National Survey on

Accountability and Transparency of Public Healthcare in Cambodia

2020

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TRANSPARENCY INTERNATIONAL Cambodia

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About TI Cambodia

Transparency International Cambodia (TI Cambodia) is a National Chapter of Transparency International, the global civil society organisation leading the fight against corruption. We work together with individuals and institutions at all levels including government, civil society, business, media and the wider public to promote integrity and fight corruption in Cambodia.

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EXECUTIVE SUMMARY

The Royal Government of Cambodia (RGC), members of the international donor community and civil society organisations have implemented a number of commendable initiatives to improve health outcomes in the country for the past decades. To date, however, still relatively little is known about the knowledge, attitudes and practices (KAP) of ordinary Cambodian citizens regarding provision of public healthcare, especially involving transparency and accountability of the provisions. These understandings are critical for building citizen awareness, engagement and participation, which are in turn vital to ensuring transparency, accountability and responsiveness of healthcare provision.

To address this gap, this report presents the findings of a nationally representative survey seeking to understand and quantify citizens' perceptions and attitudes toward transparency and accountability of public healthcare in Cambodia, as well as their awareness and experience in seeking the services in the country. This survey took place in October 2017, collecting responses from 1,596 individuals from 200 villages in 100 communes across all 25 provinces of Cambodia.

It is hoped that the survey will provide evidence to relevant governmental and non-governmental organisations, as well as development partners, looking to deepen their understanding about citizens' perceptions of and attitudes toward provision of public healthcare in Cambodia. This knowledge, in turn, can help them in the formulation or reform of policies and programmes to increase accountability, transparency and quality of public healthcare.

MAIN FINDINGS

- The understanding of price list and fee exemption at public health facilities is still low. 65% of the respondents did not know that public health facilities were required to publicly display their price list and fee exemption although those with higher education and income level tend to know better. About the same percentage (64.5%) claimed that they have not seen the price list or fee exemption. Even larger proportion of respondents (92.8%) did not know that health centres were required to publicly post the information regarding annual revenues and expenditures of the facilities, and a large majority of them also supported that public health facilities should post the information about its annual budgets.
- Informal payment is seen as the most common form of corruption. 59.8 % of the respondents claimed that it is the most common form of corruption, although 62.2% agreed that informal payment constituted corruption. Informal payments are needed to ensure better attention and improved quality of services. Of those who offered informal payment, 78.4% of them claimed that informal payments are made even if the healthcare provider did not request the payment.
- Corruption most likely to come from a midwife or nurse. 39.7% of those who experienced a malpractice at public health facilities claimed that midwife is most prone to corruption which was then followed by nurse (31.8%).
- While some people said they did not know the causes of corruption in public health facilities, most of them said greed (58.3%) and low salary (15.3%) were the most known motivating factors for corruption. The impact of corruption in the public health sector is seen as “very serious” or “somewhat serious” (86.4% of total respondents). The impact being death accounts for 49.2% or deterioration of a patient’s health (41.6%). The impact affects all demographics.
- The majority of respondents believe healthcare professionals accredited to public hospitals should not be allowed to run/work for private practice. 63.1% of the total respondents did not think healthcare professionals working at public health facilities should be allowed to work for private facilities. The most common reasons are ‘increasing absenteeism’ (53.3%), ‘they are employees of the government’ (47.1%) and ‘health professionals will neglect public duties’ (33.3%). Although 36.9% of the total respondent supported public health professionals should also be allowed to work for private practice, the most common reasons are that they can only work after public hours (42.4%) and that they can work as long as it does not affect their performance at public health facilities or ensure that public work is top priority (35.3%).
- Most respondents (79.8%) said that they or a member of their household had sought healthcare service in the past two years. Private health facilities are

more commonly used than public health facilities. Reasons for why people chose to use private facilities were that private facilities were perceived to offer better service and quality and that they took less time. Private facilities are more commonly used by those who have high education and income and those are in urban areas. The primary reasons why people chose to use public health facilities were that the facilities had lower fees (57.1%) and that they were closer to respondents' homes (31.3%). The most popular public health facility used by respondents is Health Center (67.3%), which is followed by District Referral Hospital (24.3%), Provincial Hospital (23.4%) and National Hospital (22.9%) respectively.

- Overall levels of satisfaction with current quality and access to public healthcare is over 75%. However, those who are very satisfactory accounts about half (36.1%) of the number while those with somewhat satisfactory accounts for another half (39.3%). A majority of the respondents who said that their level of satisfaction was less than 'very satisfactory' did not dare to talk or make a complaint or did not know/did not answer the question.
- Most respondents felt that corruption in the public health sector had decreased somewhat (40.4%) or that the government is doing 'fairly well' at fighting corruption in public health sector (47.2%). However, when asked what individuals could do to fight corruption, the majority either did not respond or did not know (31.6%), or said ordinary people could not do anything (27.0%).
- Most respondents said they would be willing to report corruption if they witnessed it occur at public health facilities (67.5%), compared to 32.5% who said they would not report it. The most common methods of reporting corruption were to write or speak to local authorities (31.6%) or write or speak directly to directors of public health facilities (27.0%), while only 4.5% said they would contact the Anti-Corruption Unit (ACU).
- Finally, the most popular ways to improve the public healthcare sector in general are to 'eliminate corruption in the healthcare sector' (28.7%), 'do not know how to improve the sector' (23.2%), 'improve medical education and training' (18.9%) and 'strengthen the judicial system and law enforcement' (18.7%).

KEY RECOMMENDATIONS

Conclusion and Recommendation for the Government

- Address low level of knowledge about price list and fee exemption. Although price list and fee exemption of public health services are usually drawn up on a board attaching to the wall of public health facilities, most respondents are still not aware of it. The fact that people with higher education and income level tend to know better may suggest that some people are not be able to read the information. The government should take initiatives to make the boards more feasible and take initiatives to raise people's attention and awareness on the price of health services. Patients should be informed in advance about the price or fees charged for certain treatments or procedures.
- Eliminate informal or unofficial payment at public health facilities. Informal or unofficial payment is considered as the best way to ensure better medical attention and improved quality of service. The fact that informal payments are made even if the healthcare provider did not request the payment may suggest that it is part of entrenched culture of most Cambodians. Public health professionals should provide medical service to the highest of their professions and standards as stipulated in the code of conduct for health practitioners and do not expect something in return. The government should also make the public aware that they should not pay unofficial payment to public healthcare providers and that constitutes corruption.
- Tackle informal and unofficial payment at the points of service delivery is very important, as midwife and nurse are perceived to be the most corrupted public healthcare providers. The fact that midwife is believed to be the most corrupted one suggests that unofficial payment happening at the times of birth delivery may be very widespread that requires further investigation. Corruption at birth delivery may hit the poor the most as they are the main service users of public facilities.
- Consider reforming/introducing health policy regarding dual practice. Dual practice in the country is deep routed and widespread and ubiquitous. Most people expressed the desire that healthcare professional accredited to public hospitals should not be allowed to work for private practices. The government should take this into serious consideration. The government should either eliminate the practice or at least strictly regulate the practice, because it affects the accessibility, equity and quality of public healthcare.
- Maximise reform efforts to increase public healthcare usage. Although public healthcare usage is slightly lower than private facilities, most of public healthcare users used the services due to its lower fees or closeness to their homes rather than quality and efficiency as offered by private facilities. The government

should make more efforts to modernise public health system so that it is able to provide more efficient and effective public healthcare.

- Empower and create enable environment for the public to raise their concerns or make complaints regarding public healthcare provision. Most respondents who were less than 'very satisfactory' did not dare to talk or make a complaint or did not know how to do it. Providing clear instruction and guideline on how to raise their concerns is equally important. Furthermore, when asked what individuals could do to fight corruption, the majority either did not respond or did not know or said ordinary people could not do anything. This suggests that people may be less empowered or feel that they cannot make any differences.
- Build trust between the public with the Anti-Corruption Unit (ACU). Although most people are willing to report corruption if they witness it at public health facilities, the most common methods of reporting were to speak to local authorities or to directors of public health facilities. Only 4.5% said they would contact the Anti-Corruption Unit (ACU). Again, elimination of corruption in health sector is very important. Most people believe that the most effective way to improve the public healthcare sector in general is to eliminate corruption.

CONTENTS

LIST OF ABBREVIATIONS

ACU	Anti-Corruption Unit
CAS	Centre for Advanced Study
CDB	Commune Database
CIPS	Cambodia Inter-Censal Population Survey
CPA	Complementary Package of Activities
CSF	Commune/Sangkat Fund
CSO	Civil Society Organisation
GAD/C	Gender and Development for Cambodia
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
H-EQIP	Health Equity and Quality Improvement Project
HEF	Health Equity Fund
IBP	International Budget Partnership
IMF	International Monetary Fund
KAP	Knowledge, Attitudes and Practices
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MPA	Minimum Package of Activities
NCDD	National Committee for Sub-National Democratic Development
NEP	NGO Education Partnership
NGO	Non-Governmental Organisation
NIS	National Institute of Statistics
OBS	Open Budget Survey
OD	Operational District
OECD	Organisation for Economic Cooperation and Development
OOP	Out of Pocket
RGC	Royal Government of Cambodia
SK	Star Kampuchea
SNA	Sub-National Administrations
SOA	Special Operating Agencies
TI	Transparency International
UHC	Universal Health Coverage

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1 INTRODUCTION

1.1. Healthcare Transparency and Accountability in Cambodia: Background and Rationale of Research

Corruption in the health sector has profound consequences on the wellbeing of citizens. It could cost lives. It creates difficulties for people, especially the poor, to access reliable health services. An IMF study across 71 countries showed that countries with high incidences of corruption have higher infant mortality rates, even after adjusting for income, female education, health spending and urbanisation. In Cambodia, corruption is a major issue facing healthcare system. A 2013 nationally representative survey conducted by Transparency International showed that nearly four in ten Cambodians had paid a bribe to obtain health-related services. This finding is consistent with a more recent study by Transparency International Cambodia which found that thirty percent of Cambodian youth encountered corruption while getting healthcare. In addition to these studies, incidents of deaths, delayed treatments and medical malpractices purportedly caused by the corrupt healthcare system have frequently been reported in the local media.

Finding an effective solution to healthcare corruption requires an appropriate diagnosis of this problem, in other words an extensive research into this issue. Unfortunately, apart from the perception surveys cited above, studies focusing exclusively on corruption in health service deliveries and how it affects citizens in Cambodia are extremely limited. Relatively little is known about how the Cambodian public perceive and experience public healthcare in the country. This nationally representative survey project contributes to addressing this gap, seeking to understand and quantify citizens' perceptions and attitudes toward public healthcare, as well as their awareness and experience in accessing public healthcare in the country.

This report presents the detailed findings of the survey. It is structured in four parts. Chapter One, here, is an introduction that provides a brief overview of the background to the study, its objectives and the research methods employed, including a description of the research design, tools and participants. Chapter Two expands on the background to the survey outlining current public healthcare policies in Cambodian context. Chapter Three presents a detailed analysis of the survey findings. Finally, Chapter Four presents the conclusions and recommendations that follow from the analysis.

1.2. Study Objectives

Through a nationally representative survey of 1,596 individuals residing across all 25 provinces of Cambodia, this survey report aims to:

- **Understand and quantify citizens' perceptions, awareness and attitudes regarding the transparency and accountability of healthcare in Cambodia; and**
- **Understand citizens' experience in using healthcare in the country.**

Transparency here refers to relevant, contextual, accessible, timely, understandable and accurate disclosure of information on actions, rules, plans and processes, while **accountability** is defined in terms of an overall accountability system, where actors are held answerable and face consequences within the government and from outside of the government. **Participation** is included as a necessary element of **good governance:** an element key to making transparency and accountability directly meaningful to citizens and to fostering an open, responsive and accountable government.

Relatively little work has explored the knowledge, perceptions and practices of ordinary citizens with respect to the issue. By working to fill these gaps in knowledge, the findings of the survey will serve two principle uses. First, the data and analysis will provide a robust evidence base for policy-makers and practitioners looking to deepen their understanding about citizens' perceptions of and attitudes toward public healthcare accountability and transparency in Cambodia. This knowledge, in turn, can help inform policies and programmes to increase public healthcare accountability and transparency. The results of the survey will, additionally, stimulate debates and inform discussions on this topic. Greater awareness among citizens and particularly their rights in these respects may work to generate demand for greater transparency and accountability in the sector. The finding will also assist TI Cambodia and its various partners in fine-tuning its existing programmes and creating various future initiatives to increase citizens' awareness, interest, and demand for greater transparency and accountability.

1.3. Research Methods

1.3.1. Research design

To pursue the objectives outlined in Part 1.2. of this report, the research followed a mixed-methods approach, combining schemes of qualitative and quantitative data collection, and reconciling primary and secondary data analysis. This research strategy was devised in consultation with TI Cambodia staff and an Advisory Board comprising stakeholders from the NGO, CSO, independent researchers and government sectors. Implementation of research was conducted in two principal phases, as below.

1. Desk review of data and information held by external sources to provide background in which to contextualise the research activities and inform research themes.
2. Nationally representative survey of 1,596 Cambodian citizens to quantify KAP surrounding public healthcare accountability and transparency.

Following each of these two phases of data collection, review and analysis, a workshop was staged including TI Cambodia staff and the Advisory Board to provide feedback and discuss emerging themes and findings. This critical feedback was used to revise and enhance elements of this research.

A summary of data sources is provided in Table 1.1. below.

Table 1.1. Research data sources

Primary sources	Secondary sources
• Nationally representative survey of 1,596 Cambodian citizens. • Consultative meetings with TI Cambodia staff. • Workshops and written submissions from an Advisory Board including stakeholders from the NGO, CSO, independent researchers and government sectors.	• Literature from international and local NGOs and CSOs. • Literature and data produced by government and ministries at the national level, including relevant policy and legal frameworks. • Academic sources.

The 1,596 entries of the survey provide a robust gender-disaggregated and multi-factorial evidence base to explore variations in KAP towards public healthcare accountability and transparency among different groups in Cambodia society. Findings of the survey have been triangulated and corroborated with the results of the desk review and testimony from TI Cambodia and other relevant sources, as above, to ensure the veracity of the data.

1.3.2. Sampling design

The core quantitative component of the study presented in this report is a nationally representative survey of 1,596 Cambodian citizens that explores KAP towards public healthcare accountability and transparency. To achieve national representation, the survey was enumerated to 1,596 Cambodian citizens' resident in 200 villages located in 100 communes across all 25 provinces of Cambodia. The sample of 1,596 respondents is representative of the Cambodian population aged 18 or older and is proportional to population by province, to urban/rural distribution and to gender. A four-stage stratified method was employed to achieve the representation, described here.

The village database prepared for the Commune Database (CDB) in 2014 by the Ministry of Planning was used as the sampling frame for sample selection. Primary and secondary sampling units were identified prior to the start of the data collection process. Primary sampling units were communes, and 100 were selected from the CDB using the Probability Proportional to Size with Linear Systematic Sampling (PPSLSS) and random start method. Secondary sampling units were villages, with two villages per commune selected using Simple Random Sampling Without Replacement (SRSWOR).

Third- and fourth- stage samples were taken as part of the data collection at field sites. The third-stage unit was the household. For these purposes, a household is defined as a group of people who presently eat together from the same pot. By this definition, a household does not include persons who are currently living elsewhere for purposes of studies or work but it does include domestic workers or temporary visitors. In multi-household dwelling structures (like blocks of flats, or backyard dwellings for renters, relatives, or household workers), each household was treated as a separate sampling unit. A sample selection of eight households was taken using Linear Systematic sampling with equal probability (LSS-EQP). Due to time constraints in the field, instead of drawing up a full village household list to sample randomly from, the sampling began at a randomly chosen household and subsequent households were sampled at intervals of five households or 10 households, for small and large villages respectively.

Individual household members were the fourth-stage sample unit. An equal probability method selected one household member for participation using a household member list and Kish grid. To achieve gender representation in the study, four female household members and four male household members were selected in each village.

1.3.3. Survey tools and enumerator training

A bespoke survey tool was developed for deployment in the large-scale survey, following from themes and issues highlighted in the desk review and the first consultative workshop (see Part 1.3.1. above). The survey was structured in three parts. The first part was a module to gather informed consent from the respondent. Enumerators read aloud to potential respondents a brief introduction to the aims and methods of the survey, as well as intended use for the data, before asking respondents whether they were willing to participate. For those who declined, the survey was terminated here. Part two sought information on KAP related to public healthcare accountability and transparency. A final third section collected basic demographic data in order to facilitate cross-sectional analysis.

The survey tool was rigorously translated and then field tested by the data collection team (five supervisors and 20 enumerators) with the assistance of TI Cambodia prior to deployment. Enumerators attend a three-day training session to build familiarity and understanding of the survey tool and its instructions. The first two days of training centred on office-based training, where the research objectives, methods, ethics, core concepts and principles were outlined to enumerators, in addition to a full run-through and discussion of all survey questions and instructions. The enumerators also conducted practice interviews with each other that served as an initial pilot test of the survey tool. The third day of training was a field-based practical session that served as the main pilot study. This pilot survey was conducted prior to the enumeration of the study, to test the suitability of the survey tool and manual, as well as the standards of enumerators. The pilot study was conducted by all members of the data collection team with a sample of respondents in two urban and rural locations in Phnom Penh and Kandal. Based on the outcomes of the field test, all aspects of the survey tool – including the language, question order, and skip logic – were refined, revised and retested as necessary in order to make the survey accessible, clear and unambiguous for both enumerators and respondents.

1.3.4. Data collection, entry and analysis

Data collection of responses from 1,596 individuals from 100 communes across 25 provinces of Cambodia, as per the sampling methodology outlined above, took place over 21 days in October 2017. An external specialist agency was recruited to implement and oversee the data collection process. For this purpose, 25 data

collection staff were deployed in teams of five persons, with each team comprised of one supervisor and four enumerators. The survey was administered face-to-face using paper forms in private locations convenient for respondents, usually the respondents' home. Each survey took approximately forty minutes to deliver. TI Cambodia staff attended field locations to conduct random spot checks on the data collection process, verifying consistency and completeness.

Data entry was conducted by the same external specialist agency. A system of double data entry using CSPro was followed as a quality control measure. TI Cambodia staff conducted random checks on input data to verify quality and accuracy. Following this, data analysis was conducted by the consultant team in 2018, using IBM SPSS.

1.3.5. Consultative approach, Advisory Board and verification of findings

TI Cambodia's approach to the promotion of public healthcare transparency and accountability is constructive engagement. Thus, the survey was undertaken in a participatory way, with the involvement of a variety of stakeholders. The rigour of the research design was enhanced by this consultative approach, which engaged a cross-section of relevant stakeholders to provide feedback on the processes and findings of the survey. Through dialogue at meetings, workshops and written submissions, the objectives, methods, tools and findings of the study were subject to several rounds of scrutiny by a team of internal and external reviewers upon whose guidance the approach and analysis of the research was subsequently refined.

To support this work, a project Advisory Board comprised of freelance consultants and representatives from NGOs, CSOs, independent researchers as well as government representatives was recruited. The Advisory Board was convened on two occasions: first, to provide constructive feedback on the survey design and questionnaire development; and second, to review the first draft of the survey report and propose actionable recommendations. Beyond this, the Advisory Board played an ad-hoc but vital role providing technical support to TI Cambodia and the consultant team in conducting the survey and continues to work to promote and develop the findings of the report.

1.3.6. Limitations

The research presented in this report was designed to generate nationally-representative data on ordinary citizen's knowledge, attitudes and practices with respect to public healthcare accountability and transparency in Cambodia. As a quantitative study, it provides a set of robust and reliable data to measure the extent and scope of these ideas and experiences in national context. However, as with any quantitative study, an inherent drawback of the research design is that, beyond the refinements made following the pilot study, the terms, questions and topics of the research were decided upon prior to implementation of the research process. Thus, the ability of a qualitative approach to redefine its own internal parameters as alternative themes and new problems arise in the research process was not facilitated.

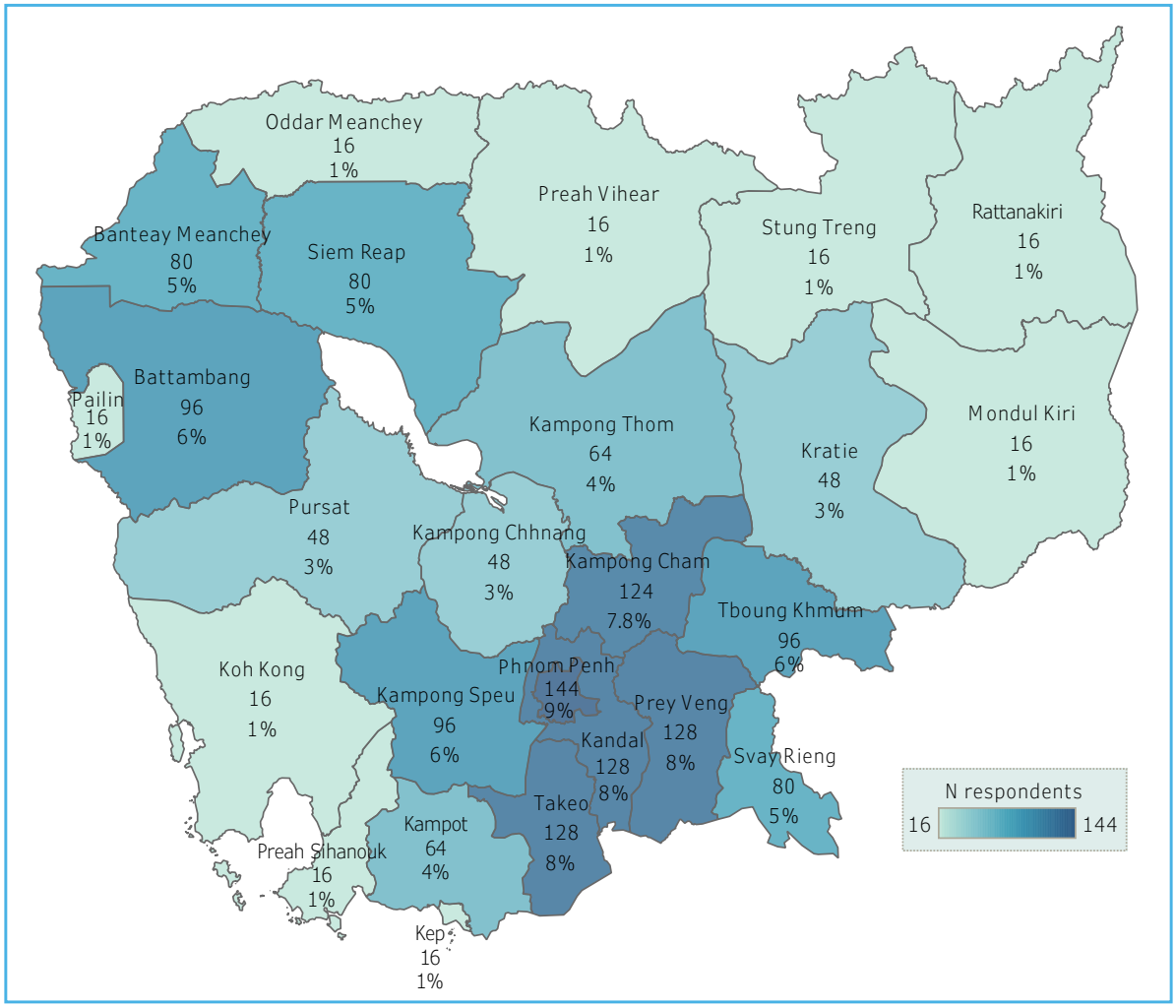
One consequent drawback is that though the proposed study illustrates readily identifiable patterns of and within knowledge and practice – for example, among population sub-groups – the scope of the research does not allow for further investigation of the underlying causes in these differences. Instead, these are highlighted as avenues for future research. In this respect, the report serves as an exploratory tool for the development of future priorities in this arena.

Finally, as a perceptions survey, this research is intended to elucidate public opinion about public healthcare accountability, accessibility and transparency. It is not intended – nor is it able – to offer a full account of the strengths and weaknesses of Cambodia's public healthcare system.

1.3.7. Profile of respondents

The following table, Table 1.2., shows the distribution of respondents across Cambodia. It demonstrates that data was collected from every province in Cambodia, with the number of respondents in each province weighted to reflect their population size. As such, only 16 interviews were conducted in each of Cambodia's seven least populous provinces: Kep, Koh Kong, Mondulkiri, Oddar Meanchey, Pailin, Rattanakiri and Stung Treng. By contrast, 144 interviews were conducted in Cambodia's most populous province, Phnom Penh. In total, 1,596 interviews were conducted across the country in order to provide a proportionally representative sample of the population.

Table 1.2. Province location of survey respondents



Source: National survey data, 2017

In order to achieve gender representation in the data, equal numbers of men and women were interviewed in the survey. In total, 798 men and 798 women took part in this study as shown in Table 1.3.

Table 1.3. Gender of survey respondents

	N respondents	Percentage respondents
Female	798	50 %
Male	798	50 %
Total – all respondents	1,596	100 %

Source: National survey data, 2017

Table 1.4. presents the socio-demographic characteristics of the survey respondents. It shows three key characteristics of the sample: age, marital status and educational level. The data shows that the largest proportion of informants are in the 28-37 year-old category, with the smallest proportion of the study being in the 18-27 year-old category. No significant difference is observed between the age ranges of the male and female participants in the survey.

In terms of marital status, by far the largest proportion of survey respondents are married. Overall, 84.1% of the sample are married, compared with only 7.8% of the sample being single and 8.1% of the sample being divorced, separated, or widowed. Notably, there are some gendered differences in the marital status of the survey. Slightly more interviewed men than women fell into the married or single categories, whilst the number of women who were divorced, separated or widowed is over triple that of men.

Regarding education level, the largest group within the sample – 40.7% of respondents – have incomplete primary education, whilst the second largest group – 20.3% of respondents – have completed primary education. A minority of the sample have secondary education or higher, with 17.7% having completed lower secondary schooling and only 6.3% have completed higher secondary schooling. The proportion of the sample who have completed post-secondary education is, at 3.1%, far smaller than the 12% who have no education. However, gender is once again important here: a smaller percentage of men than women have no education – 9.8% compared with 14.3% – and less women (1.9%) in the sample have post-secondary education, compared with men (4.3%).

Table 1.4. Socio-demographic characteristics of survey respondents

Age in years

	All	%	Female	%	Male	%
18-27	253	15.9%	138	17.3%	115	14.4%
28-37	401	25.1%	220	27.6%	181	22.7%
38-47	291	18.2%	151	18.9%	140	17.5%
48-57	378	23.7%	184	23.1%	194	24.3%
58 +	273	17.1%	105	13.2%	168	21.1%
Total – all respondents	1,596	100%	798	100%	798	100%

Marital status

	All	%	Female	%	Male	%
Single	125	7.8%	57	7.1%	68	8.5%
Married	1,342	84.1%	643	80.6%	699	87.6%
Divorced, separated or widowed	129	8.1%	98	12.3%	31	3.9%
Total – all respondents	1,596	100%	798	100%	798	100%

Educational level

	All	%	Female	%	Male	%
No schooling	192	12.0%	114	14.3%	78	9.8%
Incomplete primary	649	40.7%	364	45.6%	285	35.7%
Complete primary	324	20.3%	155	19.4%	169	21.2%
Complete lower secondary	282	17.7%	108	13.5%	174	21.8%
Complete higher secondary	100	6.3%	42	5.3%	58	7.3%
Post-secondary	49	3.1%	15	1.9%	34	4.3%
Total – all respondents	1,596	100%	798	100%	798	100%

Location

	All	%	Female	%	Male	%
Urban	352	22.1%	176	22.1%	176	22.1%
Rural	1,244	77.9%	622	77.9%	622	77.9%
Total – all respondents	1,596	100%	798	100%	798	100%

Source: National survey data, 2017

Table 1.5. highlights the socio-economic characteristics of the survey respondents. It presents data on the employment status, household income and category and household status of the sample. Overall, it shows that 81.5% of the sample are employed, with a greater percentage of women (18.3%) than men (9.4%) "inactive", meaning neither employed nor looking for work.

The same table shows the monthly income categories of the respondents. It demonstrates a relatively equal distribution across income quintiles and a small variance between men and women. Household status, by contrast is overwhelmingly in the category "owner occupier", with 94.1% of the sample occupying their own homes, compared with only 4% who rent a property. A further 1.8% of the sample live in properties they neither own nor rent.

Table 1.5. Socio-economic characteristics of survey respondents

Employment status

	All	%	Female	%	Male	%
Employed	1,300	81.5%	607	76.1%	693	86.8%
Unemployed	75	4.7%	45	5.6%	30	3.8%
Inactive	221	13.8%	146	18.3%	75	9.4%
Total – all respondents	1,596	100%	798	100%	798	100%

Household monthly income category

	All	%	Female	%	Male	%
First quintile, under $41	318	19.9%	168	21.1%	150	18.8%
Second quintile, $41-$78	315	19.7%	148	18.5%	167	20.9%
Third quintile, $79-$100	342	21.4%	179	22.4%	163	20.4%
Fourth quintile, $101-$160	324	20.3%	152	19.0%	172	21.6%
Fifth quintile, over $160	292	18.3%	147	18.4%	145	18.2%
Prefer not to say	5	0.3%	4	0.5%	1	0.1%
Total – all respondents	1,596	100%	798	100%	798	100%

Household status

	All	%	Female	%	Male	%
Owner occupier	1,502	94.1%	753	94.4%	749	93.9%
Rent	64	4.0%	34	4.3%	30	3.8%
Not owned, but free	29	1.8%	11	1.4%	18	2.3%
Other	1	0.1%	0	0%	1	0.1%
Total – all respondents	1,596	100%	798	100%	798	100%

Source: National survey data, 2017

Photo credit by PHOURN Yu, Freelance designer

2 OVERVIEW OF HEALTHCARE IN CAMBODIA

Cambodia's healthcare system has seen significant improvement in the last three decades. Health outcomes have improved substantially, with life expectancy at birth rising from 58 years in 2000 to 69 in 2015. Maternal and infant mortality have rapidly improved with maternal mortality declining from 1,020 per 100,000 live births in 1990 to 161 per 100,000 in 2015. Childhood immunisation coverage has expanded with 84% of children aged 12-23 months immunised against measles in 2016 compared with 52% in 2002. The expansion has contributed to a sharp fall in infant and under-five mortality rates, dropping from 45 and 54 per 1,000 live births in 2010 to 28 and 35 per 1,000, respectively, in 2014.

Although significant improvements have been made over the years, Cambodia's health outcomes still rank the lowest in the Southeast Asian region. For instance, while its maternal mortality rate of 161 per 100,000 live births in 2015, Cambodia comparatively lags behind neighbouring countries – Thailand at 20 per 100,000 live births and Vietnam at 55 per 100,000 live births. The country's rate of immunisation against measles which stands at about 84% of children aged between 12 and 23 months in 2016 is lower than Myanmar at 91%, Vietnam at 99% and Thailand at 99%. Similar to many low and middle-income countries, Cambodia is facing a double burden of infectious and non-communicable diseases. While malaria, tuberculosis and HIV infections are still widespread, there is growing burden of diabetes, hypertension and hypercholesterolaemia for the adult population which places the strain on the country's health system.

Health System and Governance

Cambodia has a health system which the Ministry of Health (MoH) is solely responsible for the provision of public healthcare. The public health system is based on a district health system model with three levels which include Central Ministry, Provincial Level and Operational District Level. The MoH administers health programmes at national provincial and health Operational District (OD) levels. The Central Ministry has three General Directorates which include Health, Administration and Finance, and Inspection. The Directorates are responsible for translating Government's

health objectives into policies, strategies and guidelines in order to reach their targets. The role of the General Directorate for Health is the most comprehensive one as it is in charge of formulating and implementing MoH policies through its eight departments.

At the sub-national level, Provincial Health Department is tasked with operating a provincial hospital and cover from one to 10 Operational Districts (OD) which was formed based on geographic and population basis. Each OD covers a population of 100,000-200,000 with at least one Referral Hospital and a number of Health Centres. While each Health Centre cover 10,000-20,000 people, Health Post which is the lowest echelon in the public health system covers 2,000–3,000 people. Under the framework of the 1995 Health Coverage Plan, the services delivered at government facilities are regulated by guidelines produced by the MoH which defines a Minimum Package of Activities (MPA) for Health Centres and a Complementary Package of Activities (CPA) for Referral Hospital.

- The Minimum Package of Activities consists mainly of preventive and basic curative services, supplemented by specific activities for vertical programmes. Less formal Health Post are located in remote areas.
- The Complementary Package of Activities are graded 1-3 on the basis of the number and composition of staff, number of beds, standard drug kit, standard medical equipment and clinical activities.
    - CPA – 1 hospitals: the lowest hospital level, with 40-60 beds, provide basic obstetric care, but with no major surgery (no general anaesthesia) and no blood bank or blood deposit;
    - CPA -2 hospitals: with 60-100 beds, provide CPA-1 services plus emergency care, major surgery and other specialised services such as blood transfusion.
    - CPA – 3 hospitals: with 100-250 beds, are the highest hospital level, provide major surgery and more activities than CPA-2 including various specialised services. All eight National Hospitals located in Phnom Penh, and 21 of 24 provincial hospitals are CPA-3 hospitals.

However, Cambodia's healthcare is supplied by numerous service providers including public and private providers. According to the Health Strategic Plan 2016-2020, there are about 1,000 public healthcare facilities and 8,000 private healthcare facilities and providers across the country (PPP, 2019). The 2010 Cambodian Demographic and Health Survey reveals that only 29% of unwell

or injured patients sought care first in the public sector. Private clinics and practitioners are particularly common for curative care, and public section are particularly frequented for promotion and prevention activities (such as essential reproductive, maternal, neonatal and child health, tuberculosis, malaria and HIV/AIDs control). The private medical sector is the point of first contact for the majority of the sick and injured population. These private providers are usually small practices, drug shop or single-person practitioners. Private pharmacists are common and frequently accessed. The growing but loosely regulated private health facilities and providers has posed a coordination challenge for government planners and policy-makers.

Health Financing System

Cambodia's healthcare is financed by a mixed of funding sources. The country spends about 6% of its GDP on health, which is slightly more than the 4.6% average spent by countries in the Southeast Asian region in 2015. The total health expenditure in 2014 for the country is estimated at about US$1 billion which is about US$68 per person. The three main funding sources are out of pocket (OOP), government and donor payments. OOP accounts for about 60% of total funding sources for the health system in the country. In capital term, each individual in Cambodia contributes about US$43 in OOP health spending in 2014. A large proportion of Cambodia's OOP is made up of spending for private sector services at pharmacies and clinics. OOP spending at public facilities represents only a small proportion of government revenues. Public facilities have introduced user fee as part of health sector reform initiated in 1996 to raise additional revenues to improve quality of services and increase staff motivation. The use fee which is raised at public facilities is used principally to finance operational costs at government hospitals and health centres (Augustin, 2015).

The Government's funding accounts for about 20% of the total health expenditure which is lower than health spending by government across lower middle-income countries while the remaining 20% is filled by the donor's funding. The Government's budget for health expenditure constitutes 6.1% of general government expenditure in 2015 which is below the 8.5% regional average for the Southeast Asia. The government allocates its funding for health largely as a regular annual budget for health activities through the Ministry of Health. However, the government also allocates fund to contribute to co-finance the country's pooled funding

arrangement with selected donors. In term of proportion of expenditures, about 30% of 2014 government's funding for health is allocated to sub-national levels while the rest was managed at the central ministry level (Augustin, 2015).

Health expenditures in Cambodia are largely dependent on external donor funding. In 2015 while average external health expenditure per capital for lower-middle income countries was US$2.6, Cambodia stood at US$13.3 which is about 512% higher than peer's average. It has risen of more than 831% from US$1.6 in 2000. However, donor's funding has seen a decline. Data from 5-year Cambodia National Health Account 2012-2016 indicates that general government health expenditure as a proportion of the averaged 21% over the 5-year period; donor funding for the same period averaged 18% while OOP spending averaged 61%. Traditionally, donor funding for health has been allocated largely as earmarked funds for disease-specific national programmes such as malaria control or the HIV/AIDS programme. However, under the H-EQIP donors in Cambodia contribute 40% of finances required to fund the HEF while the government fund the remaining 60%. With the continuing growth of Cambodia's economy and maturation to middle-income status, it is expected that many donors will reduce or withdraw their health sector funding support. Global health initiatives, such as the Global Fund or GAVI, the vaccine alliance, have already requested increased government co-financing.

Major Health Reforms

Cambodia's health system has undergone continuous reforms since 1990s when the Ministry of Health (MoH) introduced the Health Coverage Plan and the Health Financing Charter to strengthen the supply of service. The early reform began with the extension of the physical infrastructure, continued through innovations in health financing and access to services, and now incorporate district health-sector management and administration. The first initiative to provide greater autonomy for local health managers is the conversion of almost one third of all Operational Districts (ODs) to the status of Special Operating Agencies (SOA). The status has provided greater degree of flexibility in human resource and financial management and receive additional funds through a direct Service Delivery Grant.

KEY REFORMS AND EVENTS

1995

Development of the Health Coverage Plan as a framework for developing the health system infrastructure, based on population and geographical criteria.

1996

Introduction of the Health Financing Charter, which paved the ways for implementing user charges at public health facilities, with exemptions for the poor; free revenues are managed locally according to inter-Ministerial Prakas of MEF and MoH.

Commencement of the Asian Development Bank Basic Health Services Project, which carries out civil works to construct and renovate health facilities, train health personnel to increase their capacity, including health services, including contracting-in and contracting-out.

1999

Piloting of the external contracting model of service delivery during 1999-2003. This built on public-private partnership in health service management by contracting international NGOs through the MoH, encompassing three main issues: (1) decentralisation, (2) use of regulated markets, and (3) harnessing the emergence of private sector and civil society.

2000

Sector-Wide Management (SWiM) framework implemented by MoH and health partners.

The first Health Equity Funds initiated in two districts (Sotnikum and Banteay Meanchey) and in Phnom Penh.

2002

Updating of the 1995 Health Coverage Plan to improve the geographic coverage of services.

2003

Adoption of the *Health Strategic Plan 2003-2007* and commencement of the first Health Sector Support Programme (2003-2008), with the principal objectives of increasing MoH service delivery capacity and performance, targeting the poor (particularly in rural areas), and reducing the impact of infectious diseases and malnutrition.

2006

Adoption of the *National Strategic Development Plan 2006-2010*, including priority strategies, actions and targets for the health sector.

Adoption of the *National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010*. This strategy focused on: service delivery, finance, human resources, information and policy/governance.

KEY REFORMS AND EVENTS

2007

Joint Annual Performance Review carried out by the MoH and development partners to assess the implementation of the Health Strategic Plan and the Health Sector Support Programme 2003-2007.

Introduction of the Midwife Incentive Scheme as a government-funded, supply-side incentive paid to midwife for facility-based deliveries.

2008

Development of the second *Health Strategic Plan 2008-2015* and the preparation of the second Health Sector Support Programme 2009-2015

Introduction of Special Operating Agencies Implementation Guidelines providing OD managers, Health Centres and Referral Hospitals with greater autonomy using internal contracting with performance-based payment and conversion of some ODs to SOA status.

Implementation of the HEF Guidelines to establish MoH authority over the growing number of HEFs operated in collaboration with local and international NGOs as implementers and contracted by the MoH.

Adoption of the government's Organic Law, which provided the framework for the decentralisation and de-concentration reform.

Adoption and implementation of the second Health Strategic Plan 2008-2015 focusing on five strategic areas: health service delivery, health financing, human resource development, health information system and health system governance.

2010

Introduction of the Fast Track Initiative for reducing Maternal and Newborn Mortality, focusing on six components: (1) assuring universal access to emergency services by improving and expanding emergency obstetric and newborn care; (2) expansion of availability of skilled birth attendance; (3) improvement of family planning through availability of abortion services in public health clinics along with regulative strengthening.

2011

Mid-term Review of Health Strategic Plan 2008-2015

2014

The draft of the National Health Financing Policy

2016

The third Health Strategic Plan 2016-2020

The Ministry of Health of Cambodia has committed to moving towards UHC and to achieving the vision of "All people in Cambodia to have better health and wellbeing, thereby contributing to sustainable socio-economic development".

2017

The National Social Protection Policy Framework 2016-2025

The government expands financial protection to more Cambodians to reduce the barrier of financial cost of care to access use.

Building on strong records of reform over the past decades, the Ministry of Health now sees moving toward universal health coverage as the framework for the continuation of the health reform process. Providing access for the poor is at the heart of health reform. Health Equity Fund (HEF) was initiated in early 2000s to balance the positive and negative impact of the use fees which was introduced since 1996. The Cambodian government has committed to provide universal health coverage (UHC) by 2030. The HEF offers some degree of financial risk protection to the poor and to stimulate the use of public health services. Beneficiaries of the HEF are identified either through the national Identification Poor Households Programme (IDPoor) carried out by the Ministry of Planning or through post identification, which is used at referral hospitals to identify poor patients who have not been pre-identified. The HEF has expanded over time and reviews suggest, on average, beneficiary households have reduced their OOP spending on healthcare and seek care less frequently in the private sector. Despite this, this overreliance on direct payment to finance healthcare in Cambodia still poses a significant challenge to the country's desire to move towards universal health coverage as there is some evidence that a substantial proportion of HEF beneficiaries still initiate healthcare seeking at private health providers where they incur considerable OOP expenses.

Photo credit by PHOURN Yu, Freelance designer

3 FINDINGS ON DELIVERY OF PUBLIC HEALTHCARE SERVICE

3.1. Understanding of user fees and fee exemptions at public health facilities

Table 3.1. shows that the majority of respondents (65%) did not know that public health facilities were required to publicly display their price list and fee exemption. Disaggregated data indicates that those with higher education and income levels are more likely to know that this information should be publicly displayed. Table 3.2. shows that an even larger percentage (92.8%) did not know that health centres were required to publicly post information regarding their annual budget, including revenues and expenditures. Table 3.3. shows that the vast majority of those surveyed (95.7%) think that public health facilities should publicly post financial information regarding their annual budget.

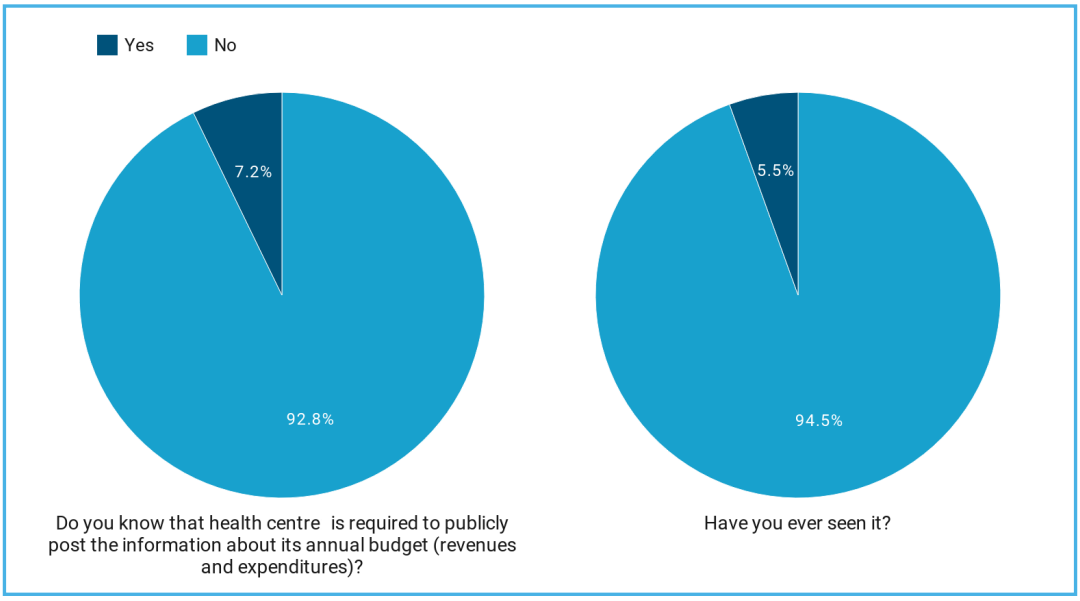
Table 3.1. Knowledge of price list and fee exemption

Do you know that all public health facilities are required to publicly display its price list and fee exemption?	Yes	No	Have you ever seen it?	Yes	No
All	35.0%	65.0%		35.5%	64.5%
Gender					
Male	32.8%	67.2%		37.8%	62.2%
Female	37.1%	62.9%		33.2%	66.8%
Age in years					
18-27	35.2%	64.8%		34.0%	66.0%
28-37	40.4%	59.6%		41.4%	58.6%
38-47	36.1%	63.9%		37.5%	62.5%
48-57	30.4%	69.6%		32.0%	68.0%
58+	31.9%	68.1%		31.1%	68.9%
Educational Level					
No schooling	19.8%	80.2%		19.3%	80.7%
Incomplete primary	31.0%	69.0%		30.5%	69.5%
Complete primary	39.5%	60.5%		40.7%	59.3%
Complete lower secondary	38.3%	61.7%		45.4%	54.6%
Complete higher secondary	50.0%	50.0%		46.0%	54.0%
Post-secondary	66.7%	33.3%		53.3%	46.7%

Household income category*				
First quintile (lowest income)	31.1%	68.9%	34.5%	65.5%
Second quintile	29.7%	70.3%	31.0%	69.0%
Third quintile	36.3%	63.7%	36.5%	63.5%
Fourth quintile	37.0%	63.0%	37.3%	62.7%
Fifth quintile (highest income)	41.1%	58.9%	38.4%	61.6%
Location				
Urban	39.2%	60.8%	36.9%	63.1%
Rural	33.8%	66.2%	35.1%	64.9%

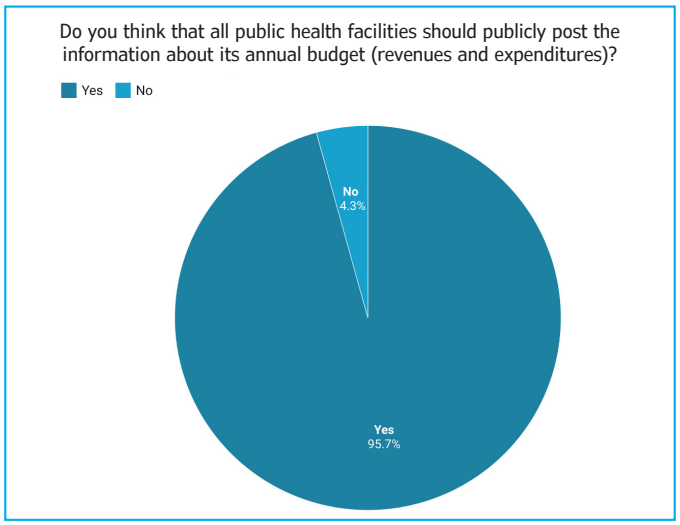
(Q69 and Q70, N=1,596, except *, where N=1,591, since 5 respondents preferred not to give their household income. Source: National survey data, 2017.)

Table 3.2. Knowledge of health centre budget information



(Q71 and Q72, N = 1,596. Source: National survey data, 2017.)

Table 3.3. Opinion on health centre budget information

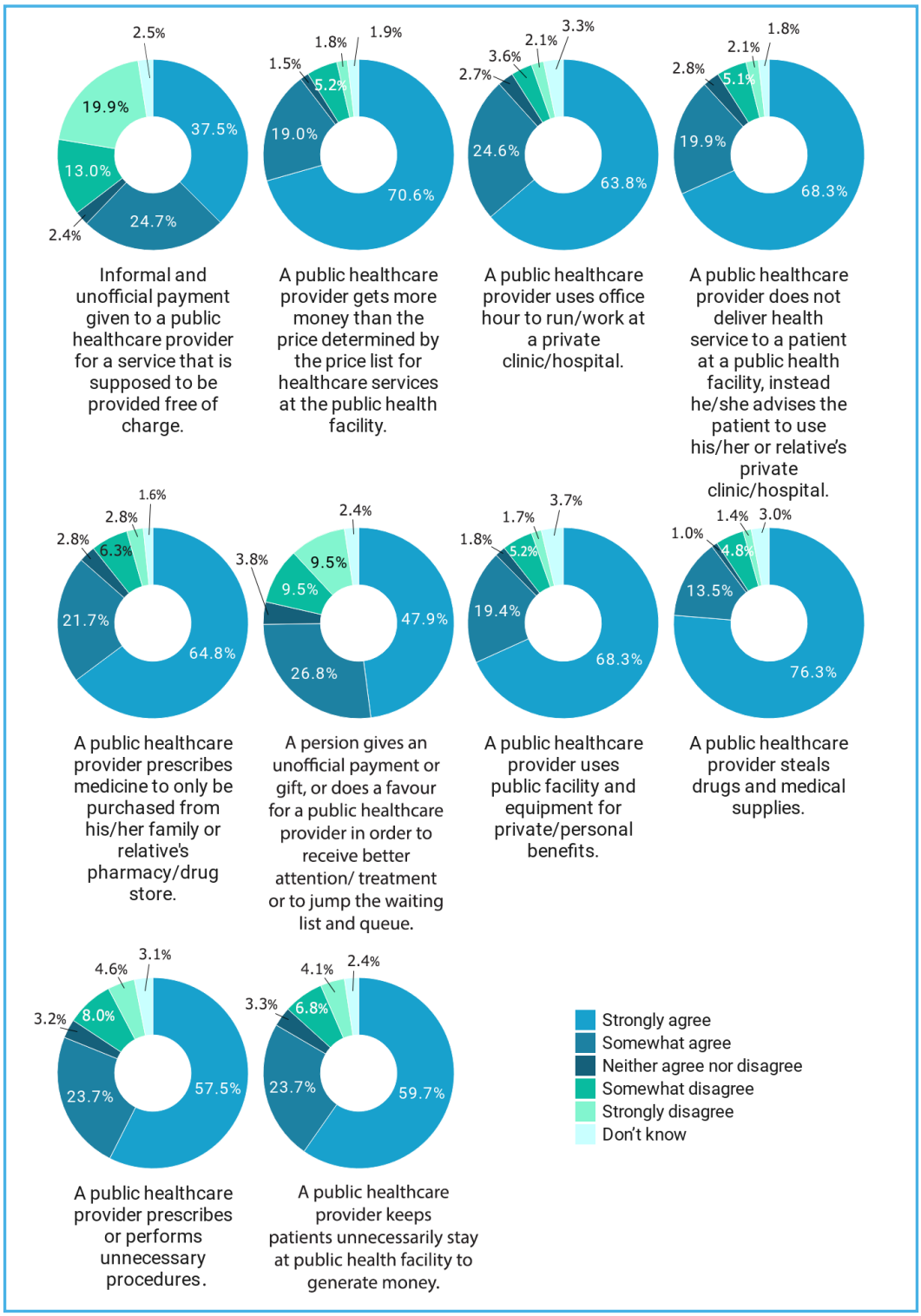


(Q73, N = 1,596. Source: National survey data, 2017.)

3.2. Understanding of corruption in delivery of public health service

Table 3.4. reflects a series of questions asked to survey respondents about their understanding of corruption in public health facilities. For all 10 questions, the majority of respondents selected either "strongly agree" or "somewhat agree" when asked whether the practices that are described constitute corruption.

Table 3.4. Understanding of corruption in delivery of public health service



(Q74, N=1,596. Source: National survey data, 2017.)

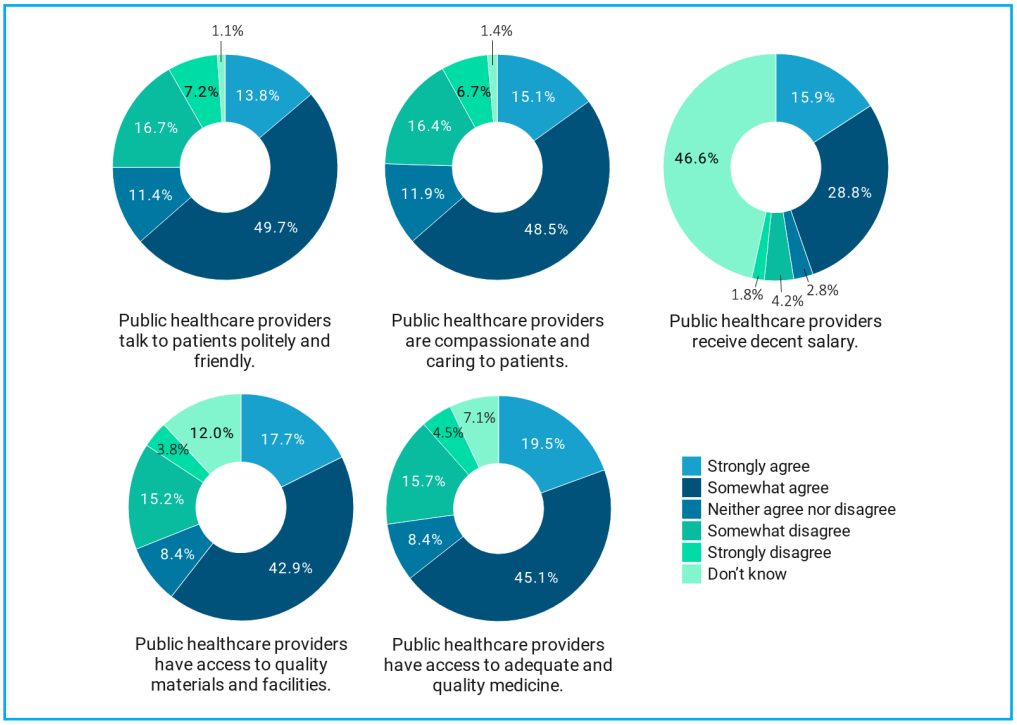
Notably, two questions relating to whether providing informal or unofficial payments was considered corruption both had the highest percentage of respondents answering "somewhat disagree" or "strongly disagree". First, 32.9% of respondents answered that the practice of providing informal payments to healthcare providers for services that are supposed to be free of charge was not a form of corruption. Similarly, 19% of respondents answered that a person giving an unofficial payment or gift, or doing a favour for a public healthcare provider in order to receive better attention/ treatment or to jump the waiting list and queue, was not a form of corruption. These responses perhaps reflect a deeply entrenched understanding within society that accepts the necessity of informal/ unofficial payments. (More information on informal payments can be found below in *Section 3.5. – Experience of using public healthcare service.*)

However conversely, the common practice of public healthcare providers also operating private clinics was widely recognised by survey respondents as corruption. Large majorities of respondents "strongly agreed" or "somewhat agreed" that it was corruption for public healthcare providers to use their office hours to run or work at a private facility (88.4% of total respondents), to not provide care at a public facility and instead direct patients to a private facility (88.2%), or to receive more money than the price determined by the price list (89.6%). Theft was also recognised as corruption, as 89.8% of total respondents "strongly agreed" or "somewhat agreed" that public healthcare providers stealing drugs or medical supplies was corruption.

3.3. Medical supply and performance

Respondents were asked their opinion regarding the availability of medical supplies and the performance of healthcare providers. The majority of survey respondents "strongly agreed" or "somewhat agreed" that healthcare providers spoke politely with patients (63.5% percent of total respondents) and were compassionate and caring (63.6%). Most respondents also felt that facilities and materials were accessible for healthcare providers (60.6%) and that they had access to adequate and quality medicine (64.6%). Many people were unsure of whether healthcare providers were paid an adequate salary, with 46.6% of people saying they did not know.

Table 3.5. Availability and performance of healthcare providers



(Q75, N=1,596. Source: National survey data, 2017.)

3.4. Characteristic and impact of corruption in delivery of public health service

The question, "In your opinion, what are the common types of corruption that you may encounter at public health facilities in Cambodia?" was asked in a spontaneous, open-ended manner, meaning no potential answers were given to respondents. Table 3.6. shows the five most commonly given answers. Multiple answers were allowed, so the total may add up to more than 100 percent.

Table 3.6. Types of corruption at public health facilities

Type of corruption	Percentage of respondents
Informal payment paid by or required from patients	59.8%
Unofficial payments for services that are supposed to be free	16.8%
Ask patients to buy drugs from his/her or relatives' pharmacy	12.3%
Absenteeism of medical staff/go home before working hours	7.6%
Unnecessary referral of patients to private facilities	7.0%
No answer given/don't know	16.0%

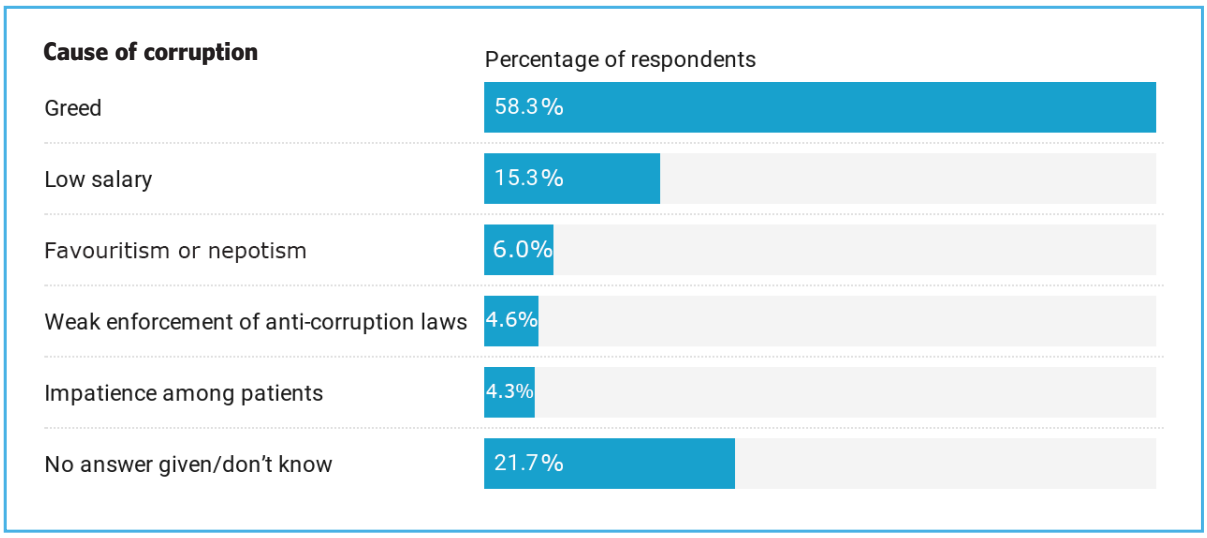
(Q76, N=1,596. Source: National survey data, 2017.)

The majority of respondents reported that in their opinion, informal payments was the most common form of corruption (59.8% of total respondents). This corroborates answers given in Table 3.4. where 62.2% of respondents agreed that informal payments constituted corruption. Many people did not know what types of corruption were at public facilities (16.0%), while only 3.6% of people said they had never witnessed corruption themselves.

3.5. Understanding of corruption in delivery of public health service

Respondents were again asked in a spontaneous, open-ended manner, their opinions on the causes of corruption in public health facilities (See Table 3.7.). While some respondents said they did not know the causes or did not answer (21.7%), the majority identified "greed" as the motivating factor behind corruption (58.3%).

Table 3.7. Causes of corruption at public health facilities

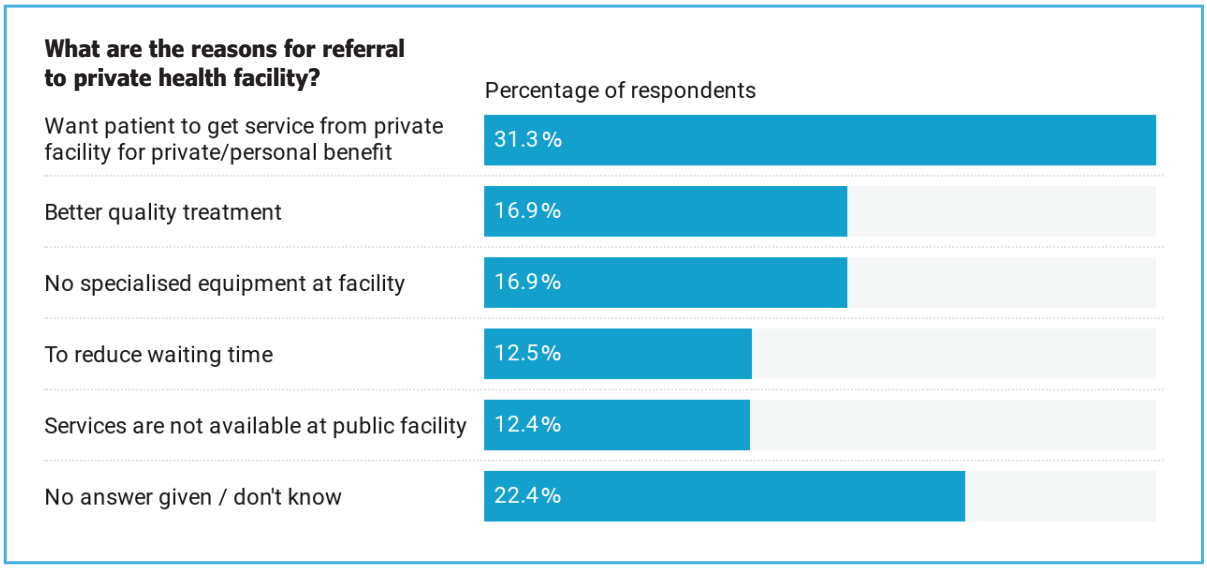


(Q77, N=1,596. Source: National survey data, 2017.)

Table 3.6. (above) shows absenteeism among medical professionals at public healthcare facilities was reported by a relatively small number of respondents as a type of corruption (7.6% of total respondents). Respondent's opinion on the reason for absenteeism were primarily that healthcare providers: Manage own private facilities (47.8%), have multiple job holdings (20.7%), and low pay (12.0%). Many respondents did not know or did not answer when asked about reasons for absenteeism (27.8% of total respondents).

Several spontaneous, open-ended questions were asked of respondents about their opinions on the reasons why patients are transferred to private healthcare facilities. The primary reason respondents gave was that the service provider wanted to gain private/personal benefit (31.3%). Other reasons reflect concerns over the competency of the public healthcare facilities, such as to get better quality treatment (16.9%), to use specialised equipment (16.9%), and to reduce waiting time (12.5%).

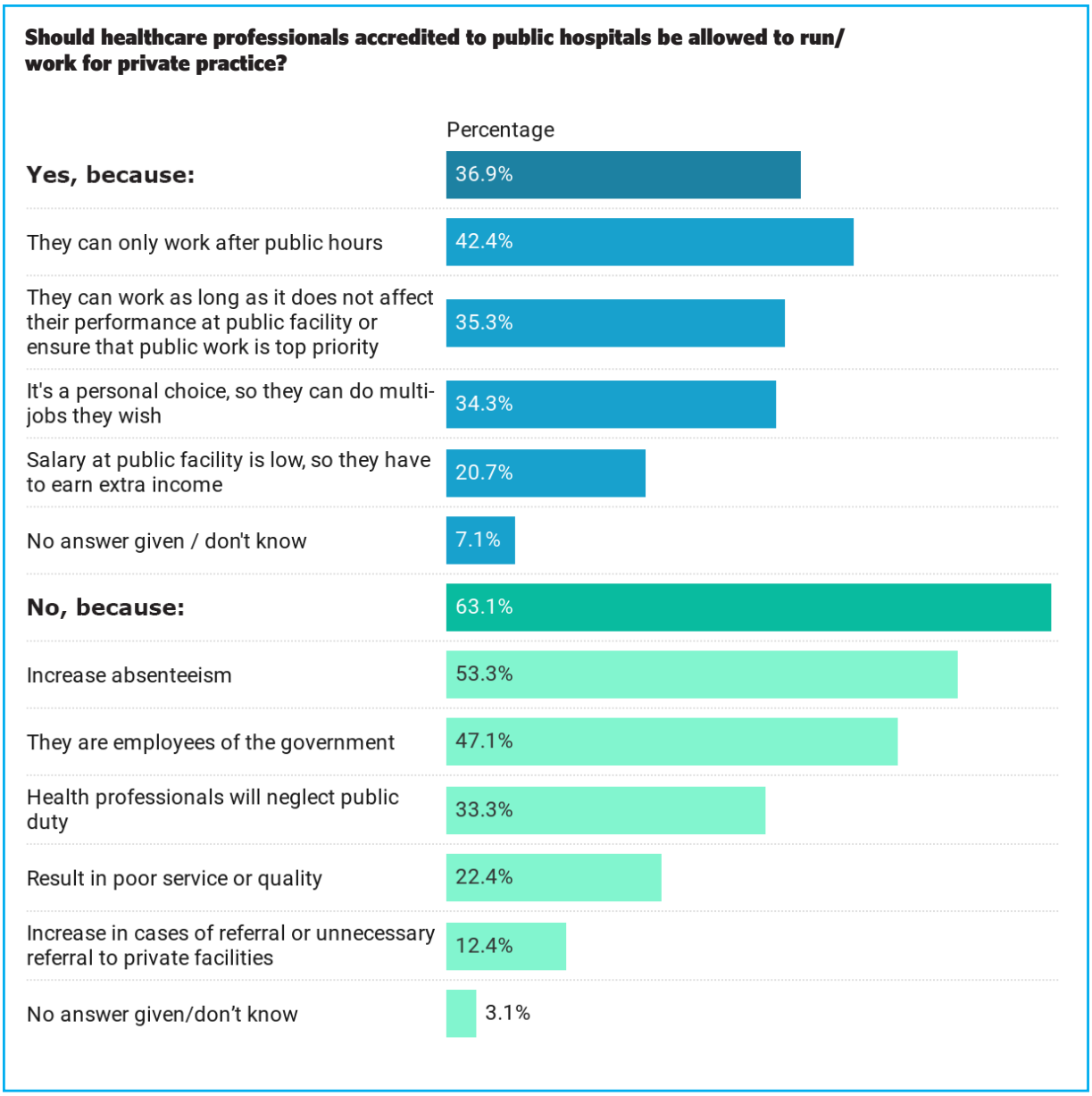
Table 3.8. Reasons for transfers or referrals to private healthcare facilities



(Q79, N=1,596. Source: National survey data, 2017.)

Table 3.9. shows that the majority of respondents do not think healthcare professionals working at public facilities should be allowed to work for private facilities as well, and shows the primary reasons that each subgroup of respondents gave for their answer. The percentage given for reasons are expressed as a percentage of the total of each subgroup (the percent of "Yes" respondents who gave each reason, or the percentage of "No" respondents who gave each reason). Multiple answers were allowed, so total percentage may add up to more than 100 percent.

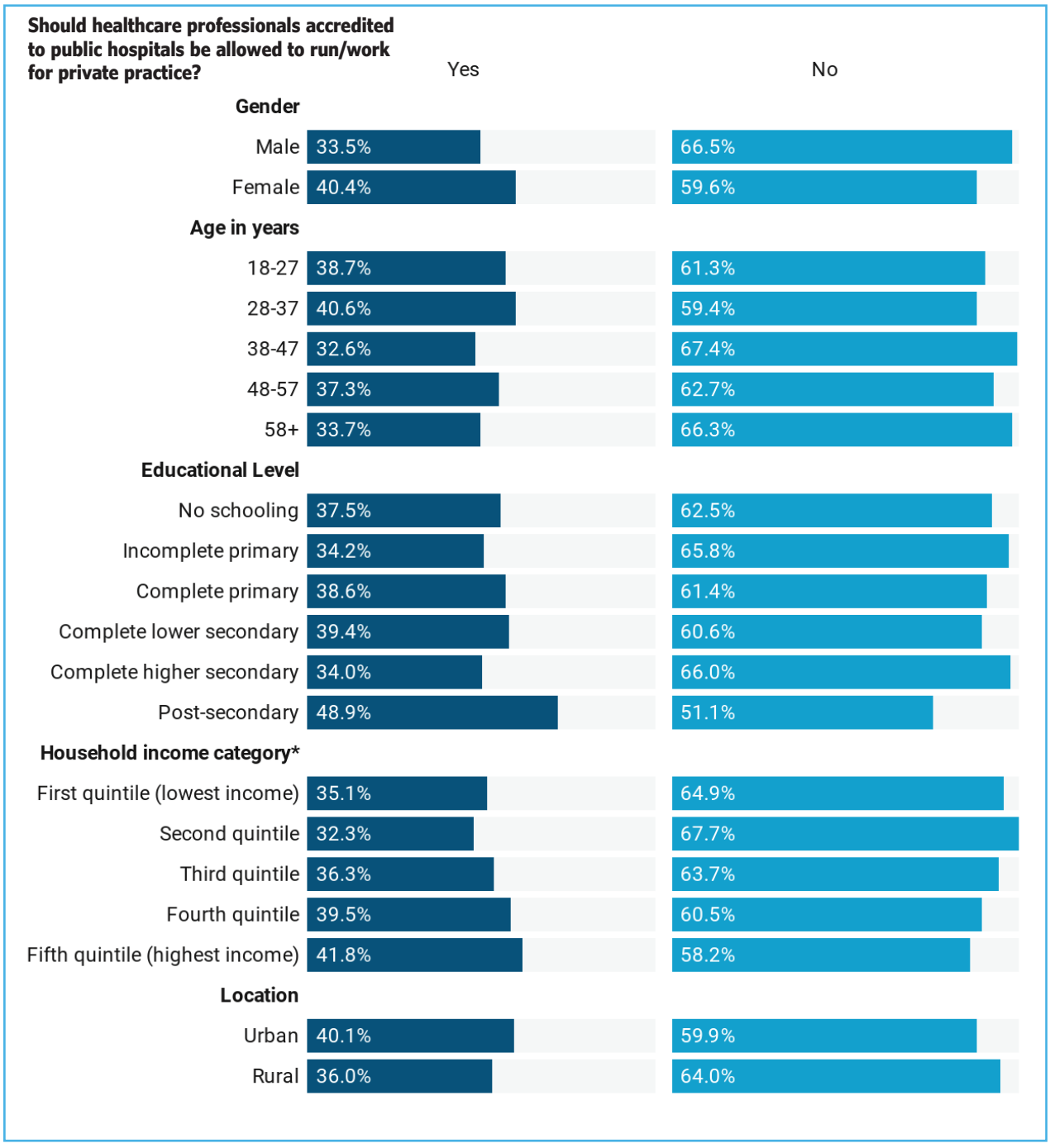
Table 3.9 Opinion on whether public healthcare providers should work at private practices



(Q80, N=1,596, Source: National survey data, 2017.)

This same information (from Table 3.9. above) regarding respondent's opinions on whether public healthcare providers should also work at private practices is displayed below in Table 3.9A. with detailed demographic data. The data indicates that women (40.5%) and those with the highest level of education (48.9%) and income (41.8%) are more likely to agree that healthcare professionals should be allowed to work in private practice.

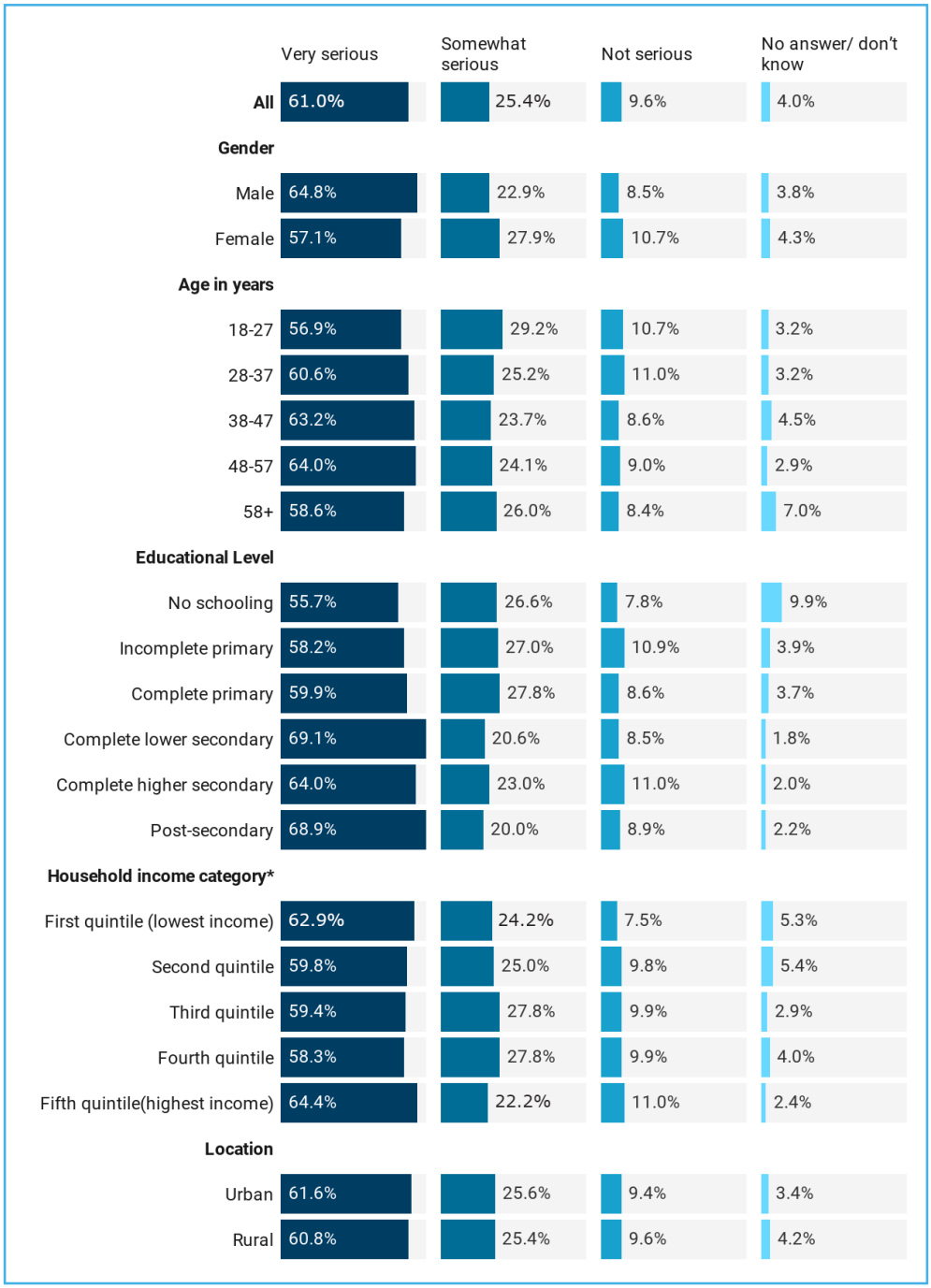
Table 3.9A. Opinion on whether public healthcare providers should work at private practices – (disaggregated demographic data)



(Q80, N=1,596 except *, where N=1,591)

Table 3.10. shows us public perceptions surrounding corruption in the public health sector. Specifically, this question asked how respondents felt about how corruption in the public health sector affected people **like them**. Answers are shown divided based on the respondent's demographic data. From the data it appears that corruption in the public health sector tends to seriously affect all demographics with no major outliers, except respondents with secondary education levels or higher.

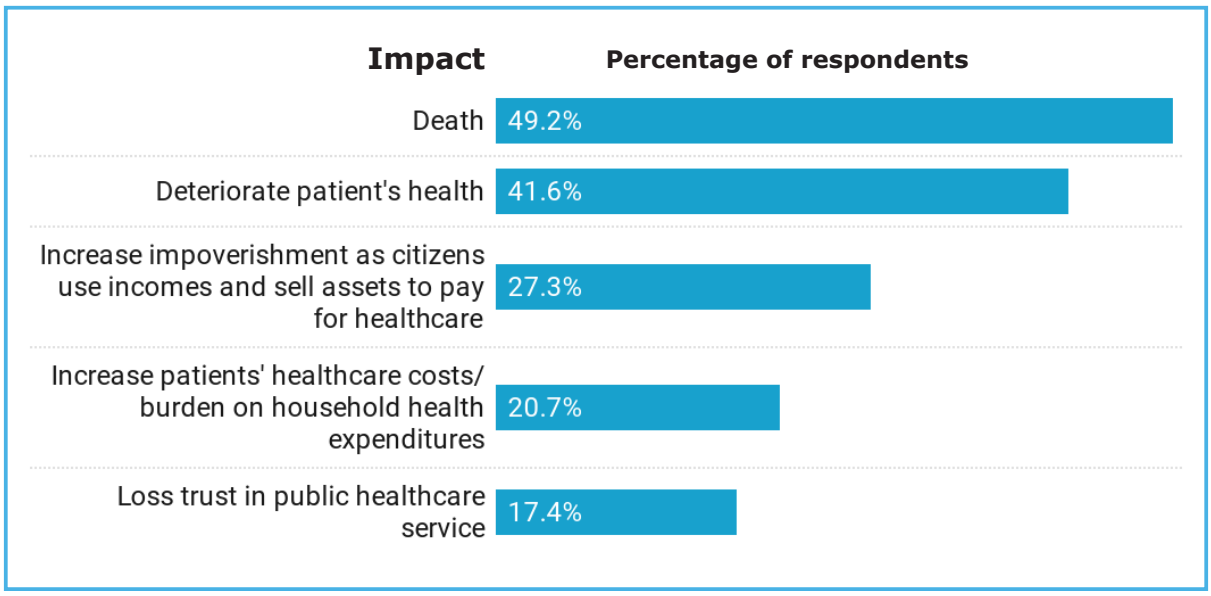
Table 3.10. Impact of corruption in public health sector on people like you



(Q82, N=1,596 except *, where N=1,591)

Respondents who ranked the impact of corruption in the public health sector as "very serious" or "somewhat serious" (86.4% of total respondents) were then asked what the impacts of that corruption were. As Table 3.11. shows, "death" was the most common answer, with nearly half of respondents (49.2%) mentioning it as an impact of corruption. This question was spontaneous, meaning possible answers were not shown to respondents and multiple answers were accepted.

Table 3.11. Types of impacts of corruption

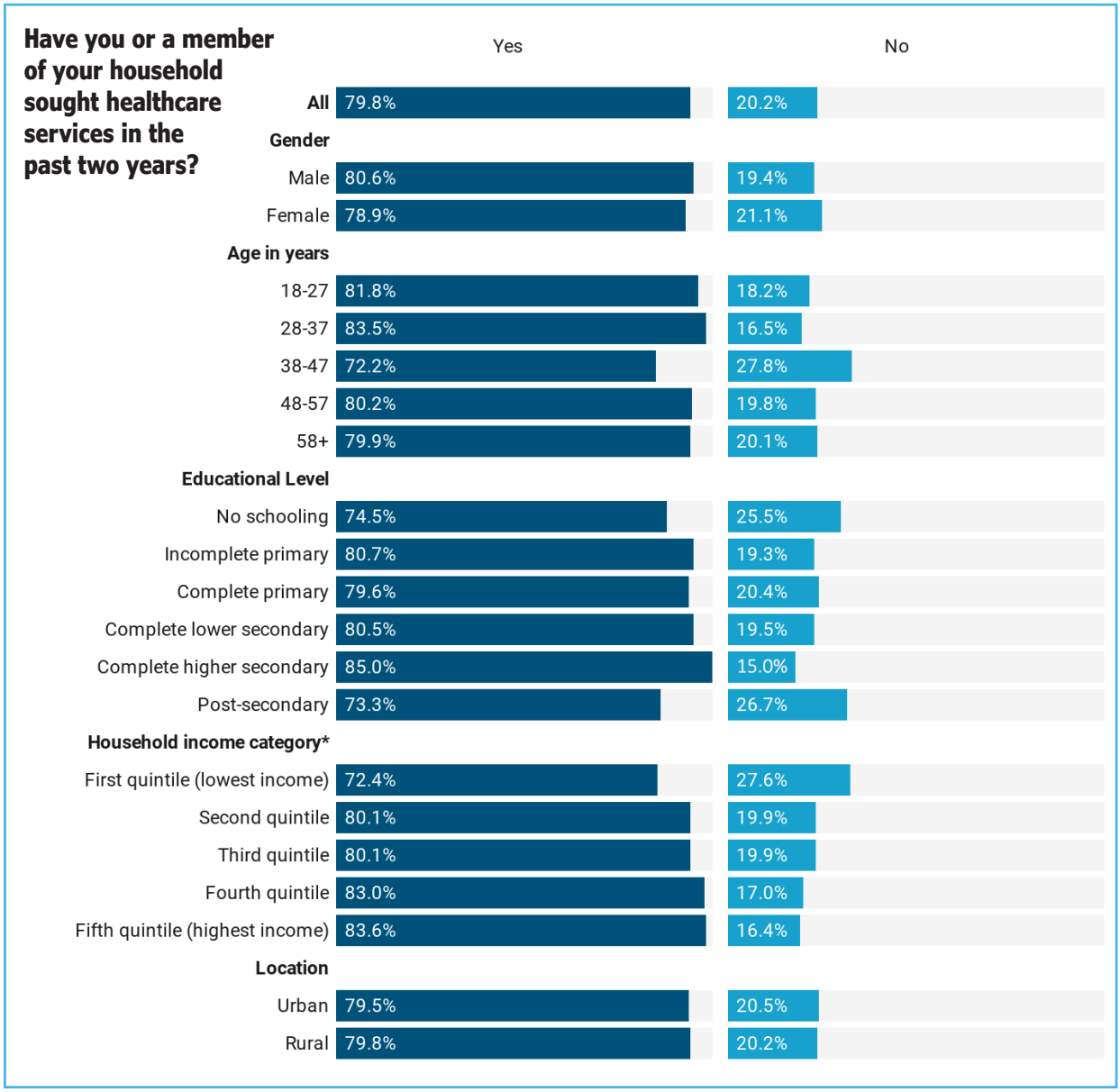


(Q83, N=1,379, Source: National survey data, 2017.)

3.6. Experience of using public healthcare service

This section will show answers to questions asked only of the respondents who said that they or a member of their household had sought healthcare services in the past two years (79.8% of total survey respondents). Based on disaggregated demographic data in Table 3.12. it appears that all demographics are largely represented within this two-year time period.

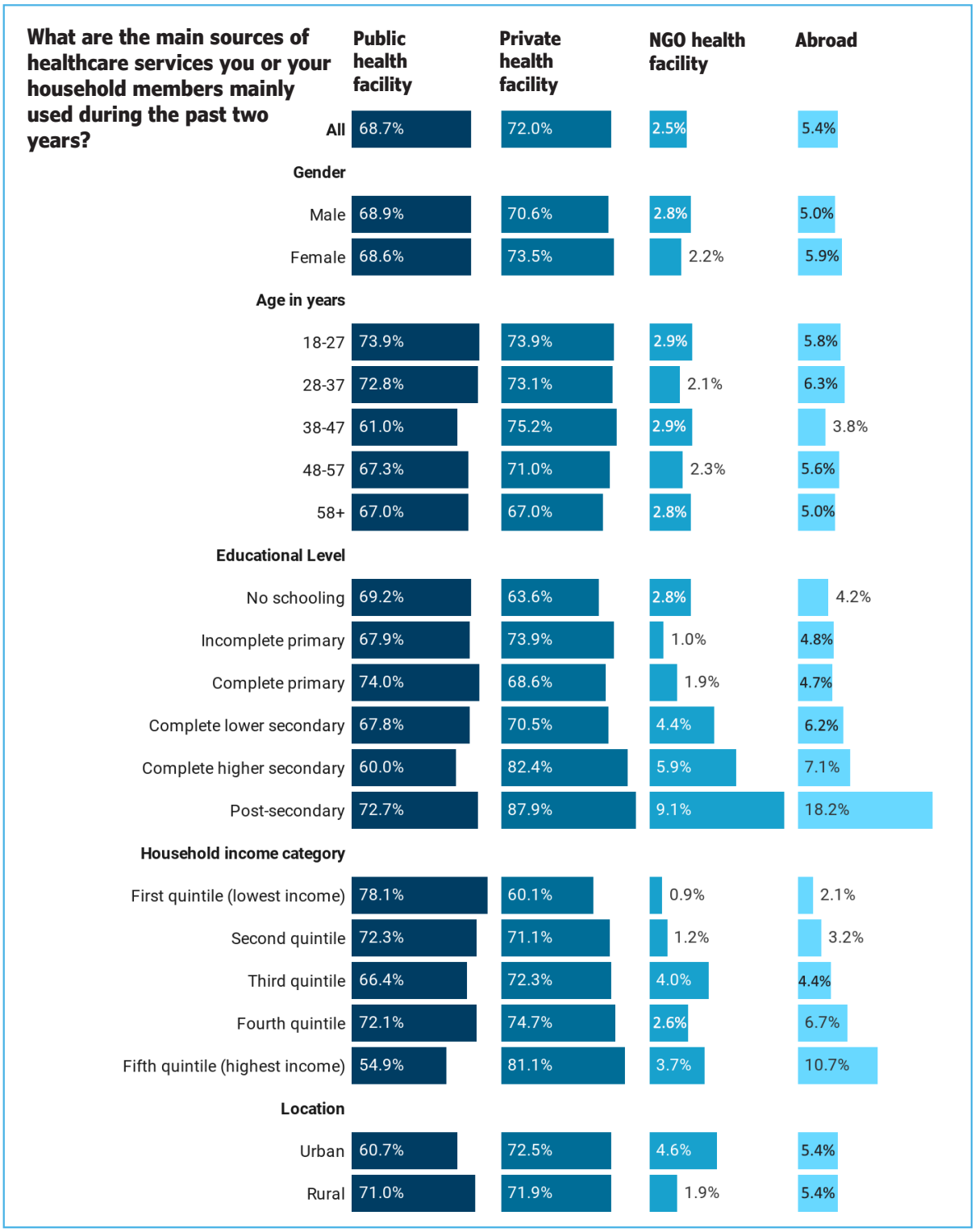
Table 3.12. Use of healthcare services



(Q84, N=1,596 except *, where N=1,591)

Table 3.13. shows what type of healthcare facilities were used by respondents or members of their households. Respondents could select more than one option. Disaggregated demographic data indicates that respondents with the highest education (18.2%) and income levels (10.7%) are more likely to access healthcare services aboard.

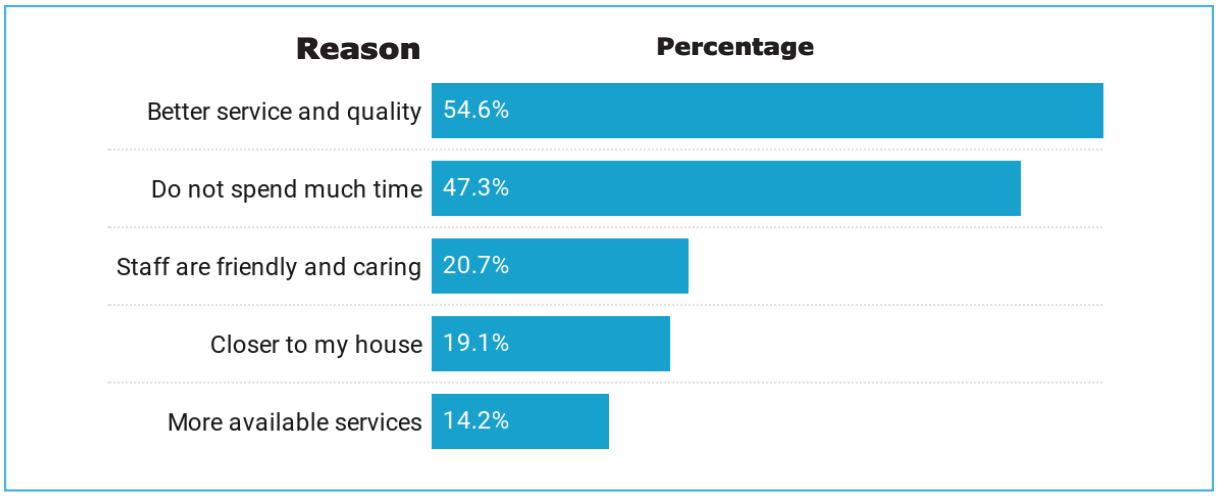
Table 3.13. The main sources of healthcare services used during the past two years



(Q85, N=1,273, Source: National survey data, 2017.)

Private health facilities were more commonly used than public health facilities. Reasons for why people chose to use private facilities were that private facilities were perceived to have better service and quality (54.6% of respondents) and that they took less time (47.3%).

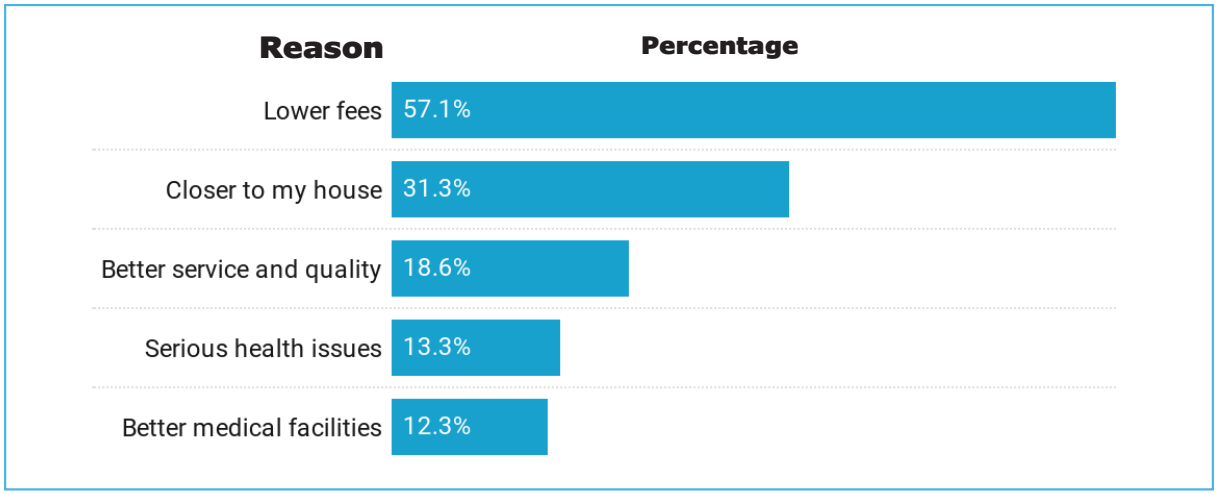
Table 3.14. Reason for using private health facilities



(Q86, N=917, Source: National survey data, 2017.)

Reasons for why people chose to use public facilities are shown in Table 3.14A. The primary reasons were that the facilities had lower fees (57.1%) and that they were closer to respondents' homes (31.3%).

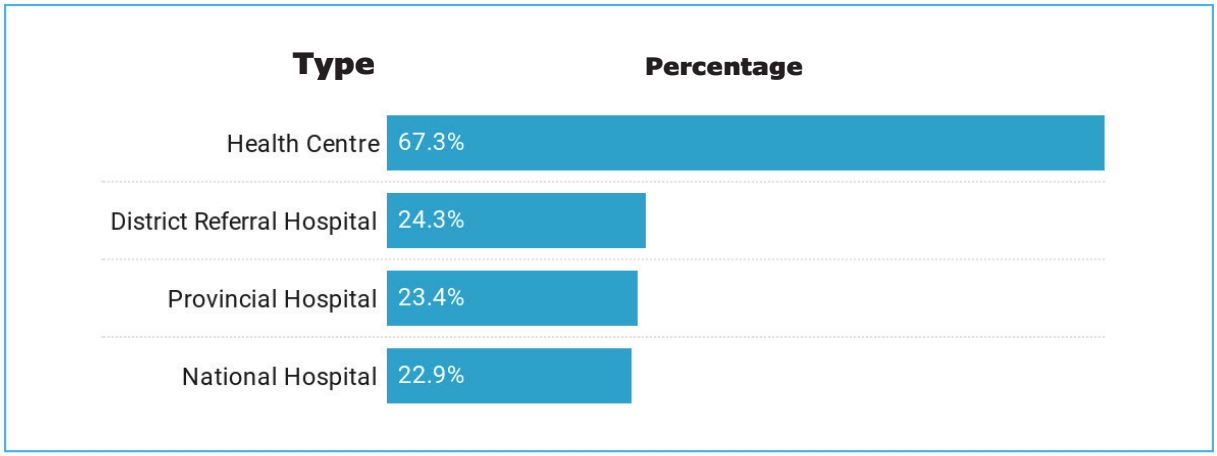
Table 3.14A. Reason for using public health facilities



(Q88, N=875, Source: National survey data, 2017.)

The reasons respondents gave for using public or private facilities show that respondents generally used private facilities because they were perceived to be of a higher quality and more efficient, while public facilities were used because they were cheaper and were closer to respondents' homes.

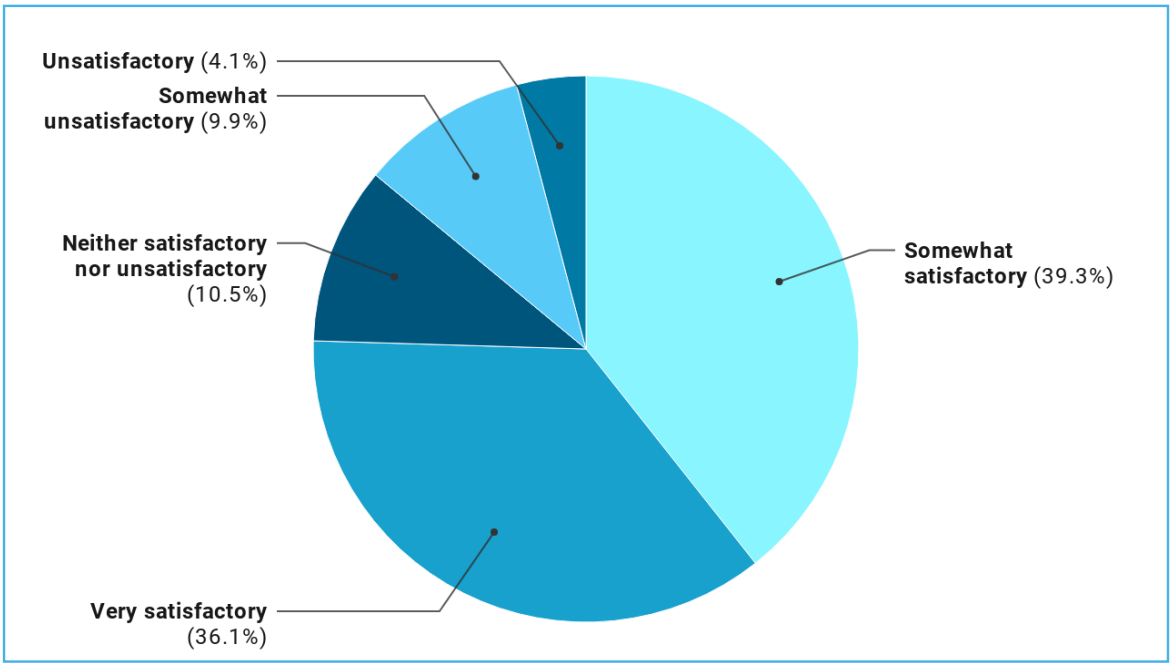
Table 3.15. Type of public health facilities used by respondents



(Q87, N=875, Source: National survey data, 2017.)

Table 3.15. above shows that health centres are the most popular public health facilities used by respondents (67.3%). Table 3.16. below shows the overall levels of satisfaction among patients seeking public healthcare services with over 75% of respondents being satisfied with public healthcare services.

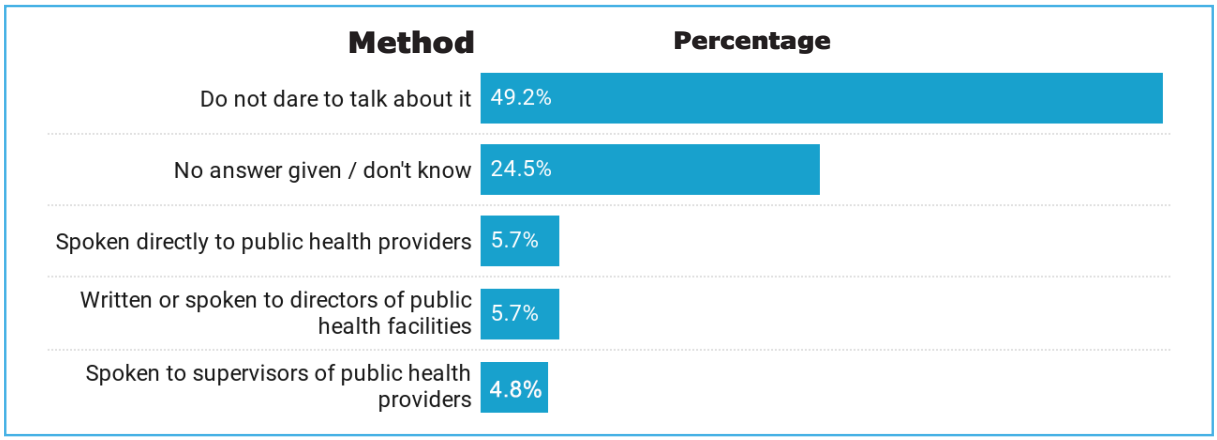
Table 3.16 Level of satisfaction seeking public healthcare services



(Q104, N=875, Source: National survey data, 2017.)

The respondents who did not say their level of satisfaction with public healthcare services was "very satisfactory" (63.9%, N=618) were asked how they raised their complaint or voiced their concern. Table 3.17. below shows that many did not dare to speak about their complaint (49.2%) or did not know/did not answer the question (24.5%), while relatively few spoke directly to their healthcare providers (5.7%).

Table 3.17. How did you raise your concern or complaint

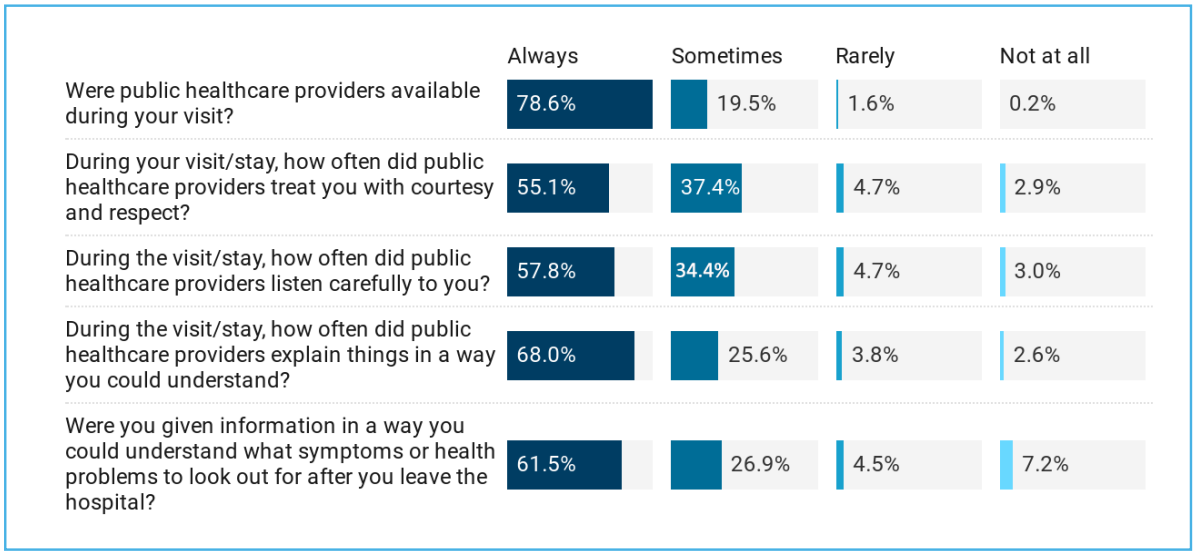


(Q105, N=618, Source: National survey data, 2017.)

Types of services sought at public facilities varied, with the most common type being gynaecology and maternity (35.5%), followed by general consultation (33.4%), non-communicable diseases (25.6%), and paediatric services (21.4%).

Respondents who used public healthcare facilities (N=875) were asked to evaluate several statements regarding their interaction with public healthcare providers. Responses are shown below in Table 3.18. More than 55% of respondents indicated that they "always" received the service asked about in each question, indicating that the majority of respondents felt public healthcare providers generally provided the services in question.

Table 3.18. Interactions with public healthcare providers

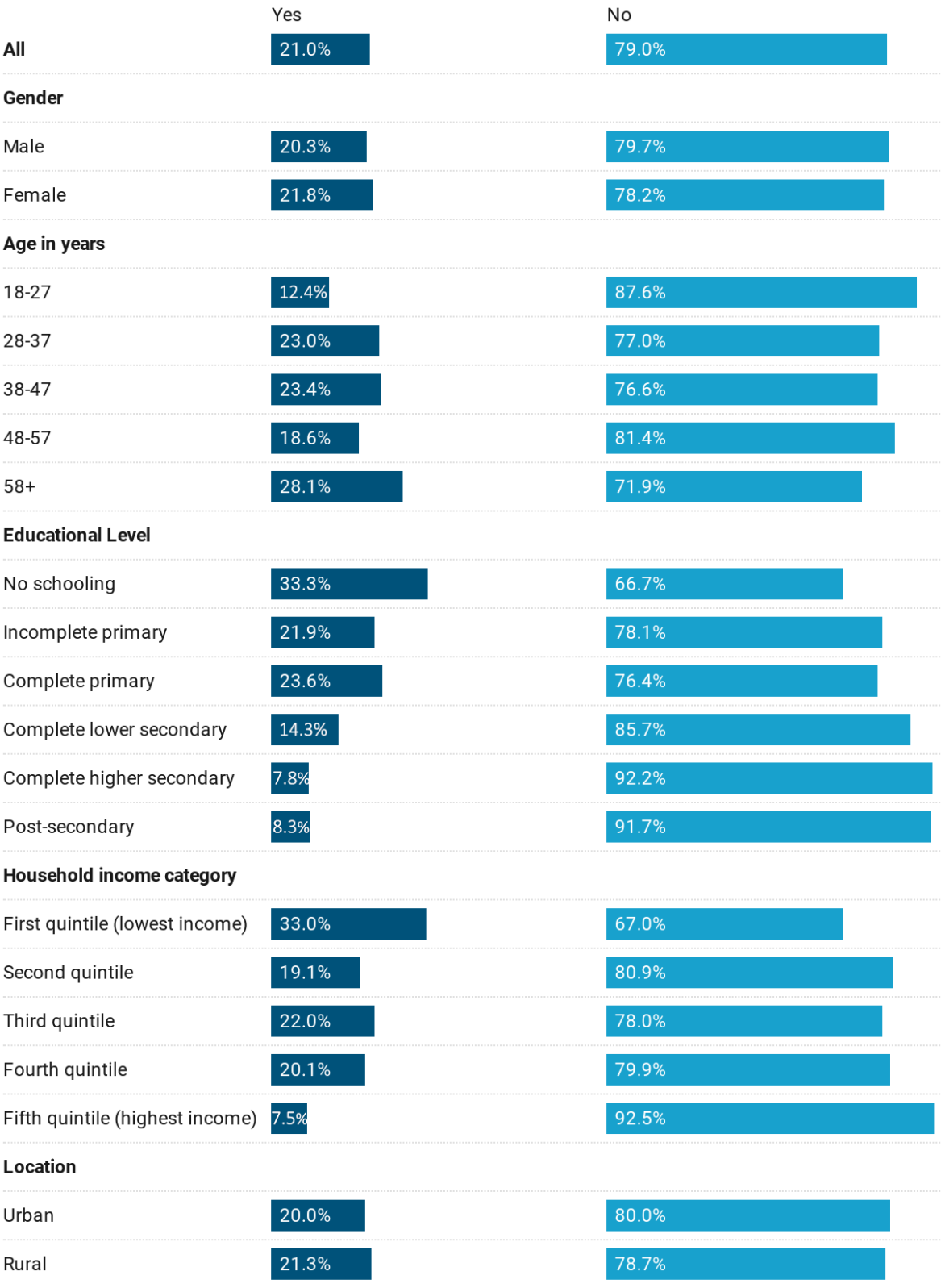


(Q90, N=875, Source: National survey data, 2017.)

Of the respondents who had sought public healthcare services (N=875), only 21% (N=184) of them said they had sought those services under coverage of social health protection schemes (ID Poor Card/Post Identification, Community Based Health Insurance or National Social Security Fund). Detailed breakdown of that data is shown in Table 3.19. Of those 184 individuals who had used health protection schemes, the majority (85.9%, N=158) used ID Poor Card. Only 6.5% (N=12) had used the NSSF. Supporting these findings is the disaggregated demographic data that indicates respondents with lowest level of education (33.3%) and income (33%) are more likely to have sought public healthcare through social health protection schemes.

Table 3.19. Use of social health protection schemes

Have you ever sought public healthcare using a health protection scheme? (ID Poor, Community Based Health Insurance, or National Social Security Fund)



(Q91, N=875, Source: National survey data, 2017.)

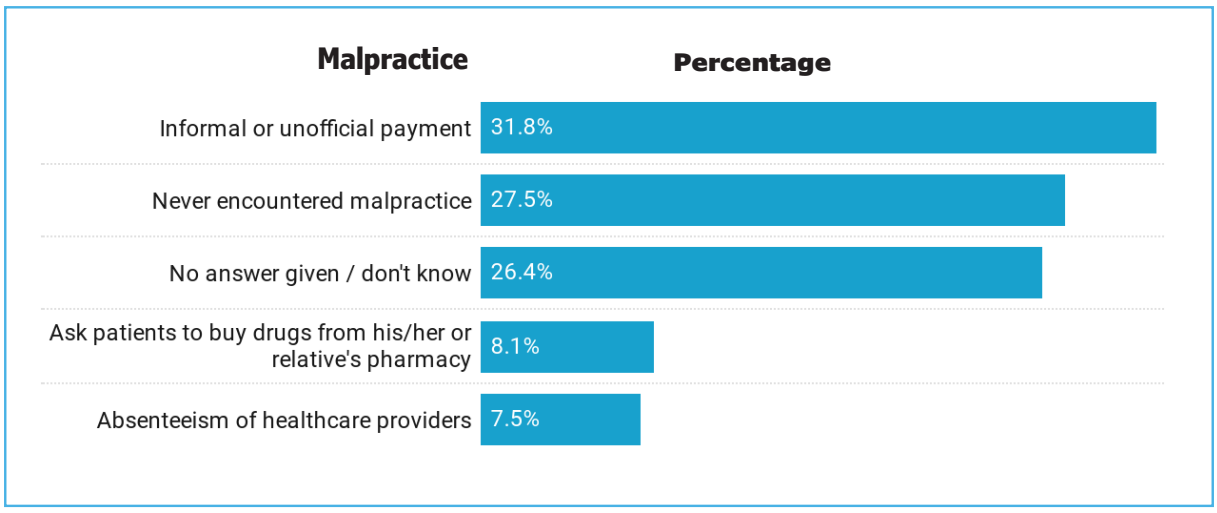
Overall, satisfaction with these social health protection schemes was positive. Of the respondents who said they had used the schemes in the past two years (N=184), 90.7% found them "very useful" or "useful", while only 9.2% found them "little useful" or "not useful".

Additionally, the majority of respondents who had used the schemes reported never encountering problems with the schemes (83.2%). Among all users of the schemes, the most commonly reported problems were that patients under the schemes do not receive proper care/attention (8.7%) and that patients under the scheme are not treated with dignity or respect (6.0%). Some respondents also reported having to make informal payments to receive service (5.4%).

A small percentage of users of public health facilities reported being denied services at public health facilities (2.9%, N=25), most commonly because the service was not available at the facility they visited.

Table 3.20. shows the incidences of malpractice at public health facilities reported by respondents who had visited public healthcare facilities. These were spontaneous questions and multiple answers were accepted. Over half of respondents (53.9%) had never encountered (27.5%) or did not answer the question/did not know (26.4%).

Table 3.20. Malpractices experienced when seeking public healthcare services



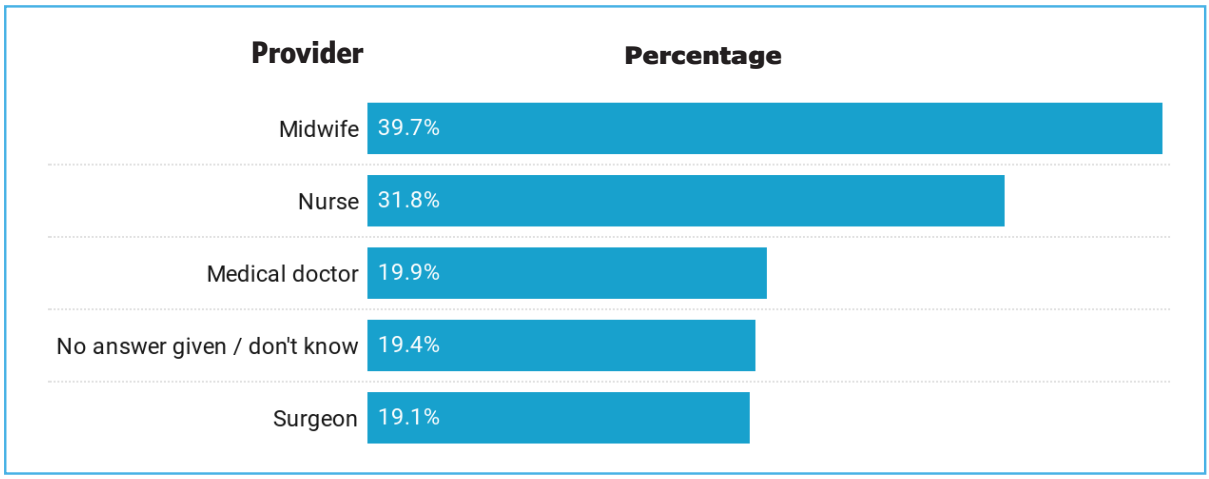
(Q97, N=875, Source: National survey data, 2017.)

The most commonly reported malpractice in public healthcare facilities was informal or unofficial payments (31.8%). Additionally, most respondents reported receiving a receipt during their visit/ stay at a public health facility (63.8%), while a sizable minority reported not receiving a receipt (36.2%).

Of the 46.1% of public health facility users who reported experiencing a malpractice (N=403), a minority reported malpractices occurred "always" (8.2%) or "often" (14.1%), while the majority said it occurred "sometimes" (66.5%) or "rarely" (11.2%).

Of the respondents who had experienced a malpractice, Table 3.21. below shows which healthcare professions were perceived by respondents to be most prone to corruption. Respondents were able to give more than one answer.

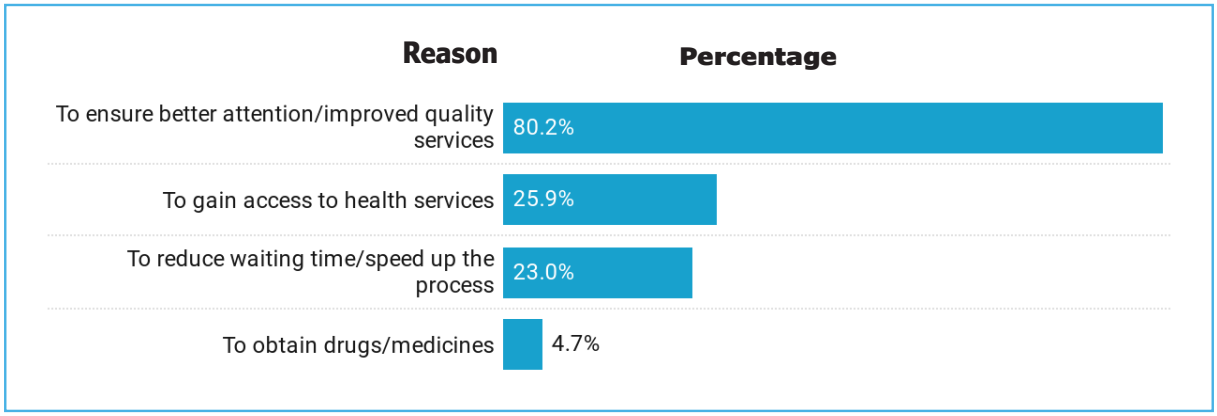
Table 3.21. Public healthcare providers most prone to corruption



(Q102, N=403, Source: National survey data, 2017.)

Of the respondents who reported making informal or unofficial payments at public health facilities (N=278), reasons for the payment are shown in Table 3.22 below. Respondents could give multiple reasons so the total percentage may equal more than 100 percent.

Table 3.22. Reason for making informal payment



(Q99, N=278, Source: National survey data, 2017.)

Of the 278 respondents who offered informal payments, the majority offered the payments even if the healthcare provider did not request the payment (78.4%). Taken together with the data in Table 3.21. and Table 3.22., this data suggests that many respondents believed that in order to ensure better attention/ improved quality services, informal payments to public healthcare providers had to be made, even if those payments were not directly solicited by healthcare providers.

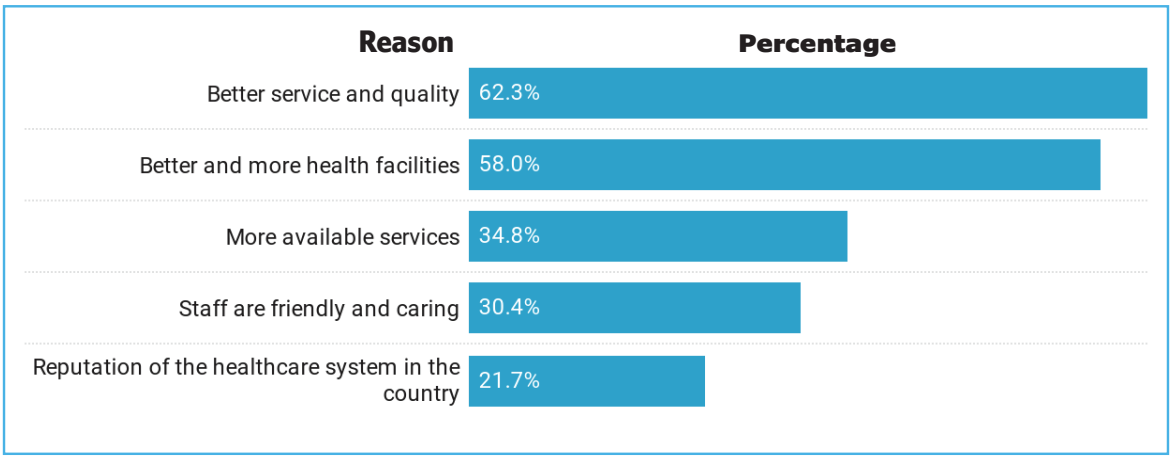
Additionally, of respondents who made informal payments (N=278), most said women tend to make the informal payments to receive better attention/service (68%), while a smaller percentage said men were more likely to make the payments (32%).

For the small number of respondents who had a member of their household seek medical services abroad (5.4%, N=69), nearly all went to either Vietnam (56.5%) or Thailand (50.7%). The total percentage is above 100 because respondents were allowed to select multiple answers indicating they went to both countries. One respondent said they had been to South Korea.

Respondents in higher income quartiles were more likely to go abroad to seek medical services. 10.7% of respondents from the highest income quintile reported going abroad for medical services, while only 2.1% of the lowest incoming quintile reported the same (See Table 3.13. above).

The range of respondents who went abroad for medical services went every year (33.3%), while some went every three months (26.1%) or every month (15.9%). Table 3.23. below shows the reasons respondents said they went abroad for medical services (respondents could give more than one answer so totals may equal more than 100 percent).

Table 3.23. Reason for going abroad for medical services



(Q108, N=69, Source: National survey data, 2017.)

Table 3.23. shows that the majority of respondents reported going abroad to receive better quality medical care. Not shown in the graph but still noteworthy is the fact that 20.3% of respondents reported going abroad for healthcare services because of lower fees.

Over the last 12 months, 1,273 respondents (79% of the total respondents) reported that they had spent money on healthcare. The amounts spent on healthcare varied widely. The majority of respondents (58.5%) reported spending 1,000,000 riel ($250 USD) or less on healthcare for their entire families in the last year. Only 3% of people reported spending more than 10,000,000 riel ($2,500 USD).

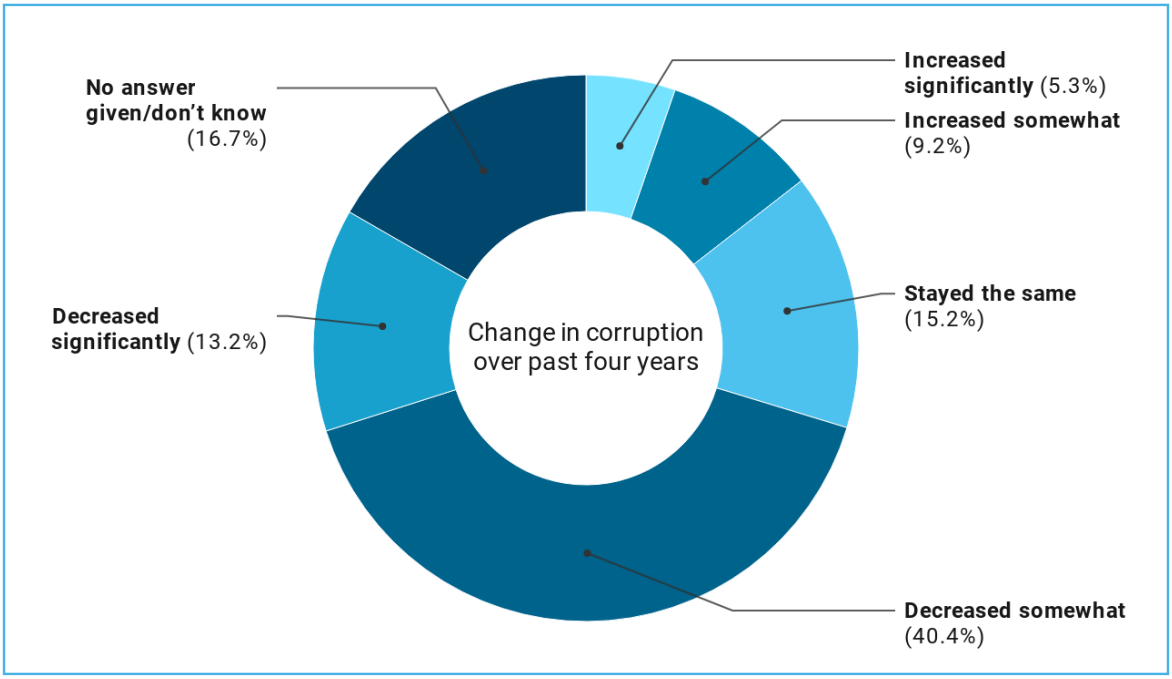
Of the 1,273 people who reported spending money on healthcare in the last year, 79.8% reported making no informal or unofficial payments.

Of the 20.2% of people who did report making informal or unofficial payments (N=257), the majority (N=136) paid less than or equal to 60,000 riel ($15 USD). About 6% of total respondents (N=107) reported paying more than or equal to 100,000 riel ($25 USD) in informal or unofficial payments. Six people (0.2% of total respondents) reported paying more than 1,000,000 riel ($250 USD) in unofficial or informal payments.

3.7. Actions to address corruption in public healthcare sector

Table 3.24. shows that most respondents felt that corruption in the public health sector had decreased somewhat or decreased significantly in the last four years (53.6% of total respondents), while fewer respondents felt it had increased somewhat or increased significantly (14.5%).

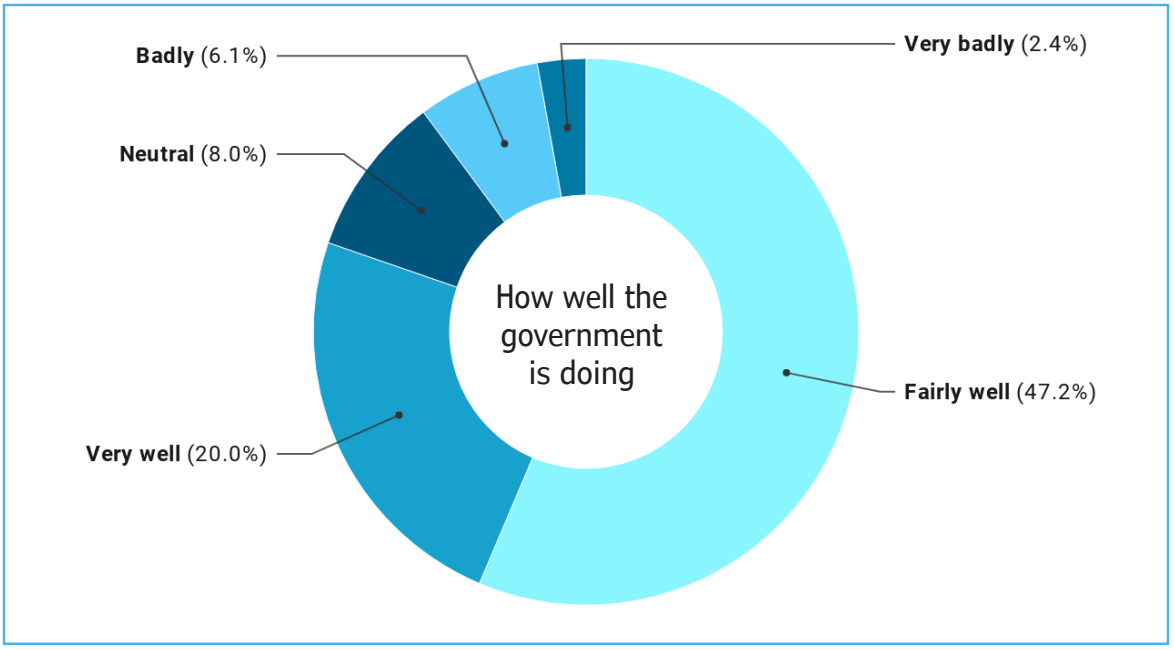
Table 3.24. Change in level of corruption in public health sector over past four years



(Q111, N=1,596, Source: National survey data, 2017.)

Table 3.25. shows the majority of respondents believe the government is doing "very well" or "fairly well" at fighting corruption in the public health sector (67.2%) while a minority feel it is doing "badly" or "very badly" (8.5%).

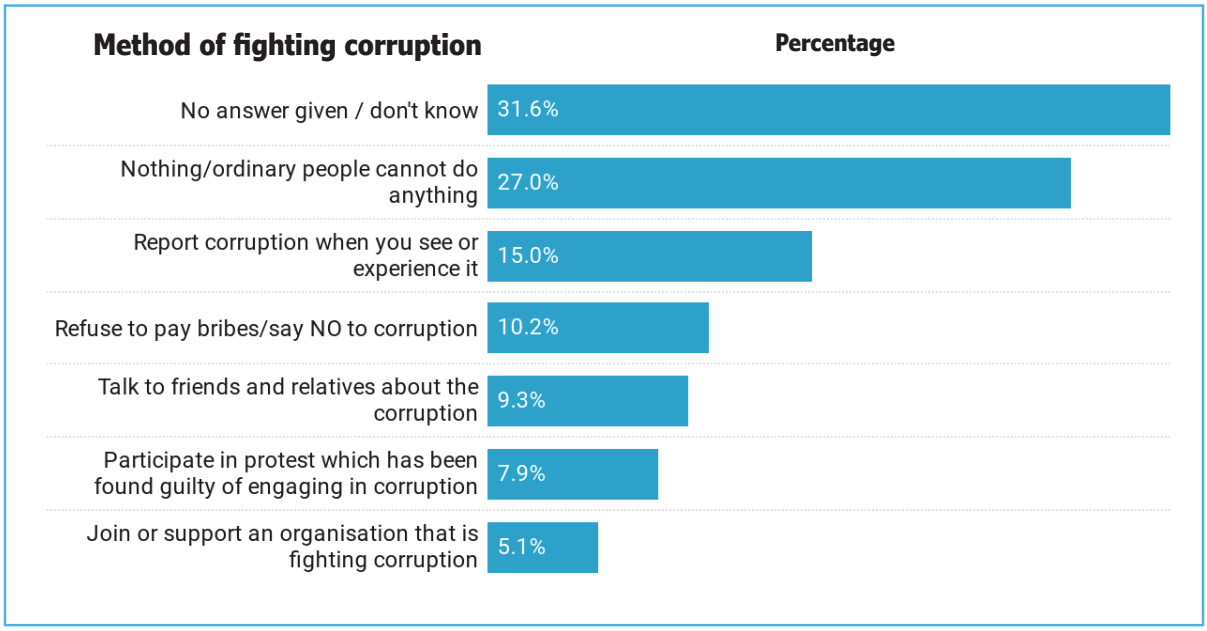
Table 3.25. How is the government doing in fighting corruption in the public health sector



(Q112, N=1,596, Source: National survey data, 2017.)

When respondents were asked what individuals could do to fight corruption, the majority either did not respond/did not know, or said ordinary people could not do anything (58.6% of total respondents).

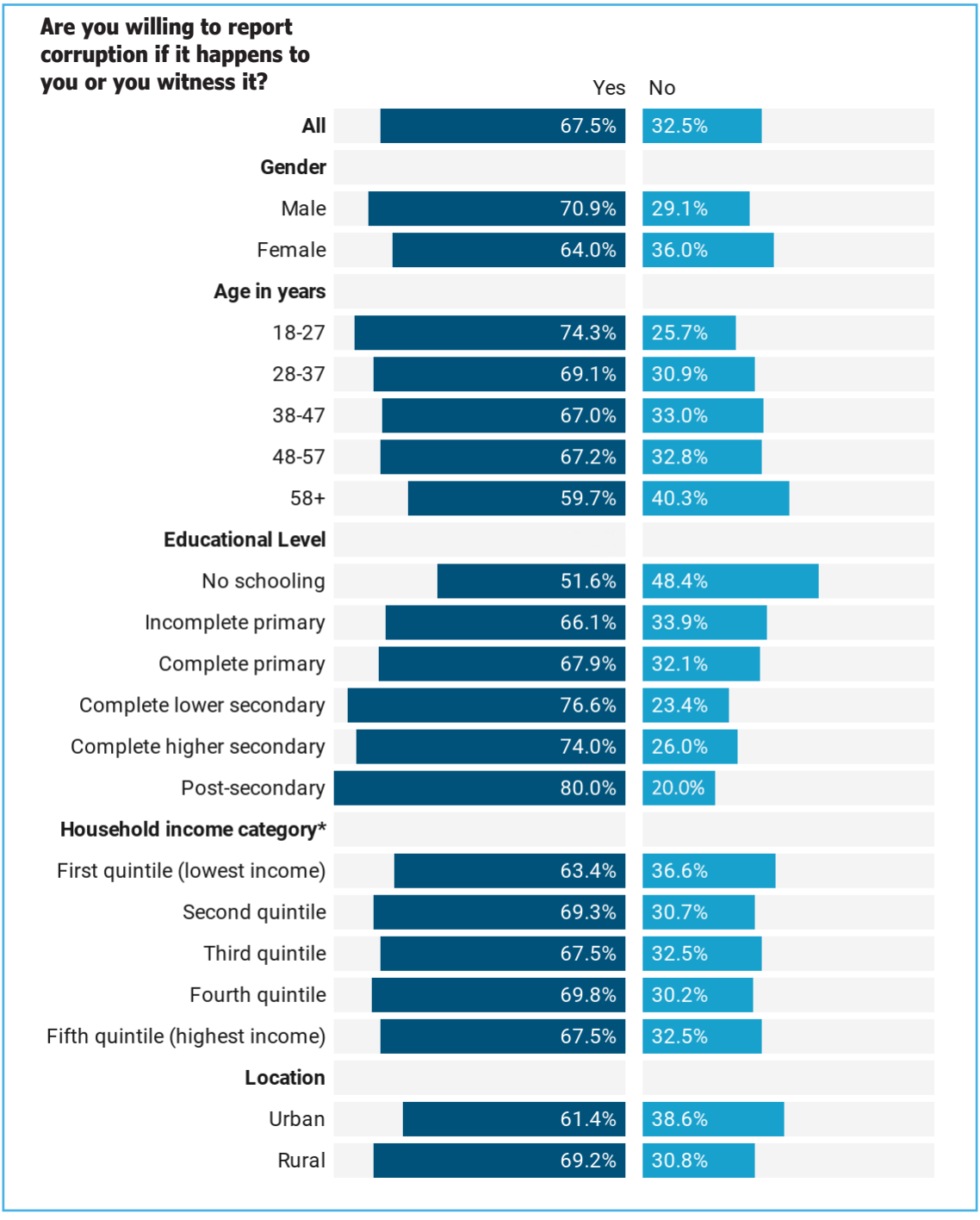
Table 3.26. What is the most effective thing an ordinary person can do to fight corruption in the healthcare sector



(Q113, N=1,596, Source: National survey data, 2017.)

Most respondents said they would be willing to report corruption if they witnessed it occur at public health facilities (67.5%), compared to 32.5% who said they would not report it. Table 3.27. below shows a detailed breakdown of who said they would be willing to report corruption. The data suggests that younger people and those with higher educations were more likely to say they would report corruption.

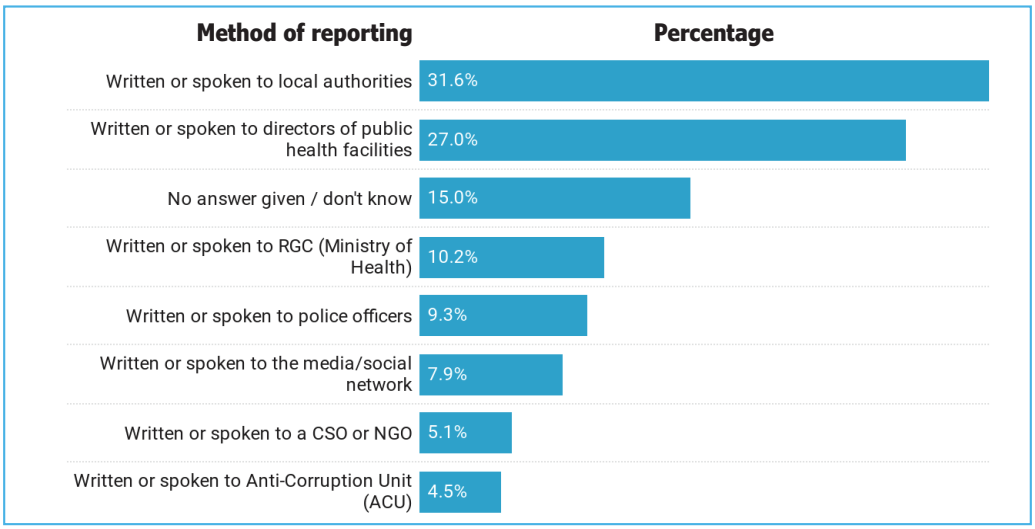
Table 3.27. Willingness to report corruption



(Q114, N=1,596 except for *, where N=1,591, Source: National survey data, 2017.)

Table 3.28. below shows the methods of how those who said they would report corruption (67.5%, N=1,077) would do so. The most common answer was to write or speak to local authorities (31.6%), while only 4.5% said they would contact the Anti-Corruption Unit.

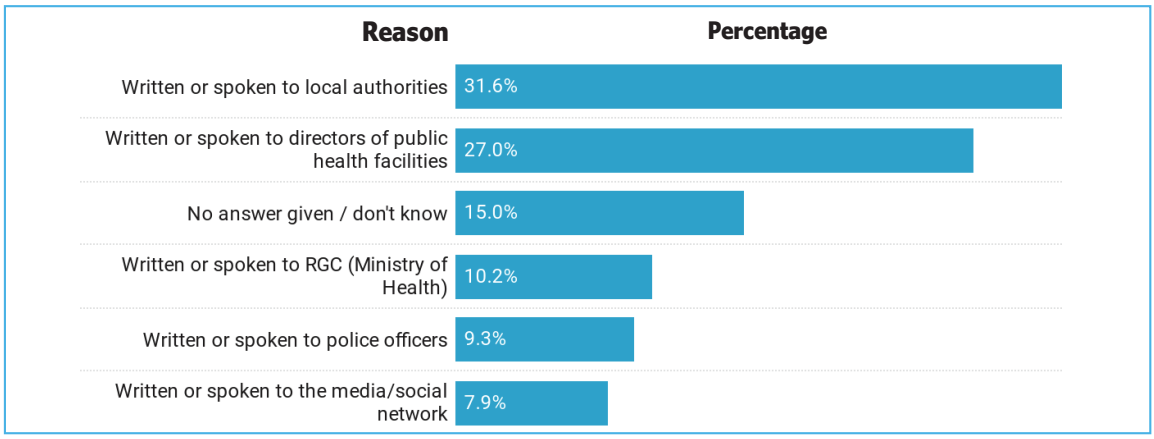
Table 3.28. For those who would report, method of reporting corruption



(Q115, N=1,077, Source: National survey data, 2017.)

Additionally, the respondents who said they would not report corruption (31.6%, N=519) were asked why they would not report. Table 3.29. below shows that the most common reasons for not reporting corruption are fear of recrimination (44.5%), a lack of knowledge about how or where to report corruption (34.9%), and a belief it is other people's business (24.3%).

Table 3.29. For those who would not report, why not



(Q116, N=519, Source: National survey data, 2017.)

Respondents were also asked a spontaneous question about what could be done to improve the public healthcare sector in Cambodia, with multiple responses allowed. Table 3.30. shows the most common responses to the question.

Table 3.30. What should be done to improve the public healthcare sector

Action	Percentage
Eliminate corruption in the health sector	28.70%
Don't know	23.20%
Improve/strengthen quality of medical education and training and capacity of healthcare providers	18.90%
Strengthening judicial system and law enforcement	18.70%
Strengthen supervisory and control mechanisms	14.30%
Promote incentives to boost morals and code of conduct	13.20%
Increase salary for healthcare providers	11.60%
More care of patients in general without discrimination with respect	8.70%
Modernise public healthcare system	8.60%
Do not tolerate corrupt practices in health sector	7.40%
Increase budget allocation for health sector	5.80%
Promote accountability and transparency in management	4.90%
Provide adequate resources (both capital and human) for public health facilities	4.40%
Recruitment and promotion are based on merits	2.40%

(Q117, N=1,596, Source: National survey data, 2017.)

The number one response was to eliminate corruption in the healthcare sector (28.7%). Many respondents did not know how to improve the sector (23.2%), while others said to improve medial education and training (18.9%) and to strengthen the judicial system and law enforcement (18.7%).

Photo credit by PHOURN Yu, Freelance designer

4 CONCLUSIONS AND RECOMMENDATIONS

Overall, the finding of this report is that:

- The understanding of price list and fee exemption at public health facilities is still low. 65% of the respondents did not know that public health facilities were required to publicly display their price list and fee exemption although those with higher education and income level tend to know better. About the same percentage (64.5%) claimed that they have not seen the price list or fee exemption. Even larger proportion of respondents (92.8%) did not know that health centres were required to publicly post the information regarding annual revenues and expenditures of the facilities, and a large majority of them also supported that public health facilities should post the information about its annual budgets.
- Informal payment is seen as the most common form of corruption. 59.8 % of the respondents claimed that it is the most common form of corruption, although 62.2% agreed that informal payment constituted corruption. Informal payments are needed to ensure better attention and improved quality of services. Of those who offered informal payment, 78.4% of them claimed that informal payments are made even if the healthcare provider did not request the payment.
- Corruption most likely to come from a midwife or nurse. 39.7% of those who experienced a malpractice at public health facilities claimed that midwife is most prone to corruption which was then followed by nurse (31.8%).
- While some people said they did not know the causes of corruption in public health facilities, most of them said greed (58.3%) and low salary (15.3%) were the most known motivating factors for corruption. The impact of corruption in the public health sector is seen as “very serious” or “somewhat serious” (86.4% of total respondents). The impact being death accounts for 49.2% or deterioration of a patient’s health (41.6%). The impact affects all demographics.
- The majority of respondents believe healthcare professionals accredited to public hospitals should not be allowed to run/

work for private practice. 63.1% of the total respondents did not think healthcare professionals working at public health facilities should be allowed to work for private facilities. The most common reasons are 'increasing absenteeism' (53.3%), 'they are employees of the government' (47.1%) and 'health professionals will neglect public duties' (33.3%). Although 36.9% of the total respondent supported public health professionals should also be allowed to work for private practice, the most common reasons are that they can only work after public hours (42.4%) and that they can work as long as it does not affect their performance at public health facilities or ensure that public work is top priority (35.3%).

- Most respondents (79.8%) said that they or a member of their household had sought healthcare service in the past two years. Private health facilities are more commonly used than public health facilities. Reasons for why people chose to use private facilities were that private facilities were perceived to offer better service and quality and that they took less time. Private facilities are more commonly used by those who have high education and income and those are in urban areas. The primary reasons why people chose to use public health facilities were that the facilities had lower fees (57.1%) and that they were closer to respondents' homes (31.3%). The most popular public health facility used by respondents is Health Center (67.3%), which is followed by District Referral Hospital (24.3%), Provincial Hospital (23.4%) and National Hospital (22.9%) respectively.
- Overall levels of satisfaction with current quality and access to public healthcare is over 75%. However, those who are very satisfactory accounts about half (36.1%) of the number while those with somewhat satisfactory accounts for another half (39.3%). A majority of the respondents who said that their level of satisfaction was less than 'very satisfactory' did not dare to talk or make a complaint or did not know/did not answer the question.
- Most respondents felt that corruption in the public health sector had decreased somewhat (40.4%) or that the government is doing 'fairly well' at fighting corruption in public health sector (47.2%). However, when asked what individuals could do to fight corruption, the majority either did not respond or did not know (31.6%), or said ordinary people could not do anything (27.0%).
- Most respondents said they would be willing to report corruption if they witnessed it occur at public health facilities (67.5%),

compared to 32.5% who said they would not report it. The most common methods of reporting corruption were to write or speak to local authorities (31.6%) or write or speak directly to directors of public health facilities (27.0%), while only 4.5% said they would contact the Anti-Corruption Unit (ACU).

- Finally, the most popular ways to improve the public healthcare sector in general are to 'eliminate corruption in the healthcare sector' (28.7%), 'do not know how to improve the sector' (23.2%), 'improve medical education and training' (18.9%) and 'strengthen the judicial system and law enforcement' (18.7%).

4.1. Recommendations

Based on the findings, the following major recommendations are made:

- Address low level of knowledge about price list and fee exemption. Although price list and fee exemption of public health services are usually drawn up on a board attaching to the wall of public health facilities, most respondents are still not aware of it. The fact that people with higher education and income level tend to know better may suggest that some people are not be able to read the information. The government should take initiatives to make the boards more feasible and take initiatives to raise people's attention and awareness on the price of health services. Patients should be informed in advance about the price or fees charged for certain treatments or procedures.
- Eliminate informal or unofficial payment at public health facilities. Informal or unofficial payment is considered as the best way to ensure better medical attention and improved quality of service. The fact that informal payments are made even if the healthcare provider did not request the payment may suggest that it is part of entrenched culture of most Cambodians. Public health professionals should provide medical service to the highest of their professions and standards as stipulated in the code of conduct for health practitioners and do not expect something in return. The government should also make the public aware that they should not pay unofficial payment to public healthcare providers and that constitutes corruption.
- Tackle informal and unofficial payment at the points of service delivery is very important, as midwife and nurse are perceived to be the most corrupted public healthcare providers.

The fact that midwife is believed to be the most corrupted one suggests that unofficial payment happening at the times of birth delivery may be very widespread that requires further investigation. Corruption at birth delivery may hit the poor the most as they are the main service users of public facilities.

- Consider reforming/introducing health policy regarding dual practice. Dual practice in the country is deep routed and widespread and ubiquitous. Most people expressed the desire that healthcare professional accredited to public hospitals should not be allowed to work for private practices. The government should take this into serious consideration. The government should either eliminate the practice or at least strictly regulate the practice, because it affects the accessibility, equity and quality of public healthcare.
- Maximise reform efforts to increase public healthcare usage. Although public healthcare usage is slightly lower than private facilities, most of public healthcare users used the services due to its lower fees or closeness to their homes rather than quality and efficiency as offered by private facilities. The government should make more efforts to modernise public health system so that it is able to provide more efficient and effective public healthcare.
- Empower and create enable environment for the public to raise their concerns or make complaints regarding public healthcare provision. Most respondents who were less than 'very satisfactory' did not dare to talk or make a complaint or did not know how to do it. Providing clear instruction and guideline on how to raise their concerns is equally important. Furthermore, when asked what individuals could do to fight corruption, the majority either did not respond or did not know or said ordinary people could not do anything. This suggests that people may be less empowered or feel that they cannot make any differences.
- Build trust between the public with the Anti-Corruption Unit (ACU). Although most people are willing to report corruption if they witness it at public health facilities, the most common methods of reporting were to speak to local authorities or to directors of public health facilities. Only 4.5% said they would contact the Anti-Corruption Unit (ACU). Again, elimination of corruption in health sector is very important. Most people believe that the most effective way to improve the public healthcare sector in general is to eliminate corruption.

Annex I. KAP Survey Tool

Module one: Informed consent

METADATA: Please fill in the following details before commencing the survey interview.

Enumerator	
Start time of interview	
End time of interview	
Capital/province	
Municipality/district/khan	
Commune/sangkat	
Village	

INTRODUCTION: Please read the following statement aloud to participant clearly and slowly before commencing the survey interview.

Hello. My name is [ENUMERATOR NAME]. I am working with an organisation called [DATA COLLECTION COMPANY NAME]. The organisation is conducting a project to find out about the people's understanding of, opinions on, and their experiences in public healthcare services in Cambodia and we would like you to participate. The project aims to build understanding about citizens' perceptions of and attitudes toward public healthcare provision in Cambodia, both at the national and sub-national levels, to help make or reform policies and programmes to increase transparency and accountability.

Now, we are completing a survey with 1,600 people all over the country to know more about their knowledge, attitudes and practices to do with public healthcare provision. The interview will take about 30 minutes. All the information we obtain will remain strictly confidential – we will not ask your name and your personal responses will never be revealed to anyone. Also, you are not obliged to answer any question you do not want to, and you may stop the interview at any time.

The objective of this survey is to learn about people's opinions. The objective is not to evaluate or criticise you, so please do not feel pressured to give any specific response and do not feel shy if you do not know the answer to a question. There is not any right or correct answer to any of the questions; I would like you to answer questions honestly, telling me about what you know, how you feel, and what you do. Feel free to answer questions at your own pace.

Do you consent to take part in this study? Please remember, even if you agree, you can still refuse to answer any question or quit at any time.

INSTRUCTIONS: Please **read aloud** the introduction and informed consent statement above to respondent before asking this question. If no, thank respondent for their time and end interview.	(1) Yes ☐ (2) No ☐ → END SURVEY

Module Two: Delivery of Public Healthcare Service

Part A: Understanding of user fees and fee exemptions at public health facilities

69. Do you know that all public health facilities are required to publicly display its price list and fee exemption?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

70. Have you ever seen it?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

71. Do you know that health centre is required to publicly post the information about its annual budget (revenues and expenditures)?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

72. Have you ever seen it?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

73. Do you think that all public health facilities should publicly post the information about its annual budget (revenues and expenditures)?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

Part B: Understanding of corruption in delivery of public health service

74. I am going to ask you if the following statements constitute corrupt practices in health sector. Could you please tell me how much you agree or disagree with each statement?

Instructions: **Read aloud** answer options. Select only **one** answer option per statement.	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)	Don't know (6)
74.1. Informal and unofficial payment given to a public healthcare provider for a service that is supposed to be provided free of charge.	☐	☐	☐	☐	☐	☐
74.2. A public healthcare provider takes more money than the price determined by the price list for healthcare services at the public health facility.	☐	☐	☐	☐	☐	☐
74.3. A public healthcare provider uses office hour to run/work at a private clinic/hospital.	☐	☐	☐	☐	☐	☐
74.4. A public healthcare provider does not deliver health service to a patient at a public health facility, instead he/she advises the patient to use his/her or relative's private clinic/hospital.	☐	☐	☐	☐	☐	☐

74.5. A public healthcare provider prescribes medicine to only be purchased from his/her family or relative's pharmacy/drug store.	☐	☐	☐	☐	☐	☐
74.6. A person gives an unofficial payment or gift, or does a favour for a public healthcare provider in order to get treatment or more attention or jump the waiting list and queue.	☐	☐	☐	☐	☐	☐
74.7. A public healthcare provider uses public facility and equipment for private/personal benefits.	☐	☐	☐	☐	☐	☐
74.8. A public healthcare provider steals drugs and medical supplies.	☐	☐	☐	☐	☐	☐
74.9. A public healthcare provider prescribes or performs unnecessary procedures	☐	☐	☐	☐	☐	☐
74.10.A public healthcare provider keeps patients unnecessarily stay at the public health facility to generate money.	☐	☐	☐	☐	☐	☐

Part C: Medical supply & performance

75. I am going to ask you some questions regarding the availability of medical supplies and performance of healthcare providers. Could you please tell me how much you agree with each statement based on your experience or observation?

Instructions: **Read aloud** answer options. Select only **one** answer option per statement.	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)	Don't know (6)
75.1. Public healthcare providers are friendly and talk to patients politely.	☐	☐	☐	☐	☐	☐
75.2. Public healthcare providers are compassionate and caring to patients.	☐	☐	☐	☐	☐	☐
75.3. Public healthcare providers receive decent salary.						
75.4. Public healthcare providers have access to quality materials and facilities.	☐	☐	☐	☐	☐	☐
75.5. Public healthcare providers have access to adequate and quality medicine.	☐	☐	☐	☐	☐	☐
75.6. The standard of hygiene at public health facilities is satisfactory.	☐	☐	☐	☐	☐	☐

75.7. Public healthcare providers strictly follow the 'code of ethics' for medical professionals.	☐	☐	☐	☐	☐	☐

Part D: Characteristic and impact of corruption in delivery of public health service

76. In your opinion, what are the common types of corruption that you may encounter at public health facilities in Cambodia?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response allowed**.	(1) Informal payment paid by or required from patients ☐ (2) Unofficial payments for services that are supposed to be free ☐ (3) Ask patients to buy drugs from his/her or relatives' pharmacy (4) Absenteeism of medical staff ☐ (5) Unnecessary transfer or referral of patients to private facilities ☐ (6) Use of public facilities and equipment for private practice ☐ (7) Billing patients for services that were unavailable ☐ (8) Unnecessarily prescribing or performing any procedures ☐ (9) Keep patients unnecessary stay at the hospital for generating revenue ☐ (10) Theft of drugs and medical supplies ☐ (11) Theft of user fee revenue, other diversion (12) Other(s) ☐ _____ (SPECIFY) (13) No answer given/Don't know

77. In your opinion, what are the causes of corruption in public health facilities (including at health centers)?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. Multiple answers allowed.	(1) Low salary ☐ (2) Greed ☐ (3) Lack of information or insufficient knowledge of patients ☐ (4) Understaffing/inadequate facilities and resources ☐ (5) Lack of patient's choices ☐ (6) Long queues, waiting times and delays ☐ (7) Impatience among patients ☐

	(8) Bureaucracy ☐ (9) Political Influence (10) Lack of incentives to boost morale ☐ (11) Inefficient supervisory and control mechanisms ☐ (12) Tolerance of such behaviour by the public sector ☐ (13) Lack of accountability and transparency in management ☐ (14) Weak enforcement of anti-corruption law ☐ (15) Lack of effective law enforcement ☐ (16) Favoritism/nepotism ☐ (17) Other(s) ☐ (18) _____ (19) (SPECIFY) (20) No answer given/Don't know ☐

78. In your opinions, what are the reasons for absenteeism of public healthcare providers from duties?

Instructions: Spontaneous response. Do not read aloud answer options. Multiple response allowed.	(1) Low pay ☐ (2) Multiple job holdings ☐ (3) Manage or work at private facilities ☐ (4) Work shifts that are too long ☐ (5) Poor attitude towards work ☐ (6) Tolerance of such behaviour by the public sector ☐ (7) Inefficient supervisory and control mechanisms ☐ (8) Other(s) ☐ _____ (SPECIFY) (9) No answer given/Don't know ☐

79. In your opinions, what are the reasons for transferring or referral to private health facility?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Patient's request ☐ (2) Services are not available at public facility ☐ (3) To reduce waiting time ☐ (4) Better quality treatment ☐ (5) Want patient to get service from private facility for private/personal benefit ☐ (6) No specialized equipment at public facility ☐ (7) Other(s) ☐ _____ (SPECIFY) (8) No answer given/Don't know ☐

80. Should healthcare professionals accredited to public hospitals be allowed to run/work for private practice?

Instructions: Select only **one.**	(1) Yes ☐ (2) No ☐

81. If Yes or No, what are the reasons?

A. YES	**B. NO**
Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	**Instructions:** Spontaneous **response.** Do not read aloud **answer options.** Multiple response **allowed.**
(1) Salary at public facility is low, so they have to earn extra income ☐ (2) They can only work after public hours ☐ (3) They can work as long as it does not affect their performance at public facility or ensure that public work is top priority ☐ (4) It's a personal choice, so they can do multi-jobs they wish ☐ (5) Other(s) ☐ _____ (SPECIFY) (6) No answer given/Don't know ☐	(1) Increase absenteeism ☐ (2) Health professionals will neglect public duty ☐ (3) Result in poor service and quality ☐ (4) Divert government medical supplies to private facilities ☐ (5) Increase in cases of unnecessary referral to private facilities ☐ (6) They are employees of the government ☐ (7) Other(s) ☐ _____ (SPECIFY) (8) No answer given/Don't know ☐

82. In your opinion, how would you rate the impacts of corruption in public health sector have on people like you?

Instructions: **Read aloud** answer options. Select only **one**.	(1) Very serious ☐ (2) Somewhat serious ☐ (3) Not serious ☐ → SKIP TO Q 84 (4) No answer given/Don't know ☐ → SKIP TO Q 84

83. If it is 'very serious' or 'somewhat serious', what are the impacts?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. Multiple response allowed	(1) Death ☐ (2) Deteriorate patient's health ☐ (3) Poor or decreased quality of public healthcare services ☐ (4) Increase patients' healthcare costs/ burden on household health expenditures ☐ (5) Increase impoverishment as citizens use incomes and sell assets to pay for health care ☐ (6) Delaying or not seeking healthcare because they can't afford it ☐ (7) Reduced utilization of services by patients who cannot pay ☐

	(8) Inequity and limited access to healthcare provision ☐ (9) Have negative effect on social status of public healthcare workers ☐ (10) Loss trust in public healthcare ☐ (11) Other(s) ☐ _____ (SPECIFY) (12) No answer given/Don't know ☐

Part E. Experience of using public healthcare service

84. Have you or any of your household members sought healthcare services in the past two years?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐ → SKIP TO NEXT SECTION

85. If yes, what are the main sources of healthcare services you or your household members mainly used during the past two years?

Instructions: **Read aloud** answer options. **Multiple response** allowed.	(1) Public health facility ☐ → IF ONLY FIRST OPTION, SKIP TO Q 87 (2) Private health facility ☐ (3) NGO's health facility ☐ → IF ONLY THIRD OPTION, SKIP TO Q 109 (4) Abroad ☐ → IF ONLY FOURTH OPTION, SKIP TO Q 106

86. If private health facility is the main source of healthcare service, why do you use the facility?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Closer to my house ☐ (2) Less time spent (3) Better service and quality ☐ (4) More available services (5) More and modern equipments and facilities ☐ (6) Staff are friendly and caring ☐ (7) Reputation of that particular private facility ☐ (8) Know medical staff there ☐ (9) Minor health issues ☐ (10) Lower fees ☐ (11) Other(s) ☐ _____ (SPECIFY)

CHECK QUESTION 85 → IF ONLY THE SECOND OPTION, SKIP TO QUESTION 109

87. If yes, which public health facility do you or your household members use?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Health Centre (HC) ☐ (2) District Referral Hospital (DRH) ☐ (3) Provincial Hospital (PH) ☐ (4) National Hospital (NH) ☐ (5) Health Post ☐ (6) Other(s) ☐ _____ (SPECIFY)

88. If yes, what are the reasons of using public health facility?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Closer to my house ☐ (2) Better service and quality ☐ (3) More available services ☐ (4) More and modern equipment and facilities ☐ (5) Staff are friendly and caring ☐ (6) Reputation of that particular facility ☐ (7) Know medical staff there ☐ (8) Serious health issues ☐ (9) Incurable diseases ☐ (10) Lower fees ☐ (11) Other(s) ☐ _____ (SPECIFY)

89. If yes, what types of public healthcare services have you sought?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) General consultation ☐ (2) Pediatric service ☐ (3) Gynecology and maternity ☐ (4) Surgery ☐ (5) Communicable diseases (Tuberculosis, HIV/AIDS, Malaria…) ☐ (6) Non-communicable diseases ☐ (7) Mental health ☐ (8) Eyes health ☐ (9) Dental health ☐ (10) Vaccination ☐ (11) Other(s) ☐ _____ (SPECIFY)

90. I would like to ask you about your experience in interaction with public healthcare providers. Could you please answer the following questions?

Instructions: **Read aloud** answer options. Select only **one** answer option per statement.	**Always (1)**	**Sometimes (2)**	**Rarely (3)**	**Not at all (4)**
90.1. Were public healthcare providers available during your visit?	☐	☐	☐	☐
90.2. During your visit/stay, how often did public healthcare providers treat you with courtesy and respect?	☐	☐	☐	☐
90.3. During the visit/stay, how often did public healthcare providers listen carefully to you?	☐	☐	☐	☐
90.4. During the visit/stay, how often did public healthcare providers explain things in a way you could understand?	☐	☐	☐	☐
90.5. Were you given information in a way you could understand what symptoms or health problems to look out for after you leave the hospital?	☐	☐	☐	☐

91. Have you ever sought public health services under coverage of the following social health protection schemes (ID Poor Card/Post Identification, Community Based Health Insurance or National Social Security Fund)?

Instructions: Select only **one**.	(1) Yes (☐ A. Health Equity Fund (ID poor Card or Post-identification), ☐ B. National Social Security Fund, ☐ C. Community Based Health Insurance] (2) No ☐ SKIP TO Q 94

92. If yes, how useful it is?

Instructions: **Read aloud** answer options. Select only **one**.	(1) Very useful ☐ (2) Useful ☐ (3) Little useful ☐ (4) Not useful ☐

93. If yes, have you ever encountered any of the following problems?

(1) Instructions: Spontaneous response. Do not read aloud answer options. Multiple response allowed.	(1) Not all services for card holders are free ☐ (2) Not all services needed are available ☐ (3) Need to pay extra informal payment ☐ (4) Public health providers were absent at the facility ☐ (5) Public health providers don't want to accept patients under the schemes ☐

	(6) Public health providers don't accept patients under the scheme but accept other patients ☐ (7) Patients under the schemes are not treated with courtesy and respect ☐ (8) Patients under the schemes do not receive proper care/attention ☐ (9) Other(s) ☐ _____ (SPECIFY) (10) No, I have never encountered such problems.

94. Have you or any of your household members ever been denied healthcare services at a public health facility?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐ → SKIP TO Q97

95. If yes, what are the reasons?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) No/not enough money to pay for the healthcare service fees ☐ (2) No/not enough money to pay extra informal fees for the services ☐ (3) Refuse to pay extra informal fees for the services ☐ (4) No/not enough money to pay for transfer fee ☐ (5) Patients are covered under social health protection schemes (HEF, CBHI, NSSF) ☐ (6) Public health providers were not absent at the facility ☐ (7) Services were not available at the facility ☐ (8) Other(s) ☐ _____ (SPECIFY)

96. If yes, when does it happen?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Day-time during work-day ☐ (2) Night-time during work-day ☐ (3) Public holidays ☐ (4) Weekends ☐ (5) Other(s) ☐ _____ (SPECIFY)

97. Have you or any of your household members experienced any of the following malpractices when you seek public healthcare services?

Instructions: **Spontaneous** response. **Read aloud** answer options. **Multiple response** allowed.	(1) Informal or unofficial payment (including gifts or any favours) ☐ (2) Unofficial payments for services that are supposed to be free ☐ (3) Unnecessary transfer to private health facilities ☐ (4) Absenteeism of healthcare providers ☐ (5) Ask patients to buy drugs from his/her or relatives 'pharmacy ☐ (6) Prescribing or performing unnecessary procedures ☐ (7) Keep patients unnecessary stay at the hospital for generating revenue ☐ (8) Harassment of patients ☐ (9) Other(s) ☐ _____ (SPECIFY) (10) No answer given/Don't know ☐ → SKIP TO Q103

IF No answer given/Don't know, → SKIP TO Q103

98. If yes, how often does it happen?

Instructions: **Read aloud** answer options. Select only **one**.	**(1) Always ☐** **(2) Often ☐** **(3) Sometimes ☐** **(4) Rarely ☐**

CHECK Q97 – IF FIRST OPTION (INFORMAL OR UNOFFICIAL PAYMENT) WAS NOT CHOSEN, → SKIP TO Q102

99. If you have made informal payment, given a gift or done a favour in order to receive services/favours you needed, what are the reasons of doing it?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	**(1) To gain access to health services ☐** **(2) To reduce waiting time/speed up the process ☐** **(3) To obtain drugs/medicines ☐** **(4) To ensure better attention/quality services ☐** **(5) Other(s) ☐** _____ (SPECIFY)

100. If public healthcare providers do not demand informal payment, gift, or favour, do you still offer it?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

101. Based on your experience or your household experience, between male and female, who tends to make informal payment, give a gift or do a favour in return for better health care/attention?

Instructions: Select only **one**.	(1) Male ☐ (2) Female ☐

102. Based on your experience, amongst public healthcare providers, who are prone to corruption?

Instructions: **Do not** read answer options. **Multiple responses** allowed.	(1) Medical doctor ☐ (2) Surgeon ☐ (3) Midwife ☐ (4) Nurse ☐ (5) Dentist ☐ (6) Psychologist/counsellor ☐ (7) Pharmacist/drug keeper ☐ (8) Laboratory technologist ☐ (9) Administrative/accounting staff ☐ (10) Other(s) ☐ _____ (SPECIFY) (11) No answer given/Don't know ☐

103. During your visit/stay, are you given a receipt when you make payment?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐

104. Based on your experience of seeking public healthcare, how would rate your level of satisfaction?

Instructions: Read answer options **aloud**. Select only **one**.	(1) Very satisfactory ☐ → SKIP TO Q106 (2) Somewhat satisfactory ☐ (3) Neither satisfactory nor unsatisfactory ☐ (4) Somewhat unsatisfactory ☐ (5) Not satisfactory ☐

105. If you are less than very satisfactory, how to raise your concern or make complaint?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Public health providers ☐ (2) Supervisors of public health providers ☐ (3) Directors of public health facilities ☐ (4) Ministry of Health ☐ (5) Written or spoken to a CSO or NGO ☐ (6) Written or spoken to a political party ☐ (7) Written or spoken to the media/social media ☐ (8) Complaint box ☐ (9) Not dare to raise complaint (10) Other ☐ _____ (SPECIFY) (11) No answer given/Don't know ☐

CHECK Q85 – IF THE FOURTH OPTION WAS NOT CHOSEN, → SKIP TO Q109

106. If you have ever sought healthcare services in other countries, where do you go?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Vietnam (2) Thailand (3) Singapore (4) Malaysia (5) China (6) France (7) India (8) Other(s) ☐ _____ (SPECIFY)

107. If yes, how often do you go?

Instructions: Select only **one**.	(1) Every month ☐ (2) Every three month ☐ (3) Every six month ☐ (4) Every year ☐ (5) Other(s) ☐ _____ (SPECIFY)

108. If yes, why do you go there?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) Closer to my house ☐ (2) Better service and quality ☐ (3) More available treatment services ☐ (4) More and modern equipments and facilities ☐ (5) Staff are friendly and caring ☐ (6) Reputation of that particular clinics/hospitals ☐

	(7) Reputation of the healthcare system in that particular country ☐ (8) Know medical staff there ☐ (9) Lower fees than domestic hospital ☐ (10) Other(s) ☐ _____

109. How much in total does your family spend on healthcare services in the past twelve months (both in public hospital and private clinic)?

110. Amongst the amount, how much do you spend on extra informal payment?

Part F. Actions to address corruption in public healthcare sector

111. In your opinion, has the level of corruption in public health sector changed, over the past four years?

Instructions: **Read aloud** answer options. Select only **one**.	(1) Increased significantly ☐ (2) Increased slightly ☐ (3) Stayed the same ☐ (4) Decreased slightly ☐ (5) Decreased significantly ☐ (6) Don't know ☐

112. In your opinion, to what extend did government put effort in combating against corruption in health sector?

Instructions: **Read aloud** answer options. Select only **one**.	(1) Make strong effort☐ (2) Make some effort ☐ (3) Neutral ☐ (4) Did not make much effort ☐ (5) Did not make effort at all ☐ (6) Don't know ☐

113. In your opinion, what would be the most affective things an ordinary person can do to fight corruption in healthcare sector?

Instructions: **Spontaneous** response**. Do not read aloud** answer options. **Multiple response** allowed.	(1) Nothing/ordinary people cannot do anything (2) Refuse to pay bribes/say 'no' to corruption (3) Report corruption when you see or experience it (4) Vote for clean candidates or parties or for parties that promise to fight corruption (5) Speak out about the problem, for example for, by calling a radio program or writing a letter (6) Talk to friends and relatives about the corruption (7) Sign a petition asking for a stronger fight against corruption (8) Join or support an organization that is fighting corruption (9) Participate in protest which has been found guilty of engaging in corruption (10) Other(s) ☐ _____ (SPECIFY) (11) No answer given/Don't know ☐

114. Are you willing to report corruption if it happens to you or you witness it?

Instructions: Select only **one**.	(1) Yes ☐ (2) No ☐ → SKIP TO Q116

115. If yes, how will you report the corruption case?

Instructions: **Do not read aloud** answer options. **Multiple responses** allowed.	(1) Written or spoken to directors of public health facilities ☐ (2) Written or spoken to Ministry of Health ☐ (3) Written or spoken to local police ☐ (4) Written or spoken to local authorities ☐ (5) Written or spoken to Anti-Corruption Unit (ACU) ☐ (6) Written or spoken to Transparency International Cambodia or call the hotline number (1292 or 7777) ☐ (7) Written or spoken to a CSO or NGO ☐ (8) Written or spoken to a political party ☐ (9) Written or spoken to the media and social media ☐ (10) Complaint box ☐ (11) Other(s) ☐ _____ (SPECIFY) (12) No given answer/Don't know ☐

116. If no, what are the reasons of not reporting?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple response** allowed.	(1) I don't know what constitutes corruption (2) I don't have enough time to report it (3) I don't know where to report it (4) I don't know how to report it (5) It is too expensive to report (e.g. due to travel or phone charges) (6) I would not be protected/I am afraid of the consequence/retaliation (7) I do not believe that reporting would be effective/solve the problem/nothing will be done/it wouldn't make a difference (8) Do not know the procedures for reporting corruption case (9) Corruption is normal/Every does it/Everyone is involved (10) Corruption is hidden/it is difficult to prove (11) The officials where they would report to are also corrupt (12) They would implicate themselves as bribe-givers (13) It is others' business, not my problem (14) Other(s) ☐ _____ (SPECIFY)

117. In your opinion, what should be done to improve public healthcare in Cambodia?

Instructions: **Spontaneous** response. **Do not read aloud** answer options. **Multiple responses** allowed.	(1) Increase budget allocation for health sector (2) Increase salary for healthcare providers (3) Improve/strengthen quality of medical education and training and capacity of healthcare providers (4) Recruitment and promotion are based on merits (5) Modernise public healthcare system (6) Provide adequate resources (both capital and human) for public health facilities (7) Promote incentives to boost morals and code of conduct (8) Strengthen supervisory and control mechanisms (9) Promote accountability and transparency in management (10) Eradicating corruption in health sector (11) Do not tolerate corrupt practices in health sector (12) Strengthening judicial system and law enforcement (13) Other(s) ☐ _____ (SPECIFY) (14) No answer given/Don't know ☐

Module three: Socio-economic background of respondent

118. Respondent gender

INSTRUCTIONS: Select only **one**.	(1) Female ☐ (2) Male ☐

119. Date of birth

INSTRUCTIONS: Please give your age.	☐☐

120. What is your current marital status?

INSTRUCTIONS: Select only **one**.	(1) Single ☐ (2) Married ☐ (3) Widowed ☐ (4) Divorced ☐ (5) Separated ☐

121. What is the highest level of education you have completed?

INSTRUCTIONS: Select only **one**.	(1) No schooling ☐ (2) Incomplete primary ☐ (3) Complete Primary ☐ (4) Complete lower secondary ☐ (5) Complete higher secondary ☐ (6) Undergraduate degree ☐ (7) Postgraduate degree ☐ (8) Vocational training ☐

122. Are you currently employed?

Instructions: Select only **one**. '**Unemployed**' refers to people who want to work, are available to work and are actively seeking employment. '**Inactive**' refers to people unable to work for a variety of reasons, which may include students, people who are unable to work due to illness or disability, retired people and housewives or other people looking after their family/ home.	(1) Yes, employed ☐ (2) No, unemployed ☐ → SKIP TO Q125 (3) No, inactive ☐ → SKIP TO Q125

123. If employed, which best describes your main employment status?

Instructions: Select only **one**. '**Own-account workers**' are people who are self-employed without paid employees. '**Unpaid family workers**' are members of the same household working without actual pay in an enterprise or farm owned by a family member.	(1) Employer ☐ (2) Employee ☐ (3) Own account worker ☐ (4) Unpaid family worker ☐ (5) Other ☐ _____ _____ (SPECIFY)

124. What is your main occupation?

Instructions: Specify role. Then select only **one**.	_____ (SPECIFY) (1) Professionals ☐ (2) Farmer ☐ (3) Worker (factory, construction, etc.) ☐ (4) Teacher ☐ (5) Business owner ☐ (6) Fishermen ☐ (7) Vendor ☐ (8) Housewife ☐ (9) Bike/motor/car repairer, electrician, goldsmith ☐ (10) Carpenter ☐ (11) Barber, Hair dresser ☐ (12) Elderly ☐ (13) Moto/car/boat drivers ☐ (14) Employee (company, bank, hotel, casino, NGOs ☐ (15) Retiree ☐ (16) Traditional therapist ☐ (17) Clergyman (18) Traditional musician (19) Village/commune chief (20) Police/military police/soldier (21) Other _____ (SPECIFY)

125. What is the annual income of the household?

Instructions: Select only **one**.	_____ (SPECIFY)

126. On what basis do you occupy your current household dwelling?

Instructions: Select only one.	(1) Owner occupier (2) Rent (3) Not owned, but free (4) Other _____ (SPECIFY)

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