

## Cambodia

*In 2016, the National Social Security Fund (NSSF) in Cambodia implemented a national social health insurance scheme for formal sector workers.*

In January 2016, the Prime Minister of Cambodia issued a sub-decree to launch a mandatory social health insurance (SHI) for formally employed workers. The sub-decree seeks to implement the health insurance branch of the 2002 Social Security Law.

The launch of the SHI was informed and boosted by a pilot Health Insurance Project (HIP) for garment sector workers. HIP was launched after a feasibility study in 2007 on the initiative of the Garment Manufacturers' Association of Cambodia (GMAC) and the NGO GRET (Professionals for Fair Development) in collaboration with NSSF and the Ministry of Labour and Vocational Training (MoLVT). The transfer of the project from GRET to NSSF under MoLVT started in 2013. The HIP team contributed its expertise to the establishment of the national scheme for formal sector workers.

The Recommendation on Social Protection Floors, 2012 (No. 202) stipulates establishing basic social security guarantees to ensure access to essential healthcare and income security for all, including children, people of working age and older persons.

The Sustainable Development Goal 1.3, part of the UN 2030 agenda, aims to implement nationally appropriate social protection systems and measures for all, including floors, supported by the Universal Social Protection partnership (USP2030).

This brief presents a successful experience of a country in extending social protection.



### Main lessons learned

- The government, workers and employers representatives progressively gained consensus on the design of the national health insurance scheme through continuous dialogue during a pilot stage that lasted seven years (2009-2016).
- The pilot phase was useful to fine tune operational processes, health care provider payment mechanism, client centred complaints management and a computerized monitoring and information system (MIS) and to build evidence on the cost of the system based on health care consumption analysis.
- After the adoption of the legal framework which made affiliation compulsory in the garment sector, the coverage expanded rapidly from 7,144 to 1.4 million workers in less than two years (2016-2018).
- Further expansion of health protection to all workers including in the informal economy will require additional investments in improving the quality of health care services, as well as adjustments in NSSF procedures, tools and administrative capacity.

## 1. Launch of the Health Insurance Project

In 2002, Cambodia adopted its first National Social Security Law, which stipulated the principles of a mandatory social security system for private sector workers. The system would include employment injury benefits and old-age, invalidity and survivors' pensions and would pave the way for further extension to the other contingencies. With ILO support, the law was gradually implemented, starting with the creation of the National Social Security Fund in 2007. The NSSF started to implement the employment injury branch in 2008 and planned to set up the health insurance branch in 2010-11.

In 2007, the French NGO GRET conducted a feasibility study regarding health insurance needs of garment workers who did not have sufficient access to health care. Following the findings of this study and in preparation for the compulsory Social Health Insurance Law which would soon be drafted, GMAC requested GRET to test the design of the health insurance branch.

In 2009, the Royal Government of Cambodia approved the launch of the health insurance project as a partnership between GRET, GMAC, MoLVT, NSSF and with support from Agence Française de Développement.

## 2. Design of the HIP and preliminary implementation

HIP initially aimed to offer an employment-based health insurance to all salaried workers in the garment industry in Cambodia. The target was 100,000 workers in Phnom Penh for the first phase which would allow to cover administrative costs (including staff cost) of the scheme.

Around 300 GMAC member enterprises were to join HIP on a voluntary basis with mandatory enrolment for their workers. However, with the 2008 economic downturn it became difficult for many enterprises and workers to join the scheme. As a result, the scheme started with voluntary enrolment of workers.

HIP covered primary health care at public health care centres as well as hospital care at contracted public health facilities (district and national) in the municipality of Phnom Penh. The scheme also included health promotion activities targeting workers' needs mainly in the area of reproductive health. HIP health care package aimed to follow the minimum standards defined by ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102) and Medical Care and Sickness Benefits Convention, 1969 (No. 130).

At the onset, workers did not have to pay any co-payment at the point of service. Upon their arrival at the facility, they could be authenticated at a dedicated counter managed by HIP hospital agents. HIP hospital agents also assisted workers and facilitated their stay in the hospital and in case of problems.

HIP contracted seven public health facilities including two national hospitals. A simple health care provider payment method based on a lump sum per major category of health care services (2 to 5 categories) was adopted. For national hospitals, HIP negotiated two simple lump sum payments; one for outpatient department services (OPD – ambulatory care) and one for inpatient department services (IPD – hospital care).

The quality of health care services was ensured by several criteria including medical staff qualifications, compliance with MOH requirements and availability of medical equipment, drugs and medical staff. However selected health care providers were often located relatively far from factories, which resulted in high transportation costs for insured workers. Furthermore, the service quality was not always met at public health centres. In this context, the mandatory referral system from public health centres to hospitals was removed giving more choice to insured workers.

In order to benefit from HIP, a contribution amounting to US\$1.60 had to be paid per worker per month.<sup>1</sup> The contribution was designed to be sufficient to cover the health care expenditures and HIP management costs (under the assumption of an outreach to 100,000

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<sup>1</sup> On average, workers earned US\$80-100 with extra hours.

insured workers). The contribution financed the coverage of the worker only as family members were not covered by the scheme. The amount of the contribution was equally paid by the employer and the worker, except in three factories that chose the automatic enrolment of all workers, and where the contribution was entirely paid by the employer.

A team of 23 persons including 11 hospital agents performed the daily management of the scheme. A dedicated MIS called HSPIS allowed the management of memberships and the production of reports on the utilization of health care services at each contracted health facility. Insured workers had the possibility to post feedback and complaints through HIP teams in factories and at health facilities and a 24x7 complaint hotline.

In order to promote the scheme, HIP teams visited the factories on a quarterly basis. Even in factories with automatic membership, HIP teams visited to ensure that workers had information on the health insurance. During these visits, HIP teams worked with both the management and worker representatives to raise awareness and avoid possible misunderstandings and resistance.

HIP was only covering about 1,900 workers in 2009.



### 3. Transfer of the HIP to the National Social Security Fund

To ensure involvement and clarify roles and responsibilities of relevant stakeholders, a Memorandum of Understanding was signed and a steering committee composed of representatives of

NSSF, the various line ministries involved in the project (labour, health and finance), GMAC, GRET, workers representatives, ILO and other development agencies was created in 2009 to provide advice on the scheme's design, operations and development. In addition, NSSF was directly involved in decisions related to the development of the management information system and choice of technology, to facilitate the future transfer of the MIS. Key NSSF staff members were also trained on the management of health insurance (including claims and provider payment processes) through specific working sessions and workshops.

The absence of a clear road map for the launch of the national health insurance by NSSF has been a difficulty for the management of the pilot. The date of the transfer of the HIP to NSSF changed several times putting financial pressure on the project, since donor funding was originally supposed to end in 2011. Similarly, the uncertainty of NSSF on technological solutions slowed down the development of the MIS. As donor support was about to end, the HIP steering committee members and donors agreed that some transfer scenarios would be presented by GRET and NSSF would have to choose its preferred option. In May 2013, four scenarios were presented and NSSF decided to integrate the HIP team into its divisions and to directly manage the contracts of the 7,144 workers insured by HIP before the effective launch of the SHI, which at that time was planned for 2014.

In October 2013, GRET transferred 17 trained HIP staff, the complaint system and the MIS to NSSF. With the financial support of AFD and NSSF, GRET continued to provide technical assistance until early 2018 for the integration of the HIP team and tools and for preparing and assisting the launch of the compulsory health insurance scheme with technical collaboration from ILO and GIZ.

#### 4. Implementation of the national health insurance scheme and expansion of coverage

The benefit package of the national health insurance scheme included, as in the HIP package, free of charge medical care in health facilities contracted by NSSF. In addition, it was extended to include sick leave and maternity benefits. The national scheme contracts both public and private facilities, especially when there is no public facility at a reasonable distance. In case of emergency, patients can access services in the nearest health facility, including in facilities that are not contracted by NSSF. In such a case, the patient has to pay the medical bill upfront and can be later reimbursed by NSSF.

The contribution evolved from a fixed amount of US\$1.6 per month per insured person to a monthly contribution rate of 2.6 per cent of the wage. The rate was determined based on an actuarial valuation done by ILO with financial support from GIZ.

The provider payment mechanism evolved and was designed in dialogue with the Ministry of Health<sup>2</sup>. This was to ensure consistency with other schemes when possible, such as the health equity funds for the poor. NSSF pays contracted health facilities based on a 52-case system where for specific cases, a standard list of procedures is defined and an average cost agreed upon. NSSF classifies contracted health facilities based on the quality of the health services. Based on this assessment, NSSF can decide to pay between 80 and 120 per cent of the indicated average cost of the case. For private health facilities, NSSF can pay up to 150 per cent of the cost due to higher service quality. Some services such as transportation are paid on a fee-for-service basis.

The management information system, HSPIS, has been upgraded to manage the increased volume of data generated by national coverage and for possible communication with other information systems, such as

the registration system for the employment injury branch of NSSF.



#### 5. Challenges to offer adequate health protection to all workers in Cambodia

In January 2016, the government officially launched mandatory health insurance for all formally employed workers. The collection of contributions started in September 2016 and the first health care services were provided in November 2016. The health insurance scheme had registered 1.4 million employees from large enterprises in September 2018.

In November 2017 the government expanded eligibility to workers of all enterprises regardless of their size. This expanded legal access to an additional 3 million workers of small and medium sized enterprises who were previously not eligible. As it implements the change, the NSSF has registered as of September 2018, 1.7 million new SME workers.

NSSF faces now the challenge of further expanding coverage to all workers including those in the informal economy. This will require adjustments of its organizational set-up to be able to deal with the identification and registration of workers outside formal employment relationships. It also requires significant supply side improvements to ensure that the health services covered are of acceptable quality.

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<sup>2</sup> Kosomak Hospital and other departments such as Hospital department, Budget department, Health Information and Planning department

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### Social Protection Floors in Action: 100 success stories to achieve Universal Social Protection and SDG 1.3

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