Cambodia: Developing a Strategy for Social Health Protection

Peter Leslie Annear
Acronyms and Abbreviations

CBHI Community-based Health Insurance
HEH Health Equity Funds
MOH (Cambodia) Ministry of Health of Cambodia
NGO non-governmental organization
NSSF (proposed) National Social Security Fund
Strategic Framework Strategic Framework for Health Financing
SHI Master Plan Master Plan for Social Health Insurance 2003-2005
SHI Committee Social Health Insurance Committee
Since the adoption of the Master Plan for Social Health Insurance 2003-2005 (SHI Master Plan), Cambodia has taken the first tentative steps towards implementing unified social health protection measures and developing the systems needed to achieve universal health insurance coverage. National policies for health strategies and financing, social health insurance, health equity funds and community-based health insurance have all been developed. The health plans have been designed to support the achievement of national development aspirations and Cambodia's Millennium Development Goals by 2015.

This document focuses on the need to achieve universal coverage within the overall framework of the development policies and planning of the Royal Government of Cambodia. The main purpose is to investigate issues related to the development of an implementation plan for the draft national Strategic Framework for Health Financing (Strategic Framework) and to contribute to improved inter-sectoral collaboration and dialogue for health planning and financing.

This document was originally prepared for discussion at the National Workshop “Promoting Sustainable Strategies to Improve Access to Health Care” that was held in Phnom Penh from 28 to 29 January 2008. The document was revised following discussions at the Workshop with Ministry of Health (MOH (Cambodia)) and other Cambodian officials and stakeholders involved in providing social health protection measures.

The document mainly discusses the SHI Master Plan and reviews the terms of reference, roles and responsibilities of the Social Health Insurance Committee (SHI Committee). It examines the critical needs, opportunities, challenges and constraints facing health planners and provides recommendations for new and effective inter-sectoral collaboration and dialogue. It also examines the opportunities for and constraints to address gender issues through the Strategic Framework and its implementation plan and suggests ways in which gender issues could be specifically addressed.

Cambodia and similar developing countries today face an environment where the users of health services have become the main source of national health financing. In such conditions, the need to develop effective social health protection measures and to address the specific needs of the poor has become critical. Fundamental to that need are issues related to health costs as a major cause of impoverishment and the impact of catastrophic medical expenditures. This case study of health financing in Cambodia notes the experiences in neighbouring Thailand in moving towards universal health insurance coverage and presents recommendations.

The health financing situation in Cambodia is unique in a number of ways:

• In total, Cambodia spends almost twice the national average rate of developing countries on health care, two thirds of which is funded by out-of-pocket expenditures.
• In contrast to most developing countries, the introduction of regulated, official user fees for public health services in Cambodia actually worked to reduce the costs of access to health services and to increase utilization of public health facilities, although official fee-exemptions systems have been inadequate to protect the poor.
• Cambodia was the first country to introduce Health Equity Funds (HEF) as an effective means to fund fee-exemption schemes at public health facilities,
mainly through the activities of a number of international and local non-governmental organizations (NGOs).

- Cambodia was the first country in which HEF were introduced effectively to address financial barriers to access for the poor, through a system that actively and systematically identifies the poor and uses HEF to fund facility user-fee-exemptions and provide for ancillary transport costs and caretaker food support.

- Different pilot projects in community-based health insurance (CBHI) have been implemented in a number of locations to meet the needs of the not-so-poor and protect them from impoverishment due to health costs.

In this document, various terms are used with the following definitions:

- Social health protection is used to mean the broadest arrangement of measures to protect the population against the impact of unaffordable health costs, including social health insurance and all other measures.

- Social health insurance is used to mean a national compulsory system of government- and employer-supported health insurance for employees, backed by national legislation and budget funding.

- Other forms of pre-payment for community and private health insurance, like CBHI, are voluntary, depend on premium sales and may be either for-profit or non-profit.

- HEF are a type of social transfer mechanism that provide subsidies for the poor and can be implemented by international or local NGOs, using funding that may be provided by donors, Government or community collections.

- Similar to HEF are subsidy schemes that are funded directly through the MOH (Cambodia) and reimburse district hospitals for user-fee-exemptions that they offer to the poor; the subsidy schemes are managed either by operational district offices or by the district referral hospitals.

- Universal coverage is more precisely “universal health insurance coverage” and is the complete availability of access to health services by the whole population, funded under nationally based health insurance arrangements (usually Government-funded) without payment by the user at the point of service.

The first section considers the background to health, health care and health financing in Cambodia, reviewing social and economic conditions, the status of national health financing and some relevant gender issues. The second section deals with the policy framework, beginning with developments to date, then considering the recently developed national health financing strategy, and finally by considering the likely path towards universal coverage. The third section specifically views the structure, aims and purposes of the SHI Committee by analyzing its terms of reference and the role it is intended to play in implementing the national strategy for social health protection. The final section presents conclusions and recommendations.

1.1. Background

Of the 177 countries listed in the United Nations Human Development Index, Cambodia ranks 129, Myanmar 130 and the Lao People’s Democratic Republic 133. Thailand ranks 74. The similarities between the three countries surrounding Thailand are evident, as are their differences from Thailand. However, certain features also distinguish each of those three countries that require closer investigation. Cambodia has a relatively homogeneous population, but has only recently emerged from a long period of conflict. At present it is predominantly rural with a rapidly growing urban sector. While the economy is growing rapidly, poverty remains widespread and income disparities are widening.
1.1.1. Economic and social conditions

Cambodia has a population of more than 14 million and a per capita gross national income of USD 430 (2005). More than 80 per cent of the population live in rural areas and are engaged mainly in subsistence agriculture. Ninety per cent of the population are Khmer and Buddhist. Approximately 35 per cent of the population live below the poverty line of USD 0.59 per day. Economic growth has averaged 8 per cent per annum in the last decade. The structure of the economy is slowly changing, with gradually increasing industrialization. Foreign aid makes a major contribution. Tables 1.1 to 1.4 summarize changes in key economic and health indicators in years since 1990.

Table 1.1. Cambodia: Population and economy, selected indicators, 1990 to 2005

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population, total (millions)</td>
<td>9.7</td>
<td>11.4</td>
<td>12.7</td>
<td>14.1*</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>3.4</td>
<td>2.8</td>
<td>2.1</td>
<td>2.0*</td>
</tr>
<tr>
<td>Rural population (% of total population)</td>
<td>87</td>
<td>86</td>
<td>83</td>
<td>81</td>
</tr>
<tr>
<td>Literacy rate, adult total (% of people ages 15 and above)</td>
<td>62</td>
<td>..</td>
<td>..</td>
<td>74*</td>
</tr>
<tr>
<td>Economy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDP (constant 2000 US$)</td>
<td>..</td>
<td>2.6</td>
<td>3.7</td>
<td>4.7</td>
</tr>
<tr>
<td>GDP growth (annual %)</td>
<td>..</td>
<td>6.5</td>
<td>8.4</td>
<td>13.4*</td>
</tr>
<tr>
<td>Gross National Income per capita, Atlas method (current US$)</td>
<td>..</td>
<td>280</td>
<td>280</td>
<td>430*</td>
</tr>
<tr>
<td>Aid (% of Gross National Income)</td>
<td>3.7</td>
<td>16.4</td>
<td>11.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Employment in agriculture (% of total employment)</td>
<td>..</td>
<td>75</td>
<td>74</td>
<td>70</td>
</tr>
<tr>
<td>Employment in industry (% of total employment)</td>
<td>..</td>
<td>5</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Employment in services (% of total employment)</td>
<td>..</td>
<td>21</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Poverty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head count ratio at national poverty line (% of population)</td>
<td>..</td>
<td>47#</td>
<td>36^</td>
<td>35^</td>
</tr>
</tbody>
</table>

Notes:

a. All data pertain to 2004 and were taken from WDI2006 unless otherwise indicated; b. 1993; c. 2001; d. 1999; * indicates data for 2005 taken from WDI2007; # Cambodia Demographic and Health Survey 2005; ^ Cambodia Socio-Economic Survey 2004.

With most development occurring in the urban economy, there is wide variation between rural and urban areas and disparities are growing in the distribution of income. Despite the positive signs of growth and development, income distribution is skewed, with the top quintile of the population taking 48 per cent of income compared to 7 per cent for the bottom quintile (table 1.2).

Table 1.2. Cambodia: Share of income by population quintile, 1997

<table>
<thead>
<tr>
<th>Quintile</th>
<th>% of total income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest population quintile</td>
<td>47.6</td>
</tr>
<tr>
<td>Fourth population quintile</td>
<td>20.1</td>
</tr>
<tr>
<td>Third population quintile</td>
<td>14.7</td>
</tr>
<tr>
<td>Second population quintile</td>
<td>10.7</td>
</tr>
<tr>
<td>Lowest population quintile</td>
<td>6.9</td>
</tr>
</tbody>
</table>


Data from the 2005 Cambodia Demographic and Health Survey indicate that major improvements in health status have occurred in recent years, most particularly a sharp decline in childhood mortality rates: life expectancy is increasing (table 1.3) and the under-5 mortality rate fell by 40 per cent from 1998 to 2003 (table 1.4).
Table 1.3. Cambodia: Health status and service delivery, selected indicators, 1990 to 2004

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1990</th>
<th>1995</th>
<th>2000</th>
<th>2005*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>54</td>
<td>55</td>
<td>56</td>
<td>61</td>
</tr>
<tr>
<td>Birth rate, crude (per 1,000 people)</td>
<td>43</td>
<td>35</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Death rate, crude (per 1,000 people)</td>
<td>13</td>
<td>12</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Fertility rate, total (births per woman)</td>
<td>5.5</td>
<td>4.8</td>
<td>4.3</td>
<td>3.9+a</td>
</tr>
<tr>
<td>Mortality rate, infant (per 1,000 live births)</td>
<td>79</td>
<td>93</td>
<td>109</td>
<td>66</td>
</tr>
<tr>
<td>Mortality rate, child (per 1,000 live births)</td>
<td>39+a</td>
<td>34+a</td>
<td>21+a</td>
<td>19+a</td>
</tr>
<tr>
<td>Mortality rate, under-5 (per 1,000 live births)</td>
<td>115+a</td>
<td>124+a</td>
<td>127+a</td>
<td>83+a</td>
</tr>
<tr>
<td>Mortality ratio, maternal (per 100,000 live births)</td>
<td></td>
<td></td>
<td>437</td>
<td>472+a</td>
</tr>
<tr>
<td><strong>Health services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births attended by skilled health staff (% of total)</td>
<td></td>
<td></td>
<td>32</td>
<td>43+c</td>
</tr>
<tr>
<td>Immunization, DPT (% of children ages 12-23 months)</td>
<td>38</td>
<td>39</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>ARI treatment (% of children under 5 taken to a health provider)</td>
<td></td>
<td></td>
<td>35</td>
<td>49+d</td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. All data pertain to 2004 and are taken from World Development Indicators 2006, supra, unless otherwise indicated;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. National Strategic Development Plan 2006-2010 (Ministry of Planning, 2006) reports life expectancy as 58 years for men and 64 years for women;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Indicates data for 2005 taken from World Development Indicators 2007;</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d. Indicates data for 2005 taken from Cambodia Demographic and Health Survey 2005;</td>
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</tbody>
</table>

The gains in health status have not been distributed equally. To finance their health costs, 80 per cent of Cambodians use savings, go into debt or sell assets, and only 16 per cent are able to pay health costs from regular income.1 As table 1.4 illustrates, recent significant gains in childhood mortality rates have not been reflected in the lower income quintiles. A survey of the poverty-reduction effects of Cambodia’s health programme2 indicated that health gains had not been shared equitably partly because the poor did not use available health services to the same extent as the rich. Consequently, the costs of health care and the impact of catastrophic health expenditures remain the major cause of new impoverishment in Cambodia.3

Table 1.4. Cambodia: Early childhood mortality rates, by income quintile, 2005

<table>
<thead>
<tr>
<th>Income quintile</th>
<th>Lowest</th>
<th>Second</th>
<th>Middle</th>
<th>Fourth</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality</td>
<td>34</td>
<td>45</td>
<td>38</td>
<td>38</td>
<td>22</td>
</tr>
<tr>
<td>Post-neonatal mortality</td>
<td>66</td>
<td>64</td>
<td>60</td>
<td>39</td>
<td>12</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>101</td>
<td>109</td>
<td>98</td>
<td>78</td>
<td>34</td>
</tr>
<tr>
<td>Child mortality</td>
<td>29</td>
<td>23</td>
<td>18</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Under 5 Mortality</td>
<td>127</td>
<td>129</td>
<td>114</td>
<td>92</td>
<td>43</td>
</tr>
</tbody>
</table>


1.1.2. Health system development and financing

From 1995, Cambodia’s health reform process focused on improving the supply of health services through a process of staff training, infrastructural development and the supply of drugs to public health facilities. Health service strengthening began with the Health Coverage Plan (under which reconstruction of district-level referral hospitals and health centres has been carried out) and the Health Financing Charter (which gave public health facilities the right to levy user fees with exemptions for the poor as a pilot project). A long period of planning and systems development has culminated in the preparation of the draft Health Strategic Plan 2008-2015 and the Strategic Framework for Health Financing 2008-2015.

Despite significant improvements in the supply of health services, the demand for health services has not increased proportionately because of a number of financial and other barriers to accessing health services, including the failure of fee-exemption systems to protect all the poor. Only 22 per cent of reported treatment episodes are provided in the public sector, where the quality of service delivery remains low. The constraints on the delivery of quality public health services include inadequate management capacity, low salary levels that in turn create an incentive for different forms of private practice, and inadequate skill levels at most health centres and some hospitals. The private health-care sector, which is diverse, largely unregulated and provides treatment of unknown quality, accounts for 48 per cent of treatment episodes. A variety of other providers such as drug vendors, traditional and religious healers and birth attendants attract 21 per cent of patients.

Nonetheless, the MOH (Cambodia) remains the main provider of national health-care infrastructure and human resources. Further, while small in absolute terms, the health budget constitutes a large and increasing proportion of national budget expenditures. Although reliable figures are not available, recurrent health spending through the MOH (Cambodia) reached as much as 12 per cent of total recurrent expenditures in the 2007 national budget, according to one estimate.4 In total, health financing is derived from various sources, including the Government budget, multilateral and bilateral donor funding, NGOs and other charitable donations, the private medical sector and household out-of-pocket spending.

Health financing in Cambodia has a number of distinct characteristics:

- An extremely high level of national health expenditure compared to other developing countries, reaching more than 10 per cent of GDP per year by 2003 (or USD 27 to USD 37 per capita per year).5
- A low absolute level of Government health spending, with recurrent budget spending at little more than 1 per cent of GDP (or approximately USD 4 per capita per year).
- A very high level of private, out-of-pocket household spending that accounts for approximately two thirds of all health expenditure (or approximately USD 25 per capita per year).
- A rising level of donor funding for health care, reaching a total of USD 114 million in 2005 (or USD 8 per capita per year).


5 Estimates vary depending on source of data for out-of-pocket spending: out-of-pocket estimated at USD 15 by the secondary assessment of Cambodian Socio-Economic Survey data, published in the Cambodian Poverty Assessment, World Bank, World Development Indicators 2006 (World Bank, 2007); USD 18 by the WHO National Health Account website (for total spending of USD 30); USD 25 by the secondary analysis of Cambodia Demographic and Health Survey 2005 data in Lane, Scaling Up for Better Health in Cambodia, supra.
Table 1.5. Cambodia: Health expenditure, by sector and out-of-pocket spending, 1998 to 2003

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Health expenditure per capita (current US$)</td>
<td>26</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Health expenditure, private (% of GDP)</td>
<td>9.4</td>
<td>9.4</td>
<td>8.8</td>
</tr>
<tr>
<td>Health expenditure, public (% of GDP)</td>
<td>1.1</td>
<td>1.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Health expenditure, total (% of GDP)</td>
<td>10.5</td>
<td>11.0</td>
<td>10.9</td>
</tr>
<tr>
<td>Out-of-pocket health expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(% of private expenditure on health)</td>
<td>90</td>
<td>85</td>
<td>85</td>
</tr>
</tbody>
</table>


According to Lane (2007), the increasing levels of Government spending and donor funding and high out-of-pocket expenditures mean that the actual level of funds available may not be a constraint on meeting health goals. However, the excessive burden of out-of-pocket payments presents a financial barrier to access to health services for the poor and constitutes a misallocation of resources in the health sector. To achieve greater equity and efficiency, a much larger share of health care must be financed through tax-funded social transfers (the health budget) and through affordable pre-payment and social disbursement mechanisms (social health insurance and equity funds).

The application of official user fees at government facilities from 1996 had a contradictory impact. In stark contrast to most developing countries, the introduction of user fees in Cambodia was associated with an increase in the utilization of public health services, primarily because the official fees in most cases replaced more expensive under-the-table charges. For example, the introduction of a regulated fee system at the National Maternal and Child Health Hospital was associated with increased patient satisfaction, higher utilization and bed occupancy rates and an increased number of hospital-based natal deliveries. However, one study showed that increased utilization was concentrated among people of higher socio-economic status and that the introduction and subsequent increase of user charges over time could still represent a "medical poverty trap" for many users.

When the 1996 Health Financing Charter approved user fee collection at public facilities, it also introduced a system of exemptions for the poor. Those exemptions were administered informally by health staff at the facility level without objective testing and at the discretion of the staff. The exemptions were unfunded and constituted a drain on income from user fees with a consequent reduction in monies available for staff incentives. Consequently, the exemption system has been only poorly implemented and has not worked fully to protect the poor, and in practice the proportion of patients receiving exemptions remains low.

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6 Lane, Scaling Up for Better Health in Cambodia, supra.
The failure of fee exemption systems is commonly related to the failure to fund them adequately.\textsuperscript{10} In Cambodia, such a failure gave rise to a new model of funded fee exemptions for the poor under the title of HEF which have worked effectively to protect the poor. HEF emerged in 2000 as a decentralized, district-based third-party scheme designed to pay fee-exemptions for the poor, commonly administered by NGOs and based on means-testing to identify the genuinely poor. Similarly, pilot schemes in CBHI emerged at the same time as a pre-payment mechanism designed to protect the not-so-poor from impoverishment owing to health costs, particularly catastrophic health expenditures.

Considering the high level of out-of-pocket expenditures, the private sector appears to play the main role in service provision. However, the private sector is varied and the quality of care is often unreliable. Much of the private out-of-pocket expenditure is used for self-medication without diagnosis or by means of prescription at private drug sellers and local market stalls. A large proportion goes towards paying additional costs for government health staff working privately. Some out-of-pocket expenditure is spent on user fees at government facilities, which may account for around 15 per cent of hospital revenues. Another proportion is spent for services at private clinics and other facilities, especially in urban areas. While growing, the private sector remains largely unregulated.

1.1.3. Gender issues

Women and their children are the main users of public health services. Data from the Ministry of Health Information System indicate, for example, that 71 per cent of outpatients attending the Phnom Penh Municipal Hospital in 2006 were female, a common result across most referral hospitals in Cambodia. However, serious challenges remain in the provision of health services for women, reflected particularly in the persistent and unacceptably high levels of maternal mortality.

Despite impressive gains in reducing childhood mortality rates, the maternal mortality ratio has remained well above 400 per 100,000 live births since the 1990s without any sign of change (table 1.3). Because of the difficulties in achieving complete and accurate reporting of maternal deaths, the estimate of maternal mortality is less than precise. However, it is known that about one woman in six who died in the seven years prior to the Cambodia Demographic and Health Survey 2005, lost her life from pregnancy-related causes.\textsuperscript{11}

The excessive mortality parallels a very low rate of utilization of public facilities for deliveries and a strong preference for home births, especially in rural areas. Only in the case of recognized obstetric complications do women generally choose to access health services. According to the Cambodia Demographic and Health Survey 2005, only 44 per cent of women nationally have a skilled attendant present during delivery, mostly midwives (up from 32 per cent in Cambodia Demographic and Health Survey 2000). Assisted births are much more common in urban areas (70 per cent of births) than in rural areas (39 per cent). Overall, 55 per cent of births are delivered by a traditional birth attendant, especially in rural areas. Nationally, 78 per cent of births are delivered at home (down from 89 per cent in Cambodia Demographic and Health Survey 2000).\textsuperscript{12} A recent survey in one rural Cambodia district (Memot, in Kampong Cham province)

\textsuperscript{12} Ibid.
found that only 20 per cent of women who had delivered during the previous 3 months had been assisted by skilled attendants, with 88 per cent of deliveries occurring at home.13

Reductions in maternal mortality remain a key challenge for national development and health planning. The National Strategic Development Plan 2006-2010 highlights the concerns about maternal mortality and sets targets to reduce the maternal mortality ratio to 243 by 2010, and to 140 by the year 2015.14 Addressing gender concerns remains a central issue in the Cambodian Millennium Development Goals for health, which specifically target education and employment opportunities for women and children and aim to reduce gender disparities within public institutions (including health services). With these concerns in mind the Reduction in Maternal Mortality Plan was drafted in 2007, focusing on advocacy, behaviour change communication, quality assurance training and improved access to facilities by use of HEF.

1.2. Health Financing Framework

1.2.1. Policy development

From 1979 to 1996, Cambodia provided public health services free of charge to the population. However, public spending was not sufficient to cover basic health-care needs. A process of health reform began in the early 1990s that led to the introduction of the Health Coverage Plan in 1996.

Health Coverage Plan

The Health Coverage Plan was conceived as a programme for infrastructural development in a range of newly defined health operational districts, placement of staff and provision of a reliable drug supply through the Central Medical Service.15 The Plan divided the country on a population basis into 76 health operational districts each with a district referral hospital and associated health centres and set minimum standards for service delivery through the Minimum Package of Activities at health centres and the Complementary Package of Activities at referral hospitals.16

Health Financing Charter

Also in 1996, the MOH (Cambodia) and the Ministry of Economics and Finance jointly approved the Health Financing Charter to provide a regulated framework for approval of official user fees and other health financing initiatives.17 The Charter authorized a pilot scheme for introducing user fees at health facilities with approval by the MOH (Cambodia) and paved the way for introducing various initiatives in health systems and health-care delivery. In a decentralized system, the health facilities themselves levy fees on an agreed scale, and 99 per cent of fee revenues are retained at the facility to be used for recurrent costs and staff incentives.

16 Under the Health Coverage Plan, the Cambodian health system is organized nationally into 76 health operational districts covering an average population of 100,000-200,000, each with a ‘referral hospital’ for secondary level health services providing Complementary Package of Activities and 10-20 ‘health centres’ for primary care providing Minimum Package of Activities. Tertiary hospital care is generally provided at ‘National Hospitals’ in the capital, Phnom Penh.
Exemptions for the poor

While the Health Financing Charter provided for exemptions for the poor (to be granted informally at the facility level), the official exemptions system was unfunded and provided inadequate coverage. In practice, exemptions were a drain on facility revenues and staff incentives and the proportion of patients receiving exemptions remained low. From the beginning, exemptions for the poor averaged around 18 per cent of patient admissions nationally, compared to the national poverty rate of more than 35 per cent. Those circumstances produced a response at both practice and policy levels. In practice, two demand-side financing schemes emerged from 2000 at the local district level, both sponsored by international and local NGOs: HEF and CBHI (see the following Subsection 1.2.2. for a description of HEF and CBHI schemes). From a policy point of view, a SHI Master Plan was drafted in 2003 and regulations for HEF and CBHI followed.

Law on Social Security

The Government has taken steps to introduce social security, beginning with a work injury programme and old age pensions. The Law on Social Security Schemes for Persons defined by the provisions of the Labour Law was enacted in September 2002. Article 1 defines those two benefits and states that other contingencies shall be subsequently determined by sub-decree based on the actual situation in the national economy. The Law stipulates that the social security schemes shall function under a national social security fund, which shall be a public self-financing institution outside any Governmental ministry and be governed by a board, with tri-partite representation, and include the MOH (Cambodia).

SHI Master Plan

The SHI Master Plan in Cambodia was prepared by the MOH (Cambodia) with technical support from WHO and was released in September 2003. It was officially launched and disseminated in 2005. A full discussion of the SHI Master Plan along with the tasks, roles and responsibilities of the SHI Committee, which has responsibility for implementing the Plan, is included in Section 1.3.

The adoption of the SHI Master Plan was based on the need to develop alternative health financing schemes in line with the projections of the Ministry of Health Strategic Plan 2003-2007. From a policy point of view, the objectives for developing social health insurance were identified as the need for (a) a stable health financing mechanism, (b) the promotion of equity in access to health care, (c) rational household expenditure on health through prepayment rather than unpredictable payment at the time of illness and (d) improvement in the health-care delivery system. The SHI Master Plan reviews the health financing situation and considers the main issues facing social health insurance; demography, the labour force and employment, the scope of existing social security systems, major health and health system issues and cultural factors.

The SHI Master Plan recommended a parallel and pluralistic approach to work towards universal health insurance coverage, comprising:

- Compulsory social health insurance through a social security framework for formal-sector salaried workers and their dependents, administered by the National Social Security Fund; coverage would be provided for private sector employees under the Labour Law (accidents, maternity, occupational health and safety) and the 2002 Social Security Law (pensions, injury and

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occupational diseases, medical care and maternity), administered by the Ministry of Labour and Vocational Training; it would be provided for Civil Servants under Decision Letter 245 (1988), including sickness and accident benefits, free health services at state hospitals, maternity leave and sick leave, administered by the Ministry of Social Affairs, Veterans and Youth.

• Voluntary insurance through the development of CBHI schemes for informal-sector, non-salaried workers and their families who can afford to contribute small premium payments on a regular basis (such schemes have been sponsored initially by different development partners and local and international NGOs working with some contracted public health-care providers).

• Social assistance through the use of district-based HEF and, later, through Government funds to purchase health insurance for non-economically active and indigent populations (a Government prakas, or decree, authorizing the reimbursement of fee-exemptions at health facilities through MOH (Cambodia) budget funding was adopted in 2007).

HEF Framework

The National Equity Fund Implementation and Monitoring Framework was adopted by the MOH (Cambodia) in September 2005. The Framework formalized the institutional arrangements needed to extend HEF operations in Cambodia from a range of schemes implemented through and by local and international NGOs. The Framework addresses five key areas:

1. Background information on HEF including policy relevance, operations and targeted outcomes.
2. Institutional arrangements for HEF expansion.
3. Criteria for the selection of health operational districts to participate in the HEF expansion process, including means for the identification of HEF beneficiaries, guidelines for the selection of HEF implementers and estimated costing.
5. Principles and methods for monitoring and evaluation of the expanded HEF system.

In early 2007, the detailed national Monitoring and Evaluation Framework for HEF was fully developed and implemented through the MOH (Cambodia) to track the performance of the existing HEF schemes managed by NGOs.

CBHI Guidelines

The “Guidelines for the Implementation of Community-based Health Insurance Schemes” were developed in April 2006 by the MOH (Cambodia) with technical support by WHO and Deutsche Gesellschaft fur Technische Zusammenarbeit (German Technical Cooperation or GTZ). The Guidelines were prepared by the SHI Committee and presented to the MOH (Cambodia) - Donor Technical Working Group for Health. The Guidelines have been presented for official approval by the MOH (Cambodia) and will be translated into formal regulations with a complementary monitoring framework. The Guidelines were designed to enable the creation of a network of CBHI schemes with common principles and to allow for eventual merging of schemes to achieve increased risk-pooling and portability between schemes. The Guidelines propose establishment

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21 Ministry of Health, WHO and GTZ, Guidelines for Implementing Community-Based Health Insurance (Phnom Penh, Ministry of Health, WHO, and GTZ, 2006).
of local CBHI Management Committees with a composition adapted to local conditions and encourage stakeholder involvement in implementation.

Under the Guidelines, CBHI schemes are required to:

- Register with the Ministry of the Interior according to regulations applying to NGOs.
- Submit to the MOH (Cambodia) for approval of implementation arrangements.
- Undertake training coordinated by the MOH (Cambodia).
- Charge premiums that are affordable for the majority of the population and involve no additional payments from beneficiaries at the point of service.
- Provide for ambulatory and in-patient care for beneficiaries and their families.
- Provide equal benefits to all insured persons regardless of pre-existing or new chronic diseases or conditions.
- Regulate qualifying periods for entitlement to benefits.
- Earmark allocations for the use of contribution revenues.
- Contract local public health-care facilities to provide services.
- Manage provider payment in advance and on a regular basis.

1.2.2. Implementation of HEF and CBHI

HEF are original to Cambodia. They emerged as localized, decentralized and district-based health-care subsidies for the poor (or funded fee-exemption system) that are funded mostly by donors and implemented by NGOs working to support public health service delivery. In Cambodia, HEF operate as a third-party-payer scheme for indigent patients in which a fund is managed at the district level by a local agent (usually a local NGO) and supervised by an international NGO. Funding is commonly from donors, but in some cases may also come from community collections and the Government. The poor are identified at or prior to the point of service and receive free care at the health facility, transport reimbursement and caretaker food support. The facility is usually reimbursed on a monthly basis directly from the fund for services provided to the poor.

Since its inauguration in three areas in 2000 (Phnom Penh, Sotnikum and Thmar Pouk), the number of HEF schemes has grown rapidly and HEF currently cover more than one half of all health districts. HEF provide improved access to health services for the poor, protect the poor from excessive health expenditures and reduce dependence on debt and asset sales to pay health costs. A comprehensive study of HEF was made through the 2005-2007 Study of Financial Access to Health Services for the Poor in Cambodia, sponsored by WHO, the MOH (Cambodia), the Australian Agency for International Development and RMIT University (Melbourne, Australia). In addition, there is a growing literature on HEF in Cambodia that shows their effectiveness in providing social health protection for the poor. A summary of the relevant literature is presented in the accompanying box with a bibliography.

The published and grey literature on the implementation of HEF indicates their effectiveness. One rural study has shown that increased utilization of health facilities under normal conditions was concentrated among people of higher socio-economic status and that the introduction and subsequent increase of user charges over time could still represent a “medical poverty trap” for many users.\(^{23}\) HEF were designed in those conditions to address the financial, geographical, informational and socio-cultural barriers faced by the poor.\(^{24}\) There have been several studies in specific locations, most commonly in Sotnikum health district, one of the first rural sites to have pioneered HEF.\(^{25}\) Comparative studies have been made of the different HEF models in Sotnikum, Thmar Pouk, Phnom Penh, Takeo and Svay Rieng\(^{26}\) and of HEF systems in Siem Reap, Otdar Meanchey and Sotnikum.\(^{27}\) One prospective study compared the possibilities for equity funds at referral hospitals in Chhlong, Pursat, Moung Russei and Mongkul Borei;\(^{28}\) Other prospective studies discussing options for health financing, user fees, HEF and community insurance have contributed to planning the introduction of different pro-poor schemes.\(^{29}\) A recent international comparative study contrasted the impact of equity funds on access for the poor in Cambodia with the removal of user-fees in Uganda, concluding that contextual issues were paramount in the success in both cases. Another considered the more general application of equity funds in low-income countries.\(^{30}\) In different locations, HEF have increased access for the poor and facilitated community participation in health service improvement, particularly through pagoda-based funds.\(^{31}\) In Phnom Penh squatter communities, HEF were found to protect the poor from the impact of health costs and to increase access to health services.\(^{32}\) A study in one rural district indicated that the financial sustainability of HEF may be improved by working through grassroots institutions, such as pagodas, although external support may still be required.\(^{33}\) A forthcoming book on social assistance and health care for the poor in Asia by the Institute of Tropical Medicine, Antwerp, includes a number of new articles on HEF in Cambodia,\(^{34}\) including that footnoted here.\(^{35}\)

\(^{23}\) Jacobs and Price, “The impact of the introduction of user fees”, supra.
\(^{26}\) Bitran and Gode, Waivers and Exemptions, supra.
\(^{29}\) M. Baubsta, Health Financing Schemes in Cambodia: Reaching the Poor with Quality Health Services (Phnom Penh, University Research Co., 2003).
Chapter I Cambodia: Developing a Strategy for Social Health Protection

In Cambodia, CBHI comprises a number of local-level, voluntary, private, non-profit micro insurance schemes funded by user premiums and managed commonly by an international or local NGO. CBHI does not target the poor, rather it targets informal sector workers and the not-so-poor, including those who have sufficient cash income to pay modest monthly premiums. The schemes pay the costs of health care for insured patients (and their families) at contracted government facilities; in practice, the facilities receive a monthly capitation payment or reimbursement for fee-exemptions to insured patients from the insurance fund. Benefits are agreed by contract with the facilities and include a list of exclusions for certain non-essential and complex services.

CBHI collectively is less widespread than HEF and currently serves a limited number of insured members in Phnom Penh and a range of rural locations at various health centres, referral hospitals and health operational districts (and perhaps province-wide in the near future). The first CBHI scheme was launched at one health centre in 1999 and the number of schemes has expanded steadily since then. Seven different local and international organizations manage (or are planning) CBHI schemes, charging monthly premiums in the range of USD 1 to USD 3 (generally with a subsidy from the insurance manager). By June 2007 there were nine CBHI schemes operating at certain locations within six provinces. Results of CBHI implementation were reported in the Access Study.

1.2.3. National health financing strategies

The development of a comprehensive strategy for national health financing is still at an early stage in Cambodia. Drafting of the national policies and implementation of the innovative demand-side financing schemes already mentioned are major achievements that provide a basis for further movement towards universal health insurance coverage. The period from 2008 to 2015 is therefore a preparatory period during which the foundations of the anticipated national approach are being laid. It is thought that advancement to universal coverage may be possible by the end of this period, which coincides with the date for the achievement of Cambodia's Millennium Development Goals for health.

Health programmes are a significant part of the Government's current framework for development planning. The National Strategic Development Plan 2006-2010 provides the overall direction for this process. Two Health Strategic Plans have been developed for 2003-2007 and 2008-2015 (currently being drafted by the MOH (Cambodia)). In addition, the Strategic Framework for Health Financing 2008-2015 has been prepared to accompany the Health Strategic Plan 2008-2015. Based on those policy documents, the opportunity currently exists to develop a detailed implementation plan for health activities in the period to 2015, one that is supported by a health financing strategy

31 In Kiriyong health district, one HEF scheme used pagodas, or Buddhist temples, as the focal point for collecting health equity funds from the community and distributing them to health centres to finance health costs for the poor. B. Jacobs and N. Price, “Community participation in externally funded health projects: lessons from Cambodia”, Health Policy and Planning (2003), vol. 18, pp. 399-410.
34 Institute of Tropical Medicine, Social Assistance and Health Care for the Poor in Asia (Antwerp, Institute of Tropical Medicine, 2008).
36 Ministry of Health, Minutes of the Social Health Insurance Committee, 26 June 2007.
that addresses the need for balance in financing sources and for improved social health protection for the poor. (The SHI Master Plan is considered in greater detail in Section 1.3).

**National Strategic Development Plan**

The National Strategic Development Plan 2006-2010 focuses on the results to be achieved in the development process for rapidly improving the lives of all Cambodians through a meaningful reduction of poverty, particularly in rural areas. The National Strategic Development Plan views the health sector as playing an important part in poverty reduction, both as a cause and a consequence of impoverishment. The Plan outlines the programmes, investments and funding necessary to build the public sector, achieve the Millennium Development Goals and implement the Health Strategic Plans.37

**Health Strategic Plans**

While challenges remain, implementation of the Health Strategic Plan 2003-200738 has made some progress in achieving the aims of strengthening health service delivery. The Plan identified six priority areas of work and 20 strategies and identified outcomes for the whole health sector, including improving access to health services for the poor, improving attitudes of health providers, improving the quality of services, ensuring a regular flow of funds to facilities, strengthening staff skills and capacities, improving the drug supply and expanding health information. The expansion of HEF and CBHI schemes (and such arrangements as the contracting of district-level public health delivery to non-governmental providers) has added to the achievement of those aims. Further progress has been made in sector-wide management through increased donor harmonization and alignment of health strategies by the MOH (Cambodia). The provision of affordable, essential hospital services is a continuing challenge across the health system. Control of communicable diseases advanced significantly with the dramatic reduction in prevalence of HIV and AIDS. Improved care for mothers and children has been reflected in increased immunization and declining childhood mortality rates.

The Health Strategic Plan 2008-2015 is currently being prepared by the MOH (Cambodia) and not yet due for release. The Plan will focus on institutional development and health financing, health system strengthening, improved mother and child health services and the control of communicable diseases. To achieve those ends, the Plan is likely to focus on moves towards a sector-wide approach (through the implementation and expansion of Sector-Wide Management) along with increased decentralization of administrative responsibilities. The Plan focuses as well on implementation of arrangements to increase social health protection for the poor and to improve services particularly in rural areas.

**Strategic Framework for Health Financing 2008-2015**

Prepared by the MOH (Cambodia) in 2007, the Strategic Framework summarizes the existing health financing situation in Cambodia and lays out the pathways towards universal coverage after 2015.39 The Strategic Framework identifies five Focus Areas for implementation activities for health financing. The Council of Ministers is to approve the Strategic Framework before its presentation at the National Health Congress in 2008. The Framework will provide the basis for improved inter-sectoral collaboration and dialogue between national ministries, donor partners and other stakeholders.

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37 Ministry of Health, National Equity Fund Implementation, supra.
The strategy recommended by the Framework is mainstreaming of the various disparate forms of health financing into a single ‘mixed model’ — based on a combination of Government funding, donor funding, assistance from NGOs, out-of-pocket expenditures, private insurance, social and community-based health insurance and HEF — that provides coverage for different segments of the population through different mechanisms. The Strategic Framework proposes a step-by-step process that first develops the existing schemes for national coverage, brings together the various health-financing initiatives into a single strategic approach and builds on those concrete achievements to move towards universal health insurance coverage under a national health insurance authority in the longer term.

The Strategic Framework advocates the need to move resources from inefficient private providers to an efficient public health system and argues that implementation of social health insurance, HEF and CBHI within a coherent plan is crucial. The Strategic Framework outlines a strategic approach that details:

- The aims and objectives of national health financing strategy
- The major sources of health financing
- Population coverage of existing financing schemes
- The institutional framework for further developments
- The milestones to be achieved in advancing towards universal coverage
- A description of the mixed-model approach
- Preparation of conditions for universal coverage.

### 1.2.4. Path to universal coverage

The vision of the Strategic Framework is that by 2015 “the different elements and institutions of the health financing system will be combined under a single strategy guided by national health priorities; social health insurance mechanisms will be in place for formal sector workers; the informal sector and the poor will be fully protected by suitable pre-payment and social-transfer mechanisms; government funding for health will be at a level appropriate for the adequate provision of services to the population; donor support will be harmonized and aligned with national priorities; and effective public-private sector cooperation will be in place. The achievement of these objectives will make the move to universal coverage possible.”

The period prior to 2015 is therefore a period of preparation in which the different current financing approaches are to be combined within a publicly funded health system to cover different levels of the population:

- HEF for the poor and indigent
- CBHI for urban and rural informal-sector workers just above the poverty line
- Social health insurance for the formal sector and civil servants
- Private insurance and user-payments for those who can afford them.

The Strategic Framework proposes a system of population coverage built on the development of those different health financing and insurance mechanisms, illustrated schematically in figure 1.1. Emphatically, figure 1.1 represents only a conceptual approximation of the current situation and is not a proposal for formal segmentation of the population. In reality, the borders between those population segments are not fixed but are fluid, as people rise out of or fall into poverty or move along the income scale. The proposed strategy is similar in some ways to earlier processes followed in such nearby countries as the Philippines and Thailand, where various schemes were developed over a long period and only recently unified in a single system aimed at universal coverage.
Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region

Figure 1.1. Cambodia: Conceptual view of coverage for different population segments

<table>
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<tr>
<th>Per cent of population by income level</th>
<th>5% Wealthy: private coverage</th>
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<tr>
<td></td>
<td>10% Urban formal sector; SHI (civil servants, private employees)</td>
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<tr>
<td></td>
<td>50% Urban and rural near-poor: User fees and CBHI</td>
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<tr>
<td></td>
<td>35% Rural and urban poor: Fee exemptions, HEF and other subsidies</td>
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Clearly, the biggest challenge lies within the middle 50 per cent of the population who require coverage through voluntary, private and community-based insurance mechanisms. Expanding the risk pool and enrolling families in coverage within this segment is a difficult and demanding task that has so far made very modest progress. Nonetheless, based on this schematic representation, the Strategic Framework proposes a step-by-step movement towards universal health insurance coverage in the years up to 2015. Figure 1.2 summarizes this step-by-step process and identifies the main milestones along the way.

Figure 1.2. Cambodia: Steps towards universal coverage, 2008 to 2015


Note:
SHI = Social Health Insurance
OOP = Out-of-pocket
SWAp = Sector Wide Approach
PFM = Public Financial Management
1.3. Social Health Insurance

The SHI Committee was established in August 2005 following the launch and dissemination of the SHI Master Plan. The Master Plan was written to support the Health Strategic Plan 2003-2007 and incorporates social health insurance for civil servants and private employees in the formal sector as well as CBHI and HEF. Since the Master Plan was prepared, conditions have changed in Cambodia, with consistent economic growth, improved health status, preparation of the new Health Strategic Plan 2008-2015, preparation of the Strategic Framework and impressive growth of the coverage by HEF.

This section considers the provisions of the SHI Master Plan within that changing context, the roles and responsibilities of and new challenges for the SHI Committee (including implementation of the Strategic Framework, key challenges related to gender, updating the SHI Master Plan and further procedures for inter-sectoral collaboration). Conclusions and recommendations follow in Section 1.4.

1.3.1. SHI Master Plan

In the current context, the SHI Master Plan must be understood within the framework of key planning documents prepared by the Government and the MOH (Cambodia). The SHI Master Plan was developed in 2003 and adopted after being updated in 2005. The overall aims of development are outlined in the National Strategic Development Plan 2006-2010. Within such a framework, the goals for the health sector are set out in the proposed first and second Health Strategic Plans (2003-2007 and 2008-2015). The Strategic Framework 2008-2015 was written to support the provisions of the Health Strategic Plan. Although it was drafted earlier, the SHI Master Plan logically appears as one important aspect within the broader Strategic Framework.

Such a hierarchy of planning documents is neither formal nor regulatory but is rather a conceptual or logical guide to understanding the relationship between planning initiatives. In fact, national health planning and the financing processes are currently much stronger than when the SHI Master Plan first appeared and since more knowledge and experience with financing measures has been accumulated. Of greatest importance is that those key documents present a consistent message in proposing the move towards increased social health protection. This current assessment of the SHI Master Plan and the SHI Committee has been prepared for UNESCAP in that light.

The SHI Master Plan presents social health insurance in the broadest sense as incorporating all existing measures of social health protection. It places each within the context of the longer-term advance towards universal coverage. The pluralistic approach proposed by the SHI Master Plan — with different types of schemes for different segments of the population — is consistent with the Strategic Framework, though the latter gives different weight to the various parts. The Master Plan identifies the following schemes:

- Compulsory social health insurance through the social security framework for formal public- and private-sector salaried workers and their dependents.
- Private (for-profit) commercial health insurance for enterprises or individuals who wish to purchase insurance for non-essential medical benefits, which may supplement but not replace social health insurance.
- Voluntary (non-profit) insurance for non-salaried informal-sector workers and their families who can contribute small regular premiums through CBHI schemes that are sponsored initially by different development partners and national NGOs in collaboration with public health-care providers.
- Social assistance through the use of HEF for non-economically active and indigent populations with Government funds used to purchase health insurance for the...
poor at a later stage (in fact, currently approved through the recent prakas).

Within that approach, the Master Plan gives most attention to the formal- and informal-sector insurance schemes (especially CBHI) and less attention to HEF (which were then in their early stages of development). The developments that have occurred since the SHI Master Plan was drafted have moved in a slightly different direction, in particular the much slower and more limited development of CBHI and the rapid expansion and established effectiveness of HEF.

**Timetable**

Table 1.6 below is based on the timeframe for introduction of social health insurance measures proposed by the SHI Master Plan (taken from Section 3.3: Stages to Reach Universal Coverage and Table 1.3: Activities and Timeframe to Cover the Population Sectors). In this table the proposed activities are compared to the actual achievement as at December 2007.

**Table 1.6. Cambodia: Time frame proposed by the SHI Master Plan, 2003 targets vs. achievements, to December 2007**

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<tr>
<td>Voluntary CBHI schemes</td>
<td>Expansion of existing schemes. New schemes through accreditation process. Achievement: Sub-Decree on Micro-insurance including provisions on CBHI finalized 2007; CBHI ad hoc</td>
<td>Expand GRET schemes. Achievement: by 2004 schemes covered 3 health centres with referral hospitals in 3 districts. Begin urban scheme. Achievement: begun at one health centre</td>
<td>Expand GRET Schemes. Achievement: by 2007, GRET/SKY schemes provided at 15 health centres in 4 provinces with referral to 4 district referral hospitals and 2 provincial hospitals. Include urban area. Achievement: Reach 80% coverage in 5 to 10 districts. Achievement: Up to 10 districts included but coverage is very low. Merge schemes at district level, then provincial level.</td>
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<td>working group established; CBHI regulations to be prepared in 2008.</td>
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<td></td>
<td>Enrolment of public sector health workers in CBHI schemes. Achievement: enrolment of some civil servants in Kampong Thom scheme has begun.</td>
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<td></td>
<td>Begin 2 other NGO schemes. Cambodian Association for Assistance to Families and Widows scheme established independently in Bantheay Meanchey (MOH (Cambodia) notes this as a sign of CBHI expansion).</td>
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**Indigent and non-economically active population**

|                   | Begin 1 to 2 schemes using equity funds to subsidize all families in community. Achievement: not yet attempted. |      |      |           |           |
|                   | Begin 1 to 2 schemes using Equity Fund to purchase health insurance cards for vulnerable families. Achievement: pilots will begin in Kampot 2007 and Kampong Thom 2008. |      |      |           |           |
|                   | Expand use of equity funds for social health insurance according to experience. Achievement: no experience yet gained. |      |      |           |           |

**Universal coverage**

|                   | Assure uniform design, through network, plan for eventual merging of Monitor, adapt, begin network regulations. Achievement: SHI Master |      |      |           |           |
|                   | Monitor, expand network. Achievement: HEF Implementation |      |      |           |           |

**Legislation.**
The achievements to date are impressive, but also indicate that the time frame proposed by the SHI Master Plan was too optimistic. In comparison, the Strategic Framework proposes a more gradual advance in the direction of universal coverage based on the expansion, strengthening and scaling-up of all existing schemes (as illustrated in figure 1.2). Recent experience indicates that building those schemes and developing the necessary institutional framework for social health insurance and social health protection are demanding tasks that require patient long-term work. That too has been the experience in neighbouring countries.

The strength of the SHI Master Plan is its provision for the preparation and introduction of social health insurance measures for private sector workers and civil servants. The institutional arrangements for such schemes are being developed through the Ministry of Labour and Vocational Training and the Ministry of Social Affairs, Veterans and Youth. The first scheme (for private sector workers) may be launched in 2009. Foreseeably, such social health insurance measures will be further developed and prepared for implementation and expansion in the years from 2010 to 2015. In the meantime, the slow development of CBHI and the rapid expansion of HEF have changed the conceptual balance between the various social protection schemes.

**HEF and CBHI**

HEF are currently the most widespread and the most effective form of social health protection provided in Cambodia. The documented evidence indicates that HEF are an effective means for providing financial access to health services for the poor, have extensive donor support, are well regarded by beneficiaries, may allow discretionary spending on health care (as opposed to “non-essential” consumption) and are associated with surprisingly little social stigma.40 HEF schemes are available in more than half of all health districts in Cambodia. In those districts, HEF effectively provide free access to health care for a large majority of the poor (who comprise one third to one half of the district population in most cases). The caution expressed in the SHI Master Plan (that despite HEF a majority of the population would still face financial barriers, and HEF would be unlikely to contribute to equity in access to health care) is therefore not well supported by the evidence.

The Master Plan anticipated that HEF would be phased out quickly in the years after 2003 and replaced by: (1) the immediate purchase of CBHI premiums for the poor in districts with less than 25 per cent poverty; and (2) the replacement over five years of equity funds by household out-of-pocket spending on CBHI premiums in districts with around 50 per cent poverty. That plan is illustrated in table 1.7, which is taken from the SHI Master Plan, Section 4.6: “Use of Equity Funds” and Table 1.6: “Contribution Subsidization through Equity Funds”.

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Table 1.7. Cambodia: Plan for changes in proportion of health-care costs contributed for insurance premiums by household out-of-pocket spending and HEF, post-2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Household</th>
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Given the expansion in coverage provided by equity funds that plan to phase out HEF by about 2009 is no longer realistic. Moreover, the proposal that HEF monies be used to purchase health insurance cards for vulnerable groups is untested, unsupported by any reliable evidence and perhaps flawed in principle if monies used to purchase CBHI premiums are less over time than the value of health services received (in which case purchasing premiums would be a wasteful and inefficient use of funds earmarked for poverty relief). Such issues need to be further tested in practice (such as through pilot schemes proposed by GTZ in Kampot and Kampong Thom).

Under current circumstances, HEF are targeted at families which live below the poverty line (35 per cent of the national population on average). CBHI is targeted not at the poor but at the 50 per cent of the population who live just above the poverty line and have sufficient cash income to purchase insurance premiums (as illustrated in figure 1.1). The challenge created by the need to extend voluntary micro insurance for health to one half of the population is already extraordinarily demanding. In building CBHI arrangements, all efforts should be focused on that task. The SHI Master Plan contributes to the need by providing for the institutionalization of CBHI and formal social health insurance measures according to uniform procedures, benefits and regulations.

**Proposed changes**

Many of the changes to the SHI Master Plan proposed in this report have been considered as well in the preparation of a social health insurance project plan currently being developed by the MOH (Cambodia) with support from GTZ. The plan is yet to be finalized and adopted but is likely to be implemented in two phases, 2007-2010 and 2008-2012. The draft plan focuses on the development of formal-sector SHI arrangements and informal-sector CBHI schemes and proposes to test ways in which linkages with social assistance programmes can best be achieved. The draft plan also proposes that the SHI Master Plan be revised and updated and provide for the development of a timetable for advancing towards universal coverage.

**1.3.2. SHI Committee**

The SHI Committee was appointed by the MOH (Cambodia) at the end of 2002 to review in-country and regional experiences with health insurance, outline strategic directions and propose regulatory measures. The Committee met for the first time and began its work following the launch of the SHI Master Plan in 2005. It comprises members from the MOH (Cambodia), international agencies and NGOs with invited representatives from collaborating ministries. The formation of the Committee was endorsed by the SHI Master Plan in line with the Health Strategic Plan 2003-2007 (under Strategy 15 in Section 1.4). The SHI Master Plan also recommended development of a long-term health insurance plan, development of health insurance guidelines, development of a plan to expand and pilot SHI schemes in a few provinces (including Phnom Penh) and monitoring and evaluation, although those proposals have proved to be overly optimistic.

Chaired by a Secretary of State of the MOH (Cambodia), the SHI Committee has 15 members and other invited representatives. The Committee comprises:
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- From one to eight officials from various departments of the MOH (Cambodia).
- From 71 to 75 representatives from WHO, Medicam (an association of health-sector NGOs in Cambodia), GTZ and GRET.
- Invited representatives of the Ministry of Social Affairs, Veterans and Youth; Ministry of Labour and Vocational Training; and Ministry of Economics and Finance; the Council of Ministers; and Ministry of Planning.

While the SHI Committee includes senior policymakers, its day-to-day work is carried out by a Technical Working Group comprising the technical-staff Committee members from the participating ministries. The Department of Planning and Health Information of the MOH (Cambodia) operates as the secretariat of the SHI Committee, which is supported also by technical advisors from WHO and GTZ. In practice, meetings of the full Committee are difficult to organize and the Technical Working Group operates as the working body of the Committee. The MOH (Cambodia) has also created the Health Insurance Policy and Implementation Unit to organize the work of the Ministry. The Unit is tasked to liaise with the various ministries, work with CBHI implementers to select new sites, accredit implementers, implement schemes, provide training and advice, develop standard health information systems, arrange cooperation with HEF schemes and with vertical disease-control programmes and conduct monitoring of all schemes.

Roles

The SHI Committee continues to meet regularly, functioning mainly as a coordinating and planning group for the four key ministries, donors and other stakeholders. The work of the Committee is moving ahead steadily, but the circumstances require slow progress as the different elements of a social health insurance system are put in place by the various stakeholders:

- The SHI Committee is chaired by the MOH (Cambodia), which also provides secretarial services to the SHI Committee. The MOH (Cambodia) retains responsibility for all issues related to health insurance and for CBHI implementation.
- The MOH (Cambodia), Ministry of Labour and Vocational Training, and Ministry of Social Affairs, Veterans and Youth are working together to include health care for private-sector employees and extension of coverage to the public sector in the Social Security Law and the Labour Law.
- The SHI Committee facilitates dialogue between the health and social ministries and the Ministry of Economics and Finance, which is responsible for the private insurance industry and for budget allocations to the health sector.
- WHO and GTZ provide technical advice and funding, and ILO is to be consulted in the development of plans for a National Social Security Fund (NSSF) administration and functions.
- GRET provides practical information and advice on the implementation of CBHI schemes.

The SHI Committee functions, therefore, as a stakeholder coordinating and advisory body and not a national health insurance board. Under the Social Security Law, an NSSF is proposed to operate all social security schemes, beginning with a work injury programme and old age pensions. The SHI Master Plan proposes that an NSSF be the administrative structure responsible for formal-sector social health insurance. The fund would be governed by an independent board with tri-partite representation from contributing partners, employers and workers. To create a constructive relationship between such a fund and the MOH (Cambodia), strict financial separation would need to be enforced, to (a) ensure that insurance contributions not fund ministry functions and (b) develop an accountable SHI administrative structure within the MOH (Cambodia).
Responsibilities

The responsibilities of the SHI Committee fall into three broad areas: developing the legislative and administrative framework for social health insurance, implementing the SHI Master Plan and supervising CBHI.

Amendments to the Social Security Law are still under consideration and being prepared by the Ministry of Social Affairs, Veterans and Youth. The Ministry has collaborated with ILO in the development of plans for an NSSF and preparation of new regulations for the Law. Further amendment to the Constitution or the Health Financing Charter may still be needed to enable implementation of social health insurance and legislative action may be required with regard to existing commercial insurance laws. The SHI Master Plan remains the guiding document for introduction of formal-sector health insurance and micro insurance measures. A detailed Plan of Action was prepared to identify the role played by each stakeholder (see “Tasks” below). The Committee continues to oversee and monitor the implementation of CBHI schemes.

Tasks

The terms of reference of the SHI Committee require that it (a) reviews in-country and regional experiences with health insurance, (b) defines the strategies for developing social health insurance in Cambodia, (c) prepares needed legislation and regulations and (d) coordinates implementation of pilot insurance schemes. A series of proposed tasks taken from the SHI Master Plan (Section 5.4, Table 1.8: “Timetable for major next steps”), the SHI Committee action plan for 2007 and activities proposed by the new SHI Unit at the MOH (Cambodia) (for completion in 2007) are summarized in table 1.8, showing the current status of the required tasks.

Table 1.8. Cambodia: SHI-proposed activities, action required and current status

<table>
<thead>
<tr>
<th>Action required</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption of the SHI Master Plan</td>
<td>SHI Master Plan was launched in 2005</td>
</tr>
<tr>
<td>MoH-Ministry of Social Affairs, Veterans and Youth discussion on Social Security Law</td>
<td>Discussions have occurred and are ongoing</td>
</tr>
<tr>
<td>Regulations on health care added to the Social Security Law developed</td>
<td>In preparation</td>
</tr>
<tr>
<td>Development of micro-insurance sub-decree</td>
<td>In preparation</td>
</tr>
<tr>
<td>Development of CBHI sub-decree</td>
<td>Included in the micro-insurance sub-decree, to be followed by CBHI regulations</td>
</tr>
<tr>
<td>Adopt NSSF sub-decree</td>
<td>Adopted in 2007</td>
</tr>
<tr>
<td>Reform civil servants schemes</td>
<td>In preparation</td>
</tr>
<tr>
<td>Develop roadmap for private-sector implementation</td>
<td>In preparation</td>
</tr>
<tr>
<td>Develop roadmap for public-sector implementation</td>
<td>In preparation</td>
</tr>
<tr>
<td>Establish MoH SHI Policy and Implementation Unit</td>
<td>SHI Unit established within the DPHI in 2007</td>
</tr>
<tr>
<td>Project plan developed and funds provided for implementation</td>
<td>Social Health Insurance Draft National Project Plan prepared in May 2007 with support from GTZ</td>
</tr>
<tr>
<td>Training materials for CBHI and public health workers prepared and training implemented</td>
<td>In preparation</td>
</tr>
<tr>
<td>Information system for CBHI developed</td>
<td>CBHI guidelines developed in 2006 including monitoring framework; database designed; regular monitoring visits arranged</td>
</tr>
<tr>
<td>Collaborate with HEF implementers in pilot testing HEF-CBHI relations</td>
<td>Field visits undertaken</td>
</tr>
<tr>
<td>New pilot areas selected: New 1 Kampot</td>
<td>A pilot programme in CBHI-HEF collaboration began in Kampot in 2007</td>
</tr>
<tr>
<td>New 2 Kampong Thom</td>
<td>A similar scheme will begin in Kampong Thom in 2008</td>
</tr>
<tr>
<td>New 3 Other</td>
<td>A number of new NGO schemes have begun or are planned (see table 1.6)</td>
</tr>
</tbody>
</table>
1.3.3. New opportunities and challenges

The SHI Committee has a well-defined work programme which it is carrying out within the constraints of time and resources. The SHI Committee also faces a number of new challenges that arise as circumstances change and progress is registered in health planning and financing initiatives. The challenges include: What will be the relationship between the SHI Master Plan and the Strategic Framework? How will the SHI Master Plan be updated to reflect more accurately the current situation? How will social health insurance mechanisms be used to address outstanding needs related to gender and health? How will the relationship between CBHI and HEF schemes be managed? What more can be done to develop intersectoral collaboration and dialogue? And just what course will be set towards the achievement of universal coverage?

In facing such challenges, the most immediate needs are to develop a realistic and achievable timetable for implementation of the arrangements essential for the longer-term transition to universal coverage. Secondly, there is a need to further develop the institutional framework for administration of social health insurance and other social health protection mechanisms. In particular, there is a need to bring the currently disparate compulsory and voluntary insurance schemes into a single framework administered by the proposed NSSF as an independent insurance board supported by the enactment of the necessary legislation and regulations. The role of the MOH (Cambodia) within an NSSF therefore needs to be strengthened, particularly with regard to defining the benefit package, provider payment method, provisions for catastrophic health expenditures and ensuring the delivery of an essential package of public health services (for example, maternal and child health). Thirdly, there is a need to consider the arrangements required for scaling-up current schemes (including CBHI and HEF) to national coverage. However, those initiatives may proceed only as quickly and effectively as the availability of time and resources allows. The constraints placed on that process by prevailing conditions and circumstances are related mainly to the need to develop required human-resource capacities at national, ministerial and local levels, the need to strengthen institutional capacities for management of social health insurance mechanisms and the availability of required development and technical-assistance resources.

Implementing the Strategic Framework

Once the Strategic Framework for Health Financing 2008-2015 is approved, it will be the guiding programme for health financing, covering public spending, donor funding, insurance arrangements and social assistance for the poor. It will also provide the strategy for the longer-term direction of universal health insurance coverage (see figure 1.2). The work of implementing both the Strategic Framework and the SHI Master Plan will thus run in parallel and must be conducted in harmony. The Strategic Framework supports the work of the SHI Committee and will be a valuable resource for its future activities.

The five “Focus Areas” defined by the Strategic Framework provide a comprehensive list of activities for strengthening health financing. They map out a programme of activities required along the path to universal coverage. The SHI Master Plan is supported by the strategies and activities detailed in Focus Area 3: Social Health Protection. The other Focus Areas are Government health expenditure, donor harmonization and alignment, financing service delivery and public-private cooperation.

Currently the necessary tasks are to (a) finalize and approve the Strategic Framework, (b) assign, through the MOH (Cambodia), responsibility for the implementation of the activities defined by the Focus Areas and (c) harmonize the provisions of the SHI Master Plan with the social health protection activities recommended by the Strategic Framework.
Among the proposals included in Focus Area 3 are provision of financial incentives for improved household health seeking behaviour, full compliance by health facilities with fee-exemption systems, scaling-up of HEF arrangements, expansion of CBHI and linkages with HEF, social health insurance for civil servants and private-sector employees and extension of social health protection to all households nationally. Among the issues identified as necessary for successful implementation are quality assurance and sound financial management at health facilities; capacity building at the MOH (Cambodia), Provincial Health Department and Operational District levels; and full collaboration with partner ministries (Ministry of Labour and Vocational Training; Ministry of Social Affairs, Veterans and Youth; Ministry of Economics and Finance and Ministry of Planning) regarding legislation and regulations for CBHI, political commitment and inter-sectoral collaboration for social health protection. The Strategic Framework recognizes the need for a common understanding of the MOH (Cambodia) role in building the social health protection system.

Addressing gender concerns

The most immediate concern for gender equality in health is meeting the needs of women for maternal care. The persistently high level of maternal mortality occurs against a background where few women access public health facilities for deliveries and less than half are assisted by a trained health professional. The most significant constraint on access to required maternal care is financial. Most women cannot afford the costs of trained health care, nor in many cases payments for health micro insurance. According to the Cambodia Demographic and Health Survey 2005, having the money needed to access services is the greatest difficulty faced by women and their families requiring health care. Three quarters of women respondents of child-bearing age cited “getting money needed for treatment” as a problem in accessing health services. The difficulty was significantly greater for the lowest wealth quintile (86 per cent of respondents) than for the highest quintile (54 per cent of respondents).

The Reduction in Maternal Mortality Plan has shown the lead in addressing this question through a range of proposals including advocacy, behaviour-change communication, quality assurance training and (most importantly) improving access to facilities by use of HEF. In addition, the UNFPA has piloted HEF arrangements for reproductive health in selected districts, and a pilot safe-motherhood programme has been included, for example, within the GRET/SKY urban CBHI scheme in Phnom Penh.

The evidence suggests that HEF and CBHI have catered for the existing needs of poorer women and their children (who comprise almost three quarters of the users of public facilities and are commonly represented in the same proportion among CBHI and HEF beneficiaries). A 2007 longitudinal study conducted in one health district (Kirivong district in Takeo province) revealed significant increases in assisted deliveries with an HEF intervention. In an initial phase of the study, the number of assisted deliveries for HEF beneficiaries was 2.3 per 1,000 population per year; and for non-beneficiaries, 8.8. In the second phase of the study, the respective rates were 4.4 and 9.8.

Therefore, a valuable opportunity currently exists to incorporate the proposals of the Reduction in Maternal Mortality Plan for earmarked HEF support to pregnant women into the SHI Master Plan and the Strategic Framework.

Focus Area 4 of the Strategic Framework proposes to develop financial incentives for rational health-seeking behaviours, including maternity grants. One possibility could be the payment of a financial incentive (for example, through HEF operators) without means testing for all deliveries carried out at a public health facility (at least, in targeted

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rural areas). That, too, would be consistent with the proposal to expand CBHI coverage and to scale-up sustainable HEF arrangements, which could include arrangements for reproductive health, in particular. Focus Area 4 also proposes to ensure compliance with the exemption regulations at all provider levels: achieving full compliance with fee-exemptions for maternal care would be a good starting point. The proposal to ensure appropriate design for compulsory insurance schemes to achieve health sector goals and priorities provides the opportunity to guarantee that the benefit package for CBHI and social health insurance for civil servants and private-sector employees specifically includes priorities for maternal care.

Under Section 4.9.5: Maternal Care, the SHI Master Plan proposes that, in view of the very high maternal mortality ratio in Cambodia and the need to increase the rate of attended deliveries, the qualifying period for maternity benefits normally included in social health insurance procedures be waived and that deliveries at public facilities should be covered after only three months contribution of premiums. The SHI Master Plan also strongly recommends that CBHI schemes develop a Safe Motherhood Programme including entitling women to all maternity services if they follow the mother and child health protocol and providing a maternity grant as an incentive for full participation in the Safe Motherhood Programme.

The CBHI Guidelines also include the recommendation for payment of a cash maternity benefit on completion of the Safe Motherhood Protocol and suggest that the usual nine-month waiting period for pregnancy-related benefits could be reduced in order to encourage delivery at public facilities.

A good start has been made, therefore, in designing programmes that address the excessive level of maternal mortality. What is needed now is to incorporate and highlight the common provisions in all relevant plans and documents. The addition of consistent procedures for maternal health benefits in the SHI Master Plan, Strategic Framework, the Maternal Mortality Plan, CBHI Guidelines and the HEF Framework would go a long way towards achieving the outcomes needed to address maternal mortality. In particular, more work needs to be done to include a clearly defined programme of activities dealing with those gender issues in the Strategic Framework and the SHI Master Plan.

**Updating the Master Plan**

There are, therefore, a number of good reasons to update the SHI Master Plan:

- To develop the role of, and to extend the range of possibilities for the SHI Committee in implementing and overseeing the provisions of the SHI Master Plan and regulations for social health insurance.

- To achieve consistency, harmony and inclusiveness between key health financing and planning documents, in particular the SHI Master Plan, the Strategic Framework and the Maternal Mortality Plan.

- To develop a realistic and achievable timetable for scaling-up existing schemes to national coverage, initiating formal-sector insurance arrangements and moving towards a position where the introduction of universal coverage becomes a realistic possibility (probably after 2015).

Within the process of updating the SHI Master Plan (as well as finalizing the Strategic Framework), a number of key questions could be introduced for further consideration:

- Could a benefit be gained (from a planning and an institutional point of view) from more carefully defining the formal-sector social security and compulsory SHI schemes, as distinct from voluntary micro-insurance (CBHI) and HEF, as each is further developed in preparation for a transition to universal coverage when appropriate in the future (provided that they remain within the same policy framework)?
• Should the proposed NSSF administer only the formal sector schemes? Is there a need for a national health insurance commission? And what institutions may otherwise be needed for administration of CBHI and HEF on a national scale?

• In view of moving towards universal coverage and preventing institutional barriers between the various schemes in the pluralistic approach proposed, could an NSSF administer be responsible for all schemes? Could this be the best way to maintain the third-party-payer status at the institutional level and facilitate the necessary technical collaboration, harmonization and standardization between?

• What is the most appropriate transition plan for dealing with the existing, widely spread, HEF schemes? Is it appropriate that those schemes be phased out in favour of household-financed micro-insurance for health care as the SHI Master Plan proposes? Can a more equitable process of covering HEF through national social security arrangements be developed? What procedures might be included in the SHI Master Plan for regulating HEF mechanisms, providing financial allocation of health insurance revenues for HEF benefits and for scaling-up HEF nationally?

• What are the most effective means for scaling up CBHI arrangements to cover that part of the population which is above the poverty line and otherwise unprotected? What sort of national arrangements are needed to increase the pace at which CBHI schemes expand to new areas? How can the risk pool for CBHI be increased? What other subsidies are needed to guarantee the financial sustainability of CBHI arrangements?

Intersectoral collaboration

The Government has established the SHI Committee as the main unit responsible for — and the main vehicle for — inter-sectoral collaboration in implementing social health protection measures. Inter-sectoral collaboration here refers to cooperation between the various stakeholders involved in promoting social protection arrangements: including ministries, donors, NGOs, health administrators, health providers, insurance providers, employers, workers and service users.

At the highest level, collaboration has been established between four key ministries to develop the administrative and regulatory framework:

1. The MOH (Cambodia) chairs the SHI Committee, maintains overall responsibility for health insurance, oversees CBHI development and monitors HEF schemes for the poor.
2. The Ministry of Labour and Vocational Training is working to set up insurance coverage for private formal sector employees, currently backed by a sub-decree.
3. The Ministry of Social Affairs, Veterans and Youth Rehabilitation is working to set up insurance coverage for civil servants, to be supported by a royal decree.
4. The Ministry of Economics and Finance regulates the private health insurance sector and provides financing for social protection.

A technical advisory group has been established between the ministries of health and of economics and finance to facilitate dialogue between those involved in the implementation of the intersectoral strategy. Collaboration with donors, NGOs, providers and the private sector is arranged through the SHI Committee and in direct bilateral contact.

Within such a framework of collaboration, the SHI Committee retains the responsibility for policy and planning related to implementation of social health protection measures. The proposed NSSF will be the administrative structure responsible for the
formal sector, governed by a board with inter-sectoral representation. The MOH (Cambodia) retains responsibility for setting priorities regarding extension of coverage, contracting with private sector health-care providers and the extension or introduction of new benefits. From the point of view of health service users, strict financial separation between the different social protection programmes (particularly through an NSSF) and the normal operations of health service management and delivery is accepted as critical and essential. With regard to private-sector health providers (who are so far excluded from participation in social health protection arrangements), the MOH (Cambodia) has been commissioned to establish systems of quality assurance and accreditation prior to their inclusion in social protection programmes.

The SHI Master Plan proposes a strategy based on close collaboration with a wide range of additional partners, including technical collaboration with GTZ and WHO, with bilateral donors to mobilize additional financial support, with UNFPA, ILO and other development partners in preparing specific programmes, with CBHI organizations such as GRET, with national disease-control programmes, local public health-care facilities and local health authorities, and with relevant NGOs.

The Strategic Framework also proposes activities within its Focus Areas that strengthen MOH (Cambodia) capacity to collaborate with the Ministry of Labour and Vocational Training; the Ministry of Planning; the Ministry of Social Affairs, Veterans and Youth; the Ministry of Economics and Finance and other ministries to maintain strong donor coordination mechanisms and to implement the guidelines developed for NGO assistance in CBHI and HEF implementation. The main challenge in maintaining effective inter-sectoral collaboration is to organize and manage such a broad programme efficiently and effectively. The SHI Committee remains the best vehicle for the task. An associated challenge is that all collaborating partners find the means and maintain the will to continue active collaboration and carry through the initiatives required of them. Again, the main constraints faced in the process are related to the availability of sufficient time and resources to complete the needed tasks.

1.4. Conclusions and Recommendations

To be better understood, this case study of social health protection in Cambodia should be read in conjunction with the SHI Master Plan and the Strategic Framework. More broadly, the advance towards universal health insurance coverage in Cambodia can be understood only within the context of the wider economic and development policies of Cambodia, best illustrated in the National Strategic Development Plan and Cambodia's Millennium Development Goals.

The main conclusions from this brief outline are that Cambodia has taken the first tentative steps on the longer-term path towards universal health insurance coverage and is in a position to continue on that path with clear direction and purpose. Along the way, there will be continual need to review arrangements, assess progress and update plans as events unfold. The opportunity to introduce universal coverage is likely to come in the years after 2015, while the period until then will be characterized by the scaling-up and consolidation of existing programmes. It is already an ambitious programme that will require constant attention and support. The next steps could be taken in conjunction with the drafting, adoption and implementation of the proposed SHI project plan.

The SHI Master Plan first introduced the idea of social health protection in Cambodia and initiated plans and preparations for universal coverage; it remains the most important guide to the introduction of social health insurance, particularly for the formal sector. The Strategic Framework provides the first road map for the longer journey towards national health financing and universal coverage. In the future, the Strategic Framework may possibly be strengthened and developed following further experience.
and may be re-presented as a formal national health financing strategy incorporating social health insurance measures.

Consistent with the projections of the SHI Master Plan, Cambodia has experienced solid economic growth in recent years, its fiscal position is stronger and it stands to gain enormously from mineral and oil discoveries. A key issue in health financing, and in the provision of social health insurance, is therefore the way in which fiscal considerations will be arranged.

The fundamental principle of the SHI Master Plan is that there be no need for user payment at the point of service delivery. It recommends correctly that no co-payment be allowed at the time of use. Those are the foundations of an effective social protection system in conditions where health costs are a major cause of impoverishment. In its projections for national coverage of social health insurance measures, in its expectations regarding the extension of CBHI coverage and in its anticipation of a more rapid advance to universal coverage, the SHI Master Plan appears to have been too optimistic. That is not to be seen as a fundamental problem; rather it simply indicates that achieving universal coverage is a difficult task that requires a prolonged period of preparation.

The SHI Master Plan was based on an administrative separation of private-employee and civil-servant formal-sector schemes (under the Ministry of Labour and Social Affairs) and informal-sector CBHI (under the MOH (Cambodia)). That division of efforts, however, is likely to narrow the possibilities for using the different social health protection mechanisms and for their unification under a single programme. The formal-sector schemes may better work in parallel; CBHI may be made available to formal-sector employees where coverage is otherwise inadequate or slow to begin. More particularly, a very large proportion of the population is to be covered by voluntary CBHI schemes under the Master Plan. In that area, the MOH (Cambodia) has a crucial role to play in setting medical standards, delivering services and promoting access to health facilities. The MOH (Cambodia) therefore needs to strengthen its monitoring role and stewardship. However, in the medium term, CBHI is likely to expand independently of the MOH (Cambodia); and, if CBHI is to achieve wide population coverage, an administrative structure with access to population, business and tax registries and the capacity for financial and social-welfare administration will be required. Such circumstances may be best addressed by including all compulsory and voluntary health insurance schemes under a single administrative programme.

The main recommendations contained in this report may be summarized as follows:

1. Begin the process of reconsidering, revising and updating the SHI Master Plan under the responsibility of the SHI Committee Technical Working Group (through the MOH (Cambodia)).

2. In updating the SHI Master Plan, consider carefully the need to harmonize its projections with those of the Draft Strategic Framework.

3. Give consideration to renaming the revised SHI Master Plan as a “Social Health Protection Master Plan” in order to include logically all health insurance and health equity schemes (not simply “insurance” schemes).

4. Within the social health protection framework, make a clear distinction between contributory (SHI and CBHI) and non-contributory (HEF and other subsidies) social health protection as well as between compulsory and voluntary insurance schemes.

5. Use the proposed SHI project plan to address the main challenges and concerns that currently confront health planners in achieving improved arrangements for social health protection.

6. Develop a consensus among stakeholders about the most accurate definition of “social health insurance” and whether it best include voluntary micro-
insurance and social transfer mechanisms or focus on compulsory formal-sector health insurance.

7. Focus immediate attention on developing programmes designed to scale-up existing CBHI and HEF schemes for national coverage, identify this as a national priority under MOH (Cambodia) stewardship and work to align donor activities with that objective.

8. Advance as quickly as possible to the establishment of the planned schemes for compulsory health insurance for civil servants and private-sector employees (with the provision that CBHI may also be extended to those sectors).

9. Pilot test and evaluate models of HEF-CBHI collaboration extensively before making plans and projections for the future combination of such schemes.

10. Develop a clear plan and a realistic timetable for the longer-term movement towards universal coverage, one that is shared by all stakeholders.

11. Build and develop the implementation framework for social health protection on the basis of the Focus Areas outlined in the Strategic Framework.

12. Strengthen the role of the MOH (Cambodia) within the proposed NSSF, establish more clearly the responsibilities of such a fund with regard to informal-sector coverage and gradually move responsibility for CBHI under that umbrella.

13. Strengthen the SHI Committee as the main body responsible for policymaking on social health insurance and for progress towards universal health insurance coverage, with formal approval by the Government.

This document is presented as a draft for further discussion among policymakers and stakeholders. It contains a number of ideas that have only just begun to emerge for further consideration. In fact the suggestions made herein reflect the progress made in recent years within the Cambodian health sector. Even so, challenges remain and progress has in some cases been uneven. The opportunity exists for stocktaking, for making a periodic assessment of progress made and for setting out an updated programme of activities. The recommendations and suggestions included in this report are presented in this spirit.

1.5. References


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