilities were drawn from official lists of public and private health facilities, which currently include approximately 721 licensed private establishments and 1,385 public ones. After applying inclusion and exclusion criteria (table 2.1), the sampling frames are as follows:

- Public sector:
 - 96 eligible district hospitals (CPA-1 and CPA-2)
 - 1,289 eligible HCs
- Private sector:
 - 24 hospitals
 - 81 polyclinics
 - 21 specialized clinics (maternity, pediatric)
 - 595 general/small clinics

Table 2.1. Inclusion and Exclusion Criteria for Survey

Sector	Inclusion criteria	Exclusion criteria
Public	District hospitals (CPA-1 and CPA-2), primary health centers	Specialized hospitals, national and provincial hospitals, standalone diagnostic centers
Private	Hospitals, polymedical clinics, medical clinics, maternity and pediatric clinics	Unlicensed facilities; ophthalmology; ear, nose, and throat (ENT), dental, cosmetic clinics, pharmacies, diagnostic centers

Source: Original for this publication.

Note: CPA = complementary package of activities.

2.1.1. Sample size calculation

Public Sector

Sample sizes for public facilities were calculated using a formula to estimate proportions with an absolute precision of 0.1. Facilities will be sampled proportionally by province and facility type, then randomly selected within each province (table 2.2).

Private Sector

Sample sizes for private facilities were purposively selected from the listing of licensed private facilities in the 11 selected provinces.

Table 2.2. Response Rate by Type of Facilities

Type of facilities	Total (N)	Sample size	Number of inter-views reached	Response rate
Public facilities				
HCs	1,289	94	94	100%
RHs	96	50	49	98%
Health care providers		244	246	101%
Patients		288	344	119%
Private facilities				
Hospital	24	10	4	40%
Polyclinic	81	30	35	117%
Clinic	595	100	101	101%
Others	21	9	5	56%
Health care providers		162	162	100%
Patients		304	324	107%
Total (across public and private)		1,291	1,364	106%

Source: Original for this publication.

Note: While the public facilities sample did not use a replacement method, replacement samples were used for private facilities, health care providers, and patients when refusals occurred. As a result, the number of private facilities, health care providers, and patients may exceed the target sample sizes. HC = health center; RH = referral hospital.

2.1.2. Sampling Approach

Public Sector

The sample was designed to be nationally representative of public HCs and RHs, and findings should be interpreted accordingly at the national level for these facilities. The private sector sample was drawn from the same provinces as the public sector; however, it is not nationally representative and should be interpreted with this limitation.

For sampling purposes, Cambodia was stratified into five regions, with Phnom Penh treated as a separate stratum. A probability-based, multistage sampling approach was applied to ensure representation across all five regions. In the first stage, provinces were selected proportional to the distribution of MPAs within each region, resulting in the inclusion of Phnom Penh and approximately half of the eligible provinces

per region, for a total sample of 11 provinces. In the second stage, facilities were randomly selected within sampled provinces, followed by the selection of patients and providers during fieldwork in the selected facilities. The provinces included in the survey were Phnom Penh, Banteay Meanchey, Kampong Cham, Kampong Chhnang, Kampot, Kratie, Preah Vihear, Prey Veng, Pursat, Takeo, and Oddar Meanchey.

Private Sector

The private sector survey was conducted in the same 11 provinces as the public sector component.

A replacement strategy was applied in cases where selected facilities were unavailable or could not be surveyed.

2.2. Health Care Provider Sampling

Health workers were selected from facilities visited during fieldwork. In hospitals, three eligible health workers were randomly chosen by lucky draw; in nonhospital facilities, one was selected using the same method. Overall, interviews included the following:

- Public sector: 95 HCs workers, 151 RH workers.
- Private sector: 106 clinic workers, 40 polyclinic workers, 12 hospital workers, and 4 specialty clinic workers.

2.3. Patient Sampling

Patient selection used systematic sampling based on estimated daily patient volume provided by facility staff. Field teams aimed to interview three patients per facility to ensure at least two completed interviews and compensate for potential shortfalls. The sampling interval was calculated as: $\text{Interval} = \lceil n/3 \rceil$ where n = anticipated patient count. A random starting point between 1 and the interval was chosen. If a patient declined, the next available patient was interviewed. In total, 668 patients were interviewed across public and private facilities.

Alongside the quantitative fieldwork, 60 IDIs were conducted with key informants. These included four PHD directors, eight OD directors, 24 health care providers, and 24 patients.

CHAPTER 3 KEY FINDINGS

3.1. Characteristics of the Surveyed Facilities

- **Public health facilities provide more continuous access than private ones.** Nearly all HCs (93.8 percent) and all RHs operated every day, including weekends and holidays, while most private facilities were limited to weekdays, with almost none open on weekends or holidays and only 1.6 percent of clinics operating daily.
- **Public facilities—especially hospitals—deliver the highest patient volumes, but overall workload remains low.** HCs had higher utilization per population (573 visits per 1,000) than RHs (109 per 1,000), though hospitals handled larger absolute volumes and all inpatient care; nevertheless, daily service workloads were modest across facilities.
- **High but incomplete service availability across public facilities.** All HCs and RHs provided at least 50 percent of required services, with most delivering 75–94 percent; however, only a very small share achieved full service completeness, and RHs showed greater variability and more moderate service gaps than HCs.
- **Service provision is strongest in MCH/FP and CDs and weaker in NCDs and specialized care.** HCs excel in maternal, child, reproductive, and CD services, but gaps persist in NCDs, mental health, and oral and eye care. RHs offer broad coverage but rarely reach full capacity in specialty, diagnostic, and NCD service categories.
- **Service range varies by facility type, with higher-level facilities offering more but still incomplete coverage.** CPA-2 facilities provide the widest service mix, CPA-1 facilities are more limited, and private facilities concentrate on outpatient, diagnostic, and general care, with specialized services such as intensive care units (ICUs), mental health, and tuberculosis (TB) remaining scarce across the private sector.

3.1.1. Facilities' Operating Hours

Health facilities open every day, ensuring uninterrupted availability of services across weekdays, weekends, and public holidays. Table 3.1 shows that public facilities offer more consistent access: 93.8 percent of HCs and all RHs operated daily, including during holidays. In contrast, most private facilities limited services to weekdays. While nearly all private hospitals, polyclinics, and clinics were open on weekdays, none operated on weekends or holidays. Only 1.6 percent of clinics reported being open every day.

Table 3.1. Proportion of Facilities Open Daily, Including Weekends and Holidays, by Facility Type

Type of facility	On Weekdays (%)	On Weekends (%)	On National Holidays (%)	Every day
Public facilities				
HCs (N=94)	100	100	93.8	93.8
RHs (N=49)	100	100	100	100
Private facilities				
Hospitals (N=4)	100	0	—	0
Polyclinics (N=35)	100	0	—	0
Clinics (N=104)	99	1.9	—	1.6
Others (N=5)	100	0	—	0

Source: Original for this publication.

Note: Every day includes weekdays, weekends, and national holidays. HCs = health centers; RHs = referral hospitals; — = not applicable; N = number of observations.

3.1.2. Patient Volume

Patient volumes remain low across public health facilities in 2024, particularly when assessed on a per capita and daily workload basis. Table 3.2 presents the median patient volume per 1,000 registered population for HCs and RHs in the entire year of 2024. HCs reported a median of 5,673 outpatient visits, equivalent to 573 visits per 1,000 registered population. RHs recorded a higher absolute outpatient volume (11,652), but a lower rate per 1,000 population (87). Inpatient services were only reported for RHs, with a median of 2,057 visits, or 24 per 1,000 population. The total patient volume per 1,000 population was 573 for HCs and 109 for RHs. However, service workload remains low, with fewer than 16 outpatient visits per day at the HCs and fewer than 32 outpatient visits per day at the RHs.

Table 3.2. Patient Volume per 1,000 Registered Population from January 2024 to December 2024, by Public Facility

	Total outpatient (Median)	Out-patient volume per 1,000 registered population (Median)	Total in-patient (Median)	In-patient volume per 1,000 registered population (Median)	Total patient volume (Median)	Total patient volume per 1,000 registered population (Median)
HCs	5,673	573	—	—	5,673	573
RHs	11,652	87	2,057	24	13,976	109

Source: Original for this publication.

Note: Patient volume per 1,000 registered population (median) = total patient volume (median)/catchment size*1000.

Outpatient service delivery at HCs in 2024 was heavily concentrated on MCH/FP, with limited utilization of NCD services (table 3.3). The highest median volume was for pediatric services (1,020 visits), while NCD care had a combined median volume of 226. Minor surgeries for adults recorded a median volume of 50.

Table 3.3. Outpatient Volume at HCs from January 2024 to December 2024, by Service Type

Service type	Number of out-patient visit (Median)
Diabetes services (adult)	35
Minor surgery (adult)	50
Other NCD services (adult)	73
Hypertension (adult)	118
Birth spacing	371
Antenatal care	545
Pediatric services (children)	1,020
Total outpatient visits	5,673

Source: Original for this publication:

Note: NCD = noncommunicable disease.

Patient volumes varied significantly by facility type in 2024, with CPA-2 facilities handling the highest outpatient and inpatient caseloads across most service categories. Table 3.4 shows patient volumes by facility type. In 2024, CPA-2 facilities had the highest outpatient (13,208) and inpatient (2,984) volumes, followed by CPA-1 facilities and RHs. Common outpatient services included diabetes, hypertension, pediatrics, and antenatal care (ANC). Child inpatient visits were most frequent, with CPA-2 facilities leading in maternal, emergency, and surgical cases.

Private health facilities were predominantly oriented toward outpatient care in 2024, with service volumes concentrated in pediatrics, ANC, and NCD management. Private facilities focused on outpatient care (median 2,700 visits), mainly pediatrics (316), ANC (193), hypertension (150), and diabetes (100). Inpatient cases were fewer (420), led by general medicine (129), child admissions, and deliveries.

Table 3.4. Patient Volume (Median) at RHs from January 2024 to December 2024, by Service Type and Health Facility Type

	RH	CPA-1	CPA-2
Total outpatient visits	11,652	11,453	13,208
Obstetrics and gynecology and antenatal care (ANC)	467	231	629
Hypertension services (adult)	479	374	752
Diabetes services	635	478	1125
Cervical cancer services (adult)	22	22	21
Pediatric care (children)	850	870	415
Minor surgery (adult)	210	226	175
Hemodialysis-outpatient services	0	0	0
Total inpatient visits	2,057	1,954	2,984
Child inpatient visits	646	639	686
Vaginal deliveries	309	243	560
C-sections	0	0	39
Elective surgeries for adults	0	0	27
Emergency surgeries	0	0	74
Inpatient medical stroke management (IV-anticoagulants, angioplasty, or stents)	0	0	0
Inpatient emergency surgical stroke management (clot removal, clipping, or coiling)	0	0	0
Inpatient hemodialysis	0	0	0
Emergency service cases for adults and children	411	386	510

Source: Original for this publication.

Note: CPA = complementary package of activities; IV = intravenous.

Service volume varied by facility type. Private hospitals recorded the highest outpatient volume (36,000), far exceeding polyclinics (3,000), clinics (2,531), and other facilities (3,000). While smaller facilities contributed to maternal and pediatric care, hospitals remained the primary providers across service categories (table 3.5).

Table 3.5. Patient Volume (Median) at Private Facility from January 2024 to December 2024, by Service Type and Facility Type

	Private health facility	Hospital	Polyclinic	Clinic	Others
Total outpatient visits	2,700	36,000	3,000	2,531	3,000
Obstetrics and gynecology and antenatal care (ANC)	193	5,400	180	190	1400
Hypertension services (adult)	150	5,475	153	125	0
Diabetes services	100	1,825	100	95	0
Cervical cancer services (adult)	10	1,080	9	10	12
Pediatric care (children)	316	3,600	100	340	2,985
Minor surgery (adult)	50	1,800	65	48	8
Hemodialysis-outpatient services	55	5,400	55	2	0
Total inpatient visits	420	1800	525.5	394	150
Child inpatient visits	45	120	35	50	100
Vaginal deliveries	15	200	17	5	27
C-sections	7	100	24	0	40.5
General medicine	129	350	164	126.5	0
Elective surgeries for adults	0	70	30	0	15
Emergency surgeries	0	20	7	0	1.5
Inpatient medical stroke management	6	24	6	5	0
Inpatient emergency surgical stroke management	0	12	0	0	0
Inpatient hemodialysis	0	0	0	0	0
Emergency service cases for adults and children	5	15	8	4	0

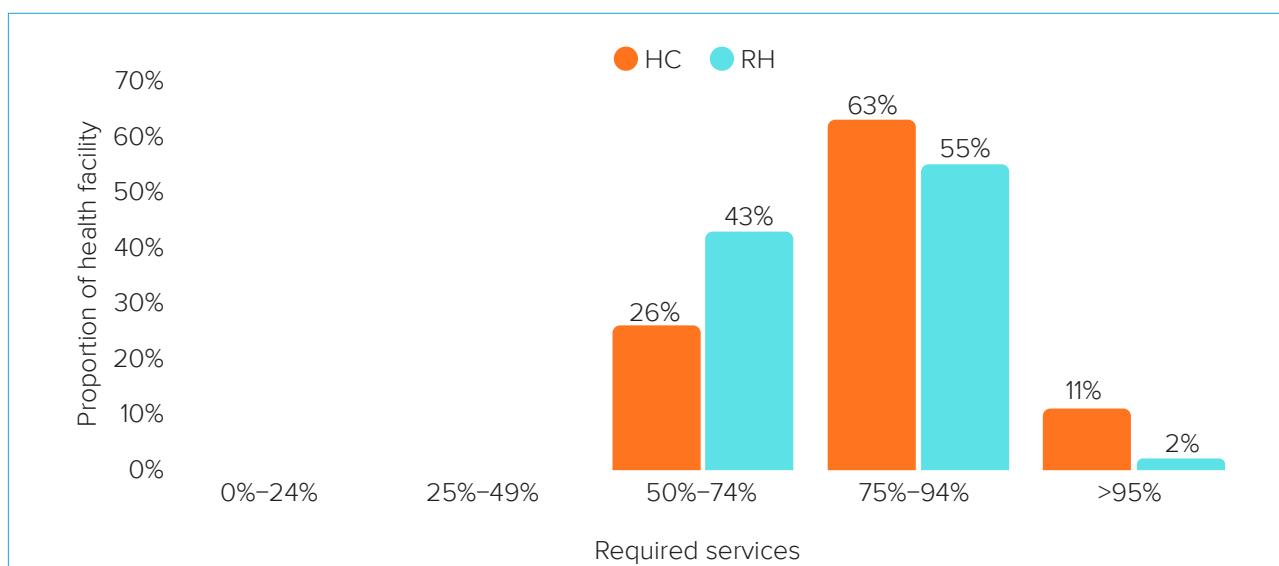
Source: Original for this publication.

3.1.3. Availability of Services

Service completeness is generally high across HCs and RHs, although RHs show greater variability and more moderate service gaps than HCs.⁴ Figure 3.1 illustrates the distribution of HCs and RHs by the number of required services offered. The analysis of required service completeness shows generally high availability of required services across both HCs and RHs. HCs perform strongly, with 63 percent of services at 75–94 percent completion and 11 percent exceeding 95 percent, while 26 percent remain at 50–74 percent. RHs have more services below full implementation, with 43 percent in the 50–74 percent range and only 2 percent above 95 percent. Neither facility type has services below 50 percent, but the data highlights the need for focused efforts to move more services into the >95 percent completion category, particularly in RHs, to ensure full service delivery.

⁴ Completeness is assessed against respective level of facilities based on the Ministry of Health's standards (MPA, CPA-1, and CPA-2).

Figure 3.1. Proportion of HCs and RH, by Number of Services Provided

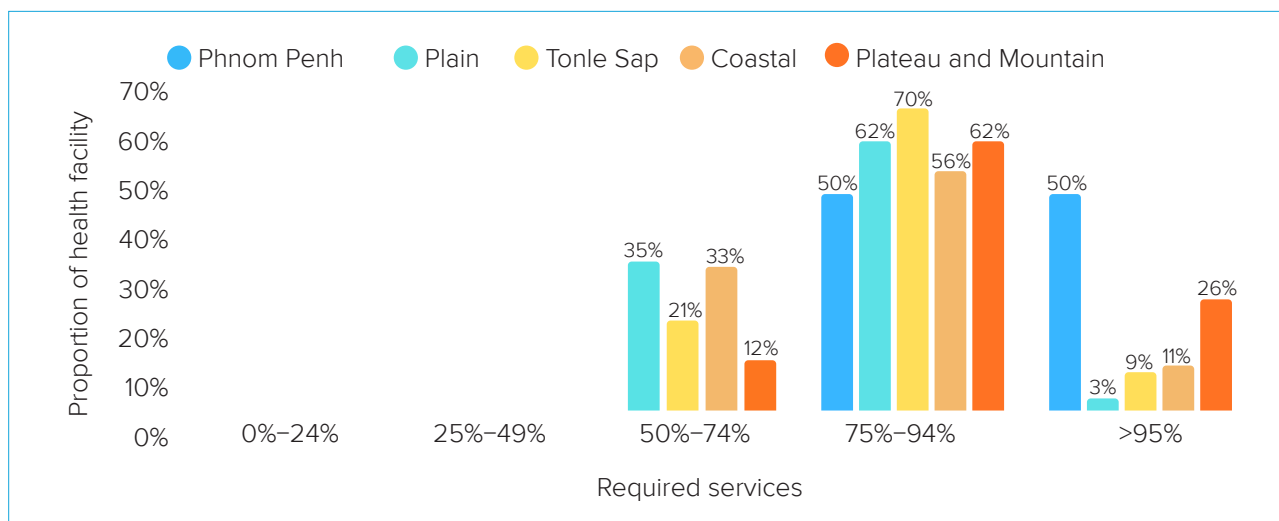


Source: Original for this publication.

Note: The completeness of services (defined as 100 percent of required services) was estimated based on subsets of required services included in MPA and CPA1-2, as the full list of required services is substantially more extensive. HC= health centers; RH = referral hospital.

Analysis of service completeness at HCs shows that Phnom Penh leads with all services above 75 percent completion and 50 percent exceeding 95 percent, reflecting full implementation. Other regions—Plain, Tonle Sap, Coastal, and Plateau and Mountain—still have a notable share of services in the 50–74 percent range. Only a small portion surpasses 95 percent, highlighting the need for focused efforts to improve service delivery and achieve full coverage across all regions (figure 3.2).

Figure 3.2. Proportion of HCs, by Required Services and by Region



Source: Original for this publication.

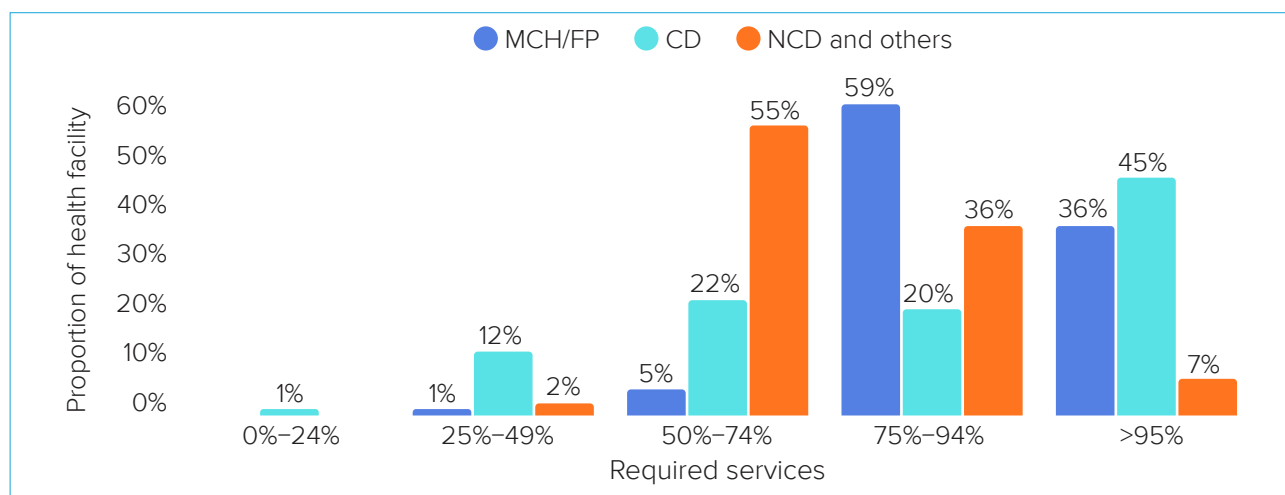
Note: The completeness of services (defined as 100 percent of required services) was estimated based on subsets of required services included in MPA and CPA1-2 facilities, as the full list of required services is substantially more extensive. Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

At the HCs, services primarily focus on MCH/FP, with only limited NCD services available. The distribution of required services at HCs shows clear variation across MCH/FP, CD, and NCD and other services. MCH/FP services demonstrate the strongest overall coverage, with 94 percent of HCs providing at least 75 percent of required services, including a substantial 36 percent achieving full (over 95 percent) service provision. Only a very small proportion of HCs fall below 50 percent service availability for MCH/FP, indicating relatively strong prioritization and integration of maternal and newborn care within health facilities.

A relatively high share of HCs (45 percent) delivers more than 95 percent of the required CD services, while a substantial proportion remains in the midrange. Specifically, 34 percent of health centers provide only 25–74 percent of services, indicating persistent gaps in the availability of comprehensive CD care.

A large service gap remained for NCD and other services, where only 7 percent of HCs offer full services, and the majority (55 percent) fall within the 50–74 percent range. This pattern suggests that while partial NCD service delivery is common, full integration remains limited. Overall, the findings highlight the need to strengthen CD and especially NCD service provision to achieve more balanced and comprehensive service delivery across HCs (figure 3.3).

Figure 3.3. Proportion of HCs Meeting Service Requirements, by Number of Required Services and Service Category

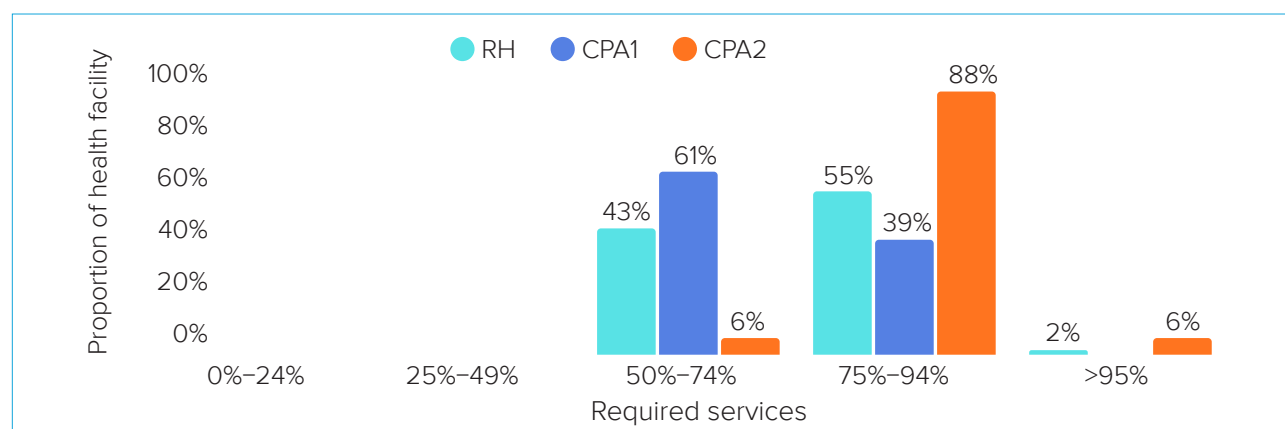


Source: Original for this publication.

Note: MCH/FP services includes ANC, delivery, postpartum care, provision of immunizations to children and mothers or women in general, nutrition, prevention of mother-to-child transmission of HIV/AIDS, integrated management of childhood illness, birth spacing, and abortion care. CD services include sexually transmitted diseases, HIV/AIDS, tuberculosis, malaria, and dengue fever. NCD services and other health problems include hypertension, diabetes, breast cancer screening, cervical cancer screening, mental health, oral health, eye care, minor surgery and wound dressing, health promotion, and community outreach services. The completeness of services (defined as >95 percent of required services) was estimated based on subsets of required services included in MPA and CPA1-2 facilities, as the full list of required services is substantially more extensive. CD = communicable disease; MCH/FP = (maternal and child health and family planning); NCD = noncommunicable disease.

No RH provided less than 50 percent of the required services. However, the provision of full required services is not consistently achieved. Few RHs provide full required services (2 percent for RHs, 0 percent for CPA-1 facilities, and 6 percent for CPA-2 facilities). Figure 3.4 summarizes the distribution of required services across RHs, CPA-1 and CPA-2 facilities.

Figure 3.4. Proportion of RHs Providing Required Services, by Facility Type (CPA-1 and CPA-2)

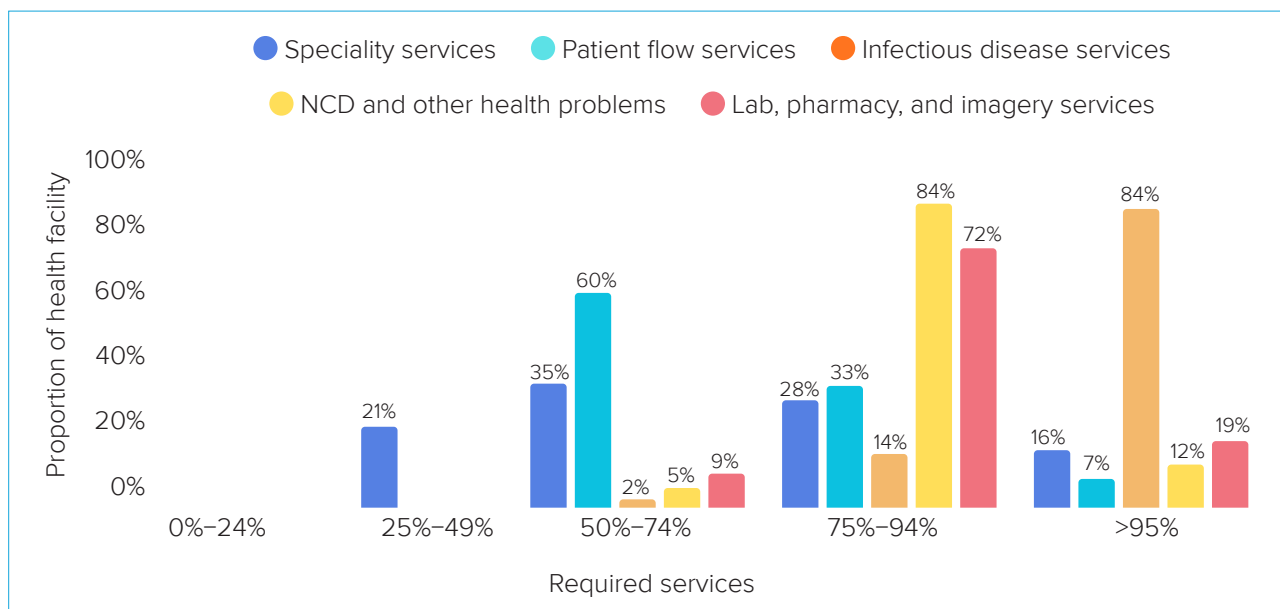


Source: Original for this publication.

Note: The completeness of services (defined as 100 percent of required services) was estimated based on subsets of required services included in MPA and CPA1-2 facilities, as the full list of required services is substantially more extensive. CPA= complementary package of activities; RH= referral hospital.

The completeness of services offered at referral hospitals varies by service group. Infectious disease services show the strongest coverage, with 84 percent of RHs offering more than 95 percent of required services and a further 14 percent offering 75–94 percent. NCD, laboratory, pharmacy, and imaging services are also broadly available, with most facilities covering 75–94 percent of services. In contrast, patient flow services are less consistently offered, with 60 percent of RHs covering only 50–74 percent, while specialty services show the largest gaps, with more than 50 percent of RHs offering less than 75 percent of required services (figure 3.5).

Figure 3.5. Proportion of RHs Providing Required Services, by Number of Services and Service Category

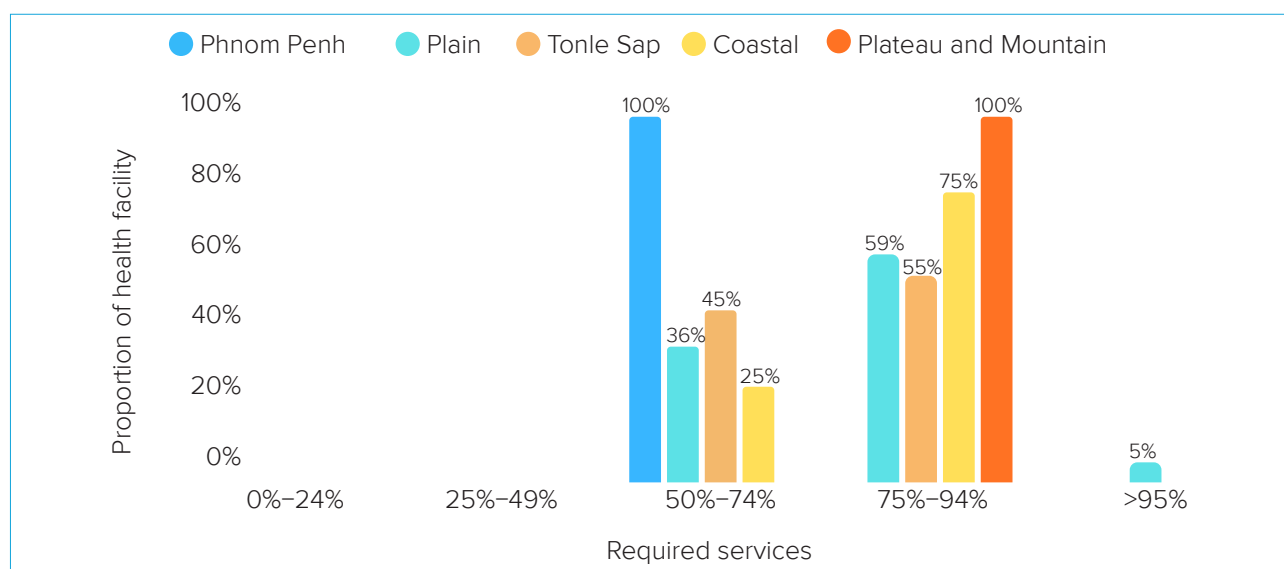


Source: Original for this publication. Note:

- Patient flow services include outpatient consultation or general outpatient department (OPD), specialized OPD, referral services, kinetic therapy, emergency services, intensive care unit (ICU), pediatrics, general medicine for adults, minor surgery, gynecology-obstetrics, and major surgery.
- Infectious diseases services include TB, HIV, malaria, and dengue.
- Other specialized services include ophthalmologic service, dentistry, ENT, head and neck treatment and surgery, dermatology, and mental health.
- NCD and other health problems include diabetes, hypertension screening, cervical cancer screening, and inpatient care.
- Laboratory and imagery services include laboratory, blood transfusion, radiology, ultrasound, and pharmacy.

Figure 3.6 shows variation in service completion at referral hospitals by region. Phnom Penh has all RHs in the 50–74 percent range. In the Plain and Tonle Sap regions, over 50 percent of RHs achieve 75–95 percent completion, though many remain below this level. The Coastal region performs relatively well, with 75 percent of RHs in the 75–95 percent range, while the Plateau and Mountain region shows the most consistent coverage, with all RHs in this range. Very few RHs exceed 95 percent completion overall.

Figure 3.6. Proportion of RHs, by Required Services and Region



Source: Original for this publication.

Note: The completeness of services (defined as >95 percent of required services) was estimated based on subsets of required services included in MPA and CPA1-2 facilities, as the full list of required services is substantially more extensive. Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

Private health facilities offer a broad range of services, with outpatient consultations, diagnostics, and pharmacy services being the most widely available across facility types. The most commonly offered services included outpatient consultation (76 percent), ultrasound (75 percent), pharmacy (74 percent), and laboratory (70 percent). Other broadly available services span infectious disease management, diagnostics, maternal health, and general care—for example, dengue treatment (54 percent), emergency services (58 percent), diabetes care (60 percent), pediatrics (62 percent), inpatient care (68 percent), and minor surgery (69 percent). See table 3.6.

Specialized services at private facilities are less common. These include: ICU services (16 percent), kinetic therapy (20 percent), TB treatment (23 percent), and mental health care (29 percent). Polyclinics offered a wider range of diagnostic and specialty services, while clinics focus on outpatient and chronic disease management. Notably, hospitals—despite their advanced role—show relatively low service coverage across most categories, suggesting a narrower specialization.

Table 3.6. Proportion of Private Facilities Offering Services, by Service Type and Facility Type

	Private facility (N=189)	Hospital (N=11)	Polyclinic (N=47)	Clinic (N=126)
Outpatient hemodialysis service	3%	9%	6%	1%
Dentistry services	5%	9%	6%	4%
Ophthalmologic services	10%	9%	17%	7%
Inpatient medical stroke management services	12%	9%	21%	10%
Ear, nose, and throat (ENT) services	14%	18%	21%	11%
Intensive care unit (ICU) services	16%	27%	40%	7%

Kinetic therapy	20%	27%	38%	13%
Tuberculosis (TB) treatment services	23%	27%	36%	19%
Mental health services	29%	18%	34%	29%
Blood transfusions	30%	27%	60%	21%
Malaria treatment services	34%	27%	43%	33%
HIV treatment services	35%	27%	40%	34%
Cervical cancer screening	37%	27%	49%	34%
Major surgery	41%	36%	68%	33%
Gynecology-obstetric services	44%	27%	55%	42%
Dermatology services	44%	18%	49%	47%
Ambulance transportation services	48%	36%	66%	41%
Specialized (outpatient department) OPD	49%	27%	70%	42%
Dengue treatment services	54%	36%	64%	53%
Radiology services	57%	36%	72%	54%
Other infectious diseases	58%	36%	66%	57%
Emergency services	58%	36%	68%	57%
Diabetes treatment	60%	27%	68%	63%
Referral services	61%	36%	72%	60%
Pediatric services	62%	36%	60%	65%
Hypertension screenings	65%	27%	72%	67%
Inpatient care	68%	36%	74%	67%
General medicine for adults	69%	27%	74%	74%
Minor surgery	69%	36%	72%	72%
Laboratory services	70%	36%	74%	71%
Pharmacy services	74%	36%	72%	79%
Ultrasound services	75%	36%	74%	78%
Outpatient consultation or general OPD	76%	36%	74%	80%

Source: Original for this publication.

Note: A total of 189 observations (N=189) were consistently applied across all service types for private facilities, 11 for private hospitals, and 47 for polyclinics, and 126 for clinics. HIV = human immunodeficiency virus.

3.2. Key Inputs into Services Delivery

- **RHs are better equipped than HCs, but infrastructure gaps persist.** Despite widespread grid connectivity, frequent power outages, limited backup generators in HCs, inadequate water access, weak ambulance availability, poor waste management, and frequent internet disruptions—especially at HCs—continue to affect service delivery across both facility types.
- **Private facilities have basic infrastructure but show major gaps.** While most private facilities maintain patient privacy and basic operations, frequent electricity interruptions, limited ambulance access (especially in hospitals), and inconsistent medical waste management persist, with polyclinics and clinics often outperforming hospitals in patient-centered infrastructure despite hospitals having more reliable power.
- **HCs and RHs show gaps in required equipment, with major gaps in specialized tools.** The shortage of specialized diagnostic and surgical tools and reliance on outdated or malfunctioning technology limits service quality and efficiency.
- **Medicine availability is generally high but rarely complete, with RHs performing better than HCs.** No facilities fell below 50 percent availability of required medicine and most HCs and RHs achieved 75–95 percent coverage, but full availability was uncommon. RHs also showed more consistent and near-complete medicine supply than HCs.
- **Public health facilities face significant human resource constraints.** Both HCs and RHs report major challenges, led by understaffing, lack of specialized expertise, and limited training capacity, with these issues more pronounced in RHs than in HCs.
- **HCs rely heavily on government funding, while RHs have more diversified revenue sources.** HCs depend mainly on national budget allocations, whereas RHs supplement government funding with higher shares of user fees and lump-sum grants, while external financing (for example, HEF, NSSF, and donors) remains minimal for both.
- **Spending priorities differ by facility type.** HCs concentrate most expenditures on salaries and social contributions, while RHs allocate a more balanced budget with larger shares devoted to medications, supplies, and infrastructure, reflecting their broader service and operational demands.
- **Private facilities rely mainly on patient payments and NSSF, with staff costs dominating expenditures.** Overall, patient OOP payments (55 percent) and NSSF contributions (42 percent) fund operations, while spending prioritizes salaries (41 percent), medicine (22 percent), and capital investments (20 percent). Polyclinics emphasize staff and capital expenditure (CAPEX) while clinics focus more on staff and medicine.

3.2.1. Infrastructure

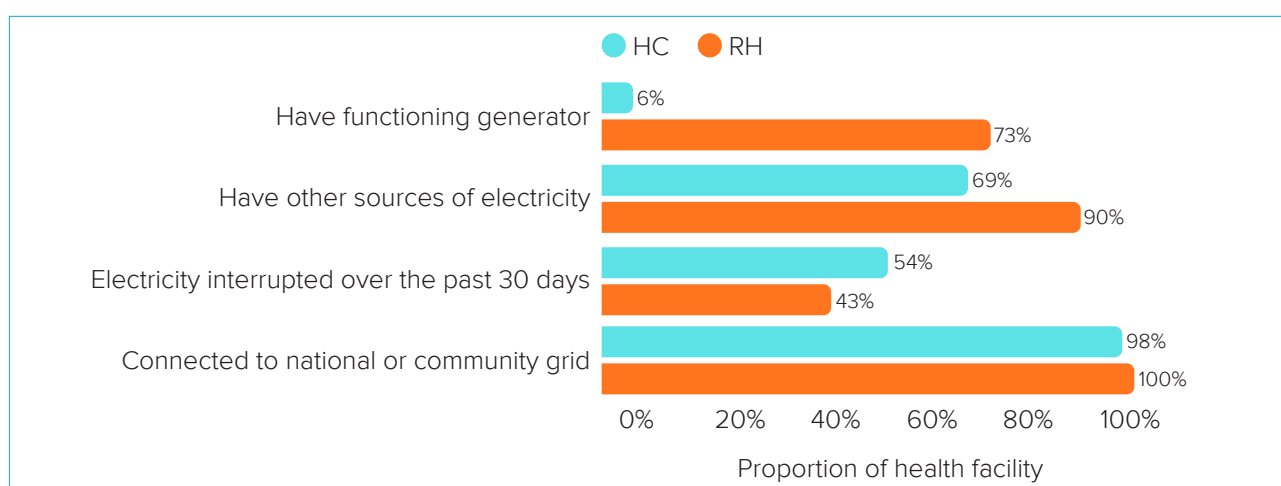
The availability of core physical infrastructure is necessary for effective health service delivery at the facility level. Access to electricity, piped water, information and communication technology (ICT) systems, and medical waste management are crucial to ensure safe and consistent care. Physical infrastructure also includes essential medical equipment and medicine, which are critical for maintaining service quality and continuity.

In Cambodia, RHs are generally better equipped across most indicators, though unreliable electricity and inadequate water supply remain key challenges. Figure 3.7 compares the availability of essential infrastructure across HCs and RHs. Although most facilities are connected to the national or community grid, frequent power outages persist, particularly in HCs. Access to piped or standpipe water is insufficient, especially at HCs, and periodic water shortages continue to disrupt service delivery across both facility types. Following is an overview of the health care infrastructure in Cambodia:

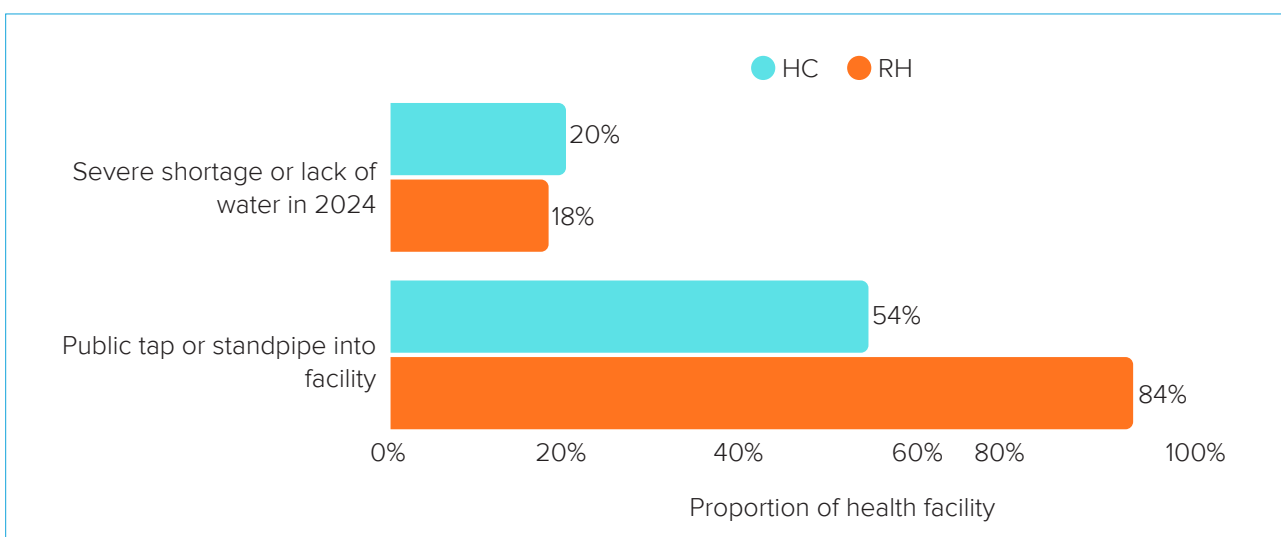
- **Electricity:** Nearly all facilities are connected to the national or community grid (98 percent of HCs and 100 percent of RHs), yet outages remain common—reported by 54 percent of HCs and 43 percent of RHs. Alternative power sources are used by 69 percent of HCs and 90 percent of RHs, but only 6 percent of HCs have functioning generators, compared to 73 percent of RHs.
- **Water access:** Piped or standpipe water is available in 84 percent of RHs and 54 percent of HCs. Water shortages affected 20 percent of HCs and 18 percent of RHs in 2024.
- **Ambulance services:** All RHs reported ambulance access, while only 75 percent of HCs did.
- **Patient privacy:** Rooms with both auditory and visual privacy are available in 88 percent of RHs and 63 percent of HCs.
- **Flood disruption:** Service disruption due to flooding was reported by 4 percent of HCs and 8 percent of RHs.
- **Medical waste management:** Formal waste collection services were used by 67 percent of RHs and 33 percent of HCs.
- **ICT access:** Internet interruptions were reported by 65 percent of HCs, compared to 29 percent of RHs.

Figure 3.7. Percentage of Public Facilities with Access to Infrastructure, by Facility Type

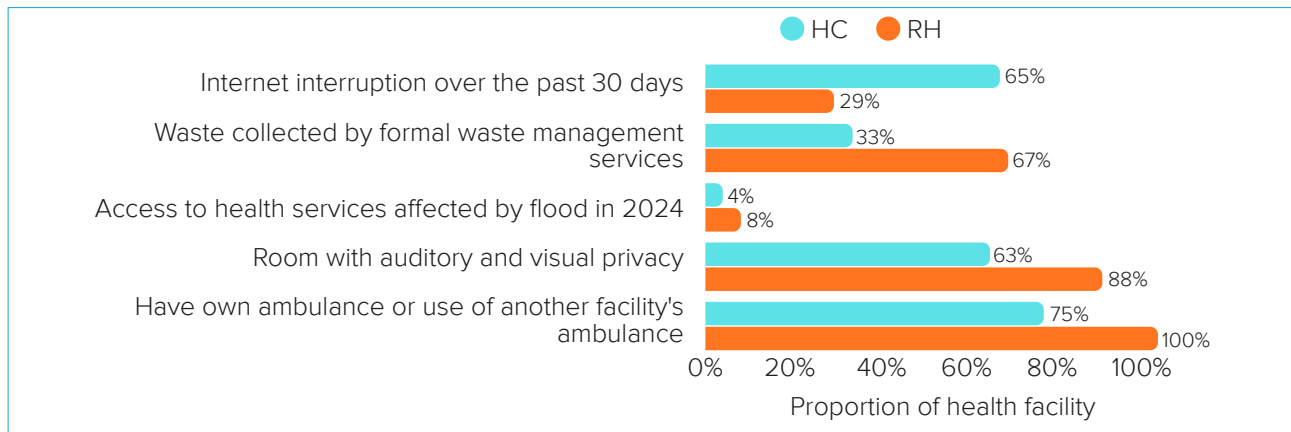
a. Electricity



b. Water



c. Other infrastructure



Source: Original for this publication.

Note: Other infrastructure includes ICT, waste management, flood, patient privacy, and ambulance access. HC = health center; RH = referral hospital.

Infrastructure access for HCs varies by region, with strong grid connectivity but notable reliability gaps. Phnom Penh shows full connection to the national grid (100 percent) and formal waste collection (100 percent), though electricity (50 percent) and internet disruptions (75 percent) remain common. In the Plain and Tonle Sap regions, nearly all HCs are connected to the grid (100 percent and 97 percent, respectively), but electricity interruptions are still frequent (57 percent and 29 percent, respectively). The Coastal region faces the greatest challenges, with high electricity interruptions (78 percent) and the highest reported water shortages (56 percent). Plateau and Mountain areas also report frequent electricity (69 percent) and internet disruptions (76 percent). Waste collection services remain limited outside Phnom Penh (22–48 percent), while most HCs report access to an ambulance through their own or nearby facilities (65–87 percent). Overall, while connectivity is high, reliability of electricity, water supply, and support services remains uneven across regions (table 3.7).

Table 3.7. Percentage of HCs with Access to Infrastructure

	Phnom Penh	Plain	Tonle Sap	Coastal	Plateau and Mountain
Electricity					
Have functioning generator	0%	12%	3%	0%	3%
Have other sources of electricity	100%	63%	73%	67%	72%
Electricity interrupted over the past 30 days	50%	57%	29%	78%	69%
Connected to national or community grid	100%	100%	97%	100%	97%
Water					
Severe shortage or lack of water in 2024	25%	14%	19%	56%	12%
Public tap or standpipe into facility	75%	60%	44%	67%	41%
Others					
Internet interruption over the past 30 days	75%	76%	37%	67%	76%
Waste collected by formal waste management services	100%	22%	48%	33%	27%
Access to health services affected by flood in 2024	0%	3%	3%	11%	4%
Room with auditory and visual privacy	50%	70%	46%	78%	68%
Have own ambulance or use of another facility's ambulance	100%	65%	83%	67%	87%

Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

RHs generally have better infrastructure access than HCs, but reliability varies across regions. Phnom Penh shows full grid connection (100 percent), waste collection (100 percent), ambulance access (100 percent), and no internet disruptions, though 50 percent experienced recent electricity interruptions. The Coastal region has stable electricity sources (100 percent) and no water shortages, but 75 percent of facilities faced power interruptions and 25 percent were affected by floods. In the Plain and Tonle Sap regions, most RHs have generators (86–64 percent) and alternative electricity (91 percent), with moderate internet (32–36 percent) and water issues (18–27 percent). Plateau and Mountain areas face the greatest challenges, with universal electricity interruptions (100 percent) and 50 percent internet disruptions, despite full grid connectivity. Overall, ambulance access (100 percent) and privacy are strong, but reliability of electricity, water supply, and support services remain uneven (table 3.8).

Table 3.8. Percentage of RHs with Access to Infrastructure

	Phnom Penh	Plain	Tonle Sap	Coastal	Plateau and Mountain
Electricity					
Have functioning generator	75%	86%	64%	50%	50%
Have other sources of electricity	75%	91%	91%	100%	50%
Electricity interrupted over the past 30 days	50%	32%	27%	75%	100%
Connected to national or community grid	100%	100%	100%	100%	100%
Water					
Severe shortage or lack of water in 2024	25%	18%	27%	0%	0%
Public tap or standpipe into facility	100%	86%	73%	100%	50%
Others					
Internet interruption over the past 30 days	0%	32%	36%	0%	50%
Waste collected by formal waste management services	100%	45%	91%	50%	50%
Access to health services affected by flood in 2024	0%	9%	9%	25%	0%
Room with auditory and visual privacy	100%	91%	73%	100%	100%
Have own ambulance or use of another facility's ambulance	100%	100%	100%	100%	100%

Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

Private health facilities generally have basic operational support and maintain acceptable patient privacy standards; however, several infrastructure and service gaps remain. Electricity interruptions are relatively common, affecting about 30 percent of facilities and posing challenges to uninterrupted service delivery. In addition, emergency referral capacity is limited, as only 63 percent of facilities have access to ambulance services, which can delay timely care for critical cases. Table 3.9 shows notable variations in the availability of physical infrastructure across private facility types.

While 65 percent of private facilities use formal medical waste collection services, a substantial proportion still rely on inadequate disposal methods, raising concerns about safety and infection control. Although the majority of facilities (74 percent) provide rooms with both auditory and visual privacy, ensuring reasonable patient confidentiality, the remaining facilities lack full privacy provisions, highlighting the need for further improvements in quality and standards of care.

Flood-related disruptions were rarely reported, with only 2 percent of facilities affected in 2024. Small

differences were observed across facility types: polyclinics were slightly more affected (4 percent) than clinics (1 percent), while hospitals and “other” providers reported no impact. This suggests that climate-related disruptions remain limited but could pose localized challenges in certain areas (table 3.9).

Table 3.9. Percentage of Private Health Facilities with Access to Infrastructure, by Facility Type

	Private health facility (N=189)	Hospital (N=11)	Polyclinic (N=47)	Clinic (N=126)	Others (N=5)
Have own ambulance or use of another facility’s ambulance	63%	36%	72%	62%	60%
Electricity interrupted over the past 30 days	30%	9%	28%	32%	40%
Room with auditory and visual privacy	74%	36%	72%	76%	100%
Waste collected by a formal waste management service	65%	36%	68%	64%	100%
Access to health services affected by flood in 2024	2%	0%	4%	1%	0%

Source: Original for this publication.

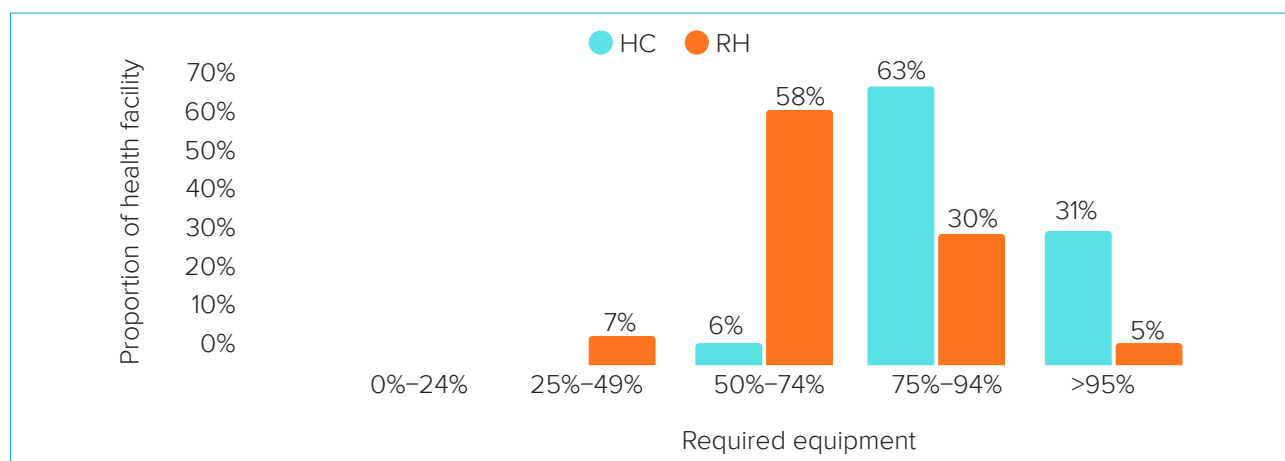
Note: N = number of observations.

PHDs and ODs highlighted a number key issues related to facility infrastructure. Many health facilities operate seasonally to respond to high demand, particularly during disease outbreaks. Buildings are frequently old, overcrowded, and in need of repair or expansion. Unreliable electricity, limited access to clean water, and inadequate sanitation infrastructure further constrain effective service delivery. The key suggestions for improvement include: renovate and expand existing hospital and HC buildings to meet growing service demands; improve basic utilities, including electricity, clean water, and sanitation systems; and ensure sufficient bed capacity and functional space for both inpatient and outpatient services.

3.2.2. Availability of Medical Equipment

Overall, both HCs and RHs show gaps in having the required equipment. While HCs demonstrate strong equipment performance, RHs appear to face greater challenges in maintaining high-functioning or fully functional equipment. Most HCs fall within the 75–94 percent range (63 percent), and a substantial share (31 percent) exceed 95 percent, indicating relatively strong equipment availability overall. In contrast, RHs are more concentrated at moderate levels, with 58 percent in the 50–74 percent range, 30 percent reaching 75–94 percent, and just 5 percent exceeding 95 percent. A small proportion of RHs (7 percent) remains at lower completeness levels (25–49 percent), whereas no HCs fall below 50 percent (figure 3.8).

Figure 3.8. Proportion of Available and Functioning Equipment Required at HCs and RHs, by Number of Equipment

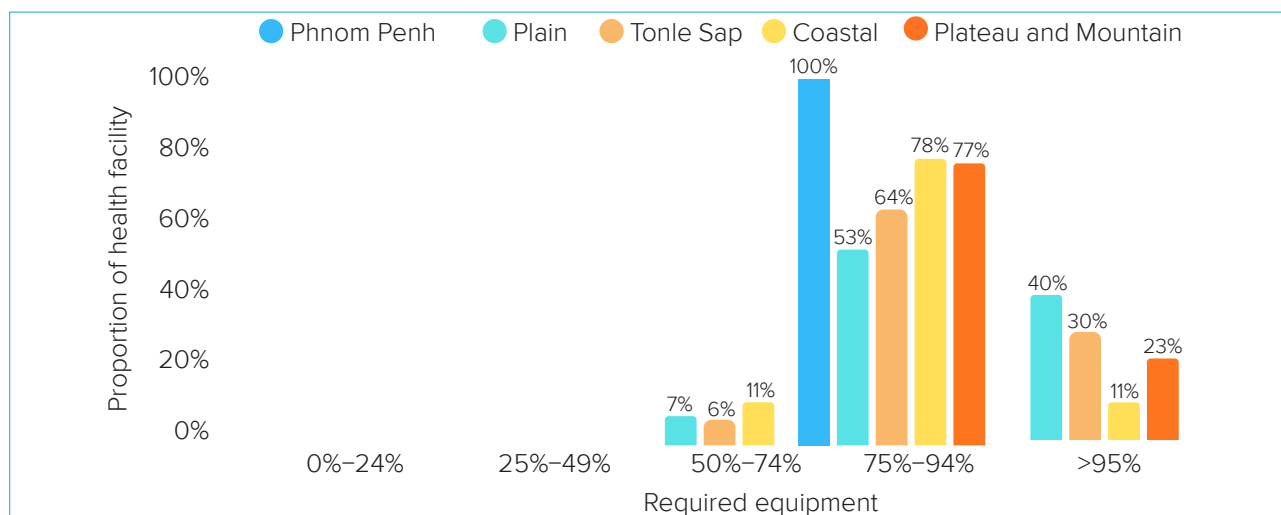


Source: Original for this publication.

Note: The completeness of equipment (defined as >95 percent of required functioning equipment) was estimated using subsets of required functioning equipment included in MPA and CPA1-2 facilities, as the full list of required functioning equipment is substantially more extensive. HC = health center; RH = referral hospital.

The required equipment availability gap in HCs is concentrated at the top end, where relatively few facilities reach higher than 95 percent. Phnom Penh has no facilities below 75 percent but none exceeding 95 percent, highlighting a clear gap in achieving full availability. The Coastal region shows the widest gap, with 11 percent of HCs still at 50–74 percent and only 11 percent above 95 percent. Plateau and Mountain areas also reflect this gap, with all facilities above 75 percent but only 23 percent exceeding 95 percent. While the Plain and Tonle Sap regions perform better, gaps remain, as 60 percent and 70 percent of HCs, respectively, do not reach higher than 95 percent availability (figure 3.9).

Figure 3.9. Proportion of Available and Functioning Equipment Required at HCs, by Region

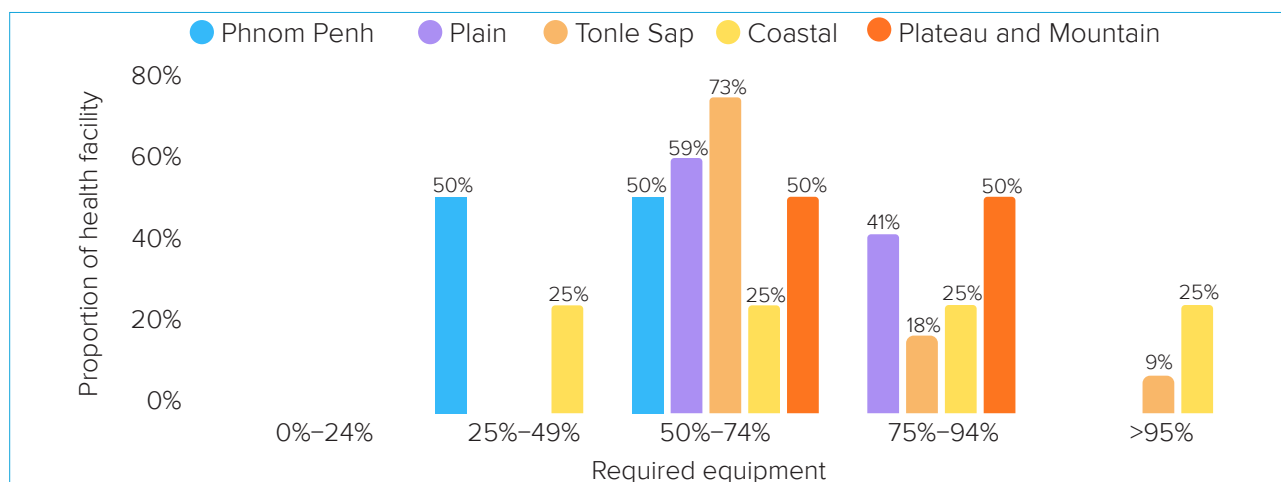


Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

Required equipment availability at RHs shows most facilities concentrated in the 50–74 percent range, with limited achievement of 95 percent and above. Phnom Penh has all facilities below 75 percent, highlighting clear gaps. The Plains and Tonle Sap show stronger performance, with most RHs between 50–74 percent and some reaching 75–95 percent, though only Tonle Sap has a small share above 95 percent. Coastal areas show a wide spread across all categories, including 25 percent above 95 percent, reflecting both strong performers and lagging facilities. Plateau and Mountain regions are concentrated between 50–95 percent but have none above 95 percent. Overall, while no RHs fall into the lowest category, very few reach full readiness, indicating persistent gaps at the top end (figure 3.10).

Figure 3.10. Proportion of Available and Functioning Equipment Required at RHs, by Region



Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

At HCs, small gaps remain in pediatric diagnostic tools and emergency equipment, which are critical for ensuring comprehensive service readiness. The lowest availability is observed for the child sphygmomanometer (88 percent), while the portable aspirator (95 percent) and stretcher (95 percent) also show minor gaps affecting emergency preparedness (table 3.10).

Table 3.10. Proportion of Available and Functioning Equipment Required at HCs, by Equipment Type

Equipment type	Proportion (N=94)
Child sphygmomanometer	88%
Otoscope set	94%
Portable aspirator, foot operated or electric	95%
Stretcher	95%
Operating light, stand type	96%
Dipstick for pregnancy test	97%
Kocher artery forceps	98%
Hemostatic forceps,	98%
Urethral catheter	98%
Scalpel handle	98%
Gynecological scissors,	98%
Delivery bed, 3 sections	98%
Kidney basin	98%
Episiotomy scissors	98%
Fetal stethoscope, monaural	98%
Wound dressing kit	98%
Weighing scale	98%
Height measuring instrument	99%
Pressure sterilizer	99%
Adult sphygmomanometer	100%
Vaccine refrigerator	100%
Vaccine carrier	100%
Ice pack	100%
Rapid test for HIV/AIDS	100%
Rapid test for syphilis	100%
Glucose meter	100%

Source: Original for this publication.

Note: AIDS = acquired immunodeficiency syndrome; HIV = human immunodeficiency virus.

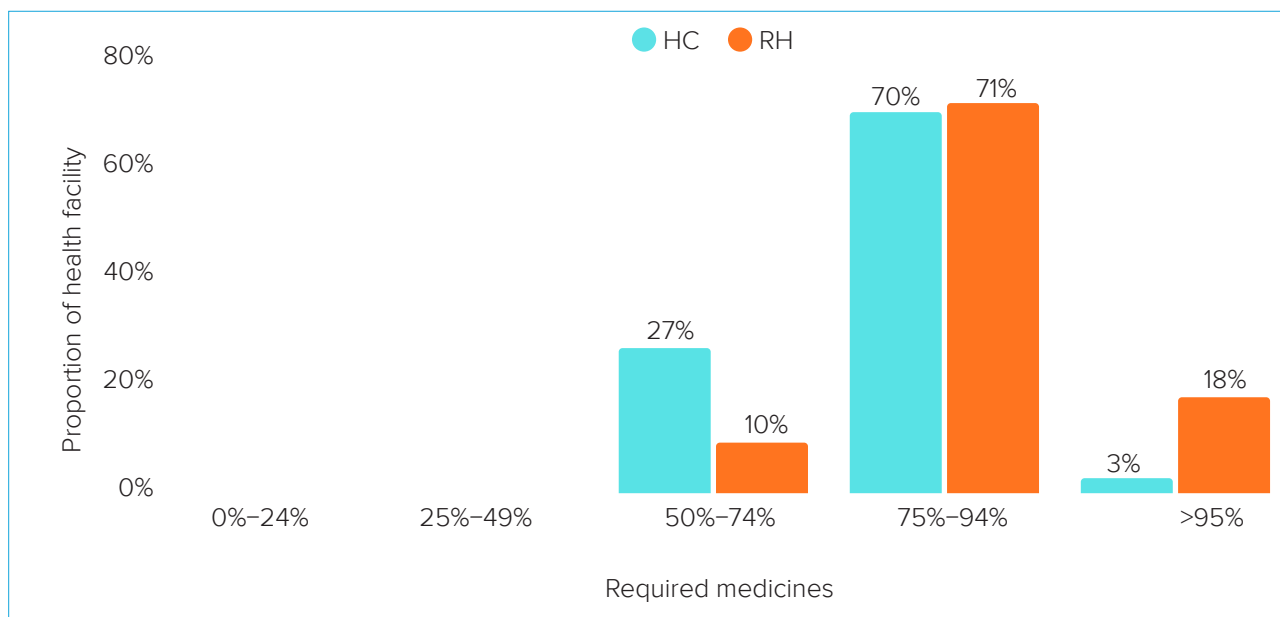
Equipment availability is high for essential maternal, child, and basic respiratory care, but remains very limited for specialized surgical and advanced diagnostic services. Table A.3 (appendix A) shows equipment availability by CPA level. Maternal and child health, newborn resuscitation, and respiratory support equipment have the highest coverage—fetal dopplers (100 percent) and resuscitators (over 90 percent). Oxygen concentrators are also widely available (85–92 percent). In contrast, specialized surgical and diagnostic tools are scarce. Craniotomy and thoracic sets are nearly absent (0–6 percent), while computed tomography (CT) scanners and mammography machines are found in only 2–6 percent of facilities.

Qualitative interviews with PHDs and ODs reveal that many public facilities rely on outdated or malfunctioning medical equipment, limiting diagnostic and treatment capabilities. The lack of modern technology also constrains efficiency and affects patient outcomes. This hinders the delivery of specialized services and reduces diagnostic and treatment efficiency. The lack of modern technology and limited capacity to operate existing tools reduces efficiency and diagnostic accuracy.

3.2.3. Availability of Medicine

Required medicine availability is generally high across both HCs and RHs, although gaps remain and full availability is uncommon, with RHs performing better than HCs. Figure 3.11 shows that a clear gap persists in achieving consistently high availability at both levels. While most facilities cluster in the 75–94 percent range (70 percent of HCs and 71 percent of RHs), only a limited proportion reach optimal levels above 95 percent, particularly among HCs (3 percent compared to 18 percent in RHs). In addition, HCs are more concentrated in the 50–74 percent range (27 percent vs. 10 percent in RHs), indicating more frequent stock shortfalls.

Figure 3.11. Medicine Availability at HCs and RHs, by Number of Medicine

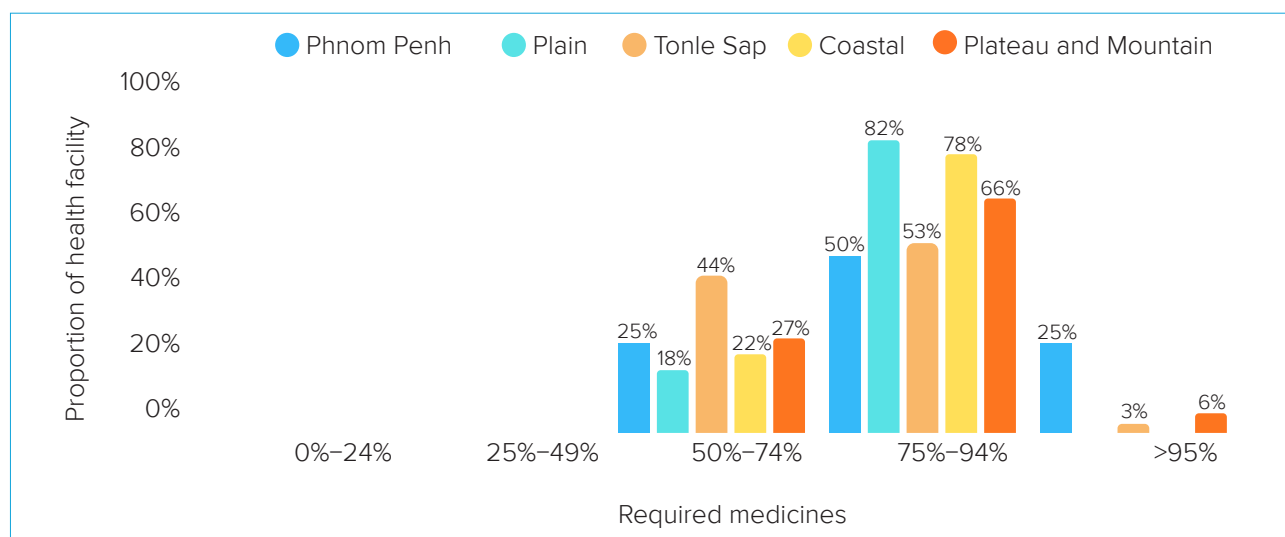


Source: Original for this publication.

Note: The completeness of medicine (defined as >95 percent of required medicine) was estimated using subsets of required medicine included in MPA and CPA1-2 facilities, as the full list of required medicine is substantially more extensive. HC = health center; RH = referral hospital.

At the HC level, medicine availability varies notably across regions, with no facilities falling below 50 percent in any region. The majority of facilities fall within the 75–95 percent range, particularly in the Plain (82 percent) and Coastal (78 percent) regions, indicating relatively strong performance. However, Tonle Sap shows the greatest gap, with 44 percent of facilities in the 50–74 percent range and only 3 percent exceeding 95 percent availability. Phnom Penh stands out with the highest share of facilities above 95 percent (25 percent), while the Plain and Coastal regions have none reaching this level. Plateau and Mountain areas show a mixed pattern, with 66 percent in the 75–95 percent range and 6 percent above 95 percent (figure 3.12).

Figure 3.12. Medicine Availability at HCs, by Region

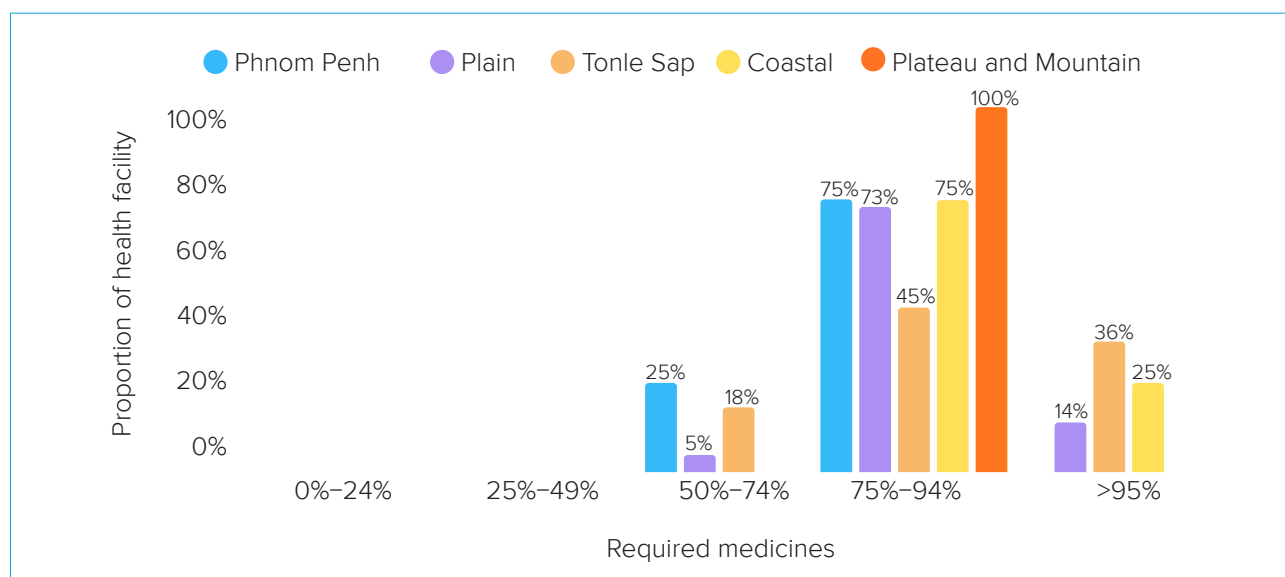


Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

Medicine availability at RHs is above 50 percent in all regions, with most facilities concentrated in the 75–95 percent range. However, gaps remain in achieving greater than 95 percent availability, reached only in Tonle Sap (36 percent), Coastal (25 percent), and Plain (14 percent), while none in Phnom Penh and Plateau and Mountain reach this level. Tonle Sap also shows the widest disparity, with 18 percent of facilities still in the 50–74 percent range. The key message is that despite generally strong availability, consistent attainment of near-complete stock levels remains limited across regions (figure 3.13).

Figure 3.13. Medicine Availability at RHs, by Region



Source: Original for this publication.

Note: Plain = Kampong Cham, Prey Veng, and Takeo Province; Tonle Sap = Banteay Meanchey, Kampong Chhnang, and Pursat Province; Coastal = Kampot Province; Plateau and Mountain = Kratie, Preah Vihear, and Oddar Meanchey Province.

Medicine availability varies substantially, with near-universal access to key essential drugs but notable gaps in commonly used antibiotics and steroids. Table 3.11 details availability of medicine at HCs. Ferrous salt + folic acid (100 percent), metronidazole (99 percent), and metformin (98 percent) were widely available. In contrast, amoxicillin (73 percent), dexamethasone (28 percent), and other steroids (20–22 percent) showed limited coverage.

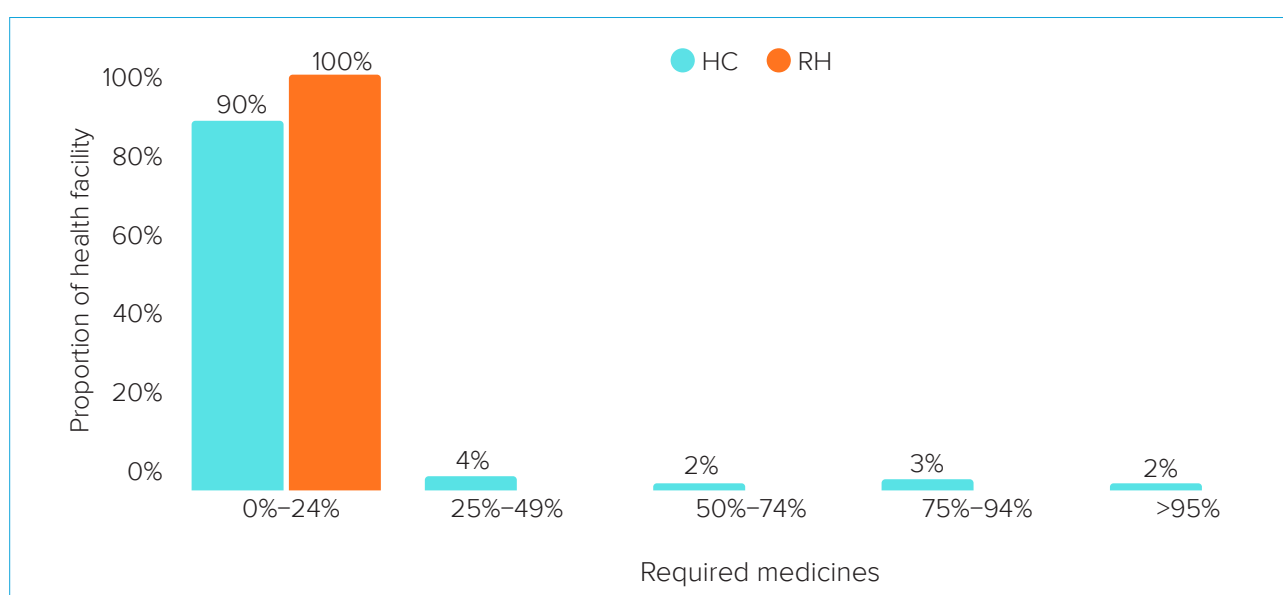
Table 3.11. Medicine Availability at HCs, by Medicine Type

Type of Medicine	Proportion (N=94)
Dexamethasone 0.75 mg tablet or capsule	20%
Atropine 1 mg per 1 ml injection	22%
Amoxicillin 250 mg, 500 mg, or 1 g injection	28%
Hydrochlorothiazide 25 mg tablet or capsule	73%
Sulfamethoxazole and Trimethoprim (Cotrimoxazole) 100 mg + 20 mg or 400 mg + 80 mg tablet	89%
Oxytocin 10 IU per ml injection	94%
Metformin	96%
Albendazole 400 mg tablet	97%
Metronidazole 250 mg or 500 mg tablet	98%
Amlodipine 5 mg tablet	99%
Ferrous salt + folic acid 60 mg + 400 µg tablet	99%
Paracetamol 250 mg or 500 mg tablet	100%

Source: Original for this publication.

Note: IU = international units; µg = microgram.

All RHs (100 percent) reported having less than 25 percent of required medicine out of stock, indicating strong medicine availability. Figure 3.14 shows that medicine stockouts are generally minimal, particularly at RHs. In contrast, HCs show slightly more variability. While the vast majority (90 percent) also reported stockouts below 25 percent, small proportions experienced higher levels of shortages. Specifically, 4 percent of HCs had 25–49 percent of medicine out of stock, 2 percent had 50–74 percent, 2 percent had 75–94 percent, and 2 percent reported complete stockout of required medicine.

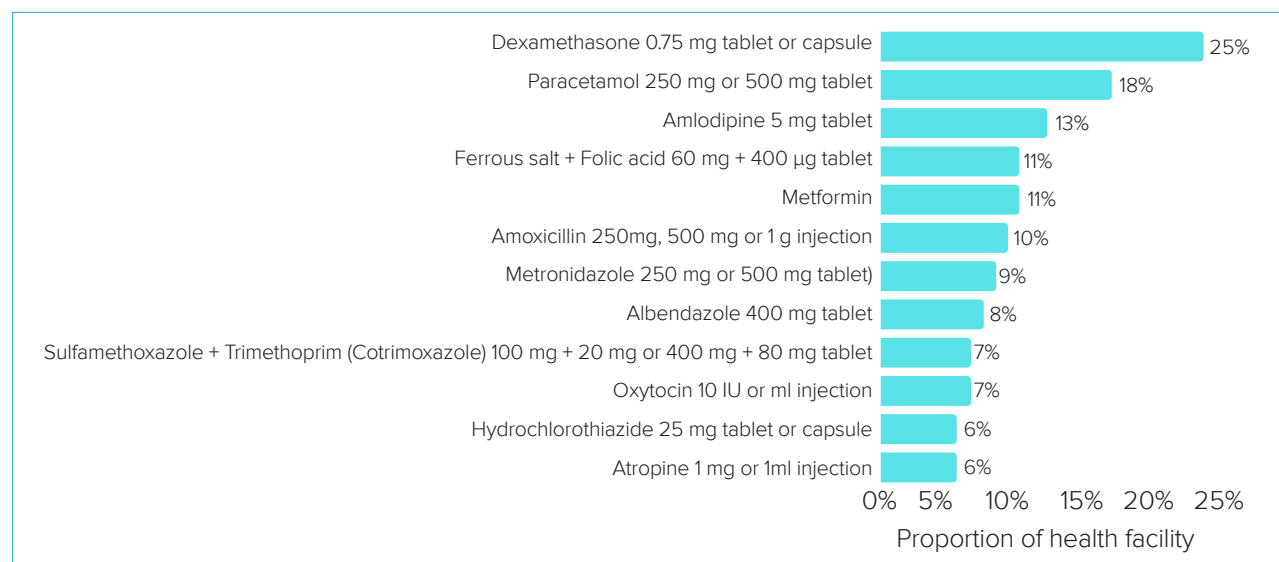
Figure 3.14. Medicine Out of Stock at HCs and RHs, by Number of Medicine

Source: Original for this publication.

Note: The completeness of medicine (defined as >95 percent of required medicine) was estimated using subsets of required medicine included in MPA and CPA1-2 facilities, as the full list of required medicine is substantially more extensive.

Stockouts vary by medicine type, with the most frequent shortages observed for dexamethasone and paracetamol, while several other essential medicine experience more limited disruptions. Figure 3.15 highlights variation by medicine type. In addition to the frequent stockouts of dexamethasone (25 percent) and paracetamol (18 percent), moderate shortages affected amlodipine (13 percent), ferrous salt + folic acid (11 percent), metformin (11 percent), and amoxicillin (10 percent). Least affected were metronidazole (9 percent), albendazole (8 percent), sulfamethoxazole + trimethoprim (7 percent), oxytocin (7 percent), hydrochlorothiazide (6 percent), and atropine (6 percent).

Figure 3.15. Medicine Out of Stock at HCs, by Medicine



Source: Original for this publication.

Note: IU = international units; µg = microgram.

Essential medicine availability is strong across RHs, although gaps persist for selected injectable and chronic disease medicine. Table 3.12 highlights strong coverage of essential medicine across all referral hospital types. Paracetamol, dexamethasone, fluconazole, amlodipine, metformin, and oxytocin were universally available. Over 94 percent of facilities also stocked ciprofloxacin, magnesium sulfate, sulfamethoxazole + trimethoprim, and amoxicillin + clavulanic acid. However, some medicine showed limited availability: amoxicillin injection (18 percent overall), insulin injection (35 percent overall, with CPA-2 facilities at 63 percent), and enalapril (50–55 percent across all types).

Table 3.12. Medicine Availability at RHs, by Medicine Type

	RH (N=49)	CPA1 (N=33)	CPA2 (N=16)
Amoxicillin 250 mg, 500 mg, or 1 g injection	18%	21%	13%
Insulin injection soluble, 100 IU per ml	35%	21%	63%
Enalapril 2.5 mg or 5 mg or 10 mg tablet	53%	55%	50%
Epinephrine (adrenaline) 1 mg per ml injection	76%	67%	94%
Metronidazole 500 mg per 100 ml injection	84%	76%	100%
Azithromycin 250 mg or 500 mg tablet	84%	85%	81%
Hydrochlorothiazide 25 mg tablet or capsule	86%	88%	81%
Ampicillin 500 mg or 1 g injection	92%	88%	100%
Atropine 1 mg per 1ml injection	92%	91%	94%
Atenolol 50 mg tablet	94%	91%	100%
Amoxicillin + Clavulanic acid 500 mg per 125 mg or 875 mg per 125 mg tablet	96%	94%	100%

Sulfamethoxazole + Trimethoprim (Cotrimoxazole) 100 mg + 20 mg, 400 mg + 80 mg or 800mg + 160 mg tablet	96%	94%	100%
Magnesium sulfate 0.5 g per ml injection	98%	97%	100%
Ciprofloxacin 100 mg, 250 mg, or 500 mg tablet or capsule	98%	97%	100%
Paracetamol 250 mg or 500 mg tablet	100%	100%	100%
Dexamethasone 4mg per ml injection	100%	100%	100%
Fluconazole 50mg or 200 mg tablet or capsule	100%	100%	100%
Amlodipine 5 mg tablet	100%	100%	100%
Metformin 500 mg tablet	100%	100%	100%
Oxytocin 10 IU per ml injection	100%	100%	100%

Source: Original for this publication.

Note: IU = international units.

Stockouts were most common for widely used medicine, while several other essential drugs experienced relatively low and infrequent supply disruptions.

The medicine most frequently out of stock were widely used drugs: dexamethasone (25 percent) and paracetamol (18 percent). medicine with moderate stockout levels included amlodipine (13 percent), ferrous salt + folic acid (11 percent), metformin (11 percent), and amoxicillin (10 percent), which are essential for managing chronic diseases, maternal health, and infections. The least frequently out-of-stock medicine were metronidazole (9 percent), albendazole (8 percent), sulfamethoxazole + trimethoprim (7 percent), oxytocin (7 percent), hydrochlorothiazide (6 percent), and atropine (6 percent).

Private health facilities generally demonstrate strong medicine availability, particularly in hospitals, although coverage varies by facility type and notable gaps persist for selected essential medicine.

Table 3.13 summarizes medicine availability across private health facilities by medicine and facility type. Private hospitals showed the highest coverage, with 75–94 percent reporting Medicine in stock. Overall, private facilities demonstrates strong availability, with 63–94 percent stocking most essential Medicine. However, gaps remain in specific Medicine. Hydrochlorothiazide was available in 75 percent of hospitals, but only 50 percent of polyclinics, 44 percent of clinics, and 20 percent of other facilities. Ampicillin showed similar variation: 75 percent availability in hospitals, 59 percent in polyclinics, 44 percent in clinics, and 60 percent in other facilities. Oxytocin was available in 75 percent of hospitals, 74 percent of polyclinics, 51 percent of clinics, and 40 percent of other facilities. Soluble insulin injections were available in 58 percent of hospitals and 52 percent of other private facilities.

Table 3.13. Medicine Availability at Private Facilities, by Medicine Type

	Private facility (N=140)	Hospital (N=4)	Polyclinic (N=34)	Clinic (N=97)	Other (N=5)
Hydrochlorothiazide 25 mg tablet or capsule	46%	75%	50%	44%	20%
Ampicillin 500 mg or 1 g injection	49%	75%	59%	44%	60%
Oxytocin 10 IU per ml injection	56%	75%	74%	51%	40%
Insulin injection soluble, 100 IU per ml	58%	100%	79%	52%	0%
Magnesium sulfate 0.5 g per ml injection	63%	100%	88%	54%	40%
Metformin 500 mg tablet	66%	50%	88%	61%	20%
Atenolol 50 mg tablet	71%	75%	82%	69%	20%
Sulfamethoxazole + Trimethoprim (Cotrimoxazole) 100 mg + 20 mg, 400 mg + 80 mg or 800 mg + 160 mg tablet	71%	75%	85%	68%	40%

Amoxicillin 250 mg, 500 mg, or 1 g injection	73%	75%	88%	67%	80%
Atropine 1 mg per 1ml injection	75%	100%	94%	69%	40%
Epinephrine (adrenaline) 1 mg per ml injection	76%	75%	91%	70%	100%
Fluconazole 50 mg or 200 mg tablet or capsule	81%	75%	88%	79%	60%
Metronidazole 500 mg per 100 ml injection	89%	100%	100%	86%	80%
Enalapril 2.5 mg, 5 mg, or 10 mg tablet	90%	100%	97%	88%	33%
Amlodipine 5 mg tablet	90%	100%	97%	91%	20%
Paracetamol 250 mg or 500 mg tablet	91%	75%	88%	93%	80%
Amoxicillin + Clavulanic acid 500 mg per 125 mg or 875 mg per 125mg tablet	91%	100%	97%	89%	80%
Ciprofloxacin 100 mg, 250 mg, or 500 mg tablet or capsule	91%	100%	100%	90%	60%
Dexamethasone 4mg per ml injection	92%	100%	100%	89%	100%
Azithromycin 250 mg or 500 mg tablet	94%	100%	94%	95%	60%

Source: Original for this publication.

Note: IU = international units.

PHDs and ODs reported that medicine and supply shortages continue to occur, especially during seasonal disease outbreaks or when deliveries from central stores are delayed. These shortages are not caused by a single failure, but rather by a sequence of interconnected supply, demand, and financing constraints that compound over time and vary across facilities. Delayed national or project-based distribution often leads to periodic shortages of essential medicine, particularly for chronic conditions such as diabetes and hypertension. These supply gaps are intensified during seasonal disease outbreaks, when sudden increases in patient demand quickly exhaust available stocks and result in temporary stockouts. To maintain service continuity, facilities frequently rely on local purchasing and operational budgets to supplement central supplies. While this coping mechanism allows care to continue, it places additional financial strain on facilities and raises concerns about long-term sustainability. At the same time, unequal consumption patterns across facilities—especially in high-volume centers—accelerate stock depletion, further widening disparities in medicine availability and reinforcing the cycle of shortages.

3.2.4. Availability of Staff and Staff Cadres

Staffing levels vary significantly across public health facilities, with HCs facing the most acute constraints. HCs, which are typically smaller and located in rural areas, reported no doctors and a median of four nurses and four midwives. In contrast, RHs are substantially better staffed across all cadres. As shown in table 3.14, RHs reported median staffing levels of 8 doctors or medical officers, 16 nurses, 13 midwives, and 17 other staff, including pharmacists, laboratory technologists, and administrative personnel. Within RHs, CPA-2 facilities consistently reported higher staffing levels than CPA-1 facilities, particularly for doctors and nurses.

Gender disparities are evident across most staff categories. Male staff dominate in nearly all clinical and nonclinical roles, with the exception of midwives, who are exclusively female. The gender gap is most pronounced among doctors and medical officers, where the overall male-to-female ratio is approximately seven to one, and even wider in CPA-2 facilities. Among nurses, male staff outnumber female staff in both

HCs and RHs. At HCs, the median number of male nurses is three compared to one female nurse. In referral hospitals, the imbalance persists, although less stark, with higher absolute numbers of both male and female nurses. Gender differences among other staff categories are comparatively limited.

These findings point to persistent disparities in staffing levels across facility types, as well as marked gender imbalances in key clinical roles. These challenges are most acute in rural HCs, where limited staff availability and a narrow skills mix may constrain service delivery.

Table 3.14. Staff Availability (Median) at Public Health Facilities, by Facility Type and by Gender

	HCs	RHs		
		Overall	CPA-1	CPA-2
Doctor or medical officer	0	8	6	11
• Male	0	7	5	8.5
• Female	0	1	1	2
Nurses	4	16	14	21
• Male	3	10	8	16
• Female	1	6	6	6.5
Midwives	4	13	11	14
• Male	0	0	0	0
• Female	4	13	11	14
Others	0	17	16	20
• Male	0	8	8	9
• Female	0	9	8	11.5

Source: Original for this publication.

Note: The analysis included only full-time staff.

Staffing levels in the private sector vary considerably by facility type, with private hospitals facilities employing the largest and most diverse workforce. As shown in table 3.15, private hospitals reported the highest median staffing levels across all cadres, including six other staff, four nurses, three doctors, and one midwife. In contrast, polyclinics, clinics, and other private facilities operate with much smaller staffing complements, particularly for doctors and nurses. This suggests a strong concentration of skilled clinical personnel within private hospitals, while smaller facilities provide more limited service capacity.

Gender patterns in private facilities differ from those observed in the public sector. Private hospitals employ a higher proportion of female staff across all categories. Female doctors outnumber male doctors by approximately two to one, and female nurses outnumber males by around five to one. Female representation is also strong among other staff, where female numbers are nearly double those of males. Gender distributions are more mixed in polyclinics and clinics. Male doctors tend to dominate in smaller private facilities, while nurses and other staff show a more balanced gender composition. As in the public sector, midwives in all private facility types are exclusively female.

Table 3.15. Fulltime Staff Availability (Median) at Private Health Facilities, by Facility Type and by Gender

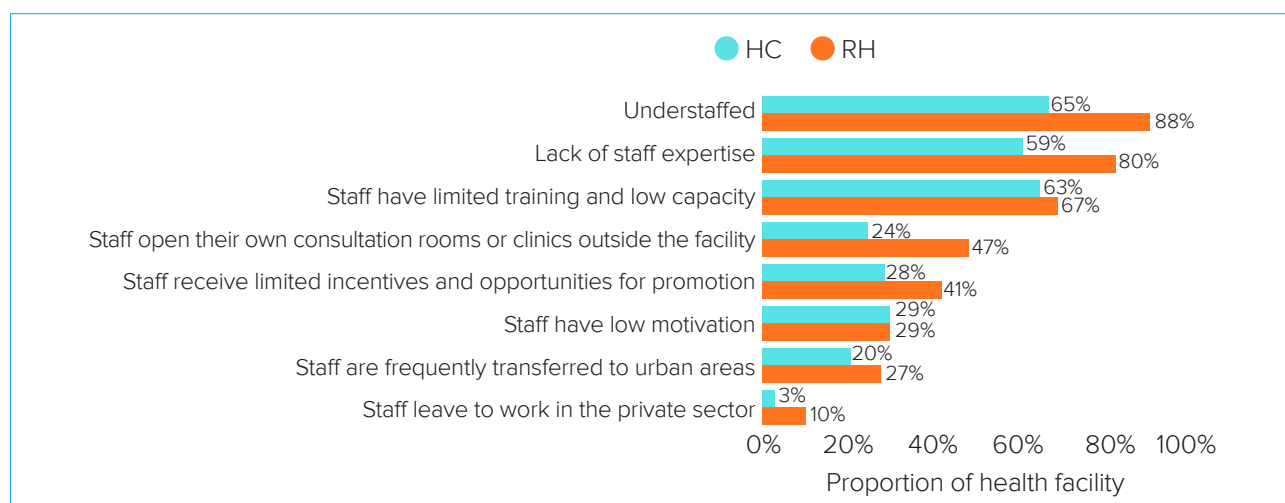
	Private facility	Hospital	Polyclinic	Clinic	Other
Doctor or medical officer	3	15	4	2	2
• Male	2	6	3	2	1
• Female	1	10	1	0	0
Nurses	4	30	6	4	1
• Male	2	5	3	1	0
• Female	2	26	3	2	1
Midwives	1	2	2	0.5	0
• Male	0	0	0	0	0
• Female	1	2	2	0	0
Others	6	48	10	5	4
• Male	3	17	6	2	2
• Female	3	32	5	2	2

Source: Original for this publication.

Note: The analysis included only full-time staff.

Staffing shortages, skills gaps, and inadequate training constrain service delivery across all public facilities, with more acute impacts at referral hospitals. Figure 3.16 highlights a consistent set of staffing challenges across both HCs and RHs. Understaffing and limited staff capacity are the most critical constraints, particularly in RHs, where 88 percent report understaffing compared to 65 percent of HCs. Gaps in staff expertise are also widespread, affecting 80 percent of RHs and 59 percent of HCs, alongside insufficient training reported by 67 percent and 63 percent of facilities, respectively. These constraints have direct implications for service quality, especially for more complex clinical services delivered at RHs.

Structural workforce issues further undermine staff retention and performance. Weak incentives, limited opportunities for career progression, and low motivation contribute to high turnover, while frequent transfers to urban areas and movement into the private sector exacerbate staffing instability. In RHs, dual practice and staff operating private clinics place additional pressure on already constrained human resources. Together, these findings underscore the need for strengthened workforce planning, improved retention incentives, and targeted capacity building across all levels of care.

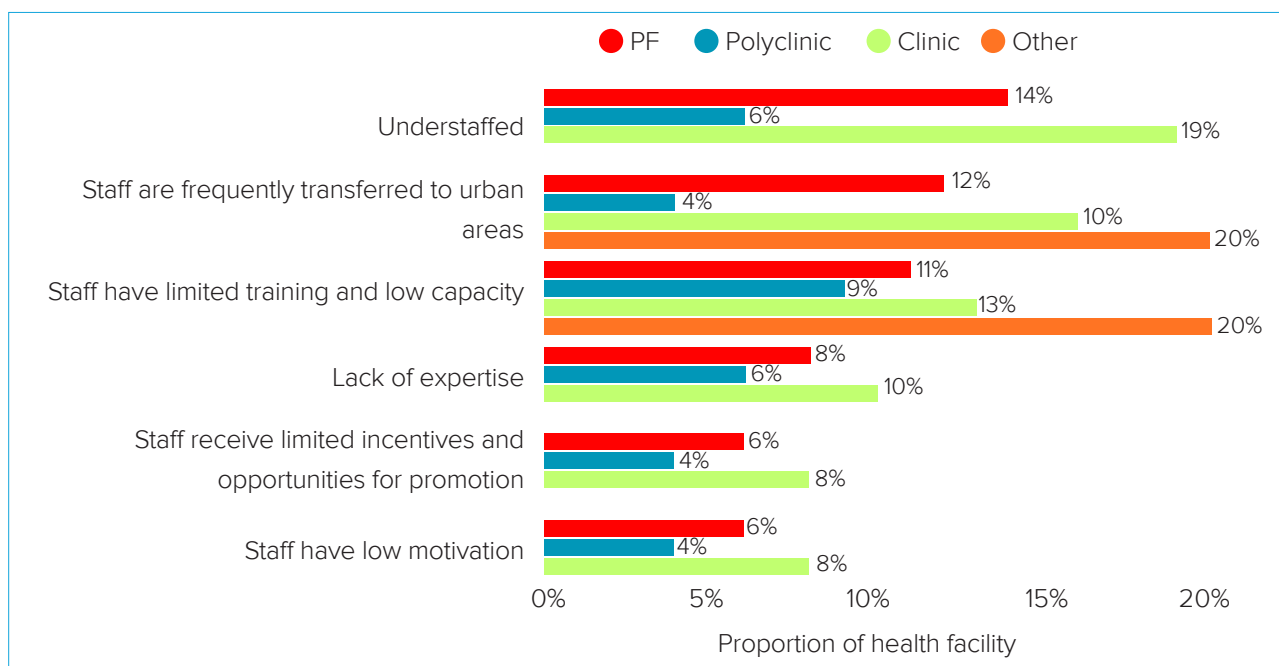
Figure 3.16. Staffing Challenges at Public Facilities, by Facility Type

Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

Staffing challenges in private facilities are generally low, with clinics facing the most constraints and polyclinics the fewest. Figure 3.17 shows that staffing challenges in private health facilities were generally low in 2024 (4–20 percent), with notable variation by facility type. Clinics and the overall private sector reported similar patterns, with top issues including understaffing (19 percent clinics and 14 percent overall), staff transfers to urban areas (16 percent and 12 percent), limited training (13 percent and 11 percent), and lack of expertise (10 percent and 8 percent). Low motivation and limited incentives were least reported (6–8 percent). Polyclinics reported the fewest challenges (4–9 percent), mainly limited training (9 percent) and understaffing (6 percent). Other facilities cited only two issues: staff transfers and limited training (both 20 percent).

Figure 3.17. Staffing Challenges at Private Facilities, by Facility Type



Source: Original for this publication.

Note: Private hospitals did not provide responses to the questions regarding staffing challenges. PF = private facility

Most providers worked standard schedules, though private facility staff worked longer hours, with time primarily allocated to outpatient rather than inpatient care. The standard schedule is five days a week, eight hours per day, while the schedule for staff in private facilities is 11.5 hours per day. Table 3.16 summarizes health care provider workload by facility type, gender, and role. Weekly time on outpatient and inpatient care averaged 15 and 14 hours, respectively, with slightly less inpatient time in private facilities and among doctors and midwives (12 hours). Administrative tasks took about six hours weekly, accounting for 20 percent of total time. Public facility staff spent more time on admin (7 hours) than private (4 hours), suggesting heavier bureaucratic demands.

Outpatient services dominated provider workloads, particularly in public facilities, while inpatient care and outreach activities accounted for a much smaller share of staff time. Outpatient care included 30 contacts per week—three times more than inpatient care. Public facilities handled more patient care (30 outpatient, 19 inpatient) than private (20 outpatient, 7 inpatient). Male staff had more outpatient contacts (25 vs. 20) but equal inpatient contacts (7). Doctors led outpatient care (45 contacts), while nurses led inpatient care (14.5 contacts). Outreach activity was minimal, averaging two days per month. Male staff spent more time (4 days) than females (2 days). Nurses and midwives averaged 3.5 and 2 days, respectively. Doctors did not participate (table 3.16).

Table 3.16. Health Care Provider Workloads, by Facility Type, Gender, and Staff Category

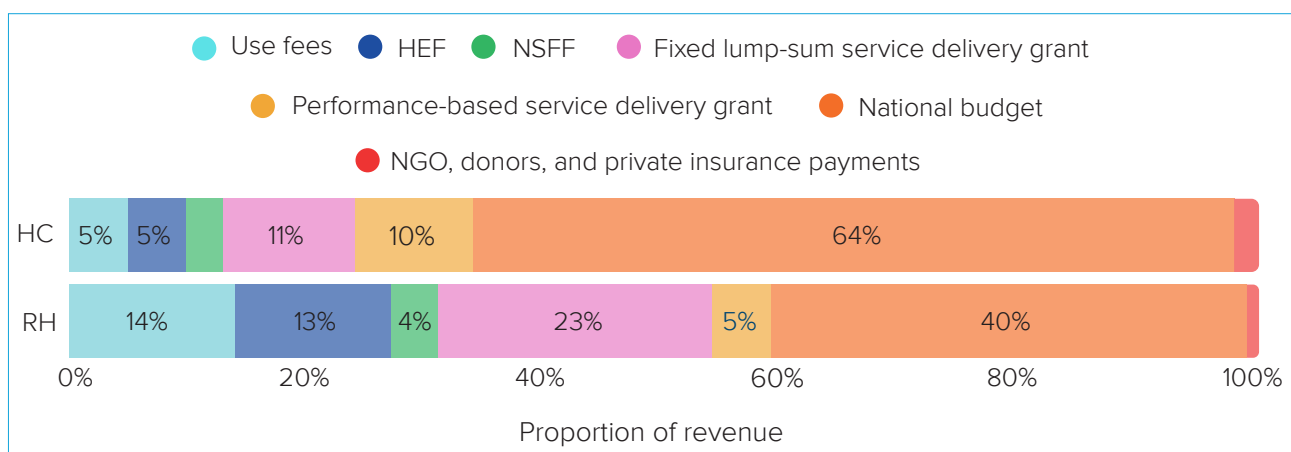
Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Number of days worked in a week (Median)	5	5	5	5	5	5	5	5
Number of hours worked on a normal weekday (Median)	8	8	11.5	8	8	8	8	8
Number of hours spent on providing care to outpatients in a week (Median)	15	15	15	15	15	15	15	15
Number of hours spent providing care to inpatients in a week (Median)	14	14	12	14	13.5	12	15	12
Number of hours spent on administrative tasks in a week (Median)	6	7	4	6	5	5	6	6
Number of outpatient contacts in a week (Median)	30	30	20	30	25	45	25	25
Number of inpatient contacts in a week (Median)	10	19	7	15	10	14	14.5	7
Number of days spent on conducting outreach in the last month (Median)	2	2	0	4	2	0	3.5	2

Source: Original for this publication.

3.2.5. Financing

HCs are more government budget–dependent, while RHs have more diversified sources of revenue, including HEF and NSSF) and user fees. HCs rely predominantly on allocations from the national budget as their main source of financing, accounting for 64 percent of total revenue. In contrast, RHs receive a more diversified mix of funding, with fixed lump-sum grants accounting for 23 percent of their revenues and user fees contributing an additional 14 percent—both higher than in HCs. Performance-based service delivery grants are relatively more significant for HCs, representing 10 percent of their funding, compared with only 5 percent for RHs. External financing sources, including the HEF, the NSSF, and NGO or donor contributions, play a minimal role in financing both types of facilities (figure 3.18).

Figure 3.18. Revenue of Public Facilities in 2024, by Facility Type and Sources of Funds

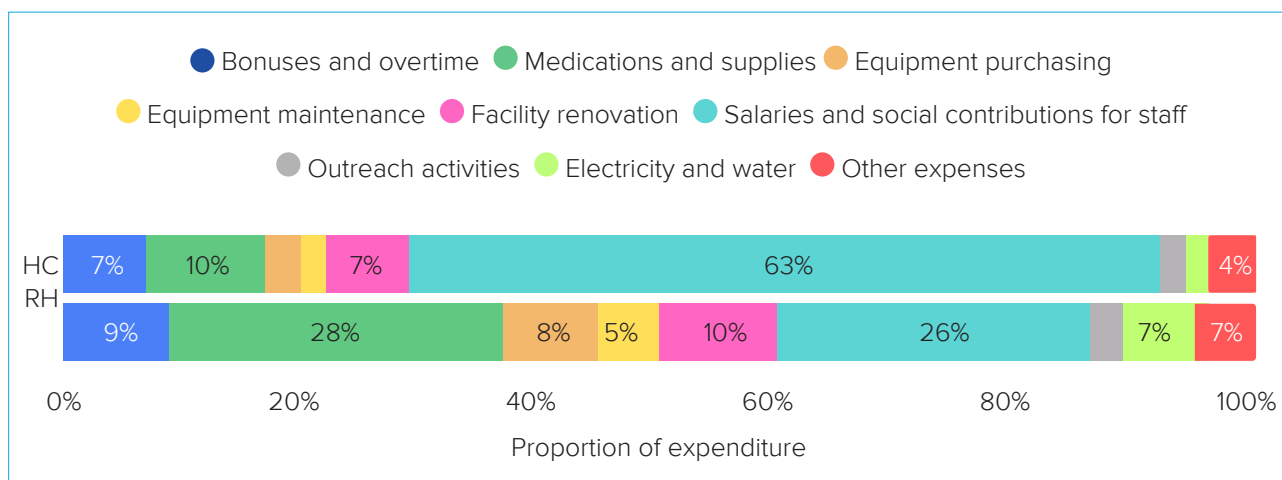


Source: Original for this publication.

Note: The mean and median revenue of public facilities are presented in table A.4 in appendix A. HC = health center; HEF = Health Equity Fund; NSSF = National Social Security Fund; NGO = Nongovernmental organization; RH = referral hospital.

HCs have a high share of salary spending, while RHs spend a higher share of funds on medications, equipment, and infrastructure. At HCs, the largest share of expenditures is on salaries and social contributions, accounting for 63 percent of total spending. Other notable expenses include medications and supplies (10 percent), bonus and overtime (7 percent), and facility renovation (7 percent). Smaller proportions are spent on equipment purchasing and maintenance, electricity and water, outreach activities, and other expenses. Expenditure patterns are more evenly distributed for RHs. Medications and supplies represent the largest portion (28 percent) of spending, followed by salaries and social contributions (26 percent) and facility renovation (10 percent). Bonus and overtime, equipment purchasing and maintenance, electricity and water, and other expenses contribute smaller shares, ranging from 2–7 percent (figure 3.19).

Figure 3.19. Expenditure of Public Facilities in 2024, by Facility Type and Sources of Funds

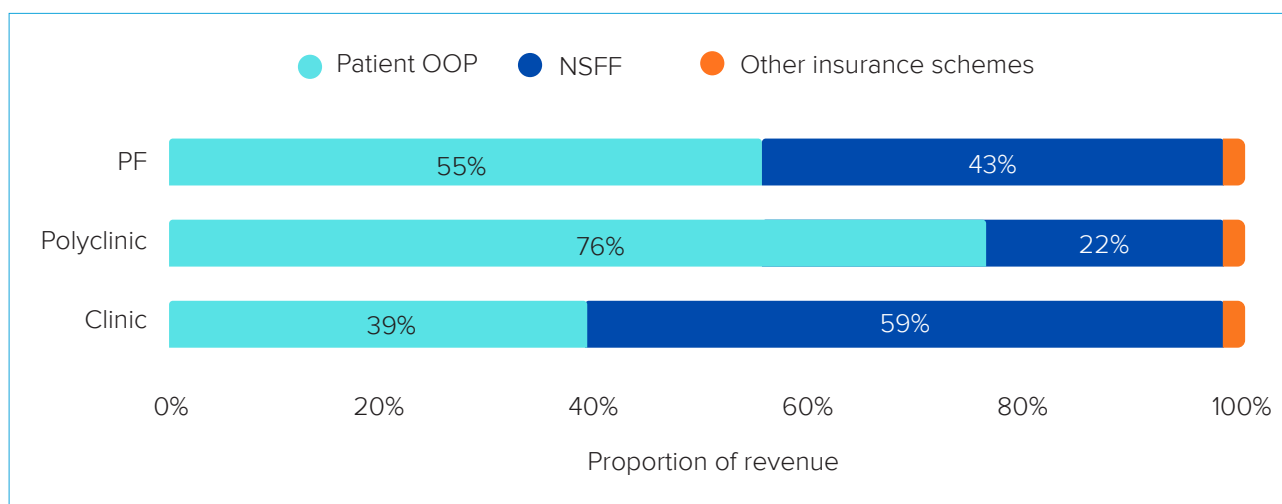


Source: Original for this publication.

Note: The mean and median expenditure of public facilities are presented in table A.5 in appendix A. HC = health center; RH = referral hospital.

Private facility revenues are dominated by patient OOP spending and NSSF funding, with polyclinics relying mainly on patient payments and clinics are more dependent on the NSSF. For private facilities, patient OOP spending and the NSSF are the main revenue sources overall, contributing 55 percent and 42 percent of total revenue, respectively. Polyclinics rely more on patient payments (76 percent), while clinics receive most funding from the NSSF (59 percent), with other insurance schemes contributing minimally (figure 3.20).

Figure 3.20. Sources of Revenue in Private Facilities, by Sources of Funds

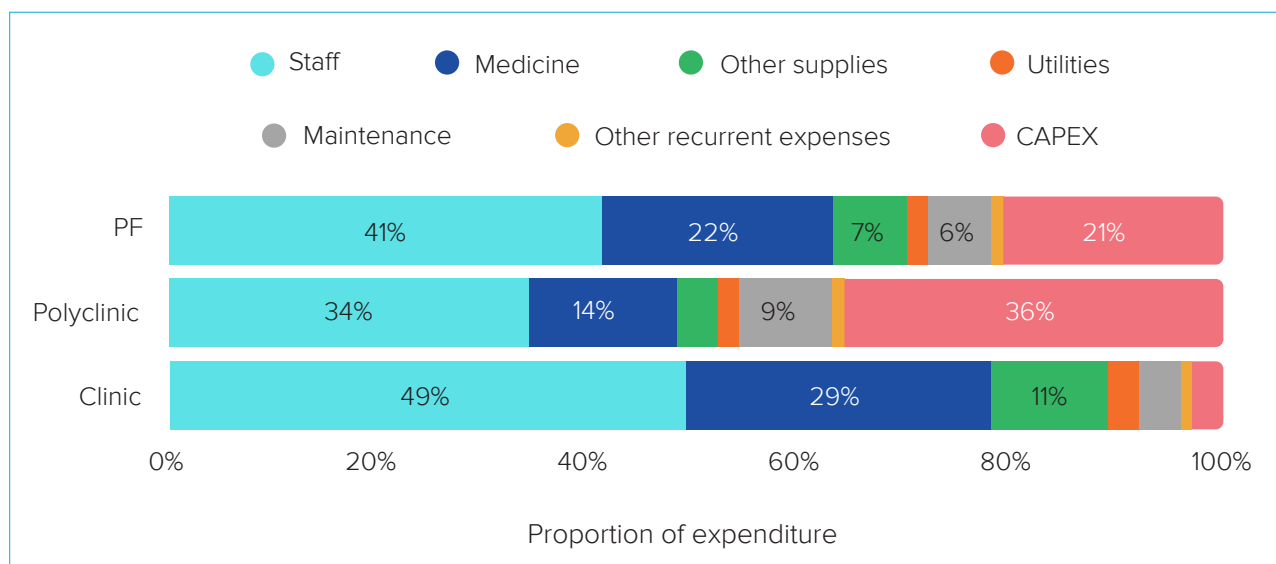


Source: Original for this publication.

Note: Private hospitals and other private facilities did not provide information on their sources of revenue. The mean and median revenue of private facilities are presented in table A.6 in appendix A. NSSF = National Social Security Fund; OOP= out-of-pocket spending; , PH = private hospital.

Expenditure patterns differ by private facility type, with polyclinics more capital intensive and clinics primarily driven by staff and medicine costs. Staff costs are the largest expenditure overall (41 percent), followed by medicine (22 percent) and capital investment (20 percent). Polyclinics spend more on staff and CAPEX, while clinics allocate a higher share to staff and medicine, with other expenses relatively smaller. Polyclinics are more capital intensive, with 36 percent of expenditure devoted to CAPEX and relatively lower spending on medicine. In contrast, clinics are primarily labor- and medicine-driven, with 49 percent spent on staff and 29 percent on medicine, and minimal CAPEX (4 percent). These differences reflect variation in service complexity and investment needs across private facilities (figure 3.21).

Figure 3.21. Expenditure in Private Facilities, by Facility Type and Use of Funds



Source: Original for this publication.

Note: Private hospitals and other private facilities did not provide information on their expenditure. The mean and median expenditure of private facilities are presented in table A.7 in appendix A. CAPEX = capital expenditure; PF = private facility.

Two key challenges were raised by PHDs and ODs regarding budget allocation and expenditure. First, rising utility and maintenance costs often exceed available allocations, leaving limited resources for essential activities such as staff training, field missions, and equipment replacement. Many facilities operate under tight budget constraints, resulting in deferred payments or the accumulation of arrears, particularly toward the end of the fiscal year. Administrative procedures and multilevel approvals cause delays in disbursement, while staff at lower levels often lack formal accounting training. Funding remains static despite increasing service demand, and public disclosure of financial information is limited, reducing transparency.

Second, operational and capital budgets remain insufficient, particularly for utilities, infrastructure upgrades, and equipment maintenance. Significant renovation and modernization are needed, especially in older health facilities. Insufficient capital investment constrains service quality and limits the ability of public facilities to meet rising public expectations, particularly in comparison with private providers. Some RHs still operate in outdated buildings with inadequate space and maintenance budgets. Shortages of advanced diagnostic and treatment equipment, including ventilators and laboratory equipment, continue to limit service capacity. medicine distribution to remote areas remains inconsistent, and digital infrastructure and information technology (IT) literacy among staff are weak, constraining the full use of new systems.

3.3. Support System to Deliver Health Care

- **Providers demonstrate strong teamwork and efficiency.** Health providers report high levels of collaboration, trust, and operational efficiency, ranging from 89 percent to 92 percent.
- **Most staff have positive management perceptions.** Most staff view management favorably, with 89 percent noting leadership by example and 91 percent citing effective communication.
- **There is high provider satisfaction with work, but lower satisfaction for structural and financial factors.** Satisfaction is highest for work responsibilities (94 percent), skill development (90 percent), and workload balance (86 percent), but lower for resources (81 percent), infrastructure (80 percent), career promotion (80 percent), and salary (74 percent).
- **Public facilities face significant financial pressures and resource constraints.** Fee exemptions reduce revenue (20 percent at HCs and 10 percent at RHs), while direct medicine procurement increases costs, especially for hypertension, diabetes, antibiotics, and vaccines. Rising utility costs, weak maintenance budgets, static funding, and growing patient demand exacerbate operational challenges.
- **Fragmented budgeting and financial management limit efficiency and flexibility.** Most facilities manage separate budgets by funding source, rely on multiple partially digital systems, and spend extensive time on budget preparation, while limited accounting skills, low IT literacy, and multilevel approval processes cause delays, reporting burdens, and reduce transparency and performance-linked resource allocation.
- **There is strong management and supervision in public facilities.** Both HCs and RHs have active management committees and receive external supervision, with most staff finding the feedback helpful for improving operations.

3.3.1. Human Resources Management

Despite persistent staffing gaps, human resource systems in both public and private facilities function reasonably well, supported by strong teamwork and collegial practices that sustain service delivery.

Qualitative findings indicate that human resource systems function reasonably well in both public and private facilities, with structured supervision, rotation, and teamwork helping maintain service continuity despite persistent staffing gaps. Public facilities rely heavily on staff commitment and peer collaboration to manage shortages, night shifts, and seasonal patient peaks, while private facilities manage workloads through clear role division and flexible task allocation. Across facilities, teamwork and collegial support are strong drivers of performance, confirming and reinforcing the positive quantitative ratings of efficiency and trust.

3.3.1.1. Recruitment, Performance Evaluation, and Performance Bonuses

Recruitment and performance evaluation systems were widely reported by health care providers. More than 78 percent indicated that these practices were in place. Recruitment was more competitive in public facilities (87 percent) than in private facilities (73 percent), and it was applied equally to male and female providers. Midwives experienced the most competitive recruitment (88 percent), followed by doctors (85 percent) and nurses (80 percent).

Similarly, over 80 percent of providers reported having formal performance evaluations and most considered these evaluations fair (78 percent). Public facilities had notably stronger systems than private ones: 93 percent of providers in public facilities reported formal evaluations and 89 percent reported fair evaluations, compared with 61 percent in private facilities. Female providers were more likely than male providers to report both formal evaluations (85 percent vs. 72 percent) and fair evaluations (84 percent vs. 67 percent). Across provider types, evaluation practices remained consistently high, particularly among midwives (88 percent formal and 86 percent fair), followed by nurses (78 percent and 75 percent) and doctors (71 percent and 65 percent). See table A.8.

Although most health care providers reported receiving performance appraisals and considered them fair, these assessments were used primarily for monitoring and improving staff performance (77 percent) and identifying training needs (59 percent). Their linkage to financial incentives or career advancement was limited. Less than 50 percent of providers (47 percent) reported that appraisals were used to award bonuses, and only 27 percent said they informed promotions or salary decisions (25 percent).

Public facilities reported greater use of performance appraisals across most functions than private facilities. In public facilities, 91 percent of providers said appraisals were used to track performance and 72 percent said they were used to identify training needs, compared with 57 percent and 40 percent in private facilities. Appraisals were also more commonly linked to bonuses and promotions in public facilities (57 percent and 31 percent) than in private facilities (33 percent and 20 percent). Salary linkage was the exception, reported more often in private facilities (34 percent) than in public ones (20 percent).

Female providers consistently reported higher use of performance appraisals across all indicators than male providers. By cadre, midwives reported the strongest use of appraisals—particularly for performance monitoring (86 percent), training needs (68 percent), bonuses (53 percent), promotions (29 percent), and salaries (25 percent). Nurses and doctors reported lower levels across most areas, including performance monitoring (75 percent and 65 percent, respectively) and training needs (59 percent and 42 percent, respectively), with fewer reporting links to bonuses, salaries, or promotions. See table A.9.

3.3.1.2. Skills, Training, and Development

Overall, training coverage for health care providers was high across facility types, genders, and staff categories. Seventy-eight percent of health care providers received training in the past 12 months. Public facilities provided greater training coverage (91 percent of health care providers) compared to only 60 percent in the private sector. The majority of doctors participated in training (87 percent), followed by midwives (82 percent) and nurses (73 percent). On average, six days of training were reported across all health facilities—both public and private. Male staff and doctors received longer training. The number of training days for male staff and doctors (10 days and 11 days, respectively) was approximately double that of female staff, nurses, and midwives (5 days, 6 days, and 5 days, respectively).

The majority of health care providers viewed the training opportunities provided by their facilities as fair: 87 percent and 88 percent in public and private facilities, respectively; and 87 percent and 88 percent for male and female providers, respectively. For nurses, midwives, and doctors, the perceived fairness of the selection process was 89 percent, 87 percent, and 84 percent, respectively. Despite high training participation, around 67 percent of health care providers across facilities, genders, and staff categories reported that training had a positive impact on work productivity, suggesting there is more room for the facilities to improve training effectiveness (see table A.10 in appendix A). This shows that positive perception of training opportunities does not necessarily indicate that all required competencies are being met, and there remains room for further improvement in training and staff development as indicated by the facility.

3.3.1.3. Health Care Provider Workload

Overall, the number of working days and hours is consistent with a standard schedule of 5 days per week and 8 hours per day across all facility types, genders, and staff categories, except that staff in private health facilities work longer hours (11.5 hours per day). Time spent on outpatient and inpatient care per week was 15 and 14 hours, respectively. Providers in private facilities, as well as doctors and midwives, spent slightly less time on inpatient care (12 hours).

The administrative workload for health care providers was consistent at around six hours across facility type, gender, and staff category, representing approximately 20 percent of the overall time spent by health care providers. The burden of administrative tasks for public health care providers (7 hours) almost double that of private health care providers (4 hours), reflecting more bureaucratic requirements in the public

health facilities. Reducing administrative workload further could allow more time for providers to focus on patient care.

Overall, providers concentrated more on outpatient care across all facility types, genders, and staff categories, with 30 outpatient contacts—three times higher than inpatient contacts. Public facilities handled more patient care in both outpatient and inpatient settings (30 outpatient and 19 inpatient contacts) compared to private facilities (20 outpatient and 7 inpatient contacts). Male staff provided more outpatient care than female staff (25 outpatient contacts vs. 20) though both had the same number of inpatient contacts (7). Doctors played a central role in outpatient care (45 contacts), followed by nurses and midwives (25 outpatient contacts each). Nurses provided the most inpatient care (14.5 contacts), followed by doctors (14 contacts) and midwives (7 contacts).

Time spent by health care providers conducting outreach was low, averaging around two days over the last month. Male staff spent more days on outreach (four days) than female staff (two days). Nurses and midwives reported spending 3.5 days and 2 days, respectively, on outreach activities, while doctors did not participate in outreach activities (see table A.11).

3.3.1.4. Working Environment as Perceived by Health Care Providers

There is strong teamwork and management across health care providers. Most reported high levels of efficiency and trust (89–92 percent), with private facilities scoring slightly higher than public ones. Male staff expressed more positive views than female staff, though both rated teamwork highly (86–93 percent) across roles (see table A.12).

Management quality was also rated positively, as 89 percent said managers lead by example and 91 percent noted effective communication. Private facilities outperformed public ones (98 percent vs. 83–87 percent). Female staff reported more favorable views, and ratings were consistently high across doctors, nurses, and midwives.

These quantitative patterns closely align with qualitative interviews, which showed that teamwork, mentorship, and supportive supervisory structures enable health providers to sustain service delivery even under resource constraints. Staff consistently reported collaborative problem solving, cross-departmental support, and routine performance feedback as core elements of a positive working environment. However, qualitative interviews also highlighted uneven management capacity in some public facilities, heavy administrative workloads, and IT literacy gaps that reduce efficiency and limit the benefits of digital tools.

3.3.1.5. Provider Satisfaction

There is high overall satisfaction among health care providers. Top areas included work responsibilities (94 percent), skill development (90 percent), and workload balance (86 percent). Lower satisfaction was reported for resources (81 percent), infrastructure (80 percent), career promotion (80 percent), and salary (74 percent). Private facility staff were generally more satisfied than public, especially in skill development, workload, and task balance. Public facilities scored slightly higher on promotion systems. Female providers reported higher satisfaction across all indicators compared to males (see table A.13). Midwives reported the highest satisfaction across most indicators, while doctors showed consistently lower satisfaction—especially with medicine availability (71 percent), infrastructure (74 percent), career advancement (70 percent), and salary (71 percent).

Qualitative interviews reinforce these results by showing that staff motivation is heavily shaped by intrinsic factors such as community appreciation, teamwork, and a sense of service. Yet staff repeatedly cited persistent shortages of skilled professionals, limited and irregular training opportunities, delays in incentive payments, and gender-related constraints as barriers to sustained job satisfaction. Public providers frequently described multitasking and administrative burdens as limiting time for clinical care, while private providers noted fewer systemic constraints but limited access to advanced training.

3.3.1.6. Motivation and Ethics

Public health care providers are primarily motivated by social service, job security, and career development, with notable differences by gender and professional role. Top motivators for public facility health care providers include serving society (88 percent), job security and prestige (74 percent), and career development (74 percent). Moderate motivators were salary and benefits (62 percent) and working conditions (62 percent), while location (58 percent), work-life balance (48 percent), and work responsibilities (40 percent) were less influential (see table A.14). Male providers rated serving society higher (100 percent) than females (80 percent). Doctors showed the highest motivation across most indicators, especially societal impact, career growth, and compensation. Midwives prioritized working conditions and work-life balance.

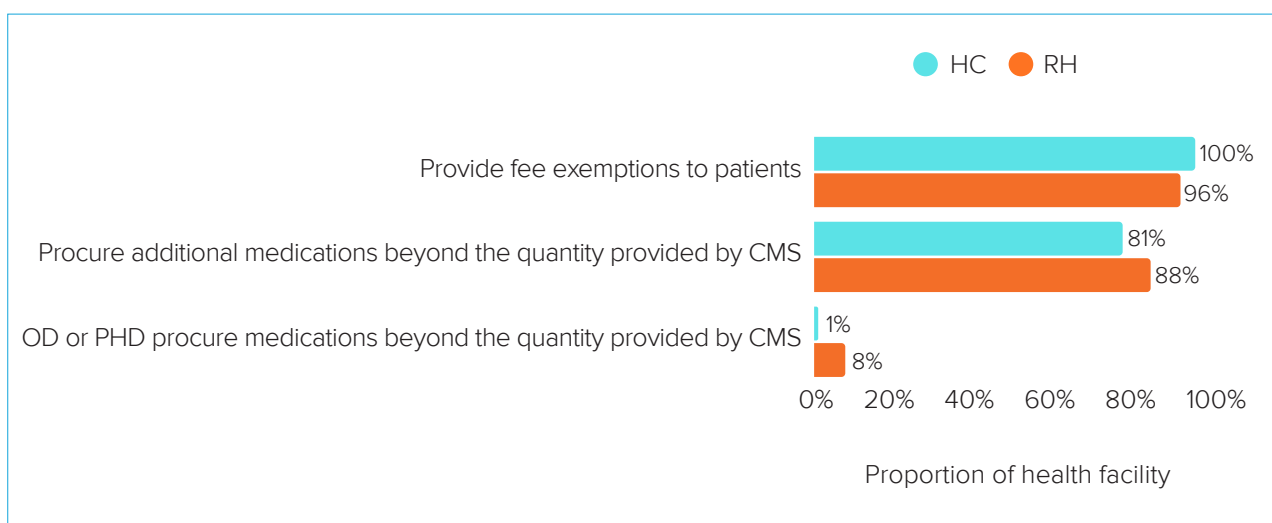
Perceived misconduct among health care providers is generally low. Top concerns include performance appraisals (10 percent), terminations (9 percent), and recruitment processes (9 percent). Most providers (74 percent) feel safe reporting misconduct (see table A.15). Public facility staff reported higher misconduct levels than private ones, especially in evaluations (12 percent vs. 6 percent) and terminations (12 percent vs. 6 percent). Private facility staff felt safer reporting issues (82 percent vs. 68 percent). Male providers cited more misconduct than females, except in appraisals. Female staff felt safer reporting misconduct. Doctors reported the highest misconduct rates across most areas, while nurses and midwives reported fewer concerns.

Qualitative data corroborate these findings by showing that most providers perceive ethical standards to be generally upheld, supported by structured supervision and accountability mechanisms. However, gaps remain in consistent policy enforcement, follow-up of performance evaluations, and transparency in HR processes. Staff also noted that dependence on donor-funded incentive schemes raises concerns about sustainability and fairness, which affects long-term motivation.

3.3.2. Public Financial Management

Public facilities face two key financial pressures: fee exemptions that reduce revenue and direct medicine procurement that increase costs. Figure 3.22 shows all HCs and 96 percent of RHs provided fee exemptions in 2024. RHs exempted 10 percent of user fees (KHR 16.6M of KHR 165M), while HCs exempted 20 percent (KHR 1.56M of KHR 7.48M). It also shows that 88 percent of RHs and 81 percent of HCs procured additional medicine. Only a small share was covered by PHDs or ODs (8 percent RHs, 1 percent HCs). Most commonly procured medicine were for hypertension, antibiotics, diabetes, and vaccines.

Figure 3.22. Fee Exemption and Procurement of Medicine for 2024, by Facility Type



Source: Original for this publication.

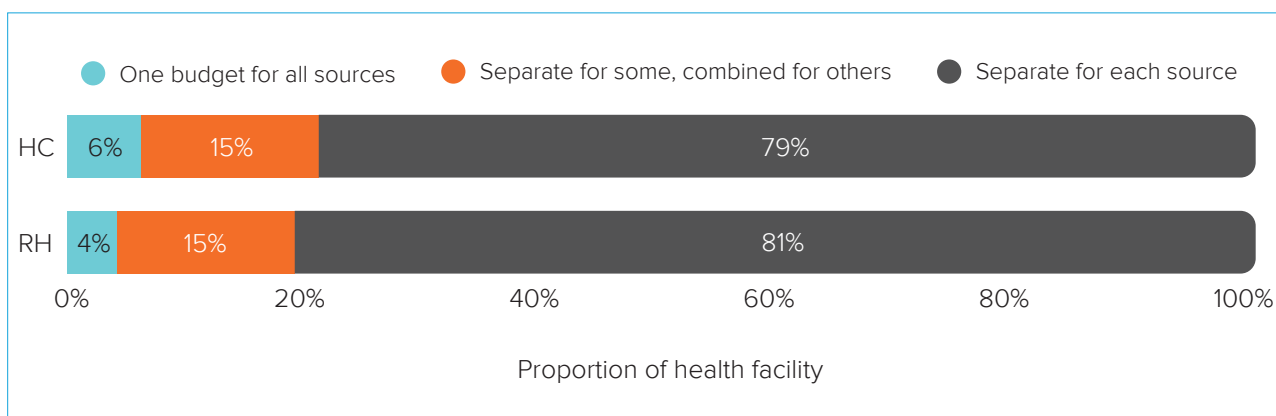
Note: HC = health center; OD = operational district; PHD = provincial health district; RH = referral hospital, CMS=Central Medical Store System.

Qualitative findings confirm that financial constraints are among the most significant operational challenges for public facilities. Staff described insufficient operational and capital budgets, rigid approval procedures that delay fund disbursement, and limited autonomy at facility level. Weak maintenance budgets, rising utility costs, and inconsistent medicine delivery in remote areas exacerbate pressures on service delivery. Many providers also noted that static funding has not kept pace with growing patient demand, creating chronic resource shortages.

Most public health facilities have fragmented budgeting. Figure 3.23 shows most HCs (79 percent) and RHs (81 percent) manage separate budgets by funding source, limiting flexibility and increasing complexity. Only 6 percent of HCs and 4 percent of RHs use fully integrated budgets, while 15 percent apply a mixed approach. This fragmentation adds to administrative burden. Figure 3.24 shows 65 percent of HCs and 63 percent of RHs spend over a month on budget preparation, with up to 13 percent of RHs taking more than three months, suggesting limited capacity.

Qualitative interviews reinforce these observations. Many staff reported limited accounting skills, heavy reporting workloads, and reliance on nonintegrated financial systems. Fragmented budgets, coupled with limited training, lead to inefficiencies and errors. Staff also emphasized that public disclosure of financial information remains limited, weakening transparency and community accountability. Figure 3.25 reveals that only half of public facilities link budgets to performance indicators, with RHs (59 percent) ahead of HCs (46 percent).

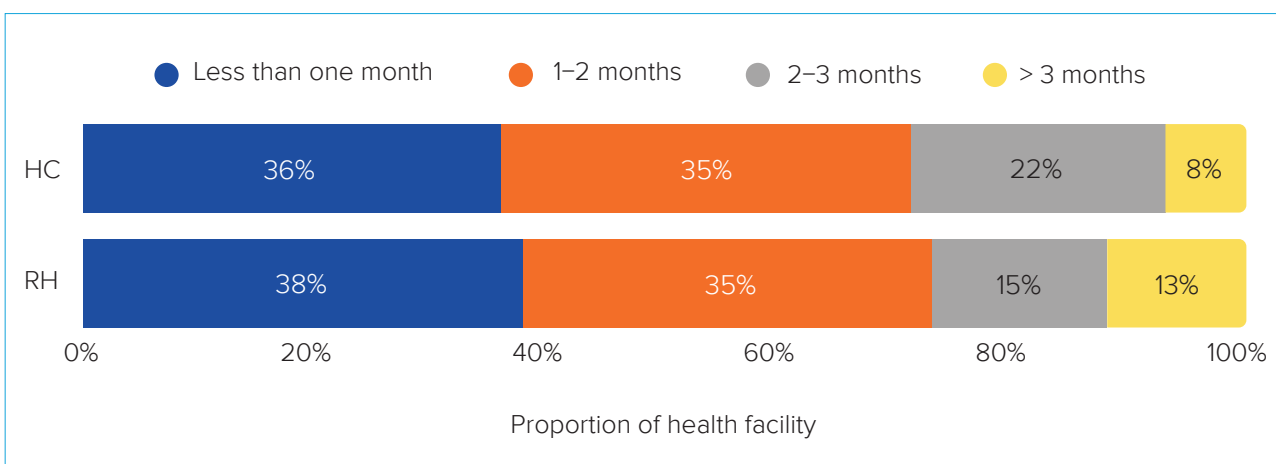
Figure 3.23. Budget Preparation, by Sources



Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

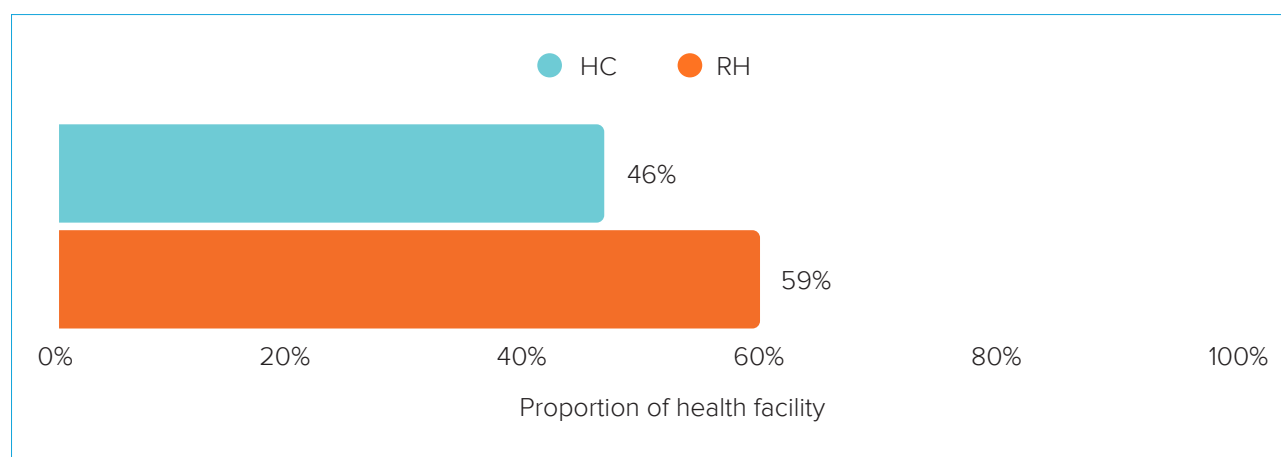
Figure 3.24. Time to Prepare Budget



Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

Figure 3.25. Proportion of Facility-Linked Budget to Performance Indicators

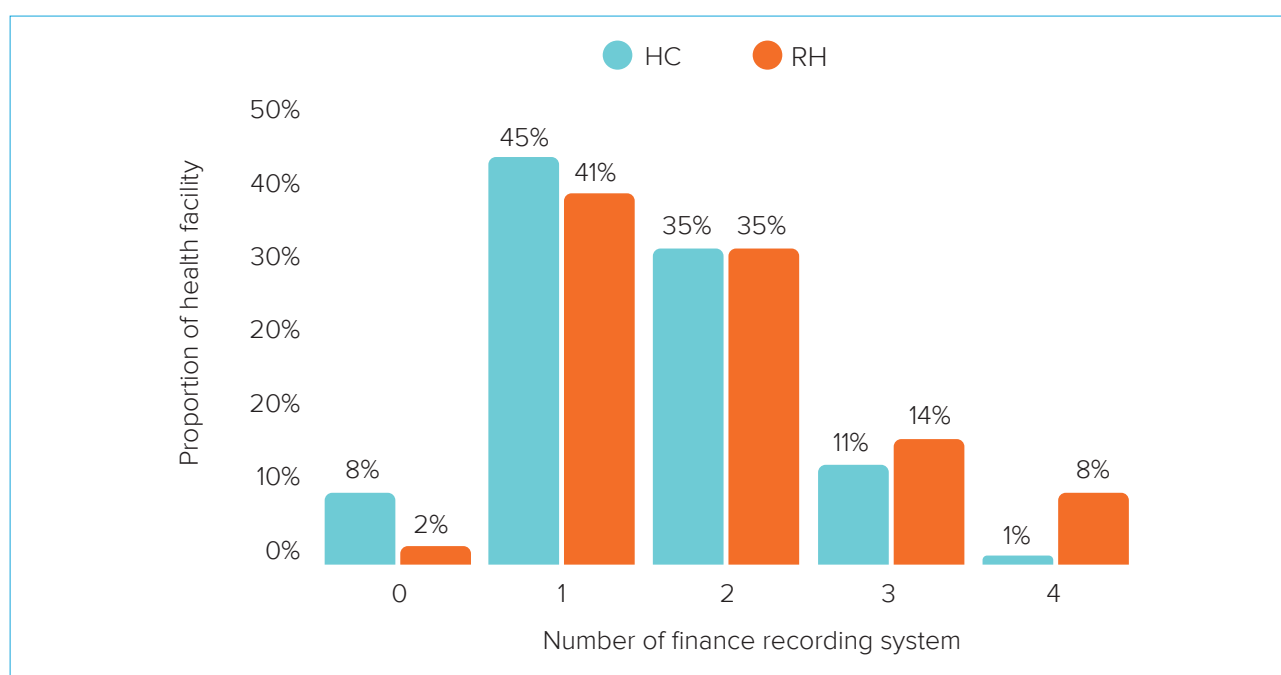


Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

Public health facilities commonly rely on multiple financial systems, increasing reporting complexity, particularly in RHs. Figure 3.26 shows that most public health facilities use multiple financial systems, creating reporting burdens. Nearly all HCs (92 percent) and RHs (98 percent) use at least one system; 80 percent of HCs and most hospitals use one or two, while 22 percent of hospitals use three or more. This leads to overlapping reporting and duplicated data entry. HCs mainly rely on self-developed systems and Microsoft Excel (68 percent), while RHs use MOH, PHD, or OD systems and Microsoft Excel (73 percent and 57 percent). Other systems are used less frequently (figure 3.27).

Figure 3.26. Proportion of Health Facilities with Multiple Financial Record Systems

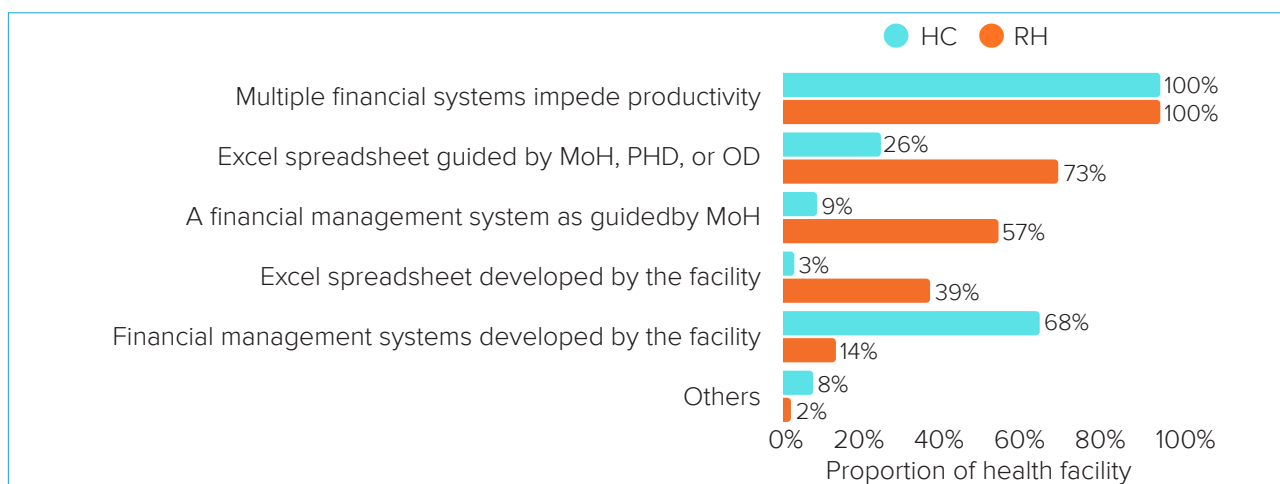


Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

Qualitative interviews demonstrated that these fragmented and incomplete digital systems are further constrained by low IT literacy, outdated equipment, and weak internet connectivity. Staff frequently described digital tools as useful but underutilized due to training gaps and machine failures. As a result, financial reporting is still perceived as compliance-driven rather than supporting strategic planning or resource optimization.

Figure 3.27. Financial Recording System Used by Health Care Facilities



Source: Original for this publication.

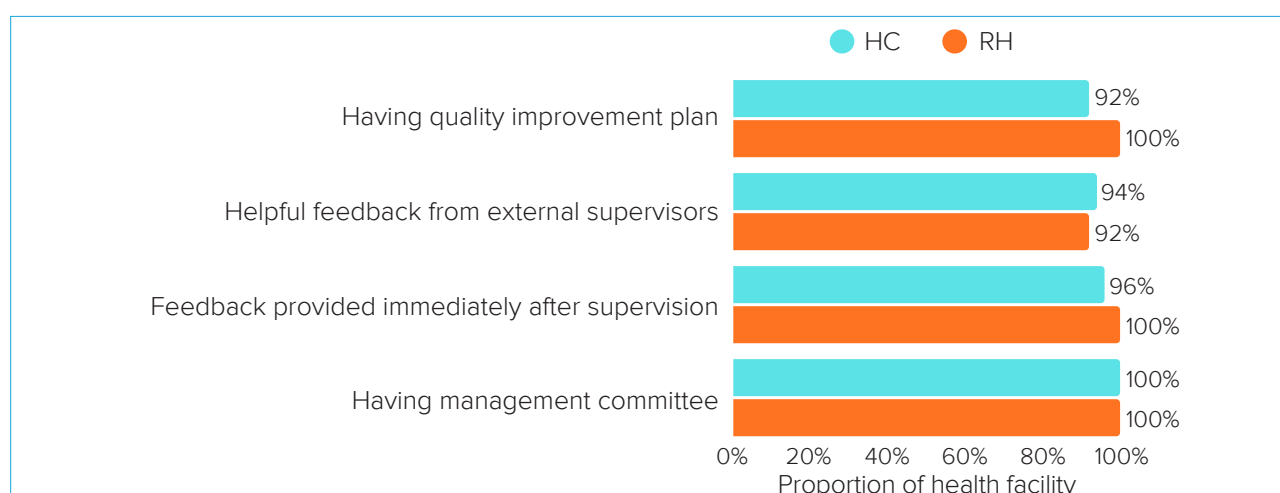
Note: HC = health center; RH = referral hospital.

Qualitative interviews also show that multilevel approval requirements and procedural formalities cause delays in budget disbursement. Errors in documentation or limited accounting skills among lower-level staff lead to repeated submissions and slow fund release, often by one or more months. Although responsibilities have been transferred downward, financial decision-making power remains concentrated at higher levels. Provinces and districts still rely heavily on budget flows controlled by the Ministry of Economy and Finance (MEF), limiting flexibility in responding to local needs.

3.3.3. Quality Assurance

Management and external supervision practices are strong across public health facilities, with near universal governance structures, regular supervisory feedback, and widespread use of quality improvement plans, with slightly stronger performance in RHs. Figure 3.28 shows the proportion of public facilities—RHs and HCs—across several indicators of management and external supervision. Overall, both RHs and HCs performed strongly on management and external supervision quality, although RHs showed slightly better performance on these indicators. All HCs (100 percent) and RHs (100 percent) reported having a management committee, suggesting a strong governance and accountability structure embedded within public facilities. All RHs (100 percent) and 96 percent of HCs reported receiving feedback from external supervision, and 94 percent of RHs and 92 percent of HCs considered the feedback from external supervisors helpful. Nearly all HCs (92 percent) and all RHs (100 percent) have a quality improvement plan in place.

Figure 3.28. Supervision and Quality Assurance at Public Health Facilities



Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

Private health facilities are monitored by their licensing agencies for quality assurance. Performance and compliance varied widely: only 36 percent of hospitals reported receiving monitoring and implementing recommended measures. In contrast, 62–72 percent of polyclinics, 71–79 percent of clinics, and 100 percent of other private facilities reported compliance (table 3.17).

Table 3.17. Supervision and Quality Assurance at Private Health Facilities

	Private facility (N=189)	Hospital (N=11)	PolyClinic (N=47)	Clinic (N=126)	Others (N=5)
Health facility received quality assurance monitoring from the agency issuing the license	76%	36%	72%	79%	100%
Monitoring agencies provided recommendations for quality improvement	68%	36%	62%	71%	100%
Recommended measures for quality improvement implemented	67%	36%	62%	71%	100%

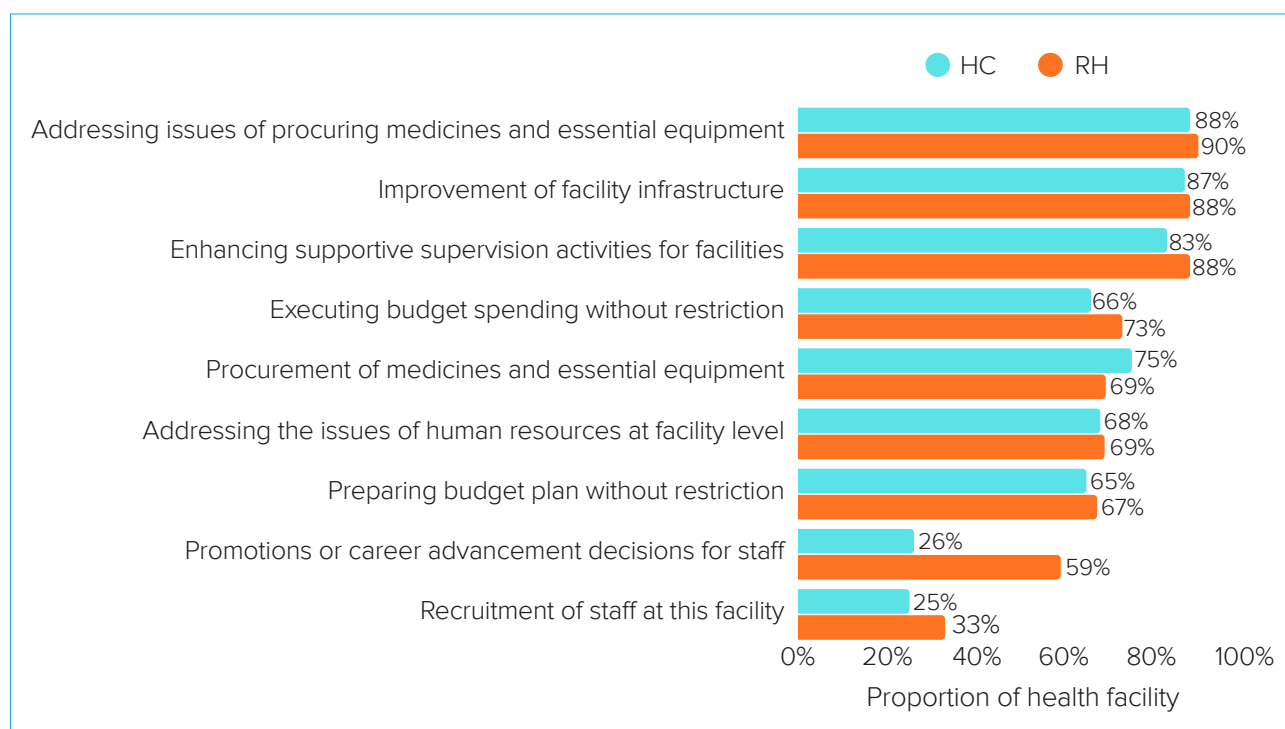
Source: Original for this publication.

Note: N = number of observations.

The qualitative findings suggest that effective implementation of regulations governing civil servant attendance and service accountability remains uneven. Ensuring full-time, round-the-clock service availability remains challenging in remote areas. Strengthening leadership, supervision, and compliance with administrative standards is needed to ensure consistent service quality. Reducing data inconsistencies and submission delays enhance the data use for planning, decision-making, and performance improvement.

Management authority indicators assess whether facilities have the autonomy to manage operations and design service delivery initiatives. This includes functions such as procurement, budgeting, and human resource management. Figure 3.29 shows that both HCs and RHs reported high levels of authority in procurement, supervision, and infrastructure. Authority to procure essential medicine and equipment was highest (84 percent for RHs and 80 percent for HCs), followed by infrastructure improvements (77 percent and 79 percent) and supervision (74 percent and 73 percent).

Figure 3.29. Management Authority at Public Health Facilities, by Facility Type



Source: Original for this publication.

Note: HC = health center; RH = referral hospital.

However, authority over financing and human resources remains limited. RHs were more likely to manage budget execution (70 percent vs. 53 percent) and staff promotion (49 percent vs. 23 percent). Authority to recruit staff was notably low—only 30 percent of RHs and 18 percent of HCs.

Qualitative interviews with PHDs and ODs showed that management and leadership capacity among HC staff also need strengthening. Many managers come from clinical backgrounds with limited training in administration, planning, or coordination. Communication between HCs and community structures is sometimes irregular, reducing local participation in health activities.

3.4. User Experience

- **Patient care patterns.** Most patients sought services for acute infections (19 percent) and NCDs (17 percent), with ANC at 12 percent. Public facilities handled more chronic, reproductive, and child health cases, while private facilities saw more acute cases. Male patients primarily sought care for infections, NCDs, and injuries, while females mainly accessed reproductive services.
- **Facility choice drivers.** Quality of care was the top reason for selecting a facility (46 percent), followed by proximity (27 percent) and insurance (8 percent). Private facilities were perceived as more trustworthy (53 percent vs. 38 percent), whereas public facilities were preferred for proximity, insurance, and lower cost.
- **Wait time and efficiency.** Overall patient wait time were low, averaging 12 minutes—slightly longer at public facilities (13 minutes) than private (11 minutes), with private facilities generally faster except for lab services.
- **Patient costs and affordability.** Average expenses were higher at private facilities (median KHR 77,500) than public facilities (median 0), with costs driven by hospital fees, lab tests, and medicine; public facilities remain largely low-cost or free, particularly for insured or low-income patients, while private care entails higher out-of-pocket payments for faster, personalized services.

3.4.1. Characteristics of Patients

Care-seeking patterns vary by facility type and gender, with public facilities focusing on chronic and reproductive care and private facilities on acute conditions. Table 3.18 shows that most patients sought care for acute infections (19 percent) and NCDs (17 percent), followed by ANC (12 percent). Other services like injuries, check-ups, family planning, and child care were less common (each <5 percent). Public facilities handled more chronic, reproductive, and child health cases, while private facilities saw more acute cases (21 percent vs. 17 percent). NCDs were more common in public facilities (23 percent) than private (11 percent). Male patients more often sought care for acute infections (23 percent), NCDs (20 percent), and injuries (7 percent). Female patients primarily accessed reproductive services—ANC (17 percent) and family planning (4 percent).

Table 3.18. Proportion of Patients Reporting Receiving Care, by Services, Facility Type and Gender

Indicators	Facility			Gender	
	Overall	Public	Private	Male	Female
Acute infection with high fever	19%	17%	21%	23%	17%
NCDs such as diabetes; heart, respiratory, high blood pressure, eye, and joint conditions	17%	23%	11%	20%	16%
Antenatal care	12%	11%	13%	0%	17%
Injuries	4%	4%	3%	7%	2%
Routine health check up	3%	2%	4%	2%	3%
Family planning	3%	4%	2%	0%	4%

Child service or vaccines	3%	5%	0%	4%	2%
Other known or suspected infectious diseases such as TB, HIV, and STIs	2%	2%	1%	2%	1%
Mental health services	1%	1%	1%	1%	1%
Postnatal care	1%	1%	0%	0%	1%
General surgery	0%	0%	0%	0%	0%

Source: Original for this publication.

Note: HIV = human immunodeficiency virus; STI = sexually transmitted infection; TB = tuberculosis.

Quality of care was the top priority for patients when selecting facilities (46 percent). This was followed by proximity (27 percent), insurance (8 percent), low cost and drug availability (5 percent each), and recommendations (1 percent). See table 3.18. Female provider availability had minimal influence. Private facilities were seen as more trustworthy (53 percent vs. 38 percent for public). Public facilities were preferred for proximity (35 percent), insurance (11 percent), and lower cost (8 percent). Male and female patients valued quality equally (49 percent). Males prioritized location slightly more than females (31 percent vs. 28 percent), while females relied more on insurance coverage (10 percent vs. 7 percent). See table 3.19.

Table 3.19. Reasons for Patients Choosing the Facility

Indicators	Facility			Gender	
	Overall	Public	Private	Male	Female
Trust in providers or high quality of care	46%	38%	53%	49%	49%
Location close to home	27%	35%	20%	31%	28%
My insurance (health card) covers this	8%	11%	6%	7%	10%
Low cost	5%	8%	1%	5%	5%
Availability of drugs	5%	5%	5%	5%	5%
Other	2%	1%	2%	2%	1%
Recommendation or referral	1%	0%	2%	1%	1%
Availability of female provider	0%	0%	0%	0%	0%

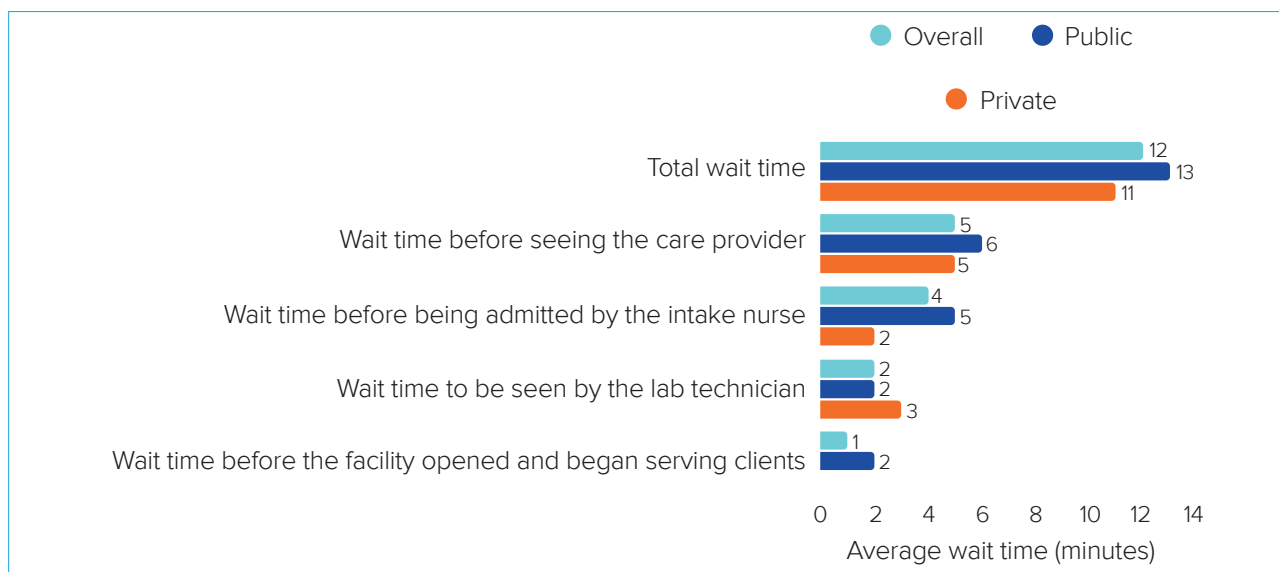
Source: Original for this publication.

Patient qualitative interviews indicated that those selecting private facilities are primarily motivated by speed, convenience, and perceived quality of care. Short wait time, prompt attention, and efficient service are repeatedly cited as major advantages of private facilities over public hospitals, although the difference

in wait time is small. In addition, patients value the presence of diagnostic equipment, such as ultrasound machines; the availability of medicine on site; and flexible scheduling options that accommodate work or family commitments. Many patients, even those with public insurance coverage, choose private care and pay OOP to obtain what they perceived to be quicker, more personalized service.

Patient wait time were low overall, with slightly longer waits in public facilities compared to private facilities. Figure 3.30 shows low overall patient wait time, averaging 12 minutes. Public facility patients waited slightly longer (13 minutes) than those at private facilities (11 minutes), especially during nurse intake (4 minutes) and before seeing a provider (5 minutes). Private facilities were generally faster, though lab services had slightly longer waits.

Figure 3.30. Wait Time by Patient, by Facility Type



Source: Original for this publication.

3.4.2. Patient Expenditures

Overall, the average total health-related expense was KHR 105,851. The main cost drivers were hospital fees (43 percent), followed by laboratory tests (31 percent) and medicine (23 percent). Spending on accommodation and food was minimal, with a median expense of zero across most categories, indicating that many patients incurred little or no direct medical cost. The median total cost for private facility (KHR 77,500) highlights the higher out-of-pocket burden in the private sector compared to public facilities (median cost 0 for both RH and HCs).

For patients who sought care at RHs, the average total expense was KHR 15,056. The largest share of cost (61 percent) came from other expenses, mainly food and related needs, while hospital fees and lab tests contributed modestly (26 percent and 10 percent, respectively).

At HCs, the average cost was much lower at KHR 2,122. Expenses were dominated by user fees (66 percent), though absolute amounts were small. Costs for lab tests and medicine were minimal, and no significant accommodation or food costs were reported, confirming that HC services are largely low-cost or free (table 3.20).

Table 3.20. Patient Expenses, by Expense Type and Facility Type

	Overall		RH		HC		Private facility	
	Mean (KHR)	%	Mean (KHR)	%	Mean (KHR)	%	Mean (KHR)	%
Hospital fees	45,935	43%	3,944	26%	1,406	66%	98,346	44%
Lab test	32,729	31%	1,488	10%	276	13%	71,223	32%
Medicine	23,999	23%	400	3%	63	3%	52,649	23%
Accommodation (outside hospital)	106	0%	-	0%	-	0%	233	0%
Other expenses (food and others)	3,082	3%	9,225	61%	378	18%	2,221	1%
Total expenses	105,851	100%	15,056	100%	2,122	100%	224,672	100%

Source: Original for this publication.

Note: HC = health center; KHR = Khmer Riel; RH = referral hospital.

Qualitative findings show that cost remains a major differentiator between public and private care.

Private facilities charge moderate to high fees, ranging from KHR 40,000 for basic diagnostics to over KHR 1,600,000 for multiday inpatient treatment. Patients often pay OOP, accepting higher expenses in exchange for rapid and personalized care.

Public facilities offer highly affordable services, frequently free for insured patients or those with poverty cards. Typical fees for consultations or medicine range from 1,000–3,000 riel, with only minimal additional costs for transportation or food. Public facilities thus remain the more cost-effective option, particularly for low-income populations.

3.4.3. Patient Satisfaction

Patient satisfaction was high across facilities, with public facilities rated higher for access and Medicine and private facilities for service environment and convenience. Table 3.21 shows high overall patient satisfaction with health care (94 percent). Most service areas scored above 90 percent, except travel convenience (80 percent) and wait time (88 percent). Public facilities rated higher for medicine availability (94 percent) and location convenience (86 percent), while private facilities scored better on privacy (94 percent), cleanliness (92 percent), and time convenience (89 percent), reflecting stronger service quality. Gender differences were minimal, though female patients reported slightly higher satisfaction in privacy, communication, and provider responsiveness.

Table 3.21. Patient Satisfaction at Health Care Facilities

Indicators	Facility			Gender	
	Overall	Public	Private	Male	Female
Overall satisfaction rate	94%	95%	94%	93%	94%
The opening hours are adequate to meet my needs	95%	93%	96%	94%	94%

The health workers explained things well	93%	93%	94%	92%	94%
The medicine in this facility is available for use	93%	94%	92%	91%	93%
The health facility is clean	91%	90%	92%	89%	91%
I had enough privacy during my visit	90%	87%	94%	87%	91%
The wait time is reasonable	88%	87%	89%	87%	87%
I felt like I could ask questions or voice concerns today when I met with the health worker	87%	87%	88%	84%	88%
Convenient to travel from my house to the health facility	80%	86%	75%	78%	79%

Source: Original for this publication.

Patients reported high satisfaction levels (80–100 percent) in both types of facilities in the qualitative interviews. In private facilities, satisfaction is driven by attentive, polite, and responsive staff; thorough consultations; clear explanations of diagnoses and treatment plans; and well-maintained, professional facility environments. Patients often perceive the cost as justified by the high level of service, speed, and quality of care.

In public facilities, satisfaction is also consistently high, especially among patients using poverty cards or insurance. Key satisfaction factors include effective treatment, attentive and respectful staff, clean and organized facilities, and the assurance of reliable medicine availability and follow-up care. Many patients highlight that public facilities offer comprehensive care that balances quality with affordability.

Qualitative interviews with patients highlight the reasons for choosing public vs. private health facilities. Public facilities attract patients mainly due to affordability, accessibility, and trust built over time. Government-supported schemes, such as health insurance and IDPoor cards, enable patients to receive free or low-cost care, making public facilities the preferred option for low-income households. Proximity, 24/7 service availability, familiarity with staff, and confidence in the medical expertise of providers further encourage continued use. Public facilities are therefore valued for both financial protection and reliable, long-term care.

Patients select private facilities mainly for faster service, convenience, and perceived quality. Short wait time, prompt attention, and efficient service are frequently cited advantages over public hospitals. Patients also value access to diagnostic equipment (such as ultrasound machines) and on-site medicine as well as flexible scheduling that accommodates work and family commitments. Even some patients with IDPoor coverage opt for private care and pay OOP to receive faster and more personalized services.

CHAPTER 4 CONCLUSIONS AND RECOMMENDATIONS

4.1. Conclusions

This report highlights a public health system with strong foundational performance, particularly in service availability, management structures, and patient experience, alongside persistent constraints that limit full service readiness, quality, and efficiency. Public health facilities play a central role in ensuring accessible and affordable care, with near universal daily operation, a strong commitment to 24/7 service provision, short patient wait time, high levels of patient satisfaction, and relatively low OOP costs compared to private facilities. These strengths underscore the importance of the public system in safeguarding equitable access to essential health services. At the same time, service delivery remains constrained by structural and operational gaps. Service utilization is modest, workloads are low, and only a small share of HCs and RHs deliver the full package of required services. Gaps persist, particularly in NCD care, specialty diagnostics, and advanced clinical services. As Cambodia's disease burden increasingly shifts toward chronic conditions, these limitations pose growing risks to the system's ability to meet population health needs.

Persistent infrastructure and supply chain weaknesses continue to undermine service completeness and reliability. Unreliable electricity and water supply, shortages of essential medicine and equipment, and limited diagnostic capacity affect both service quality and patient confidence, especially in rural and remote areas. These constraints contribute to care seeking in the private sector, where costs are higher and quality more variable, despite the strong performance of public facilities on affordability and patient experience.

Human resource challenges further constrain service delivery. HCs typically operate without doctors, and RHs face widespread understaffing and skills gaps. Despite these constraints, facilities rely heavily on staff commitment, teamwork, and collegial support to maintain service continuity. Health care providers report high job satisfaction and strong intrinsic motivation, suggesting that workforce performance could be substantially strengthened through improved staffing norms, targeted training, retention incentives, and greater flexibility in staff deployment, particularly outside urban areas.

Support systems for management and oversight are generally strong. Management committees, quality improvement plans, and external supervision are nearly universal across public facilities. However, limited facility autonomy over budgeting and human resource management, fragmented financial reporting systems, and limited use of performance-based financing reduce efficiency and accountability. Addressing these systemic bottlenecks will be critical to translating strong governance structures into improved service delivery outcomes.

Overall, Cambodia's health system has established a solid platform for accessible and patient centered care. Building on these strengths will require targeted investments in infrastructure, medicine, equipment, and human resources, alongside reforms to financial and managerial autonomy at the facility level. By closing gaps in service completeness and adapting the system to evolving health needs, Cambodia can strengthen public sector performance and move closer to universal, high-quality, and equitable health care for all.

4.2. Recommendations

Over the short term, efforts should focus on ensuring reliable service delivery, particularly for NCDs and primary care services, through improved staffing, supply chains, and patient-centered care. In the medium term, these reforms should transition toward more structural improvements, including stronger workforce planning, upgraded infrastructure, diversified and sustainable financing, greater facility autonomy, and institutionalized quality improvement systems that explicitly integrate patient experience and service standards. Detailed recommendations are presented in table 4.1.

Table 4.1. Detailed Recommendations for Improving the Service Delivery of Health Care Facilities in Cambodia

Domain	Key challenges	Recommendations		Responsible agencies
		Short-term (1–2 years)	Medium-term (3–5 years)	
Service characteristics	Service availability across public facilities is generally high but remains incomplete. Service provision is strongest in MCH/FP and CD care, but remains notably weaker in NCD and specialized care.	Strengthen the NCD program by ensuring the adequate availability of essential medicine and increasing attention to community awareness and engagement.	Enforce service completeness to ensure that the essential services package implemented at the facility level comply with facility accreditation standards. The services package should be periodically updated to reflect the growing needs in emerging areas, including NCD management.	MoH
		Focus on strengthening inputs and support systems, with priority given to addressing gaps in human resources for health and other capacity constraints that limit facilities' ability to deliver the full package of required services.		MoH, MCS
Key inputs to service delivery	Infrastructure gaps persist despite widespread grid connectivity. Frequent power outages, limited backup generators in HCs, and inadequate water access continue to hamper service delivery. HCs and RHs continue to face gaps in availability of essential equipment, particularly specialized diagnostic and surgical tools, with outdated or malfunctioning technology affecting service quality and efficiency. medicine availability is generally high, with most facilities achieving 75–95 percent coverage. However, full availability remains uncommon.	Strengthen the supply chain for the provision of medicine and equipment to improve availability and access to these essentials.	Upgrade health facility infrastructure and equipment. A stock-taking exercise should be conducted to assess of facility infrastructure and equipment for readiness gaps and provide inputs for upgrade plans.	MoH, MEF

	Public health facilities face significant human resource shortages, particularly due to understaffing, limited specialized expertise, and inadequate training capacity.	Address critical staffing shortages in public facilities by revising staffing norms, accelerating recruitment, and practicing redeployment, especially to the rural areas. Enhance skill development training for health facility staff.	Develop medium-term human resource plans and institutionalize recruitment and redeployment of staff to address structural workforce shortages.	MoH, MCS
	HCs rely heavily on government funding, while RHs have more diversified revenue sources. HCs depend mainly on national budget allocations, whereas RHs supplement government funding with higher shares of user fees and lump-sum grants, while external financing (for example, from the HEF, the NSSF, and donors) remains minimal for both.	Diversify funding sources for HCs by strengthening links to health insurance schemes, health equity funds, and external partners to reduce reliance on the national budget and improve financial resilience.	Diversify and stabilize facility-level financing by strengthening integration with insurance schemes, health equity funds, and external financing mechanisms.	MoH, MEF
Support system	There is high provider satisfaction with work, but lower levels for structural and financial factors. Satisfaction is highest for work responsibilities (94 percent), skill development (90 percent), and workload balance (86 percent), but lower for resources (81 percent), infrastructure (80 percent), career promotion (80 percent), and salary (74 percent).	Expand and better leverage performance-based financing mechanisms to incentivize improvements in service readiness, availability of inputs, and efficient use of resources across facility types.	Formalize the linkage between performance evaluations and career progression by connecting appraisal results to promotions and salary adjustments with clear performance thresholds.	MoH, MCS, MEF

	Linkage to financial incentives or career advancement was limited. Less than 50 percent of providers reported that appraisals were used to award bonuses (47 percent), and only 27 percent said they informed promotions or salary decisions (25 percent).	Clarify and communicate how performance evaluations link to rewards by introducing guidance that connects appraisal results to bonuses and recognition.		MoH, MCS, MEF
	Staffing shortages, skills gaps, and inadequate training constrain service delivery across all public facilities, with more acute impacts at referral hospitals.	Strengthen competency-based training through rapid skills gap assessments and more practical, on-the-job learning.	Fully align training systems with service delivery needs through routine skills assessments, standardized competency-based curricula, and post-training evaluations.	MoH, MCS
	Fragmented budgeting and financial management limit efficiency and flexibility. Most facilities manage separate budgets by funding source, rely on multiple partially digital systems, and spend extensive time on budget preparation, while limited accounting skills, low IT literacy, and multilevel approval processes cause delays, reporting burdens, and reduce transparency and performance-linked resource allocation.	Reduce administrative burden by streamlining financial management systems and harmonizing and reducing parallel reporting and budgeting requirements.	Gradually increase facility-level autonomy over budget planning, execution, and human resource management to support more responsive decision-making.	MoH, MEF

User experience	Quality of care was the top reason for selecting a facility (46 percent), followed by proximity (27 percent) and insurance (8 percent).	Improve quality of care in public facilities. Investments should focus on upgrading clinical standards for NCD management, improving management of chronic diseases, and enhancing MCH services.	Link quality improvement plan explicitly to patient experience outcomes, not only clinical indicators. Invest in training on communication, respectful care, and patient engagement to improve patient centered behaviors of staff, thus enhancing patient trust. Introduce patient feedback systems and review the comments regularly. Link patient feedback to the quality improvement plans at the facility level. Incorporate user experience indicators (for example, waiting time, respectful care, and service continuity) into facility performance-based financing.	MoH
	Average expenses were higher at private facilities (median KHR 77,500) than public facilities (median 0), with costs driven by hospital fees, lab tests, and medicine. Public facilities remain largely low-cost or free, particularly for insured or low-income patients, while private care entails higher out-of-pocket payments for faster, personalized services.		To address higher out-of-pocket costs in private facilities, policies should expand insurance coverage and encourage strategic partnerships with private providers for acute care.	MoH, MEF

Source: Original for this publication.

Note: CD = communicable disease; HC = health center; HEF = Health Equity Fund; IT = information technology; KHR = Khmer riel; MCH/FP = Maternal and Child Health and Family Planning; MCS = Ministry of Civil Service; MEF = Ministry of Economy and Finance; MoH = Ministry of Health; NCD = noncommunicable disease; NSSF = National Social Security Fund.

Table A.1. Definition of Public and Private Health Facility

Public health care service	Definition
MPA	Minimum package of activities – Preventive and basic curative services provided by health centers (HCs), including neonatal, child health services, maternal health services, prevention and treatment of communicable diseases, treatment of noncommunicable diseases, and so on
CPA-1	Complementary package of activities – A CPA-1 referral hospitals (RH) is required to have 40–60 beds and provide basic health care services without major surgery or blood bank.
CPA-2	A CPA-2 RH provides CPA-1 services with 60–100 beds and it is required to provide emergency care services and grand surgery (with general anesthesia).
CPA-3	A CPA-3 RH has the highest level of health services, with 100–250 beds. In addition to CPA-2 health services, a CPA-3 RH provides specialized health services and a blood bank.
National hospital	A national hospital provides tertiary and highly specialized care.
Private health facility	A private health facility in Cambodia is a healthcare institution owned and operated by private entities, providing medical services to the public for profit or non-profit, and licensed by the Ministry of Health
Private hospital	A private hospital is a privately owned health facility that provides comprehensive inpatient and outpatient services, including diagnosis, treatment, and patient admission. It typically has inpatient beds, employs a range of health professionals, offers diverse medical and surgical services, and is equipped with advanced diagnostic and treatment facilities.
Polyclinic	A polyclinic is a private health facility that provides multiple outpatient services across different medical specialties. It typically offers consultations, basic diagnostic services, and minor procedures, but does not provide inpatient care.
Clinic	A clinic is a private health facility that provides basic outpatient care, including consultations, simple treatments, and preventive services. It typically has limited staff and equipment and does not offer inpatient care.

Sources: Original for this publication, based on Ministry of Health Cambodia (2000); Law on the Management of Private Medical, Paramedical and Medical Aide Services, and other relevant regulatory frameworks.

Table A.2. Quantitative Research Questionnaires

Types	Administered to	Topics covered
Health facility	Facility in-charge	• Basic characteristics • Outpatient, inpatient, and referral • Management and supervision • Patient fees, revenue, and expenditure • Staffing • Services • Training • Infrastructure • Equipment and supplies • Medicine
Health care providers	Doctors, nurses, and mid-wives	• Recruitment • Training • Performance assessment • Incentives • Provider satisfaction
Outpatient exit	Sample of outpatients throughout the day who came for health care at each health facility	• Demographics • User focus including wait time • Services received • Out-of-pocket expenditures and time costs • Experience and satisfaction with the health care services

Source: Original for this publication.

Table A.3. Proportion of Available and Functioning Equipment Required at RHs, by Equipment Type

Department	Equipment	RH	CPA1	CPA2
Pediatric department	Aspirator (foot operated and/or electric)	95%	96%	94%
	Oxygen concentrator	93%	93%	94%
	Perfusor (infusion pump)	21%	19%	25%
	Infant resuscitator	84%	81%	88%
	Child resuscitator	86%	85%	88%
	Infant incubator	58%	56%	63%
General medicine department	Aspirator (foot operated and/or electric)	88%	89%	88%
	Oxygen concentrator	86%	81%	94%
	Adult resuscitator	88%	85%	94%

Surgical department	Aspirator (foot operated and/or electric)	84%	74%	100%
	Minor surgery set	95%	93%	100%
	Oxygen concentrator	84%	74%	100%
	Amputation set	23%	22%	25%
	Extension continue traction set	19%	7%	38%
	Craniotomy instrument set	0%	0%	0%
	Laparotomy set	37%	0%	100%
	Urology set	5%	0%	13%
	Thoracic set	2%	0%	6%
Obstetrics/ gynaecology department	Adult resuscitator	93%	96%	88%
	Aspirator (foot operated and/or electric)	86%	81%	94%
	Doppler, foetal heart detector	100%	100%	100%
	Dilatation & Curettage set	93%	89%	100%
	Forceps obstetric	74%	63%	94%
	Oxygen concentrator	91%	85%	100%
	Vacuum-extractor	100%	100%	100%
	Caesarean section set	42%	11%	94%
	Caesarean hysterectomy set	33%	7%	75%
	Delivery set	98%	100%	94%
	Cervix reparation set	91%	89%	94%
	Episiotomy and perino repair set	95%	96%	94%
Tuberculosis department	Oxygen concentrator	84%	81%	88%
	Adult resuscitator	91%	89%	94%

Operating theatre	Apparatus anaesthesia and accessories	37%	0%	100%
	Aspirator (foot operated and/or electric)	37%	0%	100%
	Adult resuscitator	37%	0%	100%
	Electro surgical unit	28%	0%	75%
	Adult forceps intubation	37%	0%	100%
	Infant forceps intubation	16%	0%	44%
	Laryngoscope set	30%	0%	81%
	Oxygen concentrator	37%	0%	100%
	Patient monitor	37%	0%	100%
	Defibrillator	9%	0%	25%
Emergency service department	Adult resuscitator	98%	96%	100%
	Paediatric resuscitator	88%	89%	88%
	Aspirator (foot operated and/or electric)	93%	89%	100%
	ICU bed	70%	67%	75%
	Oxygen Concentrator	88%	89%	88%
	Patient monitor	98%	96%	100%
	Respirator (Automatic ventilator, electronically controlled)	53%	44%	69%
	Defibrillator	14%	7%	25%
	Laryngoscope set adult	53%	41%	75%
	ECG unit	67%	67%	69%
Imagery	Ultrasound portable	53%	52%	56%
	X-ray mobile	40%	44%	31%
	X-ray diagnostic table, stand	67%	56%	88%
	ECG unit	70%	70%	69%
	CT scan	2%	0%	6%
	Mamogram	0%	0%	0%
Sterilization equipment	Sterilizer, dressing, pressure type	93%	96%	88%
	Stove gas single burner	37%	37%	38%

Source: Original for this publication.

Note: CPA = complementary package of activities; CT = computed tomography; ECG = electrocardiogram; ICU = intensive care unit;

N = number of observations; RH = referral hospital.

Table A.4. Revenue of Public Facilities in 2024, by Facility Type and Sources of Funds

Sources of revenue	HCs			RH		
	Median (KHR)	Mean (KHR)	%	Median (000 KHR)	Mean (000 KHR)	%
User fees	7483.3	11,800	5%	165,000	263,000	14%
HEF (all categories)	8812	13,100	5%	171,000	241,000	13%
NSSF	3430	8,375	3%	46,300	74,000	4%
Fixed lump-sum service delivery grant	35000	27,900	11%	450,000	429,000	23%
Performance-based service delivery grant	7119.09	24,300	10%	58,800	94,600	5%
National budget (chapters 60, 61, 63, and 64)	145000	156,000	64%	728,000	737,000	40%
NGOs, donors, or private insurance payments	1572	3,954	2%	16,300	15,700	1%
Total revenue	8916	245,429	100%	154,000	1,854,300	100%

Source: Original for this publication.

Note: HEF = Health Equity Fund; NGO = nongovernmental organization; NSSF = National Social Security Fund.

Table A.5. Expenditure of Public Facilities in 2024, by Facility Type and Sources of Funds

Expenditure	HC (N=69)			RH (N=21)		
	Median (000 KHR)	Mean (000 KHR)	%	Median (000 KHR)	Mean (000 KHR)	%
Salaries and social contributions for staff	45,119	91,121	63%	110,000	230,711	26%
Bonuses and overtime	5,880	10,448	7%	40,800	78,561	9%
Medications and supplies	9,720	14,710	10%	219,112	244,195	28%
Equipment purchasing	3,610	5,026	3%	40,000	72,973	8%
Equipment maintenance	1,850	2,585	2%	30,000	40,407	5%
Facility renovation	8,000	9,871	7%	55,967	84,884	10%
Outreach activities	1,200	2,041	1%	0	18,469	2%
Electricity and water	2,212	3,671	3%	45,600	57,768	7%
Other expenses	4,094	5,359	4%	51,398	57,900	7%
Total expenses	95,412	144,835	100%	825,543	885,869	100%

Source: Original for this publication.

Note: HC = health center; KHR = Khmer riel; RH = referral hospital.

Table A.6. Sources of Revenue in Private Facility, by Sources of Funds

	Overall				Polyclinic				Clinic			
	N	Median (000 KHR)	Mean (000 KHR)	%	N	Median (000 KHR)	Mean (000 KHR)	%	N	Median (000KHR)	Mean (000KHR)	%
Patient OOP	169	205,000	1,008,288	55%	38	645,750	4,874,232	76%	131	209,100	423,797	39%
NSSF	169	252,150	778,754	42%	38	492,000	1,388,604	22%	131	319,800	640,707	59%
Other insurance schemes	169	2,481	45,490	2%	38	34,850	117,096	2%	131	2,878	26,322	2%
Total	169	459,631	1,832,532	100%	38	1,172,600	6,379,932	100%	131	531,778	1,090,830	100%

Source: Original for this publication.

Note: NSSF = National Social Security Fund; OOP = out-of-pocket (spending).

Table A.7. Expenditure in private facility, by facility type and by use of fund

	Overall				PolyClinic				Clinic			
	N	Median (000 KHR)	Mean (000 KHR)	%	N	Median (000 KHR)	Mean (000 KHR)	%	N	Median (000 KHR)	Mean (000 KHR)	%
Staff	103	143,500	272,031	41%	30	307,500	384,051	34%	73	100,450	225,996	49%
Medicine	103	55,350	142,869	22%	30	123,000	163,578	14%	73	49,200	134,361	29%
Other supplies	103	14,760	48,261	7%	30	41,000	45,334	4%	73	9,020	49,462	11%
Utilities	103	4,408	16,035	2%	30	12,300	25,268	2%	73	4,100	12,243	3%
Maintenance	103	4,510	40,963	6%	30	13,325	100,930	9%	73	2,050	16,322	4%
Other recurrent expenses	103	0	5,109	1%	30	410	7,134	1%	73	0	4,276	1%
CAPEX	103	0	135,132	20%	30	6,150	415,330	36%	73	0	19,983	4%
Total	103	311,600	660,403	100%	30	715,860	1,141,625	100%	73	253,175	462,644	100%

Source: Original for this publication.

Note: CAPEX = capital expenditure.

Table A.8. Recruitment and Performance Evaluation, by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Participate in a recruitment competition for the first job (% of health care providers)	83%	87%	73%	84%	84%	85%	80%	88%
Over the last year, performance has been formally evaluated (% of health care providers)	80%	93%	61%	72%	85%	71%	78%	88%
Believe performance evaluations are fairly conducted (% of health care providers)	78%	89%	61%	67%	84%	65%	75%	86%

Source: Original for this publication.

Table A.9. Performance Evaluation Practices, by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Public	Private		Male	Female	Doctor	Nurses	Midwives
Keep track of and improve my performance (% of health care providers)	77%	91%	57%	70%	82%	65%	75%	86%
Assess what types of training I should receive (% of health care providers)	59%	72%	40%	50%	65%	42%	59%	68%
Award me a bonus (% of health care providers)	47%	57%	33%	38%	53%	41%	45%	53%
Promote me to a new position (% of health care providers)	27%	31%	20%	26%	27%	20%	27%	29%
Set my pay (% of health care providers)	25%	20%	34%	22%	28%	26%	26%	25%

Source: Original for this publication.

Table A.10. Training Received by Health Care Providers over the Last 12 months, by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Received training over the last 12 months (% of health care providers)	78%	91%	60%	83%	76%	87%	73%	82%
Number of training days over the last 12 months (Median)	6	6	6	10	5	11	6	5
Fair selection of health care providers to participate in training (% of health care providers)	87%	87%	88%	88%	87%	84%	89%	87%
Trainings had positive impact on productivity (% of health care providers)	65%	65%	64%	65%	65%	68%	61%	67%

Source: Original for this publication.

Table A.11. Health Care Providers Workload, by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Number of days worked in a week (Median)	5	5	5	5	5	5	5	5
Number of hours worked on a normal weekday (Median)	8	8	11.5	8	8	8	8	8
Number of hours spent on providing care to outpatients in a week (Median)	15	15	15	15	15	15	15	15
Number of hours spent providing care to inpatients in a week (Median)	14	14	12	14	13.5	12	15	12
Number of hours spent on administrative tasks in a week (Median)	6	7	4	6	5	5	6	6
Number of outpatient contacts in a week (Median)	30	30	20	30	25	45	25	25
Number of inpatient contacts in a week (Median)	10	19	7	15	10	14	14.5	7
Number of days spent on conducting outreach in the last month (Median)	2	2	0	4	2	0	3.5	2

Source: Original for this publication.

Table A.12. Teamwork and Management Quality, by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Teamwork and collaboration								
My team operates as efficiently as possible, given our resources (% of health providers agree)	89%	85%	94%	86%	90%	90%	86%	91%

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Health care providers in this health facility trust one another to fulfill the commitments they make (% of health providers reported agree)	92%	88%	98%	90%	93%	91%	93%	91%
I completely trust my colleagues' decisions about medical treatments in this facility (% of health providers reported agree)	92%	89%	97%	90%	93%	93%	91%	93%
Management quality								
My manager leads by setting a good example (% of health providers reported agree)	89%	83%	98%	88%	89%	91%	90%	86%
My manager communicates effectively (% of health providers reported agree)	91%	87%	98%	90%	92%	90%	93%	91%

Source: Original for this publication.

Table A.13. Provider Satisfaction by Facility Type, Gender, and Staff Category

Indicators	Facility			Gender		Staff		
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
Clear work responsibilities (% of health providers reported satisfy)	94%	94%	94%	91%	96%	94%	93%	96%
Opportunities for skill development (% of health providers reported satisfy)	90%	87%	93%	86%	92%	78%	93%	91%
Manageable workload (% of health providers reported satisfy)	86%	79%	96%	78%	90%	80%	84%	91%
Balance between clinical work (providing care to patients) and administrative tasks (% of health providers reported satisfy)	83%	78%	92%	78%	87%	87%	80%	86%

Availability of Medicine and equipment that is required to do my job (% of health providers reported satisfy)	81%	70%	98%	72%	85%	71%	82%	84%
Quality of infrastructure that is required to do my job (% of health providers reported satisfy)	80%	73%	92%	74%	84%	74%	80%	84%
Promotion system in my current role at this facility (% of health providers reported satisfy)	80%	81%	79%	73%	84%	70%	80%	84%
Satisfied with my salary (% of health providers reported satisfy)	74%	67%	85%	69%	77%	71%	73%	77%

Source: Original for this publication.

Table A.14. Motivation to Work in Public Service, by Facility Type and Provider Type

Indicators	Facility	Gender		Staff		
	Public	Male	Female	Doctor	Nurses	Midwives
Opportunity to serve society (% of health providers)	88%	100%	80%	100%	89%	83%
Job security, status, and prestige (% of health providers)	74%	70%	77%	89%	67%	74%
Career development and training opportunities (of health providers)	74%	70%	77%	89%	56%	83%
Additional benefits apart from salary (% of health providers)	62%	70%	57%	78%	56%	61%
Good working conditions, predictable working hours, and interesting work (% of health providers)	62%	65%	60%	33%	72%	65%
Good location and travel opportunities (% of health providers)	58%	70%	50%	78%	67%	43%
Good work-life balance (% of health providers)	48%	50%	47%	33%	50%	52%
Work responsibilities (% of health providers)	40%	45%	37%	44%	44%	35%

Source: Original for this publication.

Table A.15. Areas Where Misconduct is Likely to Occur

Indicators	Facility		Gender		Staff			
	Overall	Public	Private	Male	Female	Doctor	Nurses	Midwives
<i>Areas of potential misconduct</i>								
Performance evaluation and measurement (% of health providers)	10%	12%	6%	8%	11%	12%	9%	11%
Terminations and disciplinary measures (% of health providers)	9%	12%	6%	12%	8%	15%	8%	9%
Selection and recruitment (% of health providers)	9%	8%	9%	10%	8%	12%	10%	6%
Training and development (% of health providers)	7%	9%	4%	10%	5%	13%	6%	5%
Promotion and career advancement (% of health providers)	6%	8%	4%	10%	5%	9%	6%	5%
Compensation and rewards (% of health providers)	4%	4%	4%	5%	3%	6%	4%	3%
Procurement (% of health providers)	2%	3%	0%	3%	2%	3%	2%	1%
<i>Reporting misconduct</i>								
Feel safe to report misconduct (% of health providers)	74%	68%	82%	69%	77%	72%	74%	74%

Source: Original for this publication.



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