

Long-Term Effects of INGOs and Privatization of Healthcare in Cambodia

by

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The Department of Political Science
in partial fulfillment of the requirements
for the degree with honors
of Bachelor of Arts
The University of Michigan
March 2017

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Acknowledgements

We would like to thank our friends for putting up with us throughout this three-year process and for listening to way more information about NGOs than they've ever been curious about. We would also like to thank our parents for supporting our trip to a developing country despite initial hesitations. We would like to thank our classmates in 494 for their insights, bar nights, and emotional support.

We would like to extend our deepest appreciations to the Honors Department for their willingness to take a risk on our unconventional project. Specifically, we are very grateful to Dr. Wessel Walker for hearing our first proposal and helping us overcome the initial roadblocks to getting our project approved.

Further thanks to Dr. Dyson and the International Institute for their help in securing the grants that made our field research possible - and to the families and donors that provided the funds.

We would also like to recognize the *many* professors who agreed to meet with us and discuss various aspects of our argument, as well as introduce us to their contacts abroad. Even in brief meetings your insights helped to shape our work.

Thank you to Professor Zeisberg who guided us and our 494 classmates through the trials, tribulations, and logistics of the thesis writing process. Your patience with our many questions and half-formulated ideas did not go unnoticed.

We would like to express our deepest gratitude to the many people we contacted in Cambodia and Thailand who were willing to provide us with their insights, experiences, and suggestions. Our project would quite literally not have been possible without your participation. A special thanks to those who sat for interviews and opened their schedules to us - the invaluable information you provided us with dramatically affected the direction and quality of our research. We are immensely grateful for the respect you showed to two undergraduates attempting their first serious research project.

Finally, we cannot begin to express how grateful we are to the two primary advisors we have had throughout this process. Dr. Mika LaVaque-Manty, thank you for taking a chance on us and enthusiastically supporting our co-authored thesis. We deeply appreciate the three years you have spent advising and guiding our efforts. In acting as our faculty sponsor prior to finding an advisor, guiding us through the IRB, and reading a multitude of our grant proposals you were absolutely indispensable to our process. Dr. Allen Hicken: thank you,

thank you, thank you for agreeing to be our faculty advisor. Your reassurances, edits, guidance, and expertise on the region were invaluable. Thank you for reading every word of our thesis - several parts several times. Thank you for trusting our vision of the project and reminding us to trust it as well.

Abstract

Outsourcing to INGOs and privatization have increasingly become solutions to low-capacity healthcare sectors in developing countries. Although these phenomena are now common, there are large gaps in the existing literature surrounding whether INGOs and the private sector improve the capacity of states in the long-term, or if the increased influence of the other sectors is ultimately counterproductive. Our research uses Cambodia as a case study to explore the interaction between each of the sectors involved in healthcare provision: the INGO sector, the private sector, and the public - or governmental - sector. In order to explore the long-term effects of these interactions, we conducted an extensive literature review, interviewed INGO directors and public health officials, collected data on health-related budgets and outcomes, and distributed surveys to actors in the healthcare field. The research we conduct suggests that if left to act as principal primary care providers in the long-term, INGOs and private providers actually decrease state capacity and create gaps that inhibit states' ability to develop. We find that both INGOs and privatization drain personnel and funds from the state, and that this is problematic given that neither of these alternative providers is able to provide effective long-term care. INGOs have labor and funding constraints that cause them to be unstable, while private providers create health systems that are inequitable and of low quality. Thus, reliance on sectors other than the government to provide the majority of healthcare is a short-sighted development policy. While our conclusions are revealing, more work is necessary to further explore the complexities of the interactions between these three sectors and what combination of actors is best able to sustainably improve health outcomes in the long-term.

I. Introduction

Overview

The Cambodian healthcare sector is divided into three primary types of care providers: the public sector, private sector, and INGOs. Public healthcare is government-provided through the Cambodian Ministry of Health, frequently referred to as the MoH. Private healthcare is provided primarily through for-profit clinics and hospitals not under the purview of the government, and small practices run by individual physicians.¹ INGOs are non-profit international organizations that have situated themselves in Cambodia in order to provide alternative healthcare services.

Our argument focuses on the interactions between these three pillars supporting health provision in Cambodia. Thus far, the government has been essentially unable to provide adequate healthcare services to its people due to a variety of factors, some of which include the destruction of the system during the Khmer Rouge, a general dearth of development work in public healthcare, and poor infrastructure creation and regulation. Despite massive amounts of international aid, the public health system has not improved sufficiently or rapidly enough to effectively meet health needs autonomously. In order to fill this gap in the provision of healthcare, the government has chosen to outsource much of its responsibility to foreign-run INGOs. Private sector practices and practitioners have assumed the responsibility of filling the remaining holes in the market.

When discussing the current healthcare situation in Cambodia it is necessary to differentiate between outsourcing and assumption of government responsibilities to citizen

¹ For the purpose of this paper, pharmacies and other smaller non-registered healthcare providers will not be included in the definition of private healthcare provision.

health. “Outsourcing” is a term describing INGOs taking on traditional state responsibilities with the government’s blessing. This generally occurs through a partnership program with an established international organization and the local government. The stated goals of these integrated partnerships are “to actively enlist private capital, both human and financial, to help governments fulfill their responsibilities for providing equitable access to high-quality public services.”² Often, however, this partnership morphs into high levels of control by the outside group and little substantive government involvement. Outsourcing can also occur more implicitly if the state’s capacity is especially low; in this scenario, there may not be a formal partnership program, but the government implicitly approves the INGOs work. Assumption, however, is used to frame the activities of healthcare providers in the private sector. In this case, there is an existing demand for healthcare, which the government is unable to supply, so private providers move into the market in order to take advantage of the latent opportunities and funding. Unlike outsourcing to a large organization, this is a market driven phenomena coordinated among many small actors. In developing countries, many of those small actors are not licensed to provide care and their work is unregulated.³ While in developed countries privatization of healthcare is a purposeful strategy adopted by governments, in this case we define “assumption by the private sector” as a phenomenon lacking active government involvement - or, in fact, defined by the government purposefully turning a blind eye.

² N. Sekhri, R. Feachem, and A. Ni, "Public-private integrated partnerships demonstrate the potential to improve health care access, quality, and efficiency," *Health Affairs* 30, no. 8 (August 2011): 5-6, doi:10.1377/hlthaff.2010.0461.

³ Peter Annear et. al, “The Kingdom of Cambodia Health System Review,” *Health Systems in Transition* 5, no. 2 (2015): 80, source: http://www.wpro.who.int/asia_pacific_observatory/hits/series/cambodia_health_systems_review.pdf.

Private assumption and INGO outsourcing, rather than giving the government the time and skills to build its own capacity, have instead further weakened the public healthcare system. Private health outsourcing undermines the public healthcare system in two ways. First, the participation of public health officials in dual practice - working in both a public and private capacity - prevents the government from maintaining an adequate supply of medical professionals and complicates the regulation of the private sector. Second, the private sector drains resources from the public sector. Although studies have shown that it provides a lower standard of care, public perceptions cause the majority of those in need of healthcare to look first to the private sector, allowing private providers to receive the majority of individual health spending instead of the public sector. The data indicates that an overwhelming percent of out-of-pocket health expenditure goes to private providers.⁴

INGOs also contribute to the continued weakness of the public healthcare system. INGOs create additional brain drain from the public sector by offering better pay and benefits than government positions, drawing skilled workers into the INGO labor force and away from public positions. Moreover, because of the perception that INGOs are more reliable funding recipients than developing governments, they draw foreign and international funding away from the Cambodian government, depriving it of available resources.

Thus, the continued reliance on the private and INGO sectors has produced a destructive cycle. The combined brain and resource drain deprives the government of the skilled labor and resources it requires to increase its health provision, and this in turn perpetuates the need for and reliance on private providers and INGOs and thus existence of privatization and INGOs. Since it appears to the government that needs are being met

⁴ Annear et. al, "The Kingdom of Cambodia Health System Review," xvii - 160.

without effort or funding on its part, it lacks the desire to do the work necessary to reassume sole provision of healthcare, which perpetuates the system. The government's lack of commitment to funding the public healthcare system is evident in the stagnate budget allocation for healthcare.

We will show that this situation has dangerous long-term implications. The INGO sector is subject to personnel constraints and mission drift as it adjusts to stay relevant and maintain its funding in a fickle global aid market. As such, INGOs may abandon services they once provided in order to “chase” funding fads in a different part of the healthcare market. This long-term instability makes INGOs an insufficient sole provider and therefore a poor substitute for nationally provided healthcare. Privately provided healthcare in Cambodia lacks regulation, which is exacerbated by the conflict of interest created by dual practice, and causes the healthcare it offers to be overpriced and of a low quality. In summation, neither INGOs nor private healthcare are a stable nor effective long-term replacement for a national healthcare system, and may in fact leave the public health system weaker than it was previously.

We have included a visual representation of our argument in Figure 1:

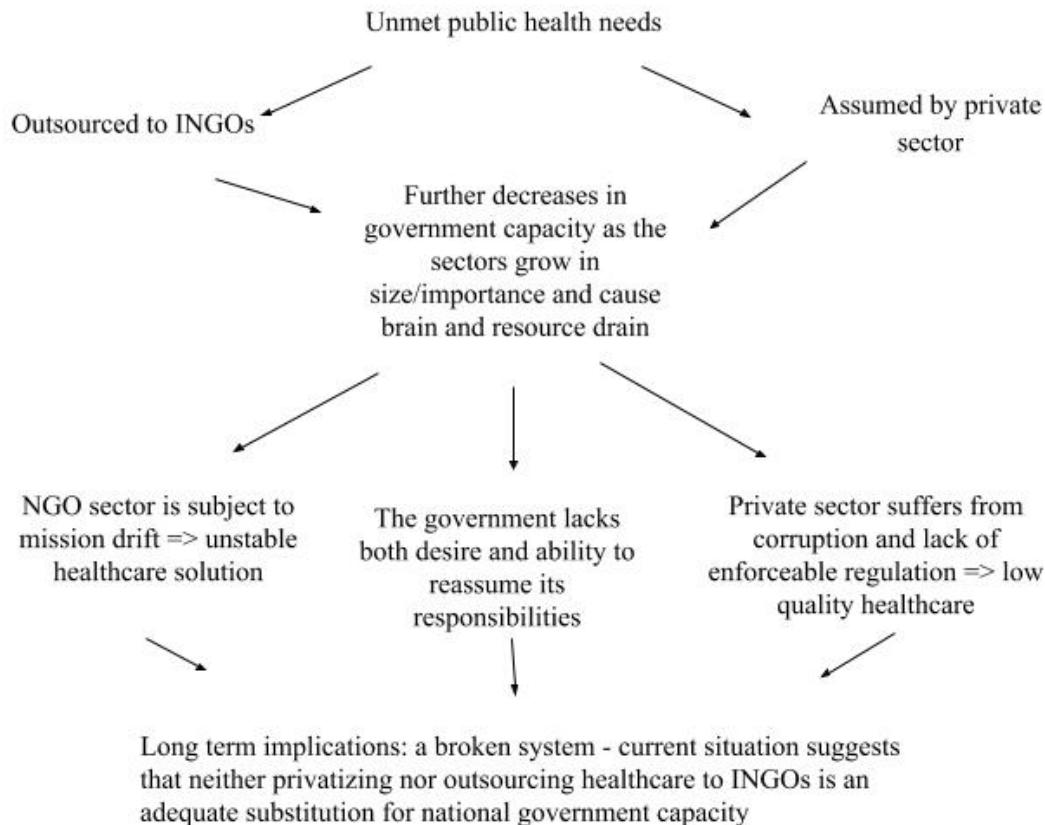


Figure 1: flowchart of argument.

Although literature abounds concerning the negative effects of both privatization and outsourcing to INGOs, to our knowledge no research has been conducted into the interactions between these two processes and the implications they may have on the capacity of public healthcare systems in developing countries in the long-term. Therefore, we traveled to Cambodia and Thailand in August of 2016 to gather data. A full discussion of our methods can be found in *Appendix A*. Based on our findings, we argue that the reliance on

the private and INGO sectors produces an undesirable cycle, which undermines both the capacity of the public sector in the present and incentives for governments to invest in the future of the public healthcare system.

With this argument in mind, we will begin by discussing the historical events that led to Cambodia's current situation and how the Cambodian healthcare system compares to other systems in the same region/income level/post-conflict status as Cambodia in order to demonstrate its value as a case study. We will then discuss the current state of the public health system and identify the systemic deficiencies that have led to the decision to outsource to INGOs and assumption by private sector actors. Then we will look at the INGO sector- definitions, how it operates, how it fits into the international civil society system, and how it operates in Cambodia particularly. After which, we will focus on privately provided healthcare- definitions, global argumentation for and against privatization, how it operates within Cambodia, and privatized healthcare outcomes. We will then lay out our research on how INGOs and privatization create resource and brain drain and thus decrease public health capacity. This will lead to a discussion of why INGOs and privatized healthcare are poor substitutes for a strong public health system (i.e. why we should care that public health capacity is decreasing). We will then complete our argument by discussing the path dependence of this situation and the difficulties the Cambodian government faces in building its capacity at this point given the aforementioned complications. To conclude, we will make suggestions for further research and the implications the Cambodian case study could have for the global community.

A Brief History

Cambodia is a particularly compelling example of the interactions between the private, public and civil society sectors due to the history of its healthcare system, and thus serves as a useful case study for our research. While the details of what led to Cambodia's healthcare situation are unique, we suggest that the processes unfolding there are applicable to a lesser degree in many developing countries. Understanding Cambodia's health sector, then, is useful to understanding a cycle that could be affecting many countries globally - especially given the rise of both privatization and international actors in recent history.

From 1975 to 1979 the Khmer Rouge attempted to return Cambodia to a model agrarian society and in the process destroyed the country's healthcare infrastructure, namely supplies, personnel, venues, water, sanitation, and education. Many of the people who died during the process were those with the highest levels of education, and many of those not killed fled the country. In 1979, it is estimated that 20 doctors, 26 pharmacists, 28 dentists, and 728 medical students remained in Cambodia.⁵ As such, Cambodia started the 1980s with a blank slate from which an entirely new health infrastructure needed to be built.

Cambodia's progression was further complicated by the operations of the United Nations Transitional Authority in Cambodia (UNTAC), which assumed temporary administration of the country from 1992 to 1993. This was the first occasion in which the United Nations (UN) took over administration of an independent state for peacekeeping reasons. This high level of involvement by the UN in Cambodia during a key moment in its development led to a surge of other international aid - particularly in the form of international non-governmental organization (INGO) missions; as one interviewee recalled,

⁵ Annear et. al, "The Kingdom of Cambodia Health System Review," 85.

“In the 90s Cambodia's whole health system was run by international NGOs. The provincial health directors worked for UNICEF and CARE and the rest.”⁶ Today, Cambodia has the second highest number of NGOs per capita in the world. The US Library of Congress estimates that there are 5,000 NGOs in Cambodia⁷ and even with about only half currently active, that equals around one active NGO for every 6,000 Cambodians. Cambodia, then, is a post conflict country marked by low income and weak infrastructure, but with a large INGO sector attempting to address its needs. The complete restart of the health sector in the 1980s, and the massive influx of INGOs in the 1990s it created, makes Cambodia a useful case study of the effects of outsourcing to INGOs and privatization. The lessons learned in Cambodia can be applied to other developing countries, even if their starting point was less dramatic than that of Cambodia.

Cambodia's Situation as Compared to its Peers

In this section we will situate Cambodia, first by expanding on its designation as a developing country, then by providing information on its current health level, and finally by discussing the health systems in place. Cambodia serves as an excellent representative of the difficulties many developing countries face, but also has both a history and uniquely large non-governmental sector which makes the effects of INGOs and the private sector particularly quantifiable.

Throughout this section (and indeed our work as a whole) we will compare Cambodia's situation with those of its peers: Vietnam, Laos, Bangladesh, and Sierra Leone. These countries have all been chosen based on their economic situation and one additional

⁶ Interview with URC employee, August 12, 2016.

⁷ Constance Johnston, “Cambodia: Law on NGOs Passed,” *Global Legal Monitor*, July 15, 2017, <http://www.loc.gov/law/foreign-news/article/cambodia-law-on-ngos-passed/>.

factor: the first three are within Cambodia's region, and the last is a post-conflict country.

The data for these countries is drawn from multiple sources including the Human Development Index (discussed later), the World Bank, the OECD, and the UN database, among others.

Cambodia is extremely poor. The GDP per capita in the country is \$1,158.7.⁸ This is not to say that the situation in Cambodia has not improved, indeed it has shown a consistent seven percent GDP growth rate per annum in recent years. Moreover in 2015 Cambodia was reclassified as a lower-middle income country per the World Bank's designations.⁹ The fact remains, however, that Cambodia is below its peers: the average GDP per capita for a lower-middle income country in 2015 was \$2,002.1.¹⁰ Even Laos- one of its closest neighbors and a country generally considered less developed than Cambodia- has a GDP per capita of \$1,818.4, nearly \$700 dollars more per person than in Cambodia.¹¹ The figure below further illuminates Cambodia's global economic position based on World Bank and UN data: again, although Cambodia was recently redesignated a lower-middle income country, its GDP per capita suggests that it is more in line with the least developed countries of the world. Furthermore, other fragile and post-conflict countries¹² have much higher GDP per capita than Cambodia.

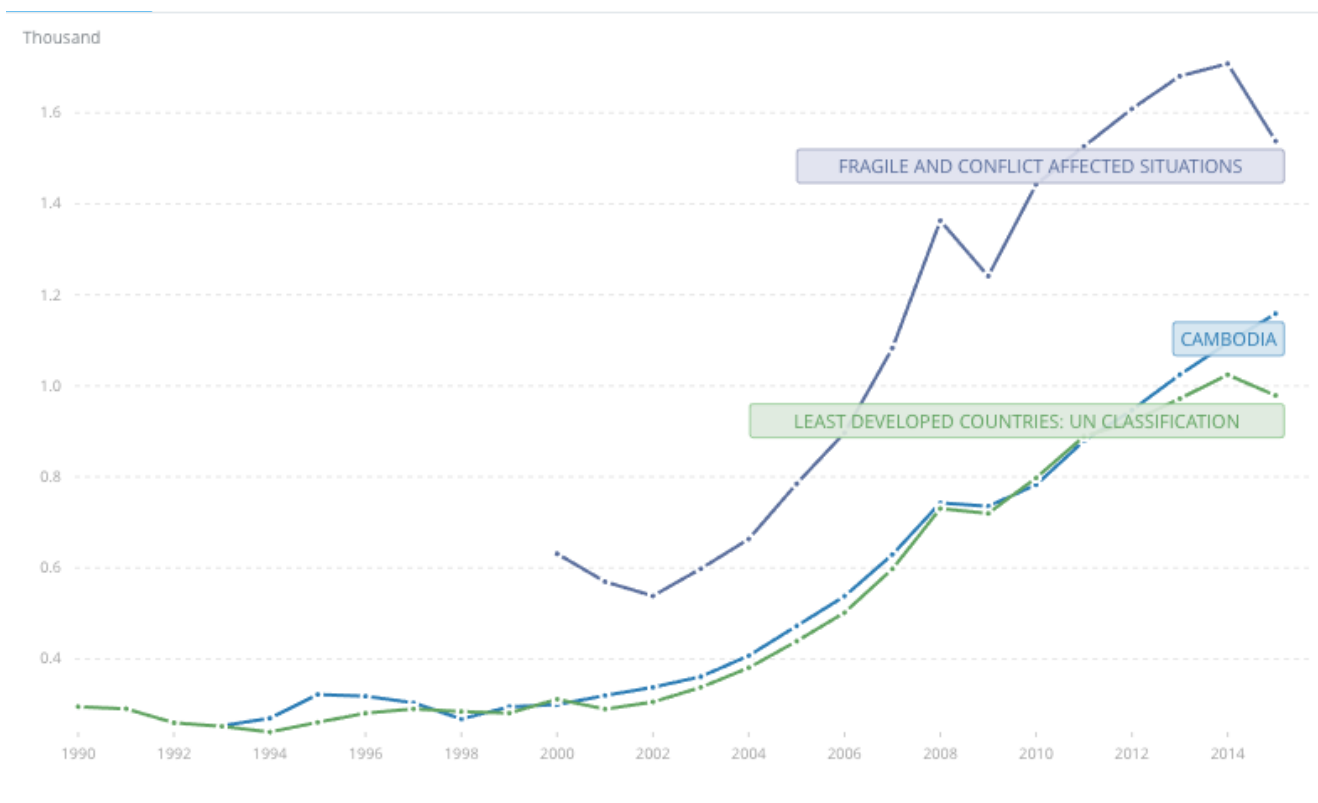
⁸ The World Bank, World Development Indicators (2015), *GDP per Capita (current US\$)*, retrieved from: <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=KH>.

⁹ Sodeth Ly, "Cambodia is now a lower-middle income country: What does this mean?" *The World Bank Blog*, August 11th, 2016, <http://blogs.worldbank.org/eastasiapacific/cambodia-is-now-a-lower-middle-income-economy-what-does-this-mean>.

¹⁰ The World Bank, World Development Indicators (2015), *GDP per Capita (current US\$)*, retrieved from: <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=XN>.

¹¹ The World Bank, World Development Indicators (2015), *GDP per Capita (current US\$)*, retrieved from: <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=LA>.

¹² As designated by the World Bank, see: <http://www.worldbank.org/en/topic/fragilityconflictviolence/brief/harmonized-list-of-fragile-situations>



(Figure 2: Cambodia's GDP per Capita in current US dollars as compared to the averages for Least Developed Countries and Fragile and Conflict Affected Situations since 1990.)¹³

Overall, the CIA Factbook describes Cambodia as “one of the poorest countries in Asia,”¹⁴ putting it at the 180th position out of 230 for GDP per capita globally.

GDP per capita can be a fairly one-dimensional metric, however. Thus, we look to the Human Development Index, a measure created by the United Nations that is a composite statistic of life expectancy, education, and income per capita indicators, to consider how Cambodia compares using a more dynamic development index. Cambodia

¹³ The World Bank, World Development Indicators (2015), *GDP per Capita (current US\$)*, retrieved from: <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=KH-F1-XL>.

¹⁴ “CIA World Factbook: Cambodia,” last modified January 12, 2017, <https://www.cia.gov/library/publications/the-world-factbook/geos/cb.html>.

fares no better using the HDI as a benchmark- it is in the 143rd position out of the 188 countries ranked.¹⁵ It is evident, then, that Cambodia can be firmly considered both a poor and developing country, even as it edges up the ladder.

We next consider the health outcomes of Cambodia's people compared to its peers, as our work is focused on health systems. The WHO estimated that in 2002 healthy life expectancy (HALE) at birth was 47.5 years (45.6 for males and 49.5 for females) in Cambodia. This was similar to Lao PDR (47.0), but significantly lower than Thailand (60.1) and Vietnam (61.3).¹⁶ As a further example, Cambodia's infant mortality rate in 2015 was 24.6 per 1000 live births. In comparison, Vietnam had a rate of 17.3 and Thailand had a rate of 10.5, however Cambodia's rate is smaller than that of Laos PDR with a rate of almost double (50.7).¹⁷ The combination of these statistics demonstrates that despite improvement, Cambodia's health outcomes remain low, and require significant improvement to reach global health standards.

In light of these data, we turn to examine the global consensus on Cambodia's health system. In 2016, the WHO ranked Cambodia at position 174 out of the 191 countries based on its health system performance.¹⁸ This exceedingly low ranking is due to Cambodia's low health expenditure and weak health provision. In 2014, Cambodia's health expenditure was 5.7% of GDP. This leaves Cambodia ranked at 127th out of 191 countries for health expenditure, according to the CIA Factbook, with the lowest ranked country spending 1.8%

¹⁵ "Human Development Index and its components," United Nations Development Programme Human Development Reports, last modified 2016, <http://hdr.undp.org/en/composite/HDI>.

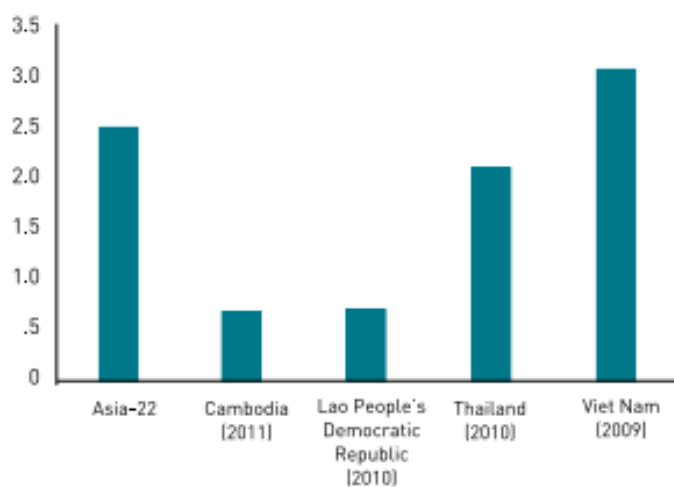
¹⁶ "The World Health Report 2004: Changing History," *The World Health Organization* (2004): 132.

¹⁷ The World Bank, World Development Indicators (2015), *Mortality Rate, infant (per 1,000 live births)*, retrieved from: <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>.

¹⁸ Ajay Tandon, Christopher Murray, Jeremy Lauer, and David Evans, "Measuring Overall Health System Performance for 191 Countries," *World Health Organization*, no. 13: 20, source: www.who.int/healthinfo/paper30.pdf.

and the highest 17.9%.¹⁹ The effects of lack of government spending on healthcare are exemplified by the number of health workers available. The World Health Organization estimates that fewer than 2.3 health workers (physicians, nurses, and midwives only) per 1,000 people is insufficient to achieve coverage of primary healthcare needs²⁰. The CIA Factbook estimates that in the Cambodian system there are only 0.17 physicians per 1,000 people - putting the healthcare system significantly below the level already defined by the WHO as insufficient. In comparison, Vietnam has 1.19 doctors per 1,000 people.²¹ Additionally, Cambodia has a ratio of 0.71 hospital beds per 1000 people, in comparison with 2.1/1000 in Thailand and 3.1/1000 in Vietnam.²² See figure below:

Hospital beds per 1000 population, selected countries



(Figure 3: Hospital beds per 1000 population, selected countries.)²³

¹⁹ “CIA World Factbook”

²⁰ “Achieving the health-related MDGs. It takes a workforce!”, World Health Organization, http://www.who.int/hrh/workforce_mdgs/en/.

²¹ “CIA World Factbook”

²² Annear et. al, “The Kingdom of Cambodia Health System Review,” 82.

²³ Eurostat Statistics Database, OECD Health Data (2012), accessed January 1, 2017. Found in: Annear et. al, “The Kingdom of Cambodia Health System Review,” 82.

These statistics, however, do not accurately represent the provision of *public* healthcare, as they include total provision of care - not just care provided by the government and the public system. This makes these numbers misleading, as “private providers outnumber government facilities.”²⁴ The numbers are even more disparate when looking at advanced care techniques and diagnostic methods, such as MRI or CT scans, which remain rare and are most commonly only available in the private sector.²⁵ That is to say: these data concerning number of doctors per 1,000 people and number of hospital beds are inflated beyond what the public sector itself is actually providing. In all, Cambodia’s health system is particularly weak, even among its economic and geographic peers.

In the future, according to the WHO, and like many of its peers, Cambodia still faces several major health challenges including, “high maternal, child and neonatal mortality,” “malnutrition,” “limited access to safe water and sanitation,” “a growing epidemic of noncommunicable diseases (NCDs),” and “the double burden of communicable diseases and NCDs.”²⁶ Although the overall health system has shown improvements, in several key indicators of health Cambodia has recently fallen further behind. For example, only 69% of households in the 2014 demographics survey report using salt with some iodine, whereas 83% reported usage in the 2010 survey.²⁷ The rate of improvement also differs drastically

²⁴ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxiv.

²⁵ Annear et. al, “The Kingdom of Cambodia Health System Review,” 84.

²⁶ “Cambodia-WHO: Country Cooperation Strategy 2016-2020,” *World Health Organization Western Pacific Region* (2016): 9,
http://apps.who.int/iris/bitstream/10665/246102/1/WPRO_2016_DPM_004_eng.pdf.

²⁷ “Cambodia Demographic and Health Survey,” *Measure DHS* (2010): 165,
<http://dhsprogram.com/pubs/pdf/Fr249/Fr249.pdf>.

between urban and rural areas. In urban areas, 52% of households have access to improved sanitation, whereas the access rates are much worse in rural areas.²⁸

In summary, Cambodia is firmly a developing country, with the low health outcomes that implies, but even among its peers it falls behind in terms of its health system's efficacy.

²⁸ “Cambodia Demographic and Health Survey,” *Measure DHS* (2010): 182.

II. The Public Sector

Description of the System

The first, and most straightforward sector, involved in health provision is the public sector. This term refers to the health system run and operated by the national government of Cambodia through its Ministry of Health (MoH). In order to provide background for the interaction between the three groups involved in healthcare, we will begin by providing an overview of the structure of Cambodia's public health system including: infrastructure, personnel, insurance system, bribes, and budgeting.

The infrastructure of the public health system is based on a layered pattern of care provision shared between the provinces and districts of the country. At the top level, the Directorate General for Health oversees health service delivery through 24 MoH Provincial Health Departments (PHDs). Within these provinces there are also a total of 81 health Operational Districts (ODs). Each PHD operates a provincial hospital and governs the ODs' operations and funding. Each operational district covers ~100,000–200,000 people with a Referral Hospital - delivering mainly secondary care, and a number of Health Centres. Health Centres operate on the smallest and most local level of care provision and cover ~10,000–20,000 people - providing mainly preventive and basic curative services. Less formal Health Posts are located in the most remote areas.²⁹

The Cambodian government has begun decentralizing healthcare with the goal of providing increased access and quality of care to rural regions in line with the passage of the *Health Strategic Plan 2008-2015*. There remains a great need for further health quality and

²⁹ Annear et. al, "The Kingdom of Cambodia Health System Review," xvii.

systems regulation. Currently, there are four laws covering the health sector: (i) the 1996 Law on the Management of Pharmaceuticals, amended in 2007; (ii) the 1997 Law on Abortion; (iii) the 2000 Law on Management of Private Medical, Paramedical and Medical Aid Services; and (iv) the 2002 Law on Prevention and Control of HIV/AIDS.³⁰ Although several strategic plans have been passed in recent years in an attempt to universalize the health system, no supporting legislation, with enforcement capabilities, for improving quality and access have been passed since 2007 - a marked decline in the rate of legislative reform.

Employment

Since 1979 and the devastation of the health workforce by the Khmer Rouge when only 25 doctors survived, significant gains have been made in rebuilding the human resources of the health sector. There is still room, however, for great improvements in both quantity and performance of staff in public health provision. Cambodia is still significantly below the WHO suggestions for number of health professionals given their population, and most of the existing staff is highly concentrated in the capital, Phnom Penh.³¹ According to data published by the MoH, they currently employ 19,457 civil servants in the health sector, “most of whom are nurses (about 46%) and midwives or midwife associates (about 24%).”³² Doctors comprise only 14% of the health workforce, with only 1% being specialists, meaning there are approximately 2,723 public health doctors in the entire country.³³ The MoH estimates that they will need to expand the total public health workforce to 32,000 by 2020 in order to meet WHO standards and raise the health worker-to-population ratio from

³⁰ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxii.

³¹ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxv.

³² Annear et. al, “The Kingdom of Cambodia Health System Review,” 87.

³³ Annear et. al, “The Kingdom of Cambodia Health System Review,” 87.

13.6 to 19.9 per 10,000 population. In order to achieve this ratio, the WHO suggests that Cambodia will have to increase both its salaries for health staff and its training and educational capacity.³⁴ Currently, the average base salary (including allowances) for a government health professional is only about \$100 per month, and doctors and specialists earn only 50% more than the average.³⁵ This is significantly lower than the average salaries for comparable countries. In an interview with an executive from the University Research Company³⁶ we were told, “the wages are really low because only just about 20 to 25 percent of the Ministry of Health budget goes on salary. In most of the poor countries that figure's 45 to 55 percent.”³⁷ Additionally, in the 2009-2010 academic year only 79 individuals graduated from public sector health institutions with a degree as a medical doctor.³⁸ Overall, the Cambodian public health system is astoundingly low on doctors, has very few entering the system, and, thus far, lacks the infrastructure to attract more.

Health Equity Fund

There is no compulsory health insurance or social health insurance coverage provided by the Cambodian government. There is a small voluntary health insurance market of private for-profit insurance companies and not-for-profit schemes, which primarily serves rural communities and urban workers, but coverage remains very low and are available only to those who can afford to pay premiums.³⁹ The relatively new subsidized Health Equity Fund (HEF) for the poor provides coverage and financial protection for approximately a

³⁴ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxv.

³⁵ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

³⁶ See: <http://www.urc-chs.com/asia/cambodia>

³⁷ Interview with URC employee, August 12, 2016.

³⁸ Midterm Review of the Health Workforce Development, DFAT (2011). Found in Annear et. al, “The Kingdom of Cambodia Health System Review,” 97.

³⁹ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxiv.

quarter of the national population - however, both the depth and breadth of the program remain limited and dependent on INGO financing; according to an executive of the INGO that manages the HEF system: “We're supposed to hand that [system] to a government agency. That's been a stated goal for the last 10 years and the government has not been able to form an agency. Due to internal politics, basically.”⁴⁰ Additionally, World Bank Report Preliminary findings show that only 46% of those qualified for the HEF use it when they need health services.⁴¹ Based on our interviews, it appears that this is largely due to two difficulties. First, illiterate individuals struggle to complete the application process. Second, receiving a Poor ID is dependent upon the approval of the community village council - a system which can be almost impossible due to favoritism practices as well as the embarrassment of being defined as “poor” within your community. This process was described to us in the interview clip included below:

The mechanism is that there is a poor ID card distributed to poor people in the community through the process mechanism of pre-identification. So if they assess my house as if oh I am poor then I am issued a card. And with that card I can go to the health center for free of charge or minimum charge or whatever it depends on the benefit package. The result was that only 46 percent of those poor people with the ID poor card use that service. And the others just use private service. So the question mark is [do we give] “A for the effort” to donor and the government for support to help all the poor people just to serve 46% and not the 100% of them?⁴²

In order to be eligible for the HEF subsidized care, a poor person must have an “Equity Card,” commonly referred to as a “Poor ID” which is issued through the national “Identification of Poor Households Program” of the Ministry of Planning - facilitated by the

⁴⁰ Interview with URC employee, August 12, 2016.

⁴¹ Kelsall and Heng, “Inclusive healthcare and the political settlement in Cambodia,” 13.

⁴² Interview with NGO employee, August 10, 2017.

village councils.⁴³ HEF benefits allow eligible poor people to seek healthcare at any *public* health facility nationwide.⁴⁴ This could have the effect of increasing traffic to public health centers rather than private facilities, as those who qualify for HEF seek to claim its benefits. In contrast, it could also reduce the incentives for private health centers to provide equitable care to those on HEF plans who are unable to pay.

Currently, the day-to-day management of the HEF system is carried out at the Operational District level. INGOs are contracted to perform the functions of a HEF Operator at these levels. The program at the largest level is currently run, operated, and largely financed by the University Research Company (URC), an INGO based in Maryland that is one of the largest INGOs regularly operating in Cambodia.⁴⁵

The HEF is relevant not only for its financing role in the public health system, but also as an example of the interactions between the MoH and the INGO sector. It also has an effect on the effectiveness of private sector health provision. All three aspects will be addressed later in our thesis.

Bribery

When describing the public health sector it is imperative to mention the system of patronage ingrained in the sector. In order to be employed by the Ministry of Health, doctors must pay a bribe between three and six thousand dollars; as summarized by one interviewee: “You buy the job. It's a franchise.”⁴⁶ They must then pay another bribe of roughly equal amount to buy their way into the province where they would like to be

⁴³ “Policy Brief on the Health Equity Fund,” *University Research Company, LLC* (August 1, 2015): 1.

⁴⁴ “Policy Brief on the Health Equity Fund,” 3.

⁴⁵ “Policy Brief on the Health Equity Fund,” 1-3.

⁴⁶ Interview with URC employee, August 12, 2016.

stationed.⁴⁷ For many, Phnom Penh, the capital city, is ideal, and those who can afford it will pay thousands of dollars to be stationed there - on top of the bribe they paid to be accepted into the MoH in the first place.⁴⁸ Once employed by the MoH, public physicians are expected to pay a yearly bribe to their head of department,⁴⁹ and there are implicit expectations of bribery at numerous other points; for example, if a superior has a baby there is an understood monetary scale for the gift given, which depends on the employee's rank. The rent and patronage system for public employees was described by one interviewee as both unspoken and astoundingly complex, he went on to say:

[It] is bizarrely opaque and bizarrely unexplainable by political scientists. No one has ever written a decent, as far as I know, no Westerner has ever understood the Cambodian patronage system. And I think it may be because - I'm not sure Cambodians understand the Cambodian patronage system. It just doesn't match anybody else's, but it's everywhere...There's a lot of things you have to do within the system...if you go to a wedding you have to do certain- every Cambodian knows exactly how much money they have to pay... And at the highest levels, you know, the secretaries of state and ministers and stuff are, you know, 25 to 50 thousand dollars. So serious amounts of money moving around. So you know what you have to do within the system. And I think, to some degree, you know what you're expected to receive, though from what I can tell that's not particularly tangible. But you don't know how it works. It's like the Wizard of Oz, it's all behind- except it's not one guy behind the curtain. And I'm not sure that anybody actually runs it exactly, the way that Daly ran Chicago.⁵⁰

Beyond bribery, family name and connections are key for advancement in the MoH. Those who do not know someone in a position of power are unlikely to be promoted or placed in a desirable province.⁵¹ In short, the public system could never be mistaken for a meritocracy- the corruption is so unavoidable that it is impossible to even enter the system

⁴⁷ Interview with URC employee, August 12, 2016.

⁴⁸ Interview with URC employee, August 12, 2016.

⁴⁹ Interview with URC employee, August 12, 2016.

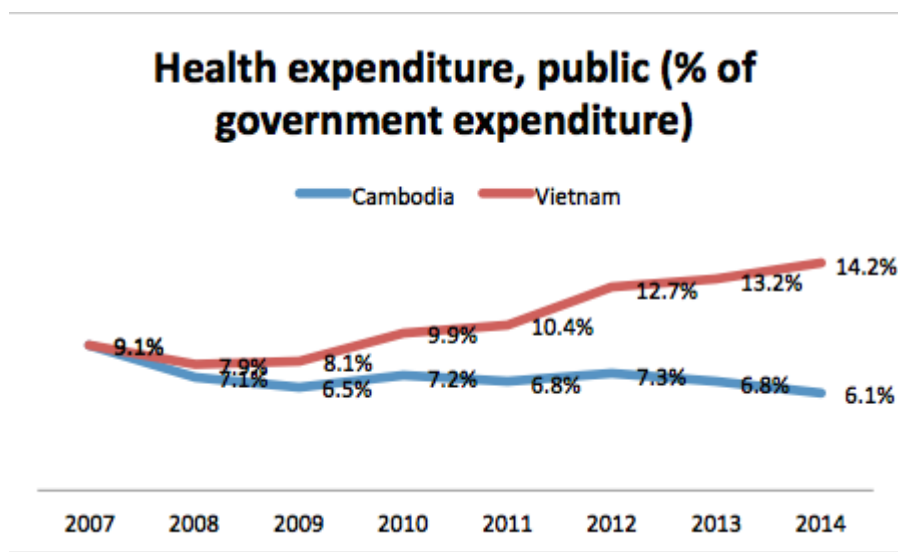
⁵⁰ Interview with URC employee, August 12, 2016.

⁵¹ Interview with World Renew employee, August 10, 2016.

without immediately participating in extortion. Those who cannot pay the bribe, do not have the connections, or would prefer to advance based on merit must find employment elsewhere.

Budget and Expenditure

One of the most important aspects of the Cambodian health system, and one to which we will refer repeatedly in this paper, is the public health budget in Cambodia. Despite increasing GDP and its redesignation to lower-middle income status as per the World Bank's designation,⁵² Cambodia's expenditure on healthcare as a percentage of total government expenditure has been decreasing, as evident in the figure below:



(Figure 4: Cambodia's health expenditure as a percent of total government expenditure from 2007 to 2014, as compared to Vietnam's.)⁵³

⁵² "How Are Income Group Thresholds Determined?" The World Bank, <https://datahelpdesk.worldbank.org/knowledgebase/articles/378833-how-are-the-income-group-thresholds-determined>.

⁵³ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) as % of General government expenditure (GGE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

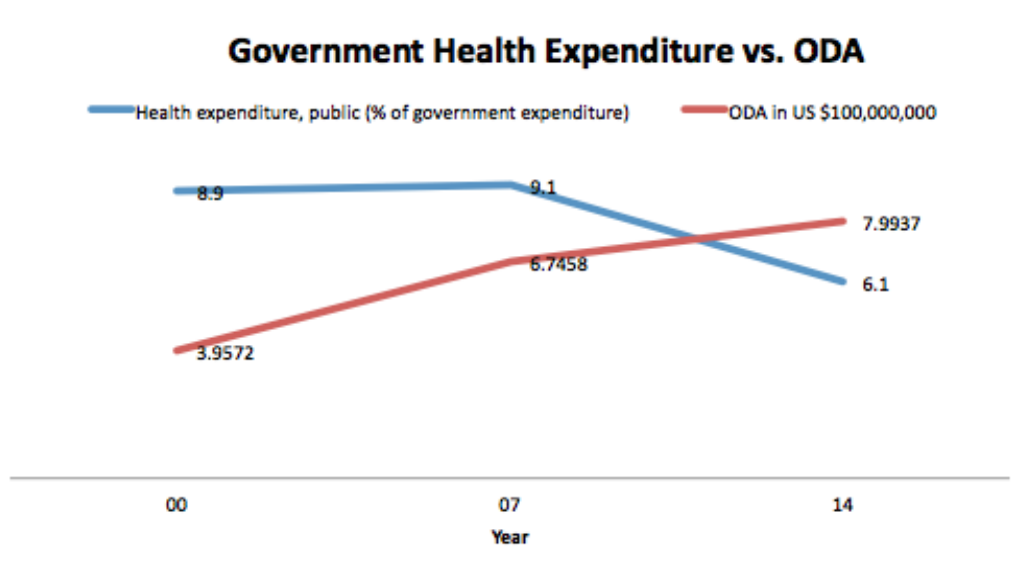
Note that in 2014 health expenditure was 6.1% of total government expenditure. In comparison, Cambodia's neighbor Vietnam spent 14.2% of its government expenditure on health in the same year- this is notable considering that in 2007 both countries spent 9.1% of their budget on health. Comparing Cambodia's health budget decrease with Vietnam's increased allocation makes clear the significance of Cambodia's downward trend. Having started from the same allocation, it is telling that Cambodia's budget for healthcare has fallen - it demonstrates that the Cambodian government has been either unwilling or incapable of maintaining a competitive level of healthcare expenditure.

To further illustrate this point, in 2014, the Cambodian government spent \$14 per capita on healthcare, less than Sierra Leone, Laos, or Vietnam.⁵⁴ Moreover, while that allocation has been increasing for Cambodia's peers, in Cambodia the trend has been largely decreasing or flat since 1995.⁵⁵ Considering how much official development aid (ODA) Cambodia receives,⁵⁶ this trend is both surprising and disturbing. The figures below put in perspective the magnitude of ODA Cambodia receives in comparison with the decreasing trend of its health expenditure:

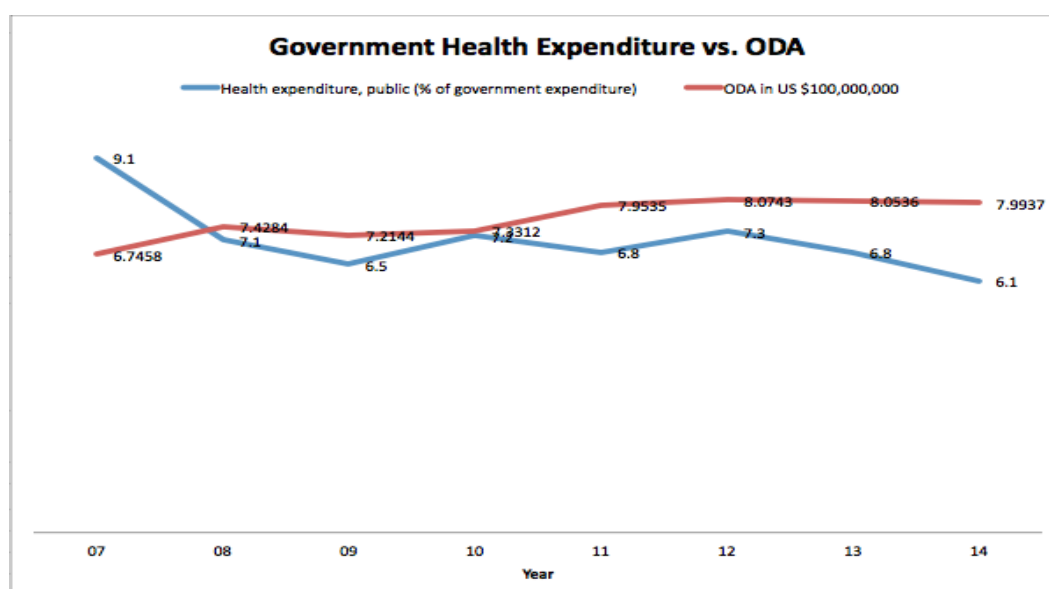
⁵⁴ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) per Capita in US\$*, retrieved from: <http://apps.who.int/nha/database/ViewData/Indicators/en>.

⁵⁵ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) per Capita in US\$*, retrieved from: <http://apps.who.int/nha/database/ViewData/Indicators/en>.

⁵⁶ The World Bank, World Development Indicators (2017), *Net official development assistance received (current US\$)*, retrieved from: <http://databank.worldbank.org/data/reports.aspx?source=2&series=DT.ODA.ODAT.CD&country=KHM>.



(Figure 5: Government health expenditure compared to ODA since 2000.)⁵⁷⁵⁸



(Figure 6: Government health expenditure compared to ODA from 2007 to 2014.)⁵⁹⁶⁰

⁵⁷ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) as % of General government expenditure (GGE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

⁵⁸ The World Bank, World Development Indicators (2017), *Net official development assistance received (current US\$)*, retrieved from:

<http://databank.worldbank.org/data/reports.aspx?source=2&series=DT.ODA.ODAT.CD&country=KHM>.

⁵⁹ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) as % of General government expenditure (GGE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

As evident in figure five, between 2000 and 2014, ODA doubled while the percentage of the public budget allocated to healthcare significantly decreased. Figure six focuses on the period between 2007 and 2014 and reinforces that the decrease in government health expenditure has not been a one time or recent change- allocations to health have been continually decreasing while ODA has remained at nearly \$800 million. Although not all ODA is directed to the health sector, a significant amount is - indeed, 19% of ODA in 2012 went to the health sector.⁶¹ Furthermore, the World Health Organization shows that the Cambodian public health system has been dependent on ODA for a large share of its health system financing since 1995.⁶² In other words, although donor money has been pouring into the health system - “there is a ton of money floating around Cambodia,”⁶³ remarked one interviewee - the Cambodian government has been spending less and less on healthcare every year. This suggests that aid is being seriously mismanaged, and that the Cambodian government is not making its health system a priority. Since health outcomes have in fact been improving,⁶⁴ it also implies that an entity other than the MoH is providing the majority of Cambodian healthcare.

Overall, the budget allocation to provide healthcare in Cambodia is far too low to adequately meet the population’s needs and its downward trend is not encouraging.

⁶⁰ The World Bank, *World Development Indicators (2017), Net official development assistance received (current US\$)*, retrieved from:

<http://databank.worldbank.org/data/reports.aspx?source=2&series=DT.ODA.ODAT.CD&country=KHM>.

⁶¹ Annear et. al, “The Kingdom of Cambodia Health System Review,” 19.

⁶² Annear et. al, “The Kingdom of Cambodia Health System Review,” 65.

⁶³ Interview with URC employee, August 12, 2016.

⁶⁴ Annear et. al, “The Kingdom of Cambodia Health System Review,” 143.

Summary

Cambodia is a country facing significant challenges to provision of adequate healthcare in their public sector: the system is underfunded, short of personnel, and has a strongly ingrained patronage system that obstructs quality, efficiency, and regulation. It is these shortages - and the increasing market demand for adequate healthcare provision - that has led to the prominent roles played by INGOs and the private sector. The question then becomes, how are the three sectors balancing their roles in the health sector and is it sufficient?

III. International Non-Governmental Organizations

Definitional

When the term “NGO” is used it refers to all forms of NGOs, those that originated in the country they provide services in and those that originated in a foreign country. NGOs that work in the country they were formed in, and are concerned with issues within that country, are termed “LNGOs” (local non-governmental organizations). NGOs that were formed in a different country are called “INGOs” (international non-governmental organizations). This describes organizations that were founded in one country, but have projects in many other countries. Often, INGOs create local offices in the country they operate in, but they remain internationally based because their management is overseen by the foreign parent organization.

While both LNGOs and INGOs are active in Cambodia, our work is focused on the mechanisms and effects of INGOs. In Cambodia, most LNGOs work under INGOs as care providers and receive their funding from them; according to the Cooperation Committee for Cambodia (CCC), which coordinates NGOs in the country, “about 85% of local organizations in the country are receiving funding support from the international NGO(s).”⁶⁵ Thus they are generally unable to sway policy on their own. INGOs, in turn, are funded by even larger multinational organizations such as the World Bank and United Nations.⁶⁶ It is also important to note that we define INGOs as their own pillar within Cambodia’s health system. This is in contrast with other literature that places NGOs as a subcategory of the private sector. For our work we draw a line between NGOs and private

⁶⁵ Interview with CCC employee, August 15, 2016.

⁶⁶ Interview with URC employee, August 12, 2016.

sector providers, with the distinction being that NGOs are not-for-profit while private care providers are for-profit. They are also not public entities; although Cambodian INGOs contribute to government funding and programs, they are not publically controlled. INGOs in our perspective are part of the so-called third sector- or civil society sector- and have a specific and unique function in society. INGOs are an entirely separate pillar in the health system that provides care and drives policy. The only other actor that does not fit neatly into the public, private, and INGO sectors, are the United Nations and other similar organizations that are technically INGOs, but are uniquely supranational and multilateral. These will be referred to separately when needed.

INGO Proliferation

The global proliferation of INGOs is not accidental. There are many benefits to INGOs that have led to their being a cornerstone of international development policy. In theory, INGOs are more accountable funding recipients than governments considering the high incidence of public graft. The US certainly takes this view; in Cambodia, USAID refuses to deliver aid through the government at all and instead works only with civil society organizations.⁶⁷ Many other countries and international aid organizations also have this policy.

Even if developing countries' governments were fully funneling aid to its intended purpose, civil society organizations may be more efficient regardless. After all, these organizations are often focused on one issue that they have both passion for and experience with. If the government lacks the infrastructure or background to tackle a complex issue,

⁶⁷ "Country Development Cooperation Strategy 2014-2018," *USAID Cambodia* (2014): 3, source: [https://www.usaid.gov/sites/default/files/documents/1861/CDCS%20Cambodia%20Public%20Version%20\(approved\).pdf](https://www.usaid.gov/sites/default/files/documents/1861/CDCS%20Cambodia%20Public%20Version%20(approved).pdf).

civil society organizations may be more suited to providing services quickly, efficiently, and equitably.

Furthermore, from an economic standpoint, in countries with low investment, as developing countries often have, it is perfectly logical for foreign funders to temporarily fill this gap by partnering with INGOs until the government can establish itself enough to take over projects. In economics, this is known as dynamic gains and hinges on the idea that short-term solutions can allow long-term progress to take place.⁶⁸ And, morally, it makes sense that funders from developed countries would offer their technical experience until their developing neighbors can build capacity themselves. In this view, foreign aid channeled through civil society organizations is absolutely legitimate in order to sidestep corruption, enjoy increased efficiency, and ultimately transfer technology and knowledge to other countries.

The key assumption in this view is that INGO involvement is *temporary*. Ideally, these organizations enter a developing country, provide training, attract funding, set up systems and infrastructure, then phase out and allow locals to maintain it. A representative from Maryknoll Cambodia,⁶⁹ an NGO/International Catholic Mission Movement, described their philosophy on the permanence of NGO missions as, “We go where we’re needed, but not wanted and leave when we’re wanted, but not needed.”⁷⁰ INGOs are intended to facilitate technology, knowledge, and capacity transfer, then leave the developing country to build on that foundation. Their neutrality in politically charged and kleptocratic countries is a benefit,

⁶⁸ Steven N. Durlauf and Lawrence E. Blume, editors. *The New Palgrave Dictionary of Economics*, 2nd ed. (London: Palgrave Macmillan, 2008), 567.

⁶⁹ See: <https://maryknollsisters.org/about-us/our-work/>

⁷⁰ Interview with Maryknoll Sister, August 12, 2016.

and they often have the international backing of powerful countries to provide monitoring and enforcement. From this theoretical perspective, INGOs are a hugely positive addition to any developing country - they provide support and transfer capacity that quicken countries' progress to stability and self-sufficiency. Indeed, INGOs are a vital part of any well-functioning society.

In Cambodia, INGOs have certainly been relied upon as a solution to the low public health capacity discussed in the previous chapter - and can unquestionably be considered one of the pillars of the health system along with private and public providers. The Ministry of Health has purposefully outsourced healthcare to INGOs in a process known as contracting, which has led to an abundance of INGOs in the country.⁷¹ Between 1997 and 1998, the MoH solicited bids from organizations in order to grant contracts for healthcare provision since the government was unable to provide healthcare itself.⁷² These contracts were defined as “a complete service delivery contract whereby the contractors have absolute responsibility for service delivery;” all awardees in the system were INGOs.⁷³ The profusion of INGOs in Cambodia was also helped along by the period in the early 1990s when UNTAC managed the country; the presence of an international organization in the country's early period of development certainly facilitated and encouraged other INGOs to establish operations there. The number of INGOs in Cambodia has only grown since: currently, as previously mentioned, the US Library of Congress estimates that there are 5,000 registered

⁷¹ OECD, *Contracting Out Government Functions and Services: Emerging Lessons from Post-Conflict and Fragile Situations*, (Paris: OECD Publishing, 2009), DOI: <http://dx.doi.org/10.1787/9789264066212-en>, 22.

⁷² OECD, *Contracting Out Government Functions and Services: Emerging Lessons from Post-Conflict and Fragile Situations*, 23.

⁷³ OECD, *Contracting Out Government Functions and Services: Emerging Lessons from Post-Conflict and Fragile Situations*, 23.

NGOs in Cambodia.⁷⁴ This translates to the second most NGOs per capita in the world. Overall, due to Cambodia's history and the policies implemented by its MoH, INGOs are a cornerstone of the Cambodian healthcare system. As one interviewee put it, "We just did their job for them."⁷⁵ Indeed, in 2012 alone NGOs and other donors spent \$209 million on Cambodian healthcare provision, more than the MoH itself.⁷⁶

Funding

INGOs are, in our definition, not for profit. As such, they rely on external funding to finance their operations. These generally come from two sources: private donations and public grants.

A large portion of INGOs' budget is from private citizen's personal donations. For example, World Renew⁷⁷ - a religious INGO active in Cambodia- received 66% of its funding (over \$23 million) from private sources between July 2015 and June 2016.⁷⁸ Similarly, Save the Children- another INGO active in Cambodia- received 43% of its 2015 operating budget from private gifts.⁷⁹ Thus, it follows that INGOs put a large portion of their time and energy into securing these donations. In order to attract donations, INGOs must appeal to the public and market their "product" - their vision of humanitarian development and aid, and the process they plan to implement - to those who might donate.

⁷⁴ Johnston, "Cambodia: Law on NGOs Passed."

⁷⁵ Interview with INGO employee, August 1, 2016.

⁷⁶ Bureau of Health Economics and Financing of the Department of Planning and Health Information, *Measuring Health Expenditure in Cambodia: National Health Accounts Report 2012*, (Phnom Penh: Ministry of Health, 2014), <http://www.dacp2014.info/asset/technical/34646.pdf>, 15.

⁷⁷ See: <http://worldrenew.net/cambodia>

⁷⁸ "How Our Funds Are Spent," World Renew, <http://worldrenew.net/money>.

⁷⁹ "Financial Information," Save the Children, http://www.savethechildren.org/site/c.8rKLIXMGIpI4E/b.6229505/k.5C4E/Financial_Information.htm.

A second and substantial portion of INGO funding is secured through grants provided by governments and other larger INGOs.⁸⁰ The former is generally the foreign aid branch of governments - such as USAID, and the latter is generally large multinational INGOs such as the United Nations or the Global Fund. INGOs write proposals to win these grants for specific projects or initiatives, and are generally in competition with other INGOs to win them.⁸¹ According to one INGO employee, this competition has increased in recent years: “It used to be [that] we would submit kind of mediocre proposals and they'd still be accepted. Now we really have to hustle. It's very competitive.”⁸² Looking again at World Renew and Save the Children: the former received 33% of their 2015 budget from grants from a variety of sources,⁸³ while the latter received 36% of theirs from US government grants alone.⁸⁴

Considering the resources required to attract private donations and apply to grants, it is unsurprising that INGOs have increasingly turned to creative sources to maintain their financing. This is evident in the rise of “corporatization”⁸⁵ and social enterprise in INGOs. Corporatization refers to INGOs raising money by selling goods or services in the private sector. Social enterprise is a specific type of corporatization where NGOs sell products or services in the name of some social issue.⁸⁶ In Cambodia, the prime example of social

⁸⁰ Interview with URC employee, August 12, 2016.

⁸¹ Interview with FHI 360 employee, August 19, 2016.

⁸² Interview with FHI 360 employee, August 19, 2016.

⁸³ “How Our Funds Are Spent.”

⁸⁴ “Financial Information.”

⁸⁵ Christina Maiers and Margaret Reynolds and Mark Haselkorn, “Challenges to Effective Information and Communication Systems in Humanitarian Relief Organizations,” *International Professional Communication Conference 2005* (2005): 89, doi: 10.1109/IPCC.2005.1494163.

⁸⁶ Khieng and Dahles, “Resource Dependence and Effects of Funding Diversification Strategies among NGOs in Cambodia,” 1431.

enterprise is Population Services Khmer (PSK),⁸⁷ an NGO that sells family planning goods, such as condoms, at discounted prices.⁸⁸ Indeed, one interviewee described the organization as “the world’s biggest condom supplier.”⁸⁹ Originally an INGO - a local office of the global organization Population Services International (PSI) - PSK gradually became fully locally managed.⁹⁰ Without its parent’s funding, PSK turned to social enterprise to support itself.⁹¹ PSK’s move to social enterprise is relevant to Cambodia in general because its income status has recently increased from low to lower middle income (as per the World Bank’s designation).⁹² This has led many international donors to move away from Cambodia to more subjectively “needy” countries- namely Myanmar- where they believe they can do more good.⁹³ In an interview with DFAT, the Department of Foreign Affairs and Trade for Australia, the conflict caused by this increase in income status was described to us: “So we're sort of concerned that you're a victim of your own success in the region and that resources are reducing when there's still threats. The risk is still there. How will these countries finance to respond when required?”⁹⁴ As funding shifts away, more and more organizations find themselves in PSK’s position - in need of funding and willing to get creative in order to secure it, sometimes through corporatization. This movement towards social enterprise and corporatization is of interest because there is neither a formal legal basis nor monitoring

⁸⁷ See: <http://www.psk.org.kh/>

⁸⁸ Interview with PSK employee, August 10, 2016.

⁸⁹ Interview with a URC employee, August 12, 2016.

⁹⁰ Interview with PSK employee, August 10, 2016.

⁹¹ Interview with PSK employee, August 10, 2016.

⁹² “How Are Income Group Thresholds Determined?” The World Bank, <https://datahelpdesk.worldbank.org/knowledgebase/articles/378833-how-are-the-income-group-thresholds-determined>.

⁹³ Interview with URC employee, August 12, 2016.

⁹⁴ Interview with DFAT employee, August 22, 2016.

institutions in place to ensure that INGOs are maintaining their accountability.⁹⁵ Indeed, research suggests that the rise in corporatization is simply a rise in INGO corruption⁹⁶ - an issue that will be addressed more fully below in the regulation portion of this chapter. We will further discuss how the need for funding decreases INGO accountability in the micromarket section of chapter six.

Regulation and Accountability

Most regulations surrounding NGOs have to do with tax-exemption status and financial accountability.⁹⁷ The United States and other well-developed capitalist democracies generally have strict tax laws for non-profits,⁹⁸ but many developing countries are far less well-regulated.⁹⁹ Countries that do have regulations on the books often lack the resources for monitoring and enforcement.¹⁰⁰ Cambodia certainly falls under the latter category: the Law on Associations and Non-Governmental Organizations (LANGO) was passed in 2015,¹⁰¹ but Cambodia lacks the ability to successfully monitor its massive and largely autonomous INGO sector.¹⁰²

⁹⁵ Sothy Khieng and Heidi Dahles, "Resource Dependence and Effects of Funding Diversification Strategies among NGOs in Cambodia," *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 26.4 (2015): 1434.

⁹⁶ Khieng and Dahles, "Resource Dependence and Effects of Funding Diversification Strategies among NGOs in Cambodia," 1431.

⁹⁷ Susannah H. Mayhew, "Hegemony, Politics and Ideology: The Role of Legislation in NGO–Government Relations in Asia," *The Journal of Development Studies* 41.5 (2005): 743.

⁹⁸ Alnoor Ebrahim, "Accountability in Practice: Mechanisms for NGOs," *World Development* 31.5 (2003): 816.

⁹⁹ Edward Mac Abbey, "Constructive Regulation of Non-Government Organizations," *The Quarterly Review of Economics and Finance* 48.2 (2008): 374.

¹⁰⁰ Mayhew, "Hegemony, Politics and Ideology: The Role of Legislation in NGO–Government Relations in Asia," 744.

¹⁰¹ Johnston, "Cambodia: Law on NGOs Passed."

¹⁰² Monir Mir and Swapan Kumar Bala, "NGO Accountability in Bangladesh: Two Contrasting Cases," *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 26.5 (2015): 1845-1846.

Where there are loopholes, INGOs have been known to take advantage. In authoritarian countries, NGOs are able to sidestep regulation if they publicly support the ruling party, which leads to the proliferation of bribery.¹⁰³ In countries where governments have put caps on the amount of foreign aid allowed, NGOs have become increasingly corporate to raise their own funds, a process discussed above, which the literature has shown leads to inefficiency and conflicts of interest.¹⁰⁴ In general, although NGOs were initially lauded as more accountable and effective funding recipients than developing governments there is next to no empirical evidence to support this.¹⁰⁵ On the contrary there has been a sharp upswing in corruption scandals among NGOs that has increased experts' concerns about NGO accountability.¹⁰⁶ Case studies have shown significant fraud, corruption, and fund mismanagement on the part of NGOs.¹⁰⁷ Indeed, the literature is firm that an increase in foreign funding to NGOs leads to less downward accountability to the group of people they intend to help.¹⁰⁸ Perhaps most strikingly, Aldashev finds that as the number of NGOs increase in a country it leads to increased inefficiency, diversion of funds, and less downwardly accountable organizations.¹⁰⁹

To date, there has been only one scandal concerning INGO mismanagement in Cambodia that we are aware of. The organization in question, MEDiCAM, allegedly “triple

¹⁰³ Mir and Bala, "NGO Accountability in Bangladesh: Two Contrasting Cases," 1836.

¹⁰⁴ Khieng and Dahles, "Resource Dependence and Effects of Funding Diversification Strategies among NGOs in Cambodia," 1427.

¹⁰⁵ Mayhew, "Hegemony, Politics and Ideology: The Role of Legislation in NGO–Government Relations in Asia," 728.

¹⁰⁶ Ebrahim, "Accountability in Practice: Mechanisms for NGOs," 813.

¹⁰⁷ Mayhew, "Hegemony, Politics and Ideology: The Role of Legislation in NGO–Government Relations in Asia," 744.

¹⁰⁸ Mir and Bala, "NGO Accountability in Bangladesh: Two Contrasting Cases," 1831.

¹⁰⁹ Gani Aldashev and Thierry Verdier, "Goodwill Bazaar: NGO Competition and Giving to Development," *Journal of Development Economics* 91.1 (2010): 60.

billed people” and stole “four hundred and something thousand dollars” from their malaria program funding, and was shut down shortly after.¹¹⁰ Regardless, the extremely high density of INGOs in Cambodia, along with their autonomy and power in the health sector, make their accountability vital and effective regulation imperative.

¹¹⁰ Interview with a URC employee, August 12, 2016.

IV. Private

Definitional

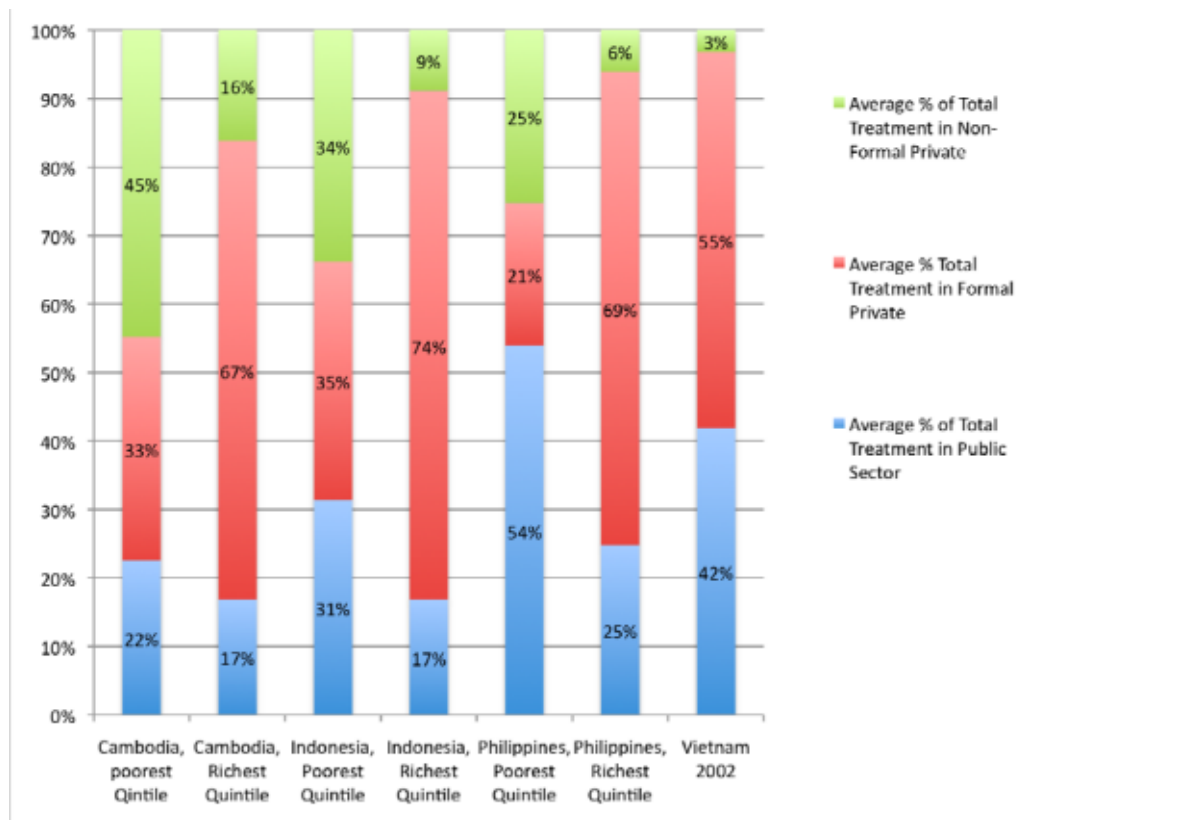
Private healthcare in Cambodia is provided primarily through for-profit clinics, hospitals not under the purview of the government, and small practices run by individual physicians. For the purpose of this paper, pharmacies and other smaller non-registered healthcare providers will not be included in the definition of private healthcare provision. In Cambodia, there is a rapidly growing, though loosely regulated, private sector with more than 5,500 licensed providers which deliver a large proportion of health services. This growing private medical sector is the point of first contact for the majority of the sick and injured population.¹¹¹ Despite the large contributions of INGO and donor government funding to public healthcare, the Center for Social Development found that “many citizens prefer to consult private (92% contact rate) rather than public (31% contact rate) health care providers.”¹¹² In other words, 92% of those seeking medical care choose to interact with private providers. Evidence suggests that the private professional healthcare sector is now larger than the public healthcare sector in some regions of Cambodia. In the province of Kampong Cham, for example, there is a base of 153 private facilities. In comparison, public sector services are provided from 141 facilities. This is of particular significance because the province has the largest population base in the country.¹¹³ The sheer size of the Cambodian

¹¹¹ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxiv.

¹¹² “Living Under the Rule of Corruption: An Analysis of Everyday Forms of Corrupt Practice in Cambodia,” *Center for Social Development* 3 (February 2005): 28.

¹¹³ Sann Chan Soeng, Jeremy Grundy, Cheng Morn, and Chham Samnang, “Evaluation of Immunization Knowledge, Practices, and Service-delivery in the Private Sector in Cambodia,” *Journal of Health, Population and Nutrition* 26.1 (2008): 96, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2740687/#B1>.

private sector - both formal (hospitals and clinics) and informal (clinic “shops” and individual doctors) - is shown in the figure below:



Source: DHS Data (Cambodia 2005; Indonesia 2007; Philippines 2003; Vietnam 2002)

(Figure 7: Source of healthcare by income quintile.)¹¹⁴

Almost 80% of Cambodians are seeking healthcare in the private sector - a percentage similar to Indonesia, but significantly smaller than in the Philippines or Vietnam.

Public-Private Partnerships

Cambodia is one of many countries in the world using privatization as a solution to fill the gaps in capacity of public healthcare. Sekhri and Feachem define the motivation

¹¹⁴ Dominic Montagu and Abby Bloom, “The Private Sector and Health Services Delivery in the EAP Region: Background Report to UNICEF on the Role and Experiences of the Private Sector in Provision of Child Health Services,” 12.

behind working with the private sector in their study of the efficacy of privatization, “the goal of any partnership with the private sector is to actively enlist private capital, both human and financial, to help governments fulfill their responsibilities for providing equitable access to high-quality services.”¹¹⁵ We use this statement to identify three goals for an effective partnership between public and private healthcare: first, creating dynamic gains for long-term public capacity, second, providing equitable access to healthcare, and third, providing high-quality care. Each of these points will be addressed in the argumentative portion of our thesis.

Process of Privatization

Privatization within the healthcare system is a growing global phenomenon - both due to independent market demand and contracted public-private partnerships. Its growth as a sector has been controversial, with supporters hailing it as the solution to weak, unresponsive, and resource-starved healthcare systems, and opponents shying away from its for-profit and often under-regulated nature.

Studies in favor of privatization focus on the possible increased patient-centredness and responsiveness of the private sector, in addition to proposing that it could produce better results at a lower overall cost. The literature also demonstrates that patient wait times are significantly lower in the private system.¹¹⁶ The improvement in both patient treatment and access to care, according to proponents, is especially important in underrepresented

¹¹⁵ Sekhri, Feachem, and Ni, “Public-private integrated partnerships demonstrate the potential to improve health care access, quality, and efficiency,” 5-6.

¹¹⁶ Pongsupap and Van Lerberghe, “Choosing between public and private or between hospital and primary care: responsiveness, patient-centeredness and prescribing patterns in outpatient consultations in Bangkok,” 81-89.

rural areas and where privatization can increase the number of healthcare providers exponentially.

Opponents, however, cite the steep costs that could be associated with increased private healthcare provision. Among these costs are brain drain, as public sector workers move to the private sector due to low wages or choose to participate in physician dual practice - risking lowering their working hours in public hospitals.¹¹⁷ In addition, it is possible that the private sector increases the inequity of access because it favors those who can afford treatment at the for-profit organizations.¹¹⁸ These arguments will be expanded upon later in our paper. This literature argues against the lower costs argument, citing evidence that private participation in healthcare is actually associated with higher expenditure. For example, Lebanon has one of the most privatized health systems in the developing world, but it spends more than twice as much as Sri Lanka on healthcare, and yet its infant and maternal mortality rates are 2.5 and 3 times higher respectively.¹¹⁹ Additionally, the difficulty of managing and regulating private providers creates inefficiencies, especially where government capacity is weak and there are too few private provider organizations to ensure price competition. This is demonstrated by the contracting process in Cambodia, where the low number of technically acceptable bids received in one of its largest schemes to contract out healthcare meant that in many cases contracts were awarded without competition - even when the overall size of the program was reduced by 40%. After this

¹¹⁷ Karl-Arne Johannessen and Terje P. Hagen, "Physician's engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study," *BMC Health Serv Res* (July 10, 2014): 14-299. Doi: 10.1186/1472-6963-24-299.

¹¹⁸ "Blind Optimism: Challenging the myths about private health care in poor countries," *Oxfam Briefing Paper* (February 2009): 7, <https://www.oxfam.org/sites/www.oxfam.org/files/bp125-blind-optimism-0902.pdf>.

¹¹⁹ "Blind Optimism: Challenging the myths about private health care in poor countries," *Oxfam Briefing Paper* (February 2009): 16.

process, private providers were found to have lower operating costs in only 20 percent of contracting programs for which data is available.¹²⁰ The low competition in the contracting bids means that the private organizations involved maintained negotiation leverage over the MoH and, accordingly, have little regulation or national management.

Regulation

The literature, although lacking in uniformity in most areas, shares one consensus: under-regulated private sectors can be dangerous and counterproductive - leading to overprescription of corticosteroids, incomplete courses of antibiotics, unnecessary and expensive surgical procedures, dangerous prescriptions of conflicting medications, and uninformed health advice - particularly in the area of family planning.¹²¹ Although these risks are present in all health sectors, their prevalence and degree are exacerbated in private sectors that have little oversight and accountability, a situation that is certainly the current case in Cambodia.

Although regulation of private healthcare remains low - and difficult to enforce, as will be discussed in the Dual Practice section of the paper- steps forward have been made in recent years by the Cambodian government. The Royal Government of Cambodia enacted legislation in its *Law on the Management of Private Medical, Paramedical and Medical Aid Services (2000)*, which stipulates the conditions under which private-sector providers can operate and identifies the roles and responsibilities of MoH for monitoring pharmaceutical practice and

¹²⁰ “Blind Optimism: Challenging the myths about private health care in poor countries,” *Oxfam Briefing Paper* (February 2009): 17.

¹²¹ Chris Vickery, Greg Rose, Steve Dixon, Lo Veasna Kiri, and Sharon Wilkinson, “Private Practitioners in Phnom Penh: A Mystery Client Survey,” *Phnom Penh Urban Health Project* (November 2001).

imports, including vaccines.¹²² Much of this legislation passed due to the identification by the MoH of private-public partnerships as integral to Cambodia's development in its *Health Sector Strategic Plan*. Due to low enforcement ability, however, there continues to be little oversight of private sector healthcare facilities. The registration of all private medical facilities and practices was made mandatory under a law adopted in late 2000, though the resources available for effectively monitoring are limited and this has so far done little to prevent the fact that in rural areas private non-medical (unqualified and unregistered) providers account for half of all health-care providers.¹²³ In fact, this number may be an underestimate given the tactics used by the Cambodian government in their survey measures. As described in our interviews, "They'll [the Cambodian government] say 'a hundred percent of...illegal pharmacies...have been shut down.' What they're really saying is '100 percent of illegal pharmacies that are not managed by Ministry of Health staff have been shut down.'"¹²⁴ This reflects the firmly entrenched patronage system present in Cambodian healthcare - a system we will expound upon in the following section.

This lack of regulation, and inability to enforce existing regulation, are significant due to the size of the private sector in Cambodia; the sector is not functioning as a secondary provider of care in Cambodia, but rather as a primary contact point for many people seeking healthcare. Thus, the dangerous healthcare practices that result from poor regulation directly affect broad swaths of the Cambodian population.

¹²² "Health Service Delivery Profile: Cambodia," *World Health Organization and Ministry of Health Cambodia* (2012): 2, http://www.wpro.who.int/health_services/service_delivery_profile_cambodia.pdf.

¹²³ Annear et. al, "The Kingdom of Cambodia Health System Review," xxii.

¹²⁴ Interview with URC employee, August 12, 2016.

V. Effects on Public Sector Capacity

Introduction

Outsourcing to INGOs and assumption by the private sector have effects on the capacity of the public sector. Although the intention is to give the state time to build its infrastructure while meeting health needs, we argue that both sectors are instead creating competition for the public sector through brain and resource drain. The former is the movement of skilled workers from the public sector into the other two sectors, and the latter is the channeling of funding and other resources to the other sectors rather than to the public sector. Overall, both processes reduce the human and physical capital of the public sector and leave it weaker than before the outsourcing and assumption occurred. We will begin by discussing the mechanics of brain drain, then will discuss resource drain.

Brain Drain

Dual Practice

The first mechanism that drains qualified individuals from the public sector is the existence of dual practitioners, defined as “physicians employed in public hospitals who also work in other types of health services, including ambulant emergency care where they substitute for private GPs (moonlighting), private not-for-profit hospitals or private for-profit hospitals and other providers.”¹²⁵ The exact number of public health staff in dual practice is unknown, but has been estimated at two-thirds of the public workforce.¹²⁶ Of

¹²⁵ Johannessen and Hagen, “Physician’s engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study,” 2.

¹²⁶ “Reforming Remuneration and HR Practices for Cambodia’s Health Professionals,” *Knowledge Brief Health, Nutrition and Population Global Practice* (November 2014): 2,

those involved, MoH employees constitute the largest proportion of health workers employed in the for-profit private sector, either as independent workers (self-employed private practitioners) or employees of nongovernmental health services.¹²⁷ This demonstrates that a large sector of the private sector's workforce is pulled directly from the public health system.

Given the opportunities in the private sector, why do some health workers go to great lengths to remain a part of the public sector? Recall that physicians entering the health system in Cambodia after graduation from medical school often pay to enter the public system, a common bribing practice in all government job areas for hiring and promotion.¹²⁸ By paying to work in the public sector, the physicians increase their chances of being able to receive a private practitioner's license and protect their private practices from government oversight. An employee at the University Research Company (URC) who works closely with the public health sector explains, "in effect purchasing your way into the Ministry of Health is purchasing the right to set up a dual practice."¹²⁹ Recently, however, a growing number of medical graduates never enter government service, indicating the expanding role and power of the private sector.¹³⁰ In addition to growing influence, employment in the private sector is desirable due to the increased wage opportunities - particularly for specialists. The average base salary (including allowances) for a government health professional is only about \$100 per month, with doctors and specialists earning only 50% more than the average. Thus, for

<http://documents.worldbank.org/curated/en/332491468236678896/pdf/933880BRI00P120ealth0Professionals.pdf>.

¹²⁷ Annear et. al, "The Kingdom of Cambodia Health System Review," 93.

¹²⁸ Interview with URC employee, August 12, 2016.

¹²⁹ Interview with URC employee, August 12, 2016.

¹³⁰ Annear et. al, "The Kingdom of Cambodia Health System Review," 93.

many doctors dual practice, principally home visits and private clinics, is still the main source of income for specialists and medical doctors. Income from these practices average between \$50 and \$350 per month.¹³¹

Although not inherently negative, studies have found physician dual practice to be concerning due to the threat of reducing the work supply in the public sector and the possible conflicts of interest for doctors who may be competing for their own patients between sectors.¹³² These risks are limited in countries that have the capacity to restrict the opportunities for dual practitioners to prioritize income and benefits over their responsibility to the public - an example being the integrated partnership success in the Norwegian system¹³³ - but this capacity is often lacking in lower and middle income countries.¹³⁴ This is exemplified by the fact that even in one of the most effective ministerial departments in the Cambodian MoH, out of around 15 staff “only four or five actually work; the remaining simply showed their face, donated a portion of their salary to their head of department and pursued private activities.”¹³⁵ This phenomenon is exemplified by the Cambodian youth and sports ministry, described to us in our interviews, “two buildings over is a classic french ministry - youth and sports. And, as far as I can tell, I mean, about once a week the parking lot is completely full. The whole rest of the week the parking lot has five cars in it. And there

¹³¹ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

¹³² Johannessen and Hagen, “Physician’s engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study,” 1.

¹³³ Johannessen and Hagen, “Physician’s engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study,” 2.

¹³⁴ Sanjay Basu, Jason Andrews, Sandeep Kishore, Rajesh Panjabi, David Stuckler, “Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review,” *PLOS Medicine* 9.6 (June 19, 2012): 1-11, doi:10.1371/journal.pmed.1001244.

¹³⁵ Tim Kelsall and Seiha Heng, “Inclusive healthcare and the political settlement in Cambodia,” *New Political Economy* (2015): 7, doi:10.1080/13563467.2015.1079174.

must be 400 to 500 employees in the building in theory.”¹³⁶ Essentially, physicians who wish to work in the private sector must pay a one-time bribe to enter the MoH in order to pave the way for receiving a private care license, and then must pay continuing bribes to the heads of their departments to ignore that they are working the majority of their hours outside of the public sector.

The Cambodian government’s failure to regulate dual practice is therefore exacerbated by the extensive connections that exist between the public and private healthcare systems. Due to the system described above, dual practice creates ties between the government and private practices, as the two sectors now share employees and are co-sources of income. The heads of department receive portions of the employee salaries only so long as those employees are successfully pursuing work in the private sector. This effectively prevents private sector regulations from being passed, because the dual employment of many public health officials in the private sector creates a conflict of interest for the government in regulating private sector activities. In our interview with URC, it was stated that, “the government doesn't regulate- and has no appetite to regulate- the private sector because it doesn't want to upset its own staff in the afternoons! The private sector is the same people in different premises.”¹³⁷ And they actually do regulate the few private practices that are not dual practice.”¹³⁸ Thus, in order to have a successful - and less monitored - practice, doctors must participate in the bribing and patronage system.¹³⁹ This cycle of employment is perpetuated as low wages and fear of corruption in the public sector

¹³⁶ Interview with URC employee, August 12, 2016.

¹³⁷ Interview with URC employee, August 12, 2016.

¹³⁸ Interview with URC employee, August 12, 2016.

¹³⁹ “Living Under the Rule of Corruption: An Analysis of Everyday Forms of Corrupt Practice in Cambodia,” 3.

drive many educated and high-skilled individuals to seek work in the other sectors, leaving less qualified individuals in positions of power and influence in the government, further retarding the ability of the government to design and implement effective healthcare policies and regulations.

In summary, a large portion of Cambodia's public health workers are being pulled into the private sector, which not only drains the public system of workers but also perpetuates a cycle of patronage.

Salaries and Benefits in INGOs

A second avenue for brain drain from the public sector is due to healthcare professionals' preference for employment in INGOs. This is largely because of salary differences: positions with INGOs pay much better than equivalent positions in the MoH. Public healthcare professionals in Cambodia are paid as civil servants,¹⁴⁰ with an average monthly salary of \$60 in 2011.¹⁴¹ By 2015, this had risen slightly to \$100 per month, including all allowances, and was only \$50 higher for doctors.¹⁴² According to one interviewee, "You can be a very experienced doctor and you'll still get 200 dollars maximum."¹⁴³ This salary is not sufficient to cover living costs, and as such Chhea notes in her study that "all staff had second jobs. This was not unusual... most health workers in Cambodia had at least one private source of income."¹⁴⁴

¹⁴⁰ Annear et. al, "The Kingdom of Cambodia Health System Review," 75.

¹⁴¹ Chhordaphea Chhea and Narelle Warren and Lenore Manderson, "Health Worker Effectiveness and Retention in Rural Cambodia," *Rural and Remote Health* 10 (2010): 8, <http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=1391>.

¹⁴² Annear et. al, "The Kingdom of Cambodia Health System Review," 76.

¹⁴³ Interview with URC Employee, August 12, 2016.

¹⁴⁴ Chhea and Warren and Manderson, "Health Worker Effectiveness and Retention in Rural Cambodia," 8.

In contrast, in 2009 (two years before Chhea's \$60 per month figure), The Cooperation Committee for Cambodia (CCC)¹⁴⁵ noted that medium sized INGOs were paying their entry level local employees an average of \$137 per month.¹⁴⁶ Although this number is for INGOs in all sectors, considering public health professionals are paid as general civil servants by the MoH, the numbers are roughly comparable. It is also important to note that the figure noted for government employees includes all allowances, while the INGO figure does not. With quantifiable benefits included, the INGO per month salary in 2009 was approximately \$163 (again, compared to \$60 per month for public civil servants two years later).¹⁴⁷

In general, INGOs have a much deeper pool of resources available with which to pay their employees. According to the Cambodian National Health Accounts, in 2012 the government spent approximately \$37 million on employee compensation while NGOs and other donors spent nearly \$57 million - one and a half times as much- on the same.¹⁴⁸ Moreover, the entire Cambodian MoH's expenditure in 2012 was roughly \$200 million,¹⁴⁹ while Save the Children (just one of the INGOs active in Cambodia's health sector) had

¹⁴⁵ "Who We Are," Cooperation Committee for Cambodia, accessed March 28, 2017, <http://www.ccc-cambodia.org/>.

¹⁴⁶ Cooperation Committee of Cambodia, *Survey of Salaries and Benefits for National Staff of International and Cambodian NGOs* (Phnom Penh: CCC, 2009), http://www.ccc-cambodia.org/downloads/publications/Salary_Survey_2009.pdf, 31.

¹⁴⁷ Cooperation Committee of Cambodia, *Survey of Salaries and Benefits for National Staff of International and Cambodian NGOs*, 32.

¹⁴⁸ Bureau of Health Economics and Financing of the Department of Planning and Health Information, *Measuring Health Expenditure in Cambodia: National Health Accounts Report 2012*, 43.

¹⁴⁹ Bureau of Health Economics and Financing of the Department of Planning and Health Information, *Measuring Health Expenditure in Cambodia: National Health Accounts Report 2012*, 17.

\$600 million in revenue in the same year.¹⁵⁰ Granted, Save the Children’s revenue is spread across multiple countries, but the fact that just one of the 5,000 NGOs in Cambodia had an operating budget three times that of the MoH is still telling. In short, INGOs can provide attractive salaries to Cambodian medical professionals and have the resources to continue to do so, making them stiff competition for the MoH.

The intangible benefits of INGOs are also a crucial aspect of health professionals’ decision to work for them rather than for the public sector. Advancement is far easier and more equitable in INGOs; those uninterested in playing the patronage and bribery game can advance within an INGO based on merit. As told to us by one locally hired INGO employee, in order to be promoted in the government you must be “involved in politics,”¹⁵¹ in other words, have connections with high ranking public officials. He found that this was not the case in INGOs.¹⁵² Considering that higher level employees in INGOs were paid an average of \$676 per month in 2009,¹⁵³ opportunities for advancement are not incidental.

Comparatively, in a 2015 public health systems report, the lack of rewards for professional achievement and provision of career development opportunities was stressed.¹⁵⁴ Moreover, the incentive schemes that exist are “fragmented and not adequately linked to performance.”¹⁵⁵ These performance incentives are inconsistent across all health facilities

¹⁵⁰ Internal Revenue Service, *Save the Children’s 2012 990 Form*, http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/2_STC_990_2012.PDF.

¹⁵¹ Interview with World Renew, August 10, 2016.

¹⁵² Interview with World Renew, August 10, 2016.

¹⁵³ Cooperation Committee of Cambodia, *Survey of Salaries and Benefits for National Staff of International and Cambodian NGOs*, 31.

¹⁵⁴ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

¹⁵⁵ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

and the criteria to receive an incentive is generally unclear to employees.¹⁵⁶ Most important, “staff... perceive the criteria to be unfair or not based on their own performance.”¹⁵⁷ In short, dedicated workers find that their efforts are more rewarded in the INGO sector, and they can advance based on merit alone. This is especially attractive to well-educated Cambodians who, despite their qualifications, cannot afford to pay the bribe to work in the government.

Furthermore, INGOs generally offer better healthcare, paid leave, life insurance, and other benefits to their employees. In CCC’s 2009 report, they note that INGO employees generally receive annual leave, sick days, maternity and paternity leave, wedding leave, accident insurance, disability insurance, severance pay, paid overtime, and salary advances, among other benefits.¹⁵⁸ These benefits are expected in INGOs since they operate in a Western system that has enforced standards for employee rights. As INGOs are part of an international labor market, both the wages and benefits they offer their employees must adhere to global standards - this is especially true if they rely on foreign funding to operate. The MoH is far from having the infrastructure to provide a similar benefit package to its employees.¹⁵⁹ Also, if Cambodians are interested in leaving the country, some INGOs offer relocation benefits, which places employees in sister organizations in other countries.¹⁶⁰ Finally, the environment in INGOs is often a draw in and of itself - employees are with

¹⁵⁶ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

¹⁵⁷ Annear et. al, “The Kingdom of Cambodia Health System Review,” 76.

¹⁵⁸ Cooperation Committee of Cambodia, *Survey of Salaries and Benefits for National Staff of International and Cambodian NGOs*, 23-28.

¹⁵⁹ Interview with URC employee, August 12, 2016.

¹⁶⁰ Interview with URC employee, August 12, 2016.

international colleagues, are gaining high level skills, and are enjoying other intangible benefits of working for a large, international organization.

Overall, the combined allure of higher salaries and better benefits draws many health professionals to work for INGOs rather than for the Cambodian government. The 2015 Cambodian *Health System Review* notes that “... there is a noticeable movement of staff from [public] civil-service to higher-paid international and private-sector positions (internal brain drain).”¹⁶¹ Furthermore, an increasing number of medical graduates do not enter the public sector in the first place, preferring to work immediately in the INGO or private sector.¹⁶²

Brain drain from the public to INGO sector is problematic in Cambodia because the public health system cannot afford to lose health professionals. As discussed in the chapter outlining Cambodia’s public health system, the MoH currently employs 19,457 civil servants in the health sector, only 14% of which are doctors, meaning there are approximately 2,723 publicly employed doctors in the whole of the country.¹⁶³ As discussed earlier in this chapter, two-thirds of those 2,723 doctors are dually employed in the private sector¹⁶⁴ and thus barely present as public providers, so the effective number of doctors is even lower. To put these figures in perspective, in order to meet WHO standards for the health worker-to-population ratio Cambodia will need a public health workforce of 32,000 in the next three years.¹⁶⁵ Furthermore, this notable shortage of medical professionals does not appear to be

¹⁶¹ Annear et. al, “The Kingdom of Cambodia Health System Review,” 93.

¹⁶² Annear et. al, “The Kingdom of Cambodia Health System Review,” 93.

¹⁶³ Annear et. al, “The Kingdom of Cambodia Health System Review,” 87.

¹⁶⁴ “Reforming Remuneration and HR Practices for Cambodia’s Health Professionals,” 2.

¹⁶⁵ Annear et. al, “The Kingdom of Cambodia Health System Review,” xxv.

improving as few Cambodians are graduating medical school (less than 80 in 2009).¹⁶⁶ Thus the drain of skilled workers is debilitating for the already short staffed public health system and has certainly contributed to its continued lack of capacity.

The movement of health professionals from the government into the INGO sector has negative impacts beyond the immediate decrease in skilled labor, namely in relation to long-term effects on regulation. This is partially the case because the bribery and patronage system is not merit based, and those who rise to positions of power may be ill-equipped to create policy. With fewer qualified people in government, and an increased ratio of those there due to patronage, strong and effective regulation of health provision is less likely to be implemented. Furthermore, the public sector is unlikely to hire more qualified individuals as it is not in their self-interest to dismantle a system they profit from. This poor outlook for health regulation is concerning for government health infrastructure in general, and the incidence of dual practice particularly. If publicly provided healthcare continues to operate at a low level of quality, more patients will prefer to seek treatment at private hospitals. Simultaneously, weak regulation allows private practitioners to continue profiting from low quality private care. In this two-pronged mechanism, officials profiting from Cambodians' use of private facilities benefit from weak regulation because it both drives patients away from the public sector and into the private sector. Thus, the migration of educated and skilled health professionals to the INGO sector perpetuates a self-reinforcing cycle where those in power in the MoH have few incentives to constrain their behavior and thereby increasingly drive away those most able - and likely - to improve the system.

¹⁶⁶ Midterm Review of the Health Workforce Development, DFAT (2011). Found in Annear et. al, "The Kingdom of Cambodia Health System Review," 97.

In summary, brain drain from the MoH into the private sector via dual practice, and into the INGO sector- due to the latter's more attractive salaries, benefits, and work environment- weakens the human capacity of the public health system. Without skilled medical professionals, the public sector has less capacity with each passing year. Furthermore, in the longer term, as the MoH hollows out, incentives to create effective regulation are decreased, suggesting worse quality of care as a result.

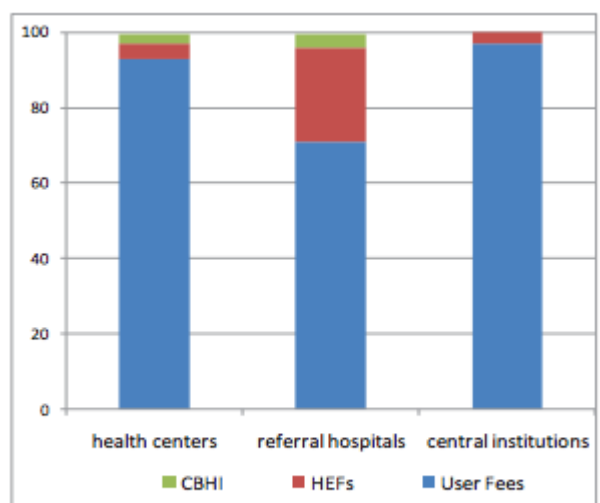
Resource Drain

We will now move on to discuss the second mechanism weakening the capacity of the Cambodian public health system: resource drain. This refers to the channeling of funding and other resources to the private and INGO sectors rather than to the public sector.

Contracting and the Cambodian Public's Health Spending

The first mechanism that drains resources from the public healthcare system is the increased prominence of the private sector in primary healthcare provision. This resource drain from the public to the private occurs in two primary ways. First, over time the expansion of the private sector and the perception that it provides higher quality care has led to the private sector receiving the vast majority of individuals' health spending. Secondly, in response to its historical lack of infrastructure - particularly in rural regions - the government has contracted private practitioners to fill the gaps in its capacity. This implies that the government continues to divert a large proportion of its own funding to developing the private provision of healthcare, rather than using the available resources to build public infrastructure.

The growth of the private sector and the corresponding increase in patients choosing to seek care outside of the public sector is significant because health system user fees generate the largest percentage of public health sector incomes (see figure below).



Sources: MOH Health Financing Report 2008

(Figure 8: Payment for health services by type of facility - in percent of total income.)¹⁶⁷

Therefore, as there is a limited supply of patients and demand for healthcare, by pulling patients from the public sector, the private sector is directly impacting the public sector's income and resources. This becomes even more evident as the private sector grows.

Although outpatient consultation rates in the public sector have increased, the use of licensed and unlicensed providers in the private sector has grown even faster. The difference in utilization growth between the public and private health sectors is striking. In 2000 21.9% of those first seeking treatment sought it in the public sector, while 38.5% sought it in the private sector. By 2005, utilization of the public sector grew to 24.4% and utilization of the

¹⁶⁷ "MoH Health Financing Report 2008," *Ministry of Health Cambodia* (2008).

private sector grew to be 51.7%.¹⁶⁸ Therefore, over the course of five years the public sector grew less than 3% in comparison with over 27% growth of the private sector. It is estimated that about two-thirds of care episodes now take place in the private sector.¹⁶⁹ According to the Health Service Delivery Profile developed by the WHO in conjunction with the MoH, “Cambodia has one of the largest shares of out-of-pocket payments in the Western Pacific Region.”¹⁷⁰ Currently, the majority of those out-of-pocket payments (68%) go to private medical services, while only 18.5% are spent in the public sector.¹⁷¹

Secondly, the Cambodian government began piloting the external contracting model of service delivery in 1999.¹⁷² This strategy built on the foundation of public–private partnerships in health service management by contracting INGOs and private facilities through the MoH, primarily to address three main issues: decentralization to rural regions with low access to healthcare, the use of regulated markets rather than unregulated and dangerous “small providers,” and finally, harnessing the emergence of private sector and civil society.¹⁷³ For example, the MoH contracted INGOs to manage the delivery of health services by public health providers in five Operating Districts.¹⁷⁴ While paying the other sectors to manage health was intended to improve and supplement government provided services, it has ended up being that the other sectors control and implement all services in

¹⁶⁸ “Cambodia Demographic and Health Survey,” *Measure DHS (2000, 2005)*.

¹⁶⁹ “Reforming Remuneration and HR Practices for Cambodia’s Health Professionals,” 2.

¹⁷⁰ “Health Service Delivery Profile: Cambodia,” 3.

¹⁷¹ “Health Service Delivery Profile: Cambodia,” 3.

¹⁷² “Blind Optimism: Challenging the myths about private health care in poor countries,” *Oxfam Briefing Paper* (February 2009): 17.

¹⁷³ Annear et. al, “The Kingdom of Cambodia Health Systems Review,” 122.

¹⁷⁴ Peter Annear and Keovathanak Khim, “Strengthening district health service management and delivery through internal contracting: Lessons from pilot projects in Cambodia,” *Nossal Institute for Global Health* 96 (November 2013): 241-249, <http://www.sciencedirect.com/science/article/pii/S0277953613001111>.

the contracted regions. This is mainly an issue due to the fact that there is still no regulation of prices or quality of private healthcare.¹⁷⁵

In conclusion, resource drain from the MoH into the private sector, caused by the perception that it provides higher quality care and the growing number of regions placed under private partnerships, has led to the private sector receiving the vast majority of individual health spending. This demonstrates that the government is continuing to divert a large proportion of its own, steadily decreasing, funding to developing the private provision of healthcare, rather than using the available resources to rebuild public infrastructure.

International Funding

A second mechanism draining available resources from the Cambodian government is via the INGO sector. This occurs largely due to the perception that INGOs are better aid recipients than developing governments. USAID, for example, has a policy to funnel aid almost exclusively through INGOs.¹⁷⁶ Considering the demonstrated inefficiency, graft, and weak infrastructure in the Cambodian government, this policy is unsurprising. Many other major donors are of the same mind. Beyond simple redirection of funds to INGOs rather than developing governments, the two also directly compete for the same grants from supranational groups - such as the UN- and government aid departments- such as DFAT. Due to INGOs' specialization in development, superior efficiency, and reputation for accountability, we expect that they are generally more successful at winning these grants. Indeed, according to one INGO employee, of most INGOs' donors "80% ... gave them

¹⁷⁵ Annear et. al, "The Kingdom of Cambodia Health Systems Review," xxii.

¹⁷⁶ "Country Development Cooperation Strategy 2014-2018," *USAID Cambodia*, 3.

\$5,000. And USAID gave them 120 million, and Gates gave them 40 million.”¹⁷⁷ Because the pool of development funding is inherently limited, if aid is funneled through INGOs rather than the Cambodian government - as a direct policy or indirectly through the allocation of grants - INGOs get more of the pie and developing governments get less. Thus, development aid has increasingly been in the hands of INGOs rather than the Cambodian government.¹⁷⁸

Indeed, the data support this narrative. According to the WHO, between 2008 and 2009, external resources as a percent of government health expenditure decreased from 62% to 42%.¹⁷⁹ This means that far less of the MoH’s expenditure on health came from foreign aid. We would expect this trend to indicate that the Cambodian government was simultaneously increasing its share of the health expenditure burden in order to maintain the same level of resources in the health sector as previously existed. This does not, however, appear to be the case. The figure below indicates that health expenditure as a percentage of

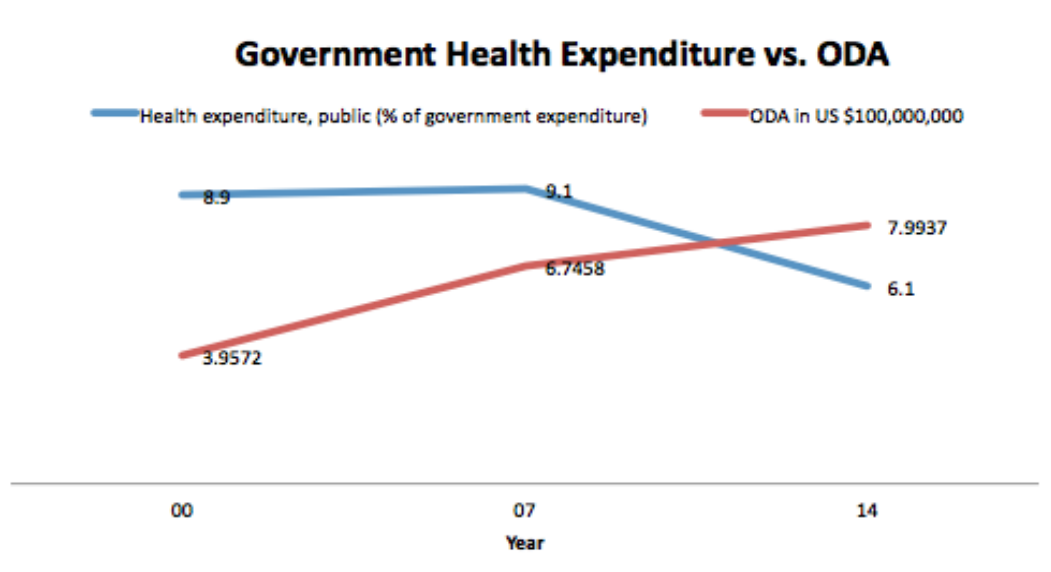
¹⁷⁷ Interview with URC employee, August 12, 2016.

¹⁷⁸ When reviewing the audited financial reports of some of the INGOs we interviewed, the magnitude of funding donors channel through INGOs is even clearer. Although these revenues are not for use specifically in Cambodia, they suggest the depth of the pool of resources INGOs have available. In 2015, Save the Children received \$246,957 in government grants and contracts (“Financial Information,” http://www.savethechildren.org/site/c.8rKLIXMGIpI4E/b.6229505/k.5C4E/Financial_Information.htm). In the same year, World Renew received \$1,216,069 in government grants (“How Our Funds Are Spent,” <http://worldrenew.net/money>) That is a million and a half dollars to two INGOs in one year alone. The year before, PSI received nearly \$232 million in US government support (“Population Services International: Consolidated Financial Statements and Supplemental Schedules,” <http://www.psi.org/wp-content/uploads/2015/08/PSI-Statutory-Audit-Report-2014.pdf>). The year after, Church World Service received approximately \$61 million in government support (“Financials,” <https://cwsglobal.org/about/financials-2/>). In comparison, the entire Cambodian health budget was \$199 million in 2012, less than PSI’s grant funding from the US alone (Bureau of Health Economics and Financing of the Department of Planning and Health Information, <http://www.dacp2014.info/asset/technicals/34646.pdf>). In short, INGOs receive massive amounts of funding from governments and supranational organizations.

¹⁷⁹ World Health Organization, Global Health Expenditure Database, *External Resources as a Percent of Public Health Spending*, retrieved from: <http://www.who.int/health-accounts/ghed/en/>.

total government expenditure has decreased to 6.1%.¹⁸⁰ This implies that the decrease in foreign aid to the MoH is not being offset by an increase in government spending on health. It is significant that the Cambodian government is not increasing its budget allocation for healthcare because it suggests that the government is comfortable allowing aid to flow to other entities, thereby decreasing its influence in the health sector.

The figure also indicates that ODA has increased over the same time period, but because the percentage of that ODA that flows through the government has decreased (from 62% to 42%, as stated above), this indicates that ODA is being channeled to other recipients within Cambodia rather than the MoH. In other words, of the pool of ODA, less is being funneled through the MoH and donors are instead circumventing the government and funding other care providers.



¹⁸⁰ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) as % of General government expenditure (GGE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

(Figure 9: Health expenditure as a percentage of government expenditure compared to ODA from 2000 to 2014.)¹⁸¹¹⁸²

The data on private expenditure further support this, as private health spending has been increasing. By 2014, 78% of total health expenditure was from private sources - an increase of over 10% in less than a decade.¹⁸³ This means that the lion's share of health financing is coming from sources outside the Cambodian government: INGOS, private citizens and donors, etc. Many are quick to assert that out-of-pocket health expenditure by Cambodians is decreasing, and this is true.¹⁸⁴ But this merely implies that while health expenditure by *households* has decreased, private expenditure by *outside sources* has been rapidly increasing. In other words, in the pie of health expenditure, the government's share has been decreasing, households' share has been decreasing, and the percentage expended by outside private sources has massively increased. This means that rather than channel aid through the MoH, donors are instead heaping aid onto other sectors - which are then providing funding for the majority of Cambodian healthcare. The reality that health financing is being taken over by non-public entities is often obscured when Cambodian health expenditure data are presented, as the increase in *total* health expenditure is most often remarked upon - a descriptor that includes spending by all sources. This misdirects from the fact that the

¹⁸¹ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *General Government Health Expenditure (GGHE) as % of General government expenditure (GGE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

¹⁸² The World Bank, World Development Indicators (2017), *Net official development assistance received (current US\$)*, retrieved from: <http://databank.worldbank.org/data/reports.aspx?source=2&series=DT.ODA.ODAT.CD&country=KHM>.

¹⁸³ World Health Organization, Global Health Expenditure Database, using The World Bank's World Health Indicators (2017), *Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)*, retrieved from: <http://apps.who.int/nha/database/Select/Indicators/en>.

¹⁸⁴ Annear et. al, "The Kingdom of Cambodia Health System Review," 46.

government's share of total health expenditure is actually decreasing and that donors are increasingly declining to direct aid through the MoH.

Data from Aidflows puts the magnitude of this INGO funding into perspective as compared to Cambodia's peers. In 2012, 3% of ODA was specifically directed to NGOs in Cambodia, or nearly \$26 million.¹⁸⁵ In comparison, in the same year, Thailand received \$4 million in NGO funding, less than one percent of all ODA it received,¹⁸⁶ and Vietnam received \$27 million, half a percent of its total ODA.¹⁸⁷ Laos¹⁸⁸ and Sierra Leone¹⁸⁹ each received approximately \$11 million in NGO funding, or 2% of each of their ODA. While the funding allocation to Cambodia's NGO sector is particularly striking, the share of ODA to the NGO sector in nearly all of the countries mentioned has increased over time.

The view from the donor perspective further reinforces this. According to USAID's Foreign Aid Explorer, in 2012, the US government disbursed \$11 million to Cambodia's health sector specifically.¹⁹⁰ Of that funding, \$7.8 million went directly to URC, the INGO that manages the Cambodian Health Equity Fund (Cambodia's version of "nationally" provided healthcare described previously).¹⁹¹ That is to say that the majority of aid the US gives to Cambodia is actually going to one - US based - INGO. Furthermore, the aid that the MoH does directly receive is often funneled back into INGOs because the government outsources much of its healthcare provision to INGOs through various health contracting

¹⁸⁵ "Cambodia," Aidflows, <http://www.aidflows.org/>.

¹⁸⁶ "Thailand," Aidflows, <http://www.aidflows.org/>.

¹⁸⁷ "Vietnam," Aidflows, <http://www.aidflows.org/>.

¹⁸⁸ "Laos," Aidflows, <http://www.aidflows.org/>.

¹⁸⁹ "Sierra Leone," Aidflows, <http://www.aidflows.org/>.

¹⁹⁰ "Cambodia," USAID's Foreign Aid Explorer, https://explorer.usaid.gov/cd/KHM?measure=Disbursements&fiscal_year=2012.

¹⁹¹ "Cambodia," USAID.

systems meant to improve capacity, as discussed in the chapter on INGOs. Thus, because donors choose to send funding to INGOs directly and because the Cambodian MoH chooses to pay INGOs to provide healthcare to its people, INGOs in Cambodia end up with the majority of health development aid. Therefore, through the various mechanisms discussed, the MoH has very little foreign resources with which to develop their public healthcare system.

In short, in terms of resources, INGOs are growing and the MoH is shrinking. More important, INGOs' presence in developing countries has directly contributed to this diversion of resources away from developing governments. Considering INGOs' supposed efficiency and accountability, their monopoly on funding is not necessarily negative. Indeed, it is possible to imagine a solution to Cambodia's need for provision of healthcare where INGOs are the sole provider of services. However, as we will address in the next chapter, INGOs are not stable healthcare providers in the long-term.

Summary

Reliance on INGOs and private providers for healthcare services in Cambodia is not without effect. On the contrary, outsourcing to INGOs and assumption by the private sector lead to brain and resource drain from the public healthcare system. The longer these alternative health systems remain in country, the weaker public infrastructure becomes as it continually loses personnel and funding. However, replacement of public health systems with INGOs and privatization, and the decreases in public capacity it leads to, is not inherently problematic. Indeed, these alternative health systems have been used as solutions to low public capacity for good reason and have many proponents. That being said, we find

that the de facto replacement of public healthcare by the other two sectors is concerning and should be paid more attention, as we will now discuss.

VI. Implications of INGOs and Privatization

Introduction

The drain of resources and personnel from the public sector into the INGO and private sectors is not inherently problematic. Both outsourcing to INGOs and privatization of healthcare have benefits that have led to their becoming healthcare alternatives when governments' systems are insufficient. Indeed, we would like to stress that both INGOs and private providers are a vital part of a well-functioning healthcare system. However, there are concerning long-term implications of outsourcing to INGOs and assumption by the private sector on public health system capacity, especially when they become the sole providers of healthcare in a country where regulation is weak. In this chapter, we will discuss why outsourcing to INGOs and privatization - and the subsequent decrease in public sector capacity from their activities - are damaging trends that deserve more attention from those focused on international development.

Why Not INGOs: the INGO Micromarket and Mission Drift

INGOs are not a stable alternative to nationally provided healthcare because they operate in their own micromarket. We define the INGO micromarket as the system of incentives and constraints to which INGOs are subject in the areas of funding and personnel, which uniquely affect their behavior. The micromarket encompasses INGOs' access to funding, methods to attract that funding, use of resources, hiring environment, and downward accountability (ability to remain accountable to local communities). Of these aspects of the micromarket, one of the most relevant to INGOs' ability to act as a long-term healthcare provider is the effect funding constraints have on their actions; one facet of this

issue is known as mission drift and will be discussed in more depth following the section on the micromarket. Although the reality that INGOs have concerns beyond just the communities they serve is known, research to date has not adequately addressed the implications. We argue that the INGO micromarket - and the secondary issue of mission drift - make INGOs a poor sole substitute for state provided healthcare. To make this evident we will discuss the definitions of both phenomena, and will then address their relevance to long-term healthcare provision.

INGO Micromarket

The INGO micromarket is a term we created to refer to a phenomenon we observed in our interviews and noted in various literatures, namely the system of incentives, labor and funding constraints under which INGOs operate.

The first supply side constraint INGOs contend with is the need for funding. This is affected not only by the inherently limited supply of funds, but also by trends in donor concerns and their effect on donor funding behavior. This latter issue is known as fad funding.¹⁹² Because INGOs must compete with each other for funding and are largely reliant on the donor community for that funding, they are sensitive to the interests of their funders. For an example of this, recall PSK's move to social enterprise in order to retain their financing from the funding section of chapter three. If the donor community's attention shifts to a new issue - maternal health rather than HIV, for example - INGOs working on the now out-dated issue are put in a tight spot. As one INGO employee succinctly said, "the

¹⁹² Karen A. Froelich, "Diversification of Revenue Strategies: Evolving Resource Dependence in Nonprofit Organizations," *Nonprofit and Voluntary Sector Quarterly* 28.3 (1999): 251, doi: [10.1177/0899764099283002](https://doi.org/10.1177/0899764099283002).

donor funding of NGOs can change overnight.”¹⁹³ INGOs, then, are beholden to the whims of donors.

This constraint - limited funding that is controlled by a community of funders who are influenced by fads - creates perverse incentives for INGOs. Namely, fad funding pushes INGOs to either pour resources into remaining attractive to donors or alter their missions to remain relevant to the current fad; this latter phenomenon is known as mission drift.¹⁹⁴ To continue our previous example: if fads change and funding shifts from HIV to maternal health, organizations that were focused on HIV can either use their resources to compete with other HIV focused organizations for this smaller pool of funding, or can change their focus to maternal health where funding is more plentiful and competition is less intense. Many choose to alter their missions to follow the funding. Thus, the funding constraint incentivizes INGOs to allow their missions to drift from issue to issue. As one INGO director described to us, in reference to another organization, “Save the Children are pretty good at nutrition but they don’t stick to their knitting, right? They don’t stick to what they do. They start chasing money. So you start to get Save the Children doing malaria work.”¹⁹⁵ This flexibility in INGOs’ missions is not inherently problematic if INGOs are operating as complementary providers of care, but is concerning if they are sole providers, as we will address in the implications section below.

The second main constraint on INGOs’ behavior is the need for personnel. INGOs are not only funneling extensive human and capital resources to secure donations and apply

¹⁹³ Interview with URC employee, August 12, 2016.

¹⁹⁴ Pierre LY, "The Effect of Ownership in Ngos? Commercial Ventures," *Annals of Public and Cooperative Economics* 83.2 (2012): 161.

¹⁹⁵ Interview with URC employee, August 12, 2016.

for grants, which requires “considerable staff, board, and volunteer effort, divert[ing] attention from other vital functions...,”¹⁹⁶ but also into attracting expatriate staff for the cause they are focused on at that moment. As organizations move between issues to maintain their funding, employees will leave and join organizations based on what issue the INGO is currently addressing. That is to say, skilled workers are loyal to causes, not to the organizations for which they work. As one long time INGO employee put it, “I’m not sure how important for most international NGO [employees] the actual NGO is... I’ve gone where what I’m interested in working on is being funded. And most people in the field do that. So while most NGOs will have a few lifers- people who are really committed to that NGO- they’re rare.”¹⁹⁷ This creates intense competition between INGOs for skilled employees, and incentivizes them to offer generous salaries and benefit packages to their expatriate staff in order to entice them to their specific organization. Organizations that are large enough will create “gigantic incentive structures,” which lead to “wage distortion,” according to one of our INGO employee interviewees.¹⁹⁸ Highly sought after employees thus circulate from INGO to INGO as causes and benefit packages shift, forming a key part of the INGO micromarket.

The restraints on funding and skilled staff complete the complex and insular system we have termed the micromarket: funding moves as donor interest does, organizations shift issues to stay on top of funding, international employees move between organizations based on the issue being addressed, organizations put large amounts of resources into attracting

¹⁹⁶ Froelich, “Diversification of Revenue Strategies: Evolving Resource Dependence in Nonprofit Organizations,” 250.

¹⁹⁷ Interview with URC employee, August 12, 2016.

¹⁹⁸ Interview with URC employee, August 12, 2016.

both funding and skilled workers, and the whole micromarket operates across multiple countries. In short, INGOs have many concerns drawing their attention and resources other than care provision, which affects their effectiveness as a long-term healthcare provider, as we will discuss shortly. However, we first turn to a further exploration of mission drift.

Mission Drift

As previously mentioned, mission drift describes an effect of INGOs' dependency on external funding to maintain their operations.¹⁹⁹ In short, mission drift is when INGOs alter their issue focus in order to keep pace with fads in funding.²⁰⁰ This occurs because INGOs are beholden to their donors, and must remain relevant to attract funding. In other words, if the public's interest in an issue changes, taking funding with it, the INGO is forced to change its area of work in order to maintain its financing. According to Froelich this "shifting of priorities to match somewhat faddish funding criteria [is] considered a key failure in the treatment and delivery of human services,"²⁰¹ and as such (unlike the INGO micromarket), mission drift and its cause - fad funding - are not issues that we identified and defined, but rather have been discussed at length in other literature.

Because INGOs compete amongst each other for a limited pool of donor resources, they must remain attractive to the donor community if they are to receive funding. This is true not only of private funds, but also of government grants; put simply, governments will not award grant funding to an organization that does work irrelevant to that government's goals, and governments' goals are often led by public interest. INGOs, then, are reliant on

¹⁹⁹ Khieng and Dahles, "Resource Dependence and Effects of Funding Diversification Strategies among NGOs in Cambodia," 1431.

²⁰⁰ Froelich, "Diversification of Revenue Strategies: Evolving Resource Dependence in Nonprofit Organizations," 250.

²⁰¹ Froelich, "Diversification of Revenue Strategies: Evolving Resource Dependence in Nonprofit Organizations," 251.

the interests of the public to receive funding, and will change their organization's mission in order to pivot towards issues that are in vogue with possible donors. An excellent illustration of fad funding was provided to us by an executive of URC:

HIV/AIDS is a good example. There was no money in AIDS. There was nothing to do about AIDS, except some pretty shaky preventive stuff, so there wasn't much money in it and nobody was particularly interested. Through the 90s- to about the mid 90s... And then all of a sudden- I mean the Durban 2000 AIDS Conference- HIV activists were successful in convincing the world that they should pay for ARVs for poor people... And all of a sudden every NGO in the world was interested in AIDS...And all of a sudden the world wanted to spend millions and millions of dollars- I mean unbelievable amounts of money- on HIV.²⁰²

In summary, fad funding in the international aid community leads to INGO mission drift. These phenomena are common issues for INGOs, but have implications - along with the micromarket in general - for their ability to operate as a sustainable provider of healthcare, which we will now discuss.

Implications of the INGO Micromarket and Mission Drift

Both the micromarket in general, and mission drift specifically, make INGOs an unstable provider of healthcare in the long-term - especially if they are solely relied upon to provide care for a specific health issue.

We have highlighted mission drift because it has concerning implications for INGOs' stability as a healthcare provider. The tendency for INGOs' missions to drift suggests that as trends change, organizations cannot be relied upon to provide care for the same health issue on which they have focused in the past. There can be no assumption that INGOs will remain loyal to one issue as funding shifts with Western fads in development

²⁰² Interview with URC employee, August 12, 2016.

aid. An organization that has previously provided HIV/AIDS prevention and treatment, to continue our previous example, might find that international concern for the issue has decreased, and funding is easier to come by if they work to address maternal health. They may then leave the HIV/AIDS sphere of healthcare and enter the maternal health sphere to attract this funding. When there are many healthcare providers, one organization leaving an issue sphere has less effect, but in Cambodia, and to a lesser extent in other developing nations, there are often only one or two providers for each issue sphere and the exit of a main care provider has serious implications. Furthermore, INGOs are usually not designed to provide general healthcare, as they are inherently issue-focused. This is related to, but not the same thing as mission drift, and makes them unsuitable to provide general healthcare to a population. This is exacerbated when the government has outsourced its responsibilities to INGOs and, due to brain and resource drain, has not built up the capacity to provide care for the issue itself. Thus, if an INGO's mission drifts and it no longer provides either broad based care or care in a specific issue sphere, a gap is left in the health system and care for that health issue is not addressed. Moreover, the vacuum created by the exit of INGOs' can leave the public health system worse off than if the INGO never entered the issue sphere in the first place, as it is highly destabilizing. Mission drift, then, is one compelling reason why INGOs cannot be relied upon to provide stable, long-term healthcare and are not a permanent solution for weak health system infrastructure in developing countries.

Furthermore, we find that the micromarket causes INGOs to operate in an insular community, separating the sector from the communities it serves, drawing its attention and resources, and decreasing its downward accountability. Unlike public healthcare providers, INGOs have interests other than the public interest which affect their behavior, and they are

influenced by more actors than just the population they are serving. Namely, INGOs must attract both funding and staff, and are beholden to the donor community before the public. Furthermore, because neither INGOs nor their staff are fixed - organizations drift to different causes and employees move between organizations - the INGO sector is highly unstable. Insular and preoccupied with funding and staff movements, the INGO sector is not downwardly accountable to the population they are supposed to be serving. That is to say, even if INGOs do not “drift” from the issue sphere they work in, they may still not be a beneficial presence.

Although a main argument in favor of INGOs is their better accountability and effectiveness as compared to developing governments, there is next to no empirical evidence to support this.²⁰³ On the contrary, the literature is firm that an increase in foreign funding leads to less downward accountability to the group of people they intend to help.²⁰⁴ Indeed, as the number of INGOs increase in a country there is increased inefficiency, more diversion of funds, and less downwardly accountable organizations.²⁰⁵ This is largely due to the INGO micromarket, which creates a disconnect between INGOs and the populations they serve. The micromarket structure of constantly shifting organizations and experts makes INGOs far less reliable than a stable entity with less turnover in its work force would be. INGOs’ insular market for funding and labor draws considerable effort. The resources INGOs must put in to maintain both their funding and their work force are substantial, and takes away from the resources and attention they could otherwise allocate to helping their

²⁰³ Mayhew, "Hegemony, Politics and Ideology: The Role of Legislation in NGO–Government Relations in Asia," 728.

²⁰⁴ Mir and Bala, "NGO Accountability in Bangladesh: Two Contrasting Cases," 1831.

²⁰⁵ Aldashev and Verdier, "Goodwill Bazaar: NGO Competition and Giving to Development," 60.

cause. The multiple concerns for INGOs - because of the micromarket they operate in - takes their attention away from healthcare provision. Thus, INGOs are less connected and accountable to the populations they serve than the national government is, and indeed may not be focused on the issue at hand even if they have not “drifted,” thus making them a poor substitute for state provided healthcare.

In all, the micromarket makes INGOs unstable healthcare providers in the long run. They can be relied upon neither to provide care for one health issue long-term, nor to put the public interest before their own. Although the flexibility of INGOs is a benefit in many ways, it is a drawback when they are relied upon to be the sole provider of secure, long-term, general healthcare. INGOs are most beneficial when they complement a state health system and provide care to niche populations and issues; as one INGO employee who works on HIV/AIDS prevention for homosexuals and sex workers said,

these groups... are sometimes very heavily stigmatized and governments just are not prepared to deal with them. Their clinic networks aren't friendly to these groups. Their parliaments are not are not friendly to these groups, sometimes these behaviors are illegal - whether it's homosexuality or drug use or prostitution. And so governments have a hard time dealing with these groups. But if they don't then these epidemics usually just continue... government services are never going to be really ready to serve these population groups.²⁰⁶

In situations like this INGOs are well-suited to provide services, but in general they cannot be relied upon as a substitute to public healthcare- which is neither beholden to the whims of donors nor accountable to any entity other than the public, and is inherently less single-issue focused.

²⁰⁶ Interview with FHI 360, August 19, 2016.

Why Not Private: Inequity and Low Quality Care

As discussed above, INGOs are not an adequate replacement for national healthcare in the long-term. In this section, we will go on to explore why privatization is also an undesirable substitute for government healthcare. This is a pressing concern, as private care is massively more utilized in Cambodia than public care - and is only continuing to grow in size and influence.

Possibly the largest concern of private sector participation is that many developing countries, including Cambodia, lack the regulatory capabilities necessary to ensure the efficiency and quality of private care. The literature, although lacking in uniformity in most areas, shares one consensus: under-regulated private sectors can be dangerous and counterproductive - leading to over prescription of corticosteroids, incomplete courses of antibiotics, unnecessary and expensive surgical procedures, dangerous prescriptions of conflicting medications, and uninformed health advice - particularly in the area of family planning.²⁰⁷ These costs are significant due to the size of the private sector in Cambodia. Private providers play a particularly large role in rural communities, as more than 40% of public sector general medical practitioners are located at central-level facilities in large cities not in rural areas.²⁰⁸ In fact, evidence suggests that the private professional health sector is now larger than the public healthcare sector in some regions of Cambodia - such as the province of Kampong Cham, as discussed previously.²⁰⁹ Thus, the private sector is not

²⁰⁷ Vickery, Rose, Dixon, Kiri, and Wilkinson, "Private Practitioners in Phnom Penh: A Mystery Client Survey," ii-16.

²⁰⁸ Annear et. al, "The Kingdom of Cambodia Health System Review," 88.

²⁰⁹ Soeng, Chan, Grundy, Morn, and Samnang, "Evaluation of Immunization Knowledge, Practices, and Service-delivery in the Private Sector in Cambodia," 96.

functioning as a secondary provider of care in Cambodia, but rather as a primary contact point for many people seeking healthcare.

Inequity of Access

The danger with such a heavy reliance on private healthcare is that it reflects a mistaken belief that private healthcare is of a higher quality than public healthcare - the common idea that you “get what you pay for.” However, individuals seeking higher quality healthcare could instead end up funding an inefficient substitute for public care- at a much higher cost. The WHO estimates that the level of out of pocket expenditure (OOP) by households for healthcare in Cambodia is unacceptably high. It peaked at 84% of Total Health Expenditure (THE) in the late 1990s²¹⁰ with the legalization of private health-care delivery, and remains around 74% as of 2014. This is high even in comparison with our relevant country indicators: Bangladesh had an OOP of 67% of THE in 2014, Lao had 34%, Sierra Leone had 61% and Vietnam had 36%.²¹¹

In a health system such as Cambodia’s, where out of pocket expenditure on healthcare by households is so high, equity of access to the healthcare system becomes a major concern. Such high out of pocket costs for healthcare, when not subsidized by an effective insurance or welfare system, can act as a significant barrier to entry for low SES individuals. The UHP Baseline demand survey (BDS) found that 14% of all household monthly income in Cambodia was spent on healthcare, predominantly in the private for-

²¹⁰ Annear et. al, “The Kingdom of Cambodia Health System Review,” 67.

²¹¹ The World Bank, World Development Indicators (2015). *Out-of-pocket health expenditure (%of total expenditure on health)*. Retrieved from: <http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS>.

profit sector.²¹² In the Cambodian health system the Health Equity Fund, the current national insurance system, exempts those who qualify from many of the costs of healthcare – a system that was proposed as a method by which to increase the poor’s access to the healthcare system. However, only public facilities are required to accept HEF payments for treatment. This becomes an issue in rural areas, where the majority of the lowest income quintile live, as there is often no nearby public hospital. Thus, individuals are forced to seek private healthcare and pay the exorbitant out of pocket costs. Many low-income households cannot afford to lose 14% of their already insufficient income to healthcare costs, and therefore do not have the option of receiving proper high-quality care. The barrier of access to healthcare created by such high costs is demonstrated by the fact that less than 46% of those who even qualify for the Cambodian “poor people’s” healthcare insurance (the HEF) seek healthcare for themselves or their families.²¹³ This percentage is even smaller in rural areas where access to healthcare is limited, mainly privately provided, and the education and resources provided by the government are fewer. In many rural areas, poor individuals are not even registered to receive HEF benefits, either due to the stigma of revealing one’s SES, a lack of literacy needed to complete the forms, or due to a lack of outreach by public officials. It is estimated that only 70% of those eligible for the HEF have begun or entered the process to receive its coverage, and even less actually finish the procedures.²¹⁴ Thus despite the seeming solution to high health costs embodied in the HEF, since its benefits do

²¹² John Holloway, “Report on the Baseline Demand Survey,” *Health Services for the Urban Poor Project* (2008): 31, <http://www.racha.org.kh/rc2008/40/HSurbanpoor.pdf>.

²¹³ Kelsall and Heng, “Inclusive healthcare and the political settlement in Cambodia,” 13.

²¹⁴ Peter Annear, “A comprehensive review of the literature on health equity funds in Cambodia 2001-2010 and annotated bibliography,” *Health Policy and Health Finance Knowledge Hub* 9 (November 2010): 42.

not apply to private facilities - the most predominant providers in poorer areas - many poor Cambodians are excluded from access to the healthcare system.

Additionally, rather than help reach the poor, private provision can increase inequity of access because it naturally favors those who can afford treatment. Data from 44 middle and low income countries suggests that higher levels of private-sector participation in primary healthcare are associated with higher overall levels of exclusion of poor people from treatment and care.²¹⁵ As mentioned above, in the Cambodian system, the HEF exempts those who qualify from many of the costs of healthcare. However, since only public facilities are required to accept HEF payments the system essentially creates disincentives for private for-profit health staff to treat them, as they know the patients will be unable to cover the high out of pocket costs. Thus, even if the private providers do give treatment, it is often at quality levels that correspond to the amount the patient is able to pay.²¹⁶ Given the prevalence of private healthcare in Cambodia (92% contact rate), particularly in rural regions where government disbursements to local public health facilities have been historically low, these disincentives are significant. Inequalities in out-of-pocket spending between income groups are widespread, with households in the highest income quintile spending sixteen times more than those in the lowest quintile²¹⁷ (See figure below). This disparity reflects “affordability not illness – the prevalence of illness is greatest in the lowest income quintile – mainly because the poor have less disposable non-food income, face greater financial barriers, and are less likely to seek care when ill.”²¹⁸

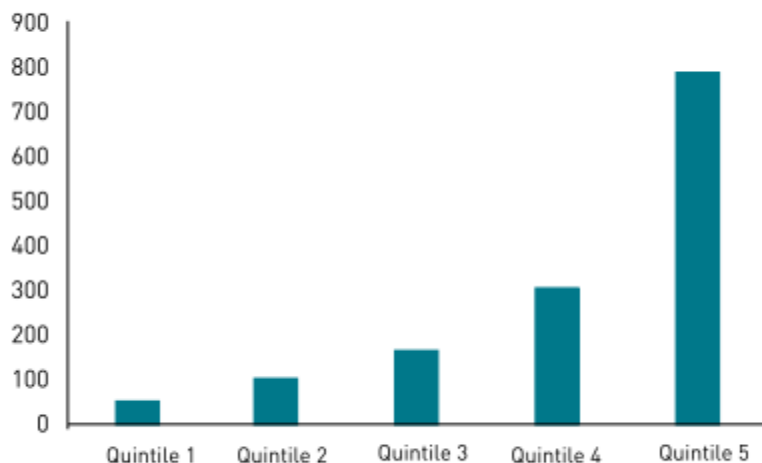
²¹⁵ “Blind Optimism: Challenging the myths about private health care in poor countries,” 4.

²¹⁶ Kelsall and Heng, “Inclusive healthcare and the political settlement in Cambodia,” 4.

²¹⁷ Annear et. al, “The Kingdom of Cambodia Health System Review,” 68.

²¹⁸ Annear et. al, “The Kingdom of Cambodia Health System Review,” 68.

Figure 3.10 Distribution of annual household OOP spending on health care by income quintile, 2012



Source: Ministry of Health, based on the CSES 2012 (NIS, 2013).

(Figure 10: Distribution of annual household OOP spending on healthcare by quintile.)²¹⁹

Low Quality Care

Even those individuals who can afford private healthcare, however, are not guaranteed a high quality of care once they arrive. A mystery client study in Phnom Penh found that “57% of consultations with private providers were potentially hazardous and only 32% met broad [Ministry of Health] guidelines.”²²⁰ A more recent study found “60 per cent, 77 per cent, and 93 per cent of cases misdiagnosed in private facilities, small private consultation rooms, and the informal sector, respectively.”²²¹ Although many countries

²¹⁹ Annear et. al, “The Kingdom of Cambodia Health System Review,” 69.

²²⁰ Vickery, Rose, Dixon, Kiri, and Wilkinson, “Private Practitioners in Phnom Penh: A Mystery Client Survey,” ii-16.

²²¹ Kelsall and Heng, “Inclusive healthcare and the political settlement in Cambodia,” 9.

successfully or semi-successfully regulate their private sectors,²²² countries with a lack of regulatory strength, such as Cambodia, often struggle to raise the care requirements for such providers, as even registering private practices as professional health providers can be difficult to accomplish and even more difficult to enforce.²²³ In all, this indicates that although Cambodia lacks a strong public health system, privatization is not the most efficient or even a sufficient means to fill the gap in health system capacity.

Indeed, studies indicate that the dangers of under regulation in the Cambodian private sector extend past misdiagnosis. Surveys of Phnom Penh's practitioners suggests that they are characterized by an unusually high prevalence of: 1) an almost exclusive focus on curative services with virtually no health prevention or promotion activities, 2) a tendency toward polypharmacy and non-evidence based prescribing, 3) a reluctance to keep records and have them open to scrutiny, and 4) little enthusiasm for the agreed MoH/WHO evidence-based treatment protocols for the management of illnesses of key public health concern.²²⁴ This conclusion was reinforced in a more recent survey of 198 private doctors, which indicated that more than half of all consultations resulted in the inappropriate prescription of drugs.²²⁵ Similarly, a quality report from 2005 indicated that nearly “80% of prescriptions are dangerous or ineffective.”²²⁶

²²² Sekhri, Feachem, and Ni, “Public-private integrated partnerships demonstrate the potential to improve health care access, quality, and efficiency.”

²²³ Kelsall and Heng, “Inclusive healthcare and the political settlement in Cambodia”.

²²⁴ Vickery, Rose, Dixon, Kiri, and Wilkinson, “Private Practitioners in Phnom Penh: A Mystery Client Survey,” ii-16.

²²⁵ Soeng, Chan, Grundy, Morn, and Samnang, “Evaluation of Immunization Knowledge, Practices, and Service-delivery in the Private Sector in Cambodia,” 96.

²²⁶ “Pharmaceutical Sector Strategic Plan 2005-2010,” *Kingdom of Cambodia Ministry of Health* (2005): 13, <http://apps.who.int/medicinedocs/documents/s22476en/s22476en.pdf>.

Although much of this problem is caused by poor training and regulation for the prescribing doctors, both in the public and private sectors, it is compounded in the private sector by market driven prescribing influenced by money and patient preferences. Many facilities in the private sector charge the patient by prescription, and therefore make more money from appointments where greater numbers of drugs are prescribed.²²⁷ Dr. Esther Wilson, an international physician working in Cambodia, describes the process of polypharmacy in her online reviews of the health system. She states that patients often leave private clinics with a small bag of multi-colored pills – most often of six different types-- without being given “an explanation of what drugs they were or what they do, let alone about possible adverse effects and contraindications.”²²⁸ See image below:

²²⁷ Frances Daily, Chhorvoin Om, Erika Vileghe, James McLaughlin, and Mary-Louise McLaws, “‘If it’s a broad spectrum, it can shoot better’: inappropriate antibiotic prescribing in Cambodia,” *Antimicrob Resist Infect Control* 5.58 (2016): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5170903/pdf/13756_2016_Article_159.pdf.

²²⁸ Esther Wilson, “Polypharmacy” *Blog*, September 6, 2013, www.estherwilson.blogspot.com/2013/09/polypharmacy.html.



(Figure 11: Bag of prescribed pills.)

Additionally, the bags almost always contain only one dose of each type of drug – irrespective of prescribing standards set by the MoH.²²⁹ This market phenomenon is also driven by many Cambodian patients’ preference for “strong” and “quality” medicine, which doctors are inclined to supply in order to increase the chances that the patient will return to their clinic over another. Dr. Florian Polsczek, a physician at the Calmette Hospital in Phnom Penh, explains this pressure: “patients had a high expectation of receiving tablets, intravenous fluids and injections, especially in private clinics; if such treatment was denied, even with an explanation, the patient was likely to lose confidence in the physician and leave

²²⁹ Wilson, “Polypharmacy”.

the hospital.”²³⁰ Due to this belief that quantity and strength of medicine equals quality, private practices have incentives to continue this dangerous prescribing behavior in order to maintain their client base and keep public trust in their provision of care high. A physician in the study conducted by Daily et al. explains saying, “Patients want ‘quality’ medicine. They don’t say ‘ceftri [ceftriaxone]’ they just say that they want ‘quality’ medicine. With stronger medicine, they believe they recover faster and leave happier.”²³¹ Physicians in the INGO sector refer to this phenomenon in the private sector as consumer-driven healthcare. Essentially, doctors provide the treatment patients want rather than the one they need in an effort to increase the rates at which patients visit their clinic. In our interview with PSK, an INGO earlier mentioned in our section on social enterprise, we were told, “I think it’s patient or consumer driven as well. There are a lot of discussions about that. You know like when you go to the clinic for fever. If the physician says ‘oh yeah you can have a nice pear and drink a lot of water’ or whatever, sometimes the patient or the family is not happy. They want to have an injection or IV... Sometimes in private clinics they just satisfy people.”²³²

As this section has made evident, privatized healthcare is not a suitable alternative or replacement for a strong national healthcare system. The care currently provided is inequitable and dangerously unregulated. While regulation could improve the quality of care private practitioners provide, considering the issue of inequality in service provision, government efforts would be better channeled into improving the public health system.

²³⁰ Florian Pilsczek, “Hospital medicine in Cambodia: a visiting doctor's perspective,” *Canadian Medical Association Journal* 165.1 (July 10, 2001): 40, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC81244/pdf/20010710s00021p37.pdf>.

²³¹ Daily, Om, Vileghe, McLaughlin, and McLaws, “‘If it’s a broad spectrum, it can shoot better’: inappropriate antibiotic prescribing in Cambodia,” 5.

²³² Interview with employee of PSK, August 10, 2017.

Minutely regulating the private sector with the intention of it serving as a sole, or majority, provider is an insufficient solution for the gaps in capacity facing the healthcare system.

Summary

In the previous chapter, we discussed the dual processes of brain and resource drain, and their detrimental effect on public sector capacity. In this chapter, we have described why decreases in public healthcare capacity and subsequent replacement of this capacity through INGO outsourcing and assumption by private providers is a concerning trend. Neither INGOs nor private healthcare are an acceptable substitute for state provided healthcare. INGOs are unstable because of their micromarket, and the private sector leads to inequitable and low quality care. Though there are many benefits to both INGO involvement in and privatization of healthcare, we find that a health sector where INGOs and private providers are the sole healthcare providers, rather than complementary providers, is an increasingly weak and undesirable substitution for blended care provision.

VII. Conclusion

The interactions between these three pillars of healthcare are not new or unknown to those in the development community. On the contrary, the implications of outside forces operating in a developing country have been oft remarked upon. But the literature and analyses from experts seems often to miss the broad picture - discussions of the effects of INGOs are in one silo, the role of private providers in another, and the outlook for developing countries' health system in yet another. A formal framework that critically examines all three is, in our view, missing. Cambodia serves as an excellent case study to examine these interactions, because both its INGO and private sectors are large and influential enough for their effects to be measurable. Based on our interviews and surveys, it is clear that individuals working in healthcare in Cambodia are aware that the current complex system produces perverse incentives, but few are aware of the whole picture.

Through our research, we attempted to begin the process of tying the literature and experiences of the three sectors into a cohesive analysis in order to tease out the implications. We argue that the use of INGOs and private providers as long-term solutions to a weak public health system is problematic. They drain the government of personnel and funding and provide poor, unstable, and inequitable care if allowed to become under-regulated majority providers. Even more concerning is the concurrent hollowing out of public sector capacity - preventing the government from reassuming control of healthcare and essentially ensuring that the other sectors continue in their majority role for healthcare provision.

It is important to note that both the literature and our research agree that INGOs and the private sector have important roles to play in the healthcare sector of developing countries - these roles however, should be either as a permanent but minority complementary provider to a strong government system, or as temporary sole providers while governments build capacity.

In fact, a robust NGO and private sector have been very important in global development goals, but to be effective they need to be well-regulated and monitored in order to ensure that they are actively contributing to increasing the government's health infrastructure and capacity.²³³ The problem in the Cambodian health sector lies in the fact that INGOs and the private sector are acting as permanent, majority providers, with the government demonstrating little interest in investing in or reassuming primary control of the sector. Investing and depending on these actors as sole providers is dangerous given the INGO sector's micromarket and likelihood of mission drift, and the private sector's lack of regulation which leads to inequity of access and low quality care.

The second concern with this balance between the three pillars is that even if the government were to attempt to reassume control, as we argue is desirable, the longer it takes to attempt it, the fewer resources - both human and financial - it will have to help it succeed. Indeed, due to the brain and resource drain described previously, as time passes, government capacity within the system is steadily decreasing.

Due to beliefs held by some that INGO and private sector solutions are preferable to state provided healthcare, and the proposition by some experts that these sectors are a

²³³ Johannessen and Hagen, "Physician's engagement in deal practices and the effects on labor supply in public hospitals: results from a register-based study".

“magic bullet” in all cases, many of these serious drawbacks have been overlooked. In fact, little has been done to prevent or alter the possible negative outcomes highlighted in this paper - largely because little research has been conducted globally, with developed governments and aid providers having largely relied on research based on assumed positive outcomes. This lack of skepticism and oversight suggests that the situation is unlikely to change without a concerted effort to highlight and study the aforementioned issues. Our research - although requiring further exploration - suggests that although developing public sectors can be inefficient and corrupt, it may be a necessary evil to continue to invest in their development in order to achieve sustainable long-term development goals. A regional health director with FHI 360 asserted in our interview with him, “that's really the only way to build capacity- is to try to deal with the corruption issues as best as you can but then really support the Ministry because these [Ministries of Health] are the ones there to stay.”²³⁴ While in the short-term circumventing the government in order to rapidly develop sectoral capacity may seem appealing, we argue that this perspective is short-sighted and it is necessary to invest in governments to create lasting change.

²³⁴ Interview with FHI 360, August 19, 2016.

VIII. Implications for Further Research

Although Cambodia is unusual in the size and influence of its INGO and private sectors, the complications it faces in balancing their interaction with its public system are not unique. Because the private and INGO sectors are so prominent in Cambodia it allows us to study the interactions and effects of these sectors with more precision than would be possible in countries where they are less visible. However, we believe the Cambodian case study nevertheless serves as a lesson for other countries: Given the negative outcomes due to outsourcing and privatization that we have discussed, it follows that similar losses of public sector capacity and harm to the health system as a whole could be occurring in other developing countries - even if on a smaller scale. While our work has drawn attention to the complex system of incentives and interactions at play, there is far more work to be done to create theoretical framework for how INGOs and privatization affect public health capacity and incentives to invest in its future. More research should be done to determine the many facets of this situation, how much of it is applicable to other developing countries, and what the ideal role for each sector is in order to create a strong health system.

The data we collected through our interviews was relatively narrow due to time and resource constraints. As such it would be beneficial to gather data from a broader cross-section of the healthcare sphere - namely physicians and employees in the public sector. In general, more research is needed to fully understand the incentives and behaviors at play in Cambodia's health sector.

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Appendix A: Methods

Although literature concerning INGOs and privatization abounds, neither a specific case study of Cambodia nor an examination of the long-term effects of outside actors' presence has been done to our knowledge. Thus, to examine our hypothesis, it was necessary for us to collect our own data. With this in mind we completed an IRB, applied for grant funding, and organized a field research trip to interview those working in our sector of interest. We also designed surveys using Qualtrics which we administered online in order to create quantitative data for us to analyze. We also collected additional data from various outside (public) sources to create a picture of the health system in Cambodia.

Interviews and Surveys

To conduct interviews we travelled to Cambodia and Thailand for three weeks in August of 2016. We conducted seventeen total interviews. Interviewees included executives of INGOs and LNGOs, USAID officials, DFAT officials, and a doctor with the Thai Ministry of Health. These interviews ranged between approximately 30 minutes to an hour and a half and roughly followed the interview guide attached in the appendix. We alternated taking the lead with asking questions and acting as the notetaker. Interviewees were selected using snowball sampling methods: we began by reaching out to contacts we were introduced to by several University of Michigan professors, as well as contacting potential candidates based on our research through email. Once we scheduled a time with the interviewee we asked them to provide the contact information for anyone else who may be interested in taking part in our interviews and sent our first contact email to them (template is attached in appendix). Transcripts and audio recordings of the interviews are available by request.

After we completed our interviews, we sent follow up emails to the participants asking them to fill out a survey relevant to their experience. The surveys were intended for physicians, university students, INGO employees, and MoH employees. The surveys were designed on Qualtrics to take approximately fifteen minutes and were designed to be completed anonymously. Participants were able to take as many surveys as were relevant to their experience: e.g. a doctor who was also the president of an INGO would take both the physicians and INGO employees surveys. We asked that the participants take the survey, as well as pass the surveys on to their organizations and contacts. Additionally, we sent emails to other organizations and contacts we found in our research requesting that they complete the surveys. Altogether we sent out approximately 325 survey requests, and received 22 responses. Because of this low response rate we did not use the survey responses as a primary source of data in this paper - rather, they were used as further background to develop our argument and as suggestions for other content areas to explore. Full survey results are available in aggregate format by request.

Outside Data

In addition to data collected through our interviews and surveys, we utilized data available online to analyze health outcomes, health systems, and financial information for Cambodia and the INGOs therein. These data sets were primarily gathered from data available on APIs created by UNICEF, WHO (including the Health Accounts dataset and Health Information and Intelligence Platform), and OECD (both datasets and published reports). We also used data published by The World Bank (Integrated Fiduciary Assessment and Public Expenditure Review, Databank), USAID, the Cambodian Government's Report on Health Expenditure from 2012, the Cooperation Committee for Cambodia, Aidflows,

Health Policy Project, Annear et al., and the financial reports of various INGOs (mentioned by name in the text). All of the above are data sources whose original data we used as supporting evidence, to create tables or graphs, or as background information.

Appendix B: Email Templates

Dear ,

We are researchers associated with the University of Michigan in the United States and are studying the role of internationally based non-governmental organizations (INGOs) in developing countries. Our work is focused on the previously unstudied effects of INGOs on the local economy and political system. Attached you will find an expanded summary of our work and research design, if of interest.

Based on your organization's prominence and the nature of its work, it would be an ideal participant in this study. Consequently, we would be most thankful if your organization could contribute to our research.

To gather this data, we would be extremely grateful if your in-country director, operations and finance officer, or other leadership team member would be willing to meet with us for a **brief interview** (less than 45 minutes). We will be in Phnom Penh from August 8th to the 15th and would be happy to come to your place of work. If interested, please respond as such and we will contact you promptly with further details.

Your participation by providing these brief responses will give invaluable insight into the impact of INGOs in Cambodia and will contribute to academic literature.

Thank you very much for your time,

Marnie A. Ginis and Alexandra Kuske
University of Michigan

The Above Translated into Khmer:

ជាទីគោរព

ពួកយើងជាអ្នកស្រាវជ្រាវដែលបានសហការជាមួយសាកលវិទ្យាល័យ មីកលីរេក ក្នុងសហរដ្ឋអាមេរិក ហើយពួកយើង
កំពុងសិក្សាទៅលើតួនាទីរបស់អង្គការមិនមែនរដ្ឋាភិបាលអន្តរជាតិ(INGOs)ក្នុងបណ្តាប្រទេសកំពុងអភិវឌ្ឍន៍។
ការងាររបស់ពួកយើងផ្តោតទៅលើផលរបស់អង្គការមិនមែនរដ្ឋាភិបាលអន្តរជាតិ(INGOs)ទៅលើសង្គមក្នុងស្រុក និង ប្រព័ន្ធនយោបាយ
ដែលមិនបានសិក្សាពីមុនមក។ ដូចដែលបានក្លាយមកជាមួយ អ្នកនឹងឃើញខ្លះៗស្រដៀងគ្នាសង្ខេបអំពីការងារ និងផែនការស្រាវជ្រាវរបស់យើង
ប្រសិនបើអ្នកចាប់អារម្មណ៍។

ផ្អែកតាមការងារកំពុងតែមានរបស់អង្គការរបស់អ្នក និងលក្ខណៈការងាររបស់វា វានឹងជាការចូលរួមប្រសើរសម្រាប់ការសិក្សានេះ។ ហេតុដូច្នេះហើយ
ពួកយើងសូមផ្ញើសំណុំឯកសារគ្រប់គ្រាន់ប្រសិនបើអង្គការរបស់អ្នកអាចជួយក្នុងការសិក្សារបស់យើង។

ដើម្បីប្រមូលទិន្នន័យនេះ ពួកយើងសូមដឹងគុណជាអនេកប្រការ ប្រសិនបើ ខាងក្រៅប្រទេស មន្ត្រីទទួលបន្ទុកខាងប្រតិបត្តិ និងហិរញ្ញវត្ថុ ឬ
សមាជិកអ្នកក្រុមដឹកនាំដទៃទៀត ដែលនឹងមានចំណងជួយពួកយើងសម្រាប់ការសម្ភាសន៍ខ្លី (តិចជាង ៤៥នាទី)។ ពួកយើងនឹងទៅក្រុងភ្នំពេញចាប់ពីថ្ងៃទី៨
ដល់ថ្ងៃទី១៥ ខែសីហា ហើយពួកយើងពិតជារីករាយដែលមកកាន់កាប់ផ្ទះធ្វើការរបស់អ្នក។ ប្រសិនបើចាប់អារម្មណ៍ សូមផ្ញើយតបតាមលេខនេះ
ហើយពួកយើងនឹងទាក់ទងយ៉ាងជាក់លាក់ជាមួយអ្នកដើម្បីផ្តល់ខ្លឹមសារលម្អិតដល់អ្នក។

ការចូលរួមរបស់អ្នកតាមរយៈការផ្ញើយតបសង្ខេបទាំងនេះ នឹងផ្តល់ឱ្យខ្លួនយើងនូវទិន្នន័យដែលយើង
ចំពោះផលប៉ះពាល់ដែលមិនអាចកាត់ផ្តាច់របស់អង្គការមិនមែនរដ្ឋាភិបាលអន្តរជាតិ(INGOs)នៅកម្ពុជា និងរួមចំណែកដល់ការសិក្សាអក្សរសាស្ត្រ ។

អគុណប្រសិទ្ធិសម្រាប់ពេលវេលារបស់អ្នក។

សាកលវិទ្យាល័យ មីកលីរេក

And Thai:

เรียน

พวกเราเป็นนักวิจัยจากมหาวิทยาลัยมิชิแกนในสหรัฐอเมริกาและกำลังศึกษาบทบาทขององค์กรนอกภาครัฐระหว่างประเทศ (INGO) ในประเทศกำลังพัฒนา งานวิจัยของพวกเรามุ่งเน้นศึกษาผลกระทบที่ยังไม่มีนักวิจัยศึกษามาก่อนของ INGO ที่มีต่อเศรษฐกิจและระบบการเมืองของท้องถิ่น ท่านสามารถอ่าน บทสรุปภาคขยายของงานวิจัย และการออกแบบการวิจัยที่แนบมาได้ หากท่านสนใจ

ด้วยความโดดเด่นและลักษณะงานขององค์กรของท่าน องค์กรของท่านเหมาะสมที่จะเข้าร่วม การวิจัยนี้เป็นอย่างยิ่ง ดังนั้นเราจึงขอคุณเป็นอย่างยิ่งหากองค์กรของท่านสามารถให้ความช่วยเหลือในงานวิจัยของเราครั้งนี้ได้

ในการเก็บข้อมูล จะเป็นพระคุณอย่างยิ่งหากผู้อำนวยการ หรือเจ้าหน้าที่ฝ่ายปฏิบัติการ และฝ่ายการเงิน หรือสมาชิกทีมผู้นำอื่น ๆ จะสละเวลาเพื่อให้สัมภาษณ์สั้น ๆ (ไม่เกิน 45 นาที) พวกเราจะอยู่ในกรุงเทพฯ ตั้งแต่วันที่ 8 ถึง 15 เดือนสิงหาคมและยินดีที่จะเดินทางไปยังสถานที่ทำงานของท่าน หากท่านสนใจ โปรดตอบกลับมาให้เรา แล้วเราจะติดต่อท่านทันทีพร้อมกับข้อมูลเพิ่มเติม

การมีส่วนร่วมของท่านโดยการตอบคำถามสั้น ๆ จะสร้างความรู้ความเข้าใจอันมีคุณค่ายิ่งเกี่ยวกับผลกระทบของ INGO ที่มีในประเทศไทย และจะเป็นคุณประโยชน์ต่อแวดวงวิชาการ

ขอบคุณอย่างยิ่งที่สละเวลาของท่าน

มหาวิทยาลัยมิชิแกน

Appendix C: Interview Template

Interviewee:
 Organization:
 Date:
 Location:

Introduction:

We are currently studying the interaction between the public sector (government) and private sector (NGOs) in the healthcare industry in Cambodia/Thailand. As a prominent member of the aforementioned communities, we were hoping you could provide insight into the interaction between the two sectors both in policy making and the actual provision of healthcare to the general public. We will be using these interviews to provide support for our senior thesis.

Confidentiality:

All information/recordings gathered through the following interview will be kept on a secure laptop that is only accessible by the PI and CI for the project. You have the option of being referred to in the final paper by your title or first name, rather than your full name and title, if you prefer. All questions are optional - feel free to decline to respond to any question that you would prefer not to answer.

All questions can be asked in person or emailed to the PI or CI at kuskale@umich.edu or mginis@umich.edu.

Introductory Questions:

1. What is your exact position within the organization? Vice chair
2. What duties/obligations does this entail?
3. Why did you choose to work for this organization?
4. How long has your organization been involved in the healthcare sector in Cambodia/Thailand?
5. Does your organization work closely with the private sector?
6. How would you describe the collaboration between the private/public sectors in policy-making?
7. How would you describe the collaboration between the private/public sectors in providing effective healthcare?

Specific, In-depth Questions:

1. Would you say that there has been an increase or decrease in NGO/private sector involvement in the healthcare sector over the last 20 years?
 - a. If there has been an increase, do you see this as positive?
 - i. If there has been an increase, has there been a corresponding increase in NGO influence in healthcare policy?
 - b. If there has been a decrease in NGO involvement, has the government begun to fill the roles that they had assumed?
2. To what degree does the government (public sector) regulate the private sector's involvement in healthcare?
 - a. What does this regulation entail?
3. Thailand at this point in time has a much stronger health sector than it did 30 years ago.
 - a. What developments do you think led to this improvement?
 - b. Did NGOs/private sector play any role in this improvement?
4. Has there been a change in the government's budget allocation for health over the last two decades?

- a. Has the focus of government healthcare programs changed over this time?
5. If you had to give advice to another developing country on how to make effective healthcare a priority what would it be?
 - a. What do you see as necessary to achieve the improvements that Thailand has?
6. Where do you see the Thai health sector going in the near future?

Appendix D: Informed Consent and Surveys

Informed Consent

Introduction: This survey attempts to collect information about differences in individual perception of the roles of NGOs and government services in the health care sector in Cambodia and Thailand.

Procedures: You will be given a questionnaire that consists of a variety of open-ended and multiple choice questions. The questionnaire consists of approximately 20 questions and will take approximately 20 minutes or less. This questionnaire will be conducted with an online Qualtrics-created survey that has been printed and translated for your convenience.

Risks/Discomforts: Risks are minimal for involvement in this survey. We ask that you answer every question, however if any question causes discomfort you may proceed to the next question without answering.

Benefits: There are no direct benefits for participants. However, it is hoped that through your participation, researchers will learn more about the way the health care system and benefits are operating in the region.

Confidentiality: All data obtained from participants will be kept confidential and will only be reported in an aggregate format (by reporting only combined results and never reporting individual ones). All questionnaires will be concealed, and no one other than the primary investigator and co-investigators listed below will have access to them. The data collected will be stored in the HIPPA-compliant, Qualtrics-secure database until it has been deleted by the primary investigator.

Participation: Participation in this survey is completely voluntary. You have the right to withdraw at any time or refuse to participate entirely. If you desire to withdraw, please notify the principal investigator at this email: kuskale@umich.edu. Or, if you prefer, inform the principal investigator as you leave.

Questions about the Research: If you have questions regarding this study, you may contact Alexandra Kuske, at kuskale@umich.edu or Marnie Ginis mginis@umich.edu, or you may ask them now.

Q1 Please type your name below. This will count as an electronic signature, but will not be linked to your specific responses to any survey.

Q2 I have read and understood the above consent form and desire of my own free will to participate in this study.

- Yes
- No

Survey Transcripts:

Survey of Doctors

Participation: Participation in this survey is completely voluntary. If you wish to skip any question, you can move on to the next question while leaving the answer space blank.

Confidentiality: All participant data will be presented only in aggregate and will not be tied to any individual. Only the co-investigators will have access to the survey data which will be stored securely on the University of Michigan Qualtrics site.

Questions: If you have questions on any part of this survey please contact Alexandra Kuske (kuskale@umich.edu) or Marnie Ginis (ginis@umich.edu).

Q1 Please select which age group you belong to:

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years or older

Q2 What religion do you practice?

- Buddhism
- Islam
- Christianity
- Jewish
- Hindu
- Other
- Non-religious

Q3 What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- No schooling completed
- Primary school
- Some secondary school, no diploma
- Secondary school graduate, diploma or the equivalent (for example: GED)
- Some university credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Q4 What is your first/primary language?

- Thai
- Khmer
- Malay
- Karen

- Chinese
- English
- French
- Burmese
- Other

Q5 What is your current employment status?

- Employed for wages
- Self-employed
- Out of work
- Homemaker
- Student
- Military
- Retired
- Unable to work

Q6 In which country are you currently living?

- Thailand
- Cambodia

Display Following Question: If In which country are you currently living? Cambodia Is Selected

Q7 Which is closest to your disposable income per month? (Taken fro CSES)

- 33,000 - 57,000
- 57,000 - 126,000
- 126,000 - 229,000
- 229,000 - 379,000
- 379,000 - 589,000
- 589,000 - 822,000

Display Following Question: If In which country are you currently living? Thailand Is Selected

Q8 Which is closest to your disposable income per month in Baht? (Taken fro SES Thailand)

- 1,310 - 2,454
- 2,454 - 3,881
- 3,881 - 6,377
- 6,377 - 16,905

Q9 In which sector are you currently employed? Please choose all that apply.

- Private sector
- Public sector
- NGO sector

Q10 The following practices occur commonly throughout the world. Please select how frequently you believe they happen in Cambodia:

	Never	Once a month	2 to 3 ties a month	Once a week	2-3 ties a week	Daily
Over prescription of antibiotics						
Over prescription of corticosteroids						
Treatment without seeing the patient in-person						
Unnecessary surgeries						

Referral of public sector patients to the doctor's private sector clinic						
Diagnosis without providing complete information to the patient						
Treatment that varies in quality by how much the patient can pay						

Q11 Please select the number of ties you have seen the following practices take place:

	Never	Once a month	2-3 ties a month	Once a week	2-3 ties a week	Daily
Over prescription of antibiotics						
Over prescription of corticosteroids						
Treatment without seeing the patient in-person						
Unnecessary surgeries						
Referral of public sector patients to the doctor's private sector clinic						
Diagnosis without providing complete information to the patient						
Treatment that varies in quality by how much the patient can pay						

Q12 Please select the number of ties you have participated in the following activities:

	Never	Once a month	2-3 ties a month	Once a week	2-3 ties a week	Daily
Over prescription of antibiotics						
Over prescription of corticosteroids						
Treatment without seeing the patient in-person						
Unnecessary surgeries						
Referral of public sector patients to the doctor's private sector clinic						
Diagnosis without providing complete information to the patient						
Treatment that varies in quality by how much the patient can pay						

Q13 What is your current employment title?

Q14 In which sector was your first health-related job?

- Private sector
- Public sector
- NGO sector

Q15 What were your primary reasons for choosing to work in your current position? Please choose all that apply.

- Salary/Wages
- Benefits (healthcare, paid leave, vacation, etc.)
- Work environment

- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- Lack of bribes
- Effectiveness/quality of service of the sector
- Less corruption

Q16 In which sector would you ideally like to be employed?

- Private Sector
- Public Sector
- NGO Sector

Q17 What are your primary reasons for wanting to be employed in this sector?

- Salary/Wages
- Benefits (healthcare, paid leave, vacation, etc.)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- Lack of bribes
- Effectiveness/quality of service of the sector
- Less corruption

Q18 In which sector do you feel that the quality of healthcare provision is the highest?

- Public Sector
- Private Sector
- NGO Sector
- All are equivalent

Display Following Question: If In which sector do you feel that the quality of healthcare provision is the highest? All are equivalent Is Selected

Q19 In which sector do you feel that the quality of healthcare provision is the lowest?

- Public Sector
- Private Sector
- NGO Sector

Q20 What do you feel is the largest challenge facing healthcare provision over the next 10 years?

- Low public trust in healthcare provision
- Low quality of private healthcare
- Low quality of public healthcare
- Availability of access to healthcare
- Funding for public healthcare
- Sustainability of NGO provided healthcare
- Cost of healthcare services
- Other

Display Following Question: If What do you feel is the largest challenge facing healthcare provision over the next 10 years? Other Is Selected

Q21 If you selected other, what do you feel is the largest challenge facing healthcare provision?

Survey of University Students

Participation: Participation in this survey is completely voluntary. If you wish to skip any question, you can move on to the next question while leaving the answer space blank.

Confidentiality: All participant data will be presented only in aggregate and will not be tied to any individual. Only the co-investigators will have access to the survey data which will be stored securely on the University of Michigan Qualtrics site.

Questions: If you have questions on any part of this survey please contact Alexandra Kuske (kuskale@umich.edu) or Marnie Ginis (mginis@umich.edu).

Q1 Please select which age group you belong to:

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years or older

Q2 What religion do you practice?

- Buddhism
- Islam
- Christianity
- Jewish
- Hindu
- Other
- Non-religious

Q3 What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- No schooling completed
- Primary school
- Some secondary school, no diploma
- Secondary school graduate, diploma or the equivalent (for example: GED)
- Some university credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Q4 In which university are you currently enrolled or, if you have completed university, from which university did you graduate?

Q5 What is your first/primary language?

- Thai
- Khmer
- Malay
- Karen
- Chinese
- English
- French
- Burmese
- Other

Q6 What is your current employment status?

- Employed for wages
- Self-employed
- Out of work
- Homemaker
- Student
- Military
- Retired
- Unable to work

Q7 In which country are you currently living?

- Thailand
- Cambodia

Display This Question: If In which country are you currently living? Cambodia Is Selected

Q8 Which is closest to your disposable income per month in Riels? (Taken from CSES)

- 33,000 - 57,000
- 57,000 - 126,000
- 126,000 - 229,000
- 229,000 - 379,000
- 379,000 - 587,000
- 587,000 - 822,000

Display This Question: If In which country are you currently living? Thailand Is Selected

Q9 Which is closest to your per capita current income in Baht (SES Thailand)?

- 1,310 - 2,454
- 2,454 - 3,881
- 3,881 - 6,377
- 6,377 - 16,905

Q10 What is the title of the ideal position in which you would like to be employed in 10 years?

Q11 In which sector would you ideally like to be employed?

- Public
- Private
- NGO
- Self-employed

Q12 For your intended position, which sector do you believe pays higher wages?

- Public
- Private
- NGO
- Self-employed

Q13 For your intended position, in which position do you think there is the highest opportunity to earn non-salary income?

- Public
- Private
- NGO

Q14 Which sector receives larger non-salary benefits (e.g. healthcare, vacation, opportunities for advancement etc.)?

- Public
- Private
- NGO
- Self-employed

Q15 Which sector is seen as a more prestigious area in which to work?

- Public
- Private
- NGO
- Self-employed

Q16 In 10 years, in which sector would you like to be working?

- Public
- Private
- NGO
- Self-employed

Q17 If yourself or a family member were ill and could go anywhere, in which hospital would you want them to be treated? Please write name of preferred hospital:

Q18 Approximately how many times have you visited a health facility in the past year for yourself or your family member?

- Not at all
- Once
- Twice
- Three times
- 4-6 times
- More than 7 times

Q19 Which health care provider do you see providing the most healthcare at the local level?

- Publically run
- Privately run
- Run by a NGO/non-profit

Survey of Government Employees

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Q1 Please select which age group you belong to:

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years or older

Q2 What religion do you practice?

- Buddhism
- Islam
- Christianity
- Jewish
- Hindu
- Other
- Non-religious

Q3 What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- No schooling completed
- Primary school
- Some secondary school, no diploma
- Secondary school graduate, diploma or the equivalent (for example: GED)
- Some university credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Q4 What is your first/primary language?

- Thai
- Khmer
- Malay
- Karen
- Chinese
- English
- French
- Burmese
- Other

Q5 What is your current employment status?

- Employed for wages
- Self-employed
- Out of work
- Homemaker
- Student
- Military
- Retired
- Unable to work

Q21 By which government are you currently employed?

- Thailand
- Cambodia

Display This Question: If By which government are you currently employed? Cambodia Is Selected

Q6 Which is closest to your disposable income per month in Riels? (Taken from CSES)

- 33,000 - 57,000
- 57,000 - 126,000
- 126,000 - 229,000
- 229,000 - 379,000
- 379,000 - 587,000
- 587,000 - 822,000

Display This Question: If By which government are you currently employed? Thailand Is Selected

Q7 Which is closest to your per capita current income in Baht (SES Thailand)? text

- 1,310 - 2,454
- 2,454 - 3,881
- 3,881 - 6,377
- 6,377 - 16,905

Q8 If you held a similar position in an NGO to your current position with the government do you think you would be paid:

- Slightly more
- A lot more
- Slightly less
- A lot less
- The same

Q9 If you held a similar position in an NGO to your current position with the government do you think your non-salary benefits (such as healthcare, vacation, paid leave, etc.) would be:

- Much better
- Slightly better
- The same
- Slightly worse
- Much worse

Q10 Do you feel that holding your position in the government or an equivalent position in an NGO is more prestigious?

- NGO
- Government
- Neither

Q11 In which do you feel it is more difficult or competitive to get a job of your description:

- NGO
- Government
- Private sector
- None

Display This Question: If In which do you feel it is more difficult or competitive to get a job of your description: None Is Not Selected

Q12 Why do you think it is more difficult in this sector?

Q13 What were your primary reasons for choosing to work in your current position with the government? Please choose all that apply:

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- No need for bribes
- Effectiveness/quality of service of the public sector
- Mission of the government organization
- Less corruption

Q14 Have you worked for the private and/or NGO sector in the past?

- Yes - the private sector
- Yes - the NGO sector
- Yes - both
- No - neither

Display This Question: If Have you worked for the private and/or NGO sector in the past? No - neither Is Not Selected

Q15 Why did you choose to leave your position in the NGO and/or private sector? Please choose all that apply.

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- No need for bribes
- Effectiveness/quality of service of the NGO sector
- Mission of the NGO
- Less corruption

Q16 Do you strive to work in an equivalent position to yours in an NGO?

- Yes
- No

Display This Question: If Do you strive to work in an equivalent position to yours in an NGO? Yes Is Selected

Q17 If yes, what are your primary reasons? Please choose all that apply.

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- No need for bribes
- Effectiveness/quality of service of the NGO sector
- Mission of the NGO
- Less corruption

Q18 If yourself or a family member were ill and you could go anywhere, in which hospital would you want them to be treated? Please write name of your preferred hospital:

Q19 Approximately how many times have you visited a health facility in the past year for yourself or a family member?

- Not at all
- Once
- Twice
- Three times
- 4-6 times
- More than 7 times

Q20 Which health care provider do you see providing health care at the local level?

- Publically run
- Privately run
- Run by a NGO/non-profit

Q21 What do you feel is the largest challenge facing healthcare provision over the next 10 years? Please choose all that apply.

- Low public trust in healthcare provision
- Low quality of private healthcare
- Low quality of public healthcare
- Availability of access to healthcare
- Funding for public healthcare
- Sustainability of NGO provided healthcare
- Cost of healthcare services
- Other

Display This Question: If What do you feel is the largest challenge facing healthcare provision over the next 10 years? Please choose all that apply. Other Is Selected

Q22 If you selected other, what do you feel is the largest challenge?

Q23 How effective do you believe the collaborations between the private and public sector have been in the healthcare sector?

- Extremely effective
- Effective
- Neutral
- Ineffective
- Extremely ineffective
- Unsure

Display This Question: If How effective do you believe the collaborations between the private and public sector have been in the healthcare sector? Not sure Is Not Selected

Q24 Why?

Q25 Has government spending/budget for health care services increased or decreased in the last 20 years?

- Increased
- Decreased
- Neither
- Unsure

Survey of NGO Employees:

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- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65 years or older

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- Buddhism
- Islam
- Christianity
- Judaism
- Hinduism
- Other
- Non-religious

Q3 What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

- No schooling completed
- Primary school
- Some secondary school, no diploma
- Secondary school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Q4 What is your first/primary language?

- Thai
- Khmer
- Malay
- Karen
- Chinese
- English
- French
- Burmese
- Other

Q5 What is your current employment status?

- Employed for wages
- Self-employed
- Out of work
- Homemaker
- Student
- Military
- Retired
- Unable to work

Q6 The NGO I work for is located in:

- Cambodia
- Thailand

Display This Question: If The NGO I work for is located in: Cambodia Is Selected

Q7 Which is closest to your disposable income per month (in thousand Riels)? (Taken from CSES)

- 33,000 - 57,000
- 57,000 - 126,000
- 126,000 - 229,000
- 229,000 - 379,000
- 379,000 - 587,000
- 587,000 - 822,000

Display This Question: If The NGO I work for is located in: Thailand Is Selected

Q8 Which is closest to your per capita current income in Baht (SES Thailand)?

- 1,310 - 2,454
- 2,454 - 3,881
- 3,881 - 6,377
- 6,377 - 16,905

Q9 What is the title of your position within your NGO?

Q10 Have you previously held a similar position with the government or the private sector?

- Yes - the government
- Yes - the private sector
- Yes - both
- No - neither

Display This Question:

If Have you previously held a similar position with the government or the private sector? Yes - the government Is Selected

Or Have you previously held a similar position with the government or the private sector? Yes - the private sector Is Selected

Or Have you previously held a similar position with the government or the private sector? Yes - both Is Selected

Q11 Why did you choose to leave your government and/or private sector position to work in an NGO? Please choose all that apply.

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- Lack of a bribe
- Effectiveness/quality of service of the NGO sector
- Mission of the NGO
- Less corruption

Q12 If you held a similar position in the government to your current position within your organization, do you think you would be paid:

- Slightly more
- A lot more
- Slightly less
- A lot less
- The same

Q13 If you held a similar position in the government to your current position within your organization do you think your non-salary benefits (such as healthcare, vacation, paid leave, etc.) would be:

- Much better
- Slightly better
- The same
- Slightly worse
- Much worse

Q14 Do you feel that holding your position in your NGO or an equivalent position in the government is more prestigious?

- NGO
- Government
- Neither

Q15 In which do you feel it is more difficult or competitive to get a job of your description:

- NGO
- Government
- Private sector
- None

Display This Question: If In which do you feel it is more difficult or competitive to get a job of your description: None Is Not Selected

Q16 What makes getting a position in the aforementioned sector more difficult?

Q17 What were your primary reasons for choosing to work in your current position with an NGO? Please choose all that apply:

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- Lack of a bribe
- Effectiveness/quality of service of the NGO sector
- Mission of the NGO
- Less corruption

Q18 Do you strive to work in an equivalent position to yours with the government?

- Yes
- No

Display This Question: If Do you strive to work in an equivalent position to yours with the government? Yes Is Selected

Q19 If yes, what are your primary reasons?

- Salary/wages
- Benefits (healthcare, vacation, paid leave, etc)
- Work environment
- Necessity (i.e. only position you could get in your field, only job you were offered)
- Prestige/social standing
- Lack of bribes
- Effectiveness/quality of service of the public sector
- Mission of the Government Organization
- Less corruption

Q20 If yourself or a family member were ill and you could go anywhere, in which hospital would you want them to be treated? Please write name of preferred hospital:

Q21 Approximately how many times have you visited a health facility in the past year for yourself or a family member?

- Not at all
- Once
- Twice
- Three times
- 4-6 times
- More than 7 times

Q22 Which health care provider do you see providing health care at the local level?

- Publically run
- Privately run
- Run by a NGO/non-profit

Q23 What do you feel is the largest challenge facing healthcare provision over the next 10 years? Please choose all that apply.

- Low public trust in healthcare providers
- Low quality of private healthcare
- Low quality of public healthcare
- Availability of access to healthcare
- Funding for public healthcare
- Sustainability of NGO provided healthcare
- Cost of healthcare services
- Other

Display This Question: If What do you feel is the largest challenge facing healthcare provision over the next 10 years? Please choose all that apply. Other Is Selected

Q24 If you selected other, what do you see as the largest challenge facing healthcare provision?

Q25 From where does your NGO receive the majority of its funding? Please select all that apply.

- Personal donations
- Private grants
- Government grants
- Fundraising events
- Social enterprise
- International organizations

Q26 Have you found that your ability to raise these funds is consistent?

- Yes
- No
- Unsure

Display This Question: If Have you found that your ability to raise these funds is consistent? No Is Selected

Q27 If not consistent, why?

- Dependent on governments fund availability
- Dependent on international aid fads/trends
- Dependent on your organizations ability to fundraise/market each year
- Dependent on government/public priorities for funding
- Other

Display This Question: If If not consistent, why? Other Is Selected

Q28 If other, please explain:

Q29 Has your mission stayed the same since the founding of your organization?

- Yes
- No
- Unsure

Display This Question: If Has your mission stayed the same since the founding of your organization? Yes Is Selected

Q30 To what degree has the mission of your organization shifted over time?

- A great deal
- A lot
- A moderate amount
- A little
- None at all

Display This Question: If Has your mission stayed the same since the founding of your organization? Yes Is Selected

Q31 How much of this change is due to the need for funding?

- A great deal
- A lot
- A moderate amount
- A little
- None at all