

# **Social Health Protection in CAMBODIA**

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**Ros-Chhun Eang**

Bureau of Health Economics and Financing,  
Department of Planning and Health Information, MOH.



# Contents

- Cambodia
- Funding source for health
- Existing legislation and regulation tools
- Social health protection mechanism
- Issue and Challenges

# Socio-demographic & Economic Indicators

## Demographic

Population	14,369,519	
Urban		15%
Rural		85%
Males	48.3%	
Females	51.7%	
Distribution of population by age group (1)		
0-4 years	11.0%	
0-14 years	39.0%	
5-14years	27.0%	
15-49 years (women in reproductive age only)	26.0%	
Annual Population Growth Rate	1.8%	
Male Life expectancy at birth		58
Female Life expectancy at birth		64

# Socio-demographic & Economic Indicators (Cont)

## Health

- Total Fertility Rate (TFR) 3.4
- Infant Mortality Rate (IMR) 66 per 1,000 live birth
- Under 5 Mortality Rate (U5MR) 66 per 1,000 live birth
- Maternal Mortality Ratio (MMR) 472 per 100,000 live births
- Crude Birth Rate (CBR) 5.6 per 1,000 population
- Contraceptive Prevalence Rate  
(currently married women, any method) (CPR) 40%

# Socio-demographic & Economic Indicators (cont)

Percentage of households with access to safe drinking water (total)	44%
- Urban	72%
- Rural	40%
Percentage of households with toilet facility within premises (total)	22%
- Urban	55%
- Rural	16%

## Education

Adult literacy age 15 and over (total)	74%
1.- Male	85%
2.- Female	64%
3.- Urban (both sexes)	84%
4.- Rural (both sexes)	72%

## Economic

GDP per capita per year	USD 513
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# Funding for health

- Regular government budget (USD6)
- Donor support (USD7)
- User fees at public facilities with an exemption system for the poor... but no budget allocated to provide exemptions!

## Alternative funding mechanisms promoting social health protection

1. Global health initiatives and national programs and exempted policy for the poor.
  - Free treatment for selected diseases (e.g. HIV/AIDS, TB, Malaria)
  - Free interventions (e.g. Vaccination)

*Mainly donor funded but also government subsidized*

# Contracting

- Supplier-side financing mechanism
- Contracts with NGOs (eg. HSSP) or facilities (eg. BTC)
  - Input: funding for service delivery (incentives and other costs)
  - Output:
    - Quantitative: defined service delivery levels (eg. Birth spacing, vaccination, deliveries)
    - Qualitative: staff behavior, facility maintenance, opening hours,..etc
- Incentive for the staff to apply the user fee schemes according to regulations, including exemption system.

# Contracting (ctd)

- Lessons learnt
  - Quality of services improved
  - Staff benefit from management support and incentives
  - Quantitative indicators satisfactory
  - Sustainability issue (donor funding)
  - Need for final contracting review exercise (under way) to draw final conclusions and design next step.

# Health Equity Funds

- Demand-side financing mechanism
- Funding provided to NGOs who ensure the following:
  - Poor people are identified (HEF card, post-identification)
  - Facilities deliver services for free when poor patients need care
  - Funds are transferred to facilities to pay for the health care received by poor patients
- Revenue from HEFs at facility level replace the user fees that patients cannot pay. They are used for incentives and operational costs

# Health Equity Funds (ctd)

## Government coordination

- HEF Implementation and Monitoring Framework (MOH)
- HEF Prakas (Inter-ministerial)
- National Poverty Identification Guidelines (MOP)

There are 45 HEF schemes

- 39 ODs
- 6 National Hospitals and 10 ODs are supported by the government budget.

# Health Equity Funds (ctd)

- Lessons learnt
  - Performance of public health facilities improved and service utilization increased
  - Access to health care is no longer denied to the poor
  - Health Staff benefit from the incentives
- Weaknesses
  - High administrative costs
  - Sustainability?
  - Coordination and harmonization of various initiatives

# Social Health Insurance

## **Wealthy:**

Tax-funded public health care with user fee schemes  
SHI coverage  
Complementary private coverage

## **Formal sector:**

Tax-funded public health care with user fee schemes  
SHI coverage.

## **Informal sector:**

Tax-funded public health care with user fee schemes  
CBHI coverage  
Gradual move to SHI

## **Poor:**

Tax-funded public health care  
HEF and other subsidies

**Social  
Transfers**



## Existing Legislative and Regulatory Tools

- ✓ Chapter 75 of the Constitution states that:  
*"The State shall organize social security schemes for workers and employees"*
- ✓ Labor Law provides for benefits for the formal sector
  - labour physician to provide primary care (Section III: Labour Health Services)
  - work-related accidents (Section IV).

## Existing Legislative and Regulatory Tools

- ✓ The Law on Social Security Schemes provides for pensions (old-age, invalidity and survivorship), occupations risks and other contingencies for the private formal sector

# Approach to SHI development

1. Compulsory Social Health Insurance
  1. Formal private sector
  2. Civil servants
2. Voluntary Insurance
  1. Community-based health insurance (CBHI)
- Social Assistance (linkage HEF & CBHI)
  - Use of equity funds to purchase health insurance for the very poor

## SHI development Status for Formal sector

1- Establishment of National Social Security Fund for private sector (MOLVT)- Sub Decree approved by the Government in March 2007.

- Currently register enterprises and employees for work injury scheme which will be started at the end of 2008
- Health insurance by 2010
- Pension scheme by 2012

2- Royal Decree and Sub Decree on Civil Servants security Benefits ; Approved in Dec 2007 and Feb 2008.

# Community Based Health Insurance (CBHI)

- Demand-side financing mechanism
- Voluntary micro-insurance organizing the following:
  - Community awareness, registration (CBHI card) and premium collection
  - Facilities deliver services for free to CBHI card holders
  - Funds are transferred to facilities to pay for the health care received by poor patients (Capitation, case based..)
- Revenue from CBHI at facility level replace the user fees. They are used for incentives and operational costs

# Providing Coverage to the Informal Sector

- Farmers, small business, self-employed (90% of pop.)
- Informal sector is broader than just the poor
- Characterized by:
  - No formal employment contract
  - No formal wages
  - Seasonal income, sometimes not cash
  - No employer to support part of the premium contribution

## CBHI (ctd)

### Government coordination

- CBHI implementation guidelines (including a monitoring framework)
- Social Health Insurance Committee: inter-ministerial committee with MOH chairmanship

# Overview of existing CBHI schemes

- Total of 5 organizations in 9 Operational districts with membership coverage of 45,438 members as of Dec 2007.
- CBHI-HEF Linkage: 4 Different Models
  1. Co-existence of HEF and CBHI implementer without financial linkage.
  2. HEF Operator becomes CBHI implementer.
  3. Benefits from micro-credit subsidy for operation of the CBHI and topping up HC staff.
  4. Use Health Equity Funds to pay for CBHI premium for the identified poor families.

# Issues and Challenges

- Quality of care
  - Provider Behavior
  - Availability of drugs and medicines in health facility
  - Availability of staff at RH and HC during official hours
- Understanding of SHI concepts, esp. provider payment
- Improving appropriate health-seeking behavior of members
- Partnership and working feedback mechanism among key players: Provider-Insurer-Member
- Sustaining membership and enrolling new members

# Issues and Challenges

- Large informal economy- approx 90% of population
- Large proportion of poor living below poverty line (35%)
- Limited managerial experience in social Health protection
- Limited ability to regulate health care providers

# Next steps

- Revise SHI MP to be SHP MP endorsed by COM.
- Enhance awareness and advocacy on SHI among policy makers and target population.
- Convert CBHI Guideline into PRAKAS and strengthen monitoring of CBHI implementation
- Intensify capacity building activities on SHI
- Strengthening coordination and collaboration with other concerned Ministries and Partners
- Document experience in linking of HEF and CBHI as input to policy development.



Thanks you  
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