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CAMBODIA Country Team
LO Veasnakiry, M.D.; MA(HMPP), MoH
Sum Sophorn, NSSF
Outlines

1. Basic Data
2. Health System Organization
3. Health Financing and Coverage
4. Challenges
5. SHP: Ways moving forwards
6. Concluding Remark
1. Basic Data

- Total geographical areas: 181,035 Sq. Kms
- Total population: 14.7 M (Nov. 2013 CIPS)
- Annual growth rate: 1.46%
- Total fertility rate: 2.8 (per 1,000 live births)
- Life expectancy at birth: M 67.1/F 71

Source: NSDP 2014-2018, RGC
1. BASIC DATA

- GDP per capita (in ‘000 Riel)
- Growth rate in GDP
- Poverty rate

1. BASIC DATA

GHE as % of GDP

GHE per capita (in $US)

Source: MoH (DBF, DPHI), WB(GDP)
2. Health System Organization

Health Sector Reform (HSR) in post conflict setting

- Initiated 1993, implemented in 1995
- The reform implies entails important transformations, both organizational (including human resources) and financial

→ Changing from administrative to population base system organization—Population size and accessibility criteria.

☑ Redefine management & service delivery functions of each level, HC-MPA and RH-CPA

☑ Reallocation and training health workforce:

☑ pre-service training, in-service training (Health Service Management)

→ Introducing new ways of health system financing (Health Financial Charter)
Health System Performance

Infant Mortality Rate
U5 Mortality Rate
MMR
Neonatal Mortality Rate
Country overall development
Peace, security, Political stability, economic growth, road infrastructure, poverty reduction, telecom, ITC, education and health (infrastructure, training…)

3. Health financing Interventions

Supply-side Interventions


Demand-side Interventions

Voucher for Reproductive Health

HEALTH EQUITY FUNDS

Special Operation Agency

User charges with exemption for the poor

Contracting Health Service

Midwifery Incentives

Planning HI scheme (NSSF)

Community Based Health Insurance

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Planning HI scheme (NSSF)
<table>
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<tr>
<th>Features</th>
<th>Health Equity Funds and Subsidy</th>
<th>CBHI</th>
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<tbody>
<tr>
<td>Main Objective</td>
<td>Removing financial barriers in access to quality health services by the poor</td>
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<td>Beneficiary</td>
<td>All poor (under the national poverty rate) Pre-ID poor, and Post-ID poor</td>
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| Benefit packages          | • HEF: MPA, CPA, transportation cost, referral, food allowance for 1 care taker of IPD patient, funeral grant.  
  • Subsidy: only MPA and CPA |      |
| Provider payment          | • HEFs: Standardized case base payment  
  • Subsidy: flat rate |      |
| Implementing arrangements | Providers: public facilities  
  • HEFs: contract base, 3rd party (HEF Implementer (monitoring) & HEF Operator (implementing),  
  • Subsidy: HC & RH via OD & PHD |      |
| Financing                 | • HEFs: National budget and DP since 2009 (40% vs 60% share of direct cost, respectively, in 2013).  
  • Subsidy: National budget |      |
| Coverage                  | 78% and 93% of the poor peoples in 2012 and 2013 |      |
**Outcome of Interventions: Access, Coverage**

**Health Equity Funds - demand side**

- **Overall health care access:**
  - More people seeking care, mainly HC, bigger increases in lower economic quintiles
  - 2004-2007 (the poorest quintile): IDP: 3.1% increase vs. 1.1%, previously, OPD: 20% increase.
  - 2005-2010: 35% of delivery at HF by the poorest quintile women.

- **Financial protection**

**Determinants of financial burden**

- Residents of ODs with HEFs have lower OOP and less likely to suffer catastrophic spending of medical indebtedness
- Rural areas are more prone to medical indebtedness and catastrophic payments

**Financial burden of payment**

- Declined catastrophic health expenditure (>40% of CTP on OOP) from 6.20% (2004) to 4.27% (2009). Similar decrease across quintiles
- Incidence of indebtedness due to illness decreased from 5.3% (2004) to 3.8% (2009)

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1. Epidemiological view point

• Despite significant reduction, maternal and child mortality in Cambodia remain high if compared with countries in the region.

• HIV/AIDS, TB and Malaria continue to pose a major public health problem and require sophisticated clinical expertise and considerable financial resources.

• The most important areas that deserve attention are non-communicable and chronic diseases that increase burden on health system - to provide better primary prevention, improve detection and management, and improve treatment and care for acute events- and other health related problems.
2. Health system perspective

• Improving equitable access to quality health services need to pay attention to service delivery expansion and quality improvement, and financial protection for the poor and vulnerable.

• Requiring considerable investment in physical infrastructure, medical technology, ICT, clinical expertise.

• Adequate staffing and skills of health personnel, appropriate remuneration and right incentive with improved accountability and performance monitoring.

• Licensing, accreditation, quality control mechanisms-well regulated private sector participation linked to a national accreditation and quality improvement system.

• Scaling up the coverage of Health Equity Funds, and integrating social health protection mechanism by rationalizing, harmonizing and transforming the existing financing schemes—Universal Health Coverage.
Historical Development Process of Social Security for Formal Sector

The current Labour Law of Cambodia was passed in 1997 by amending the 1992 Labor Law.

The first Social Security Law was passed by the Parliament in September 2002.

In 2004 the ILO experts came to study the feasibility of the scheme and the administrative design.

In 2007 the sub-degree concerning the establishment of the National Social Security Fund (NSSF) was adopted.

NSSF was fully functional at end of 2008.
Legal entity with autonomy in administration and self-financing.

Administers the schemes of Social Security protection in accordance with the National Social Security Law and the provisions of the Social Security related Sub-Decrees.

All technical issues are under the supervision of the Ministry of Labor and Vocational Training (MoLVT), while the Ministry of Economy and Finance (MEF) needs to approve all finance related issues.
Role of the Governing Body

- NSSF is guided and monitored by the Governing Body, which consists of a tripartite representation of employers, employees, and the government.

- The chairman of the board gets nominated by the Minister of Labor. The NSSF Director is an ex-officio Member (automatic). Other representatives get nominated by their related organization.

- They must have never been convicted of misdemeanor or criminal charges.

- The chairman and members of the Governing Body except ex-officio member (permanent member) are appointed by sub-degree for a 3-year mandate issued by MoLVT as request from the organization they represent.
**Member:**
- 1,019,130 Members (September of 2014)
- 6,915 Employers
- Coverage in 24 Provinces

**Premium:** Employers pay 0.8% of each average staff’s salary.
## The Past

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<td>Work Injury Scheme Implementation</td>
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<td>Health Insurance Pilot Project (HIP/GRET)</td>
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<td>Preparation of National SHI for formal sector workers</td>
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**Objective**

- **Stabilize statistic and financial data** in order to calculate the right premium rate for NSSF
- Develop **tools and skills** to be transferred to NSSF
- **Train/inform** all stakeholders of major challenges of such scheme

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<th>Start date</th>
<th>2009</th>
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<td>Membership in 2014/09</td>
<td>11 GARNMENT factories around Phnom Penh 8,432 workers covered</td>
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<td>Benefit package</td>
<td>OPD, IPD, Delivery in public contracted health facilities</td>
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<tr>
<td>Premium</td>
<td>1.6 USD/worker – 50% employer, 50% employees</td>
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| Contact rate at HF  | OPD: between 1 or 2 contacts per year (depending on the factories)  
                      | IPD: 6.5% per year |
LUMP SUM Payment
(Former) HIP

Fee for Service Payment
WI SCHEME

CASE BASED PAYMENT
WI + SHI

MPA 5 Cases
CPA1 8 Cases
CPA2 12 Cases
CPA3 11 Cases

TOTAL 36 Cases

Fee for Service Payment for Special Cases

Start SHI National Scheme at NSSF
Prakas on Social Health Insurance

Software Requirement definitions

HSPIS System:
- Development/Adaptation
- Test
- Implementation
- Roll out

Q1, 2014  Q2, 2014  Q3, 2014  Q4, 2014
Moving forwards: Social health Protection

**STRATEGIC OBJECTIVES**

1. Financial risk protection
2. Equitable and fair funding
3. Efficiency of service delivery
4. Quality services
5. Transparency

**FINANCING FUNCTIONS**

- Resource mobilization
- Pooling: who will manage them
- Purchasing: buy services (supply or demand)
- Stewardship: regulation and monitoring

**FINANCING OPTIONS**

1. Medium term
   - Along policy objectives and Financing functions
2. Long term
   Considering:
   - UHC of Social health Protection
Health Financing Strategic Components

- **Institutions**: NSSF (private sector), NSSF-C (civil servants), Informal sector (MoH)--enrolment

- **Universal population coverage**: risk pooling and financial protection against the cost of illness--

- **Benefit package** (criteria for quality of care)- risk pooling and financial protection against the cost of illness

- **Purchasing services**: ensure quality of health services that are conducive for good health while making optimal use of available resources

- **Sources, level and management of funds**: raise sufficient funds to allow for the delivery of essential health services and enabling their purchase

- **Regulation**: ensure the delivery of quality health care and establishment of rules and regulations with clarifications of stakeholders’ roles
Concluding remark

- The Royal Government of Cambodia’s strong political commitment to achieving MDGs, esp. reducing maternal and childhood mortality and to reducing poverty and development of social health protection.

- Evidence base policy interventions – country specific choices

- A combined set of both supply-side interventions (service readiness) and demand-side interventions (removing barriers in access to and utilization of health services, geographically, financially, bureaucratically).

- Technical & financial support of Development Partners
THANK YOU