SOCIAL HEALTH INSURANCE IN CAMBODIA

PROPOSAL FOR A MASTER PLAN

Prepared in collaboration with the Ministry of Health Cambodia

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CONTENTS

Executive Summary

As in many other developing countries, Cambodia has encountered difficulties in financing health care out of its government budget. Throughout the period of health sector reform in Cambodia, serious efforts were been made to improve health systems and health care financing. The current pressure is to reach a more adequate, stable and efficient health care financing system that will promote improvement in quality in the delivery of an appropriate volume and mix of health services and remove financial barriers to seeking health care. The Government of Cambodia now recognizes the potential of social health insurance as a major health care financing method in the future.

Recognition to develop alternative health financing schemes is given in the Five Year Implementation Framework of the Ministry of Health for 2003-2007. A Health Insurance Committee was appointed at the end of 2002, and WHO was requested to provide technical assistance in the development of a Master Plan for Social Health Insurance for Cambodia.

The Master Plan first reviews the current situation of health care financing, including increased government funding, user fees and the new equity funds. The next section reviews the major determinants of social health insurance: demography, the labour force and employment, the scope of existing social security systems in Cambodia, major health and health system issues and cultural factors. Within these areas, the major risks to the sustainable implementation of social health insurance are health care worker conditions in the public sector, the lack of awareness of social protection mechanisms in all population sectors and the high proportion of the population with incomes below the poverty line.

The Master Plan recognizes the multiple objectives of developing social health insurance for Cambodia as the implementation of a stable financing mechanism, the promotion of equity in access to health care, facilitating rational household expenditure on health through regular prepayment rather than unpredictable payment at the time of illness and as a means of promoting improvement in the health care delivery system.

To reach universal health insurance coverage in Cambodia, a parallel and pluralistic approach is recommended. This approach comprises:

- Compulsory social health insurance through a social security framework for the public and private salaried sector workers and their dependents, through addition of health care to the Social Security Law passed in 2002 and administered by the National Social Security Fund.

- Voluntary insurance through the development of community based health insurance (CBHI) schemes sponsored by different development partners, national non-government organizations in the initial stage and health care providers for non-salaried workers' families that can contribute on a regular basis. Social health

insurance for this population sector should include all family members registered in the Cambodian Family Book.

- Social assistance through the use of equity funds and later government funds to purchase health insurance for non-economically active and indigent populations.

The Master Plan calls for accreditation of all community schemes, regardless of sponsorship, to enable the creation of a network of schemes following the same core principles, and to allow for eventual merging of schemes to increase risk pooling, to enable portability between schemes and eventually to reach universal coverage.

The plan proposes that social health insurance schemes offer a comprehensive range of health care benefits, including primary health care in the community and hospital based outpatient and inpatient care. Health care benefits should be the same for the salaried labour sector and dependents, covered by the National Social Security Fund, and for the populations covered by the CBHI schemes.

With regard to contributions, for the formal salaried workers to be covered by a compulsory national social security system, the monthly contribution should be a percentage of salary, to be shared by employer and salaried employee (with employer contributing at least 50%). For civil servants, it may be necessary to increase salaries to compensate for any deduction of social health insurance contribution from the low wages. For the population that could be covered by voluntary insurance, through expanded and new micro or CBHI schemes, a flat rate contribution amount is recommended. The amount should initially be about 4% of family income, with the same amount for all households in the same scheme. It is strongly recommended that the compulsory and voluntary schemes do not apply co-payments at the time of use. Every effort should be made to demonstrate that prepayment does indeed cover the costs of care at the time of use.

A major objective of social health insurance in Cambodia is to reduce poverty caused by paying for health care, and to prevent already vulnerable rural families from falling into deeper poverty when facing health problems. The non-economically and very low-income population indeed cannot maintain membership in the CBHI schemes. The Master Plan proposes collaboration between the Ministry of Health and the development partners to enable use of the Equity Funds to purchase health insurance cards for the vulnerable populations that cannot regularly pay all or part of the regular contribution from household income. Equity Funds could be used in two ways, in conjunction with social health insurance. In communities in which less than 25% of the population have incomes below the poverty line, the Equity Fund could be used to purchase health insurance cards for the identified poorest families, at the same contribution level as other households enrolled in the CBHI scheme. The second option, which may in fact be preferable, is that in communities in which around 50% of the population have incomes below the poverty line, the Equity Fund could be used to subsidize all households, without prior identification of the poorest, through a uniform subsidy, which will be reduced and replaced by household contribution over a period of five years. That is, the

contribution burden would be shared, with an increasing share for the households over time and as household income increases.

The Master Plan recommends that capitation be used as the major provider payment mechanism, to the extent possible, through contracts with accredited health care providers in both the public and private sectors. The information systems of the schemes will need to support an effective quality assurance programme. The schemes need to convey to the insured population that it is important for them to express satisfaction and report dissatisfaction. It is essential that providers know that satisfaction with their services is monitored, according to indicators acceptable to all the parties.

A proposal for the allocation of health insurance revenues is included. The allocation should facilitate the provision of the health care benefits with improved quality, attention to special health and health system issues, and a reasonable level of reserves, with administrative costs kept to a minimum. The basic requirements of an information system to support the management and quality assurance functions of social health insurance are defined.

The Master Plan then proposes a series of activities and programmes to deal with the major risks and threats to the sustainable implementation of social health insurance as a major financing mechanism in Cambodia. The areas covered include major health issues, health system issues including health workers in public health facilities, the private providers of health care and health insurance, maternal mortality, motor vehicle accidents and the need for uniformity in the design of CBHI schemes.

As the next steps, the document proposes that the contents of this Master Plan be discussed within the Ministry of Health, and then with the development partners assisting in health sector reform. On the basis of the decisions and commitment of the government, a detailed Plan of Action can be developed, defining the role of each partner based on a declaration of willingness to provide technical and/or financial support.

There is some urgency in dealing with the issue of the addition of health care to the Social Security Law and dialogues. The next step would be dialogue between the relevant Ministries: MOH, MOSALVY and the Ministry of Economics and Finance. Within the Ministry of Health, a crucial next step would be the creation of a Health Insurance Policy and Implementation Unit. A timeframe for the next steps is proposed.

WHO can assist in preparation of the Plan of Action for the initial phase and collaborate with the bilateral donors to mobilize financial support. WHO presents the Master Plan with the confidence that the introduction of social health insurance on a significant scale in the coming years can assist the government in promoting health, preventing poverty linked to ill-health and improving the level of funding and quality of health care. The goal of universal health insurance coverage is considered feasible and advantageous for the Cambodian population.

1. BACKGROUND

1.1 HEALTH CARE FINANCING REFORM

As in many other developing countries, Cambodia has encountered difficulties in financing health care out of its government budget. Health care financing was therefore an important component of the Health Sector Reform project undertaken over the last decade, with the technical assistance of the World Health Organization and funded by a consortium of donors.

The recognition of the potential of social health insurance as a major health care financing method for Cambodia in the future comes after a decade of health sector reform and development. In neighbouring countries, compulsory health insurance for the formal labour sector was introduced in Thailand (1991), Viet Nam (1992) and Laos (1999). Viet Nam's Social Security System is now accelerating efforts to increase voluntary insurance for the informal sector, and in 2001 Laos started independent community based health insurance schemes in selected populations. China began reform of its social health insurance system for urban workers in the mid-1990 by shifting to municipal level pooling and is attempting to re-instate Rural Cooperative Medical Schemes.

Throughout the period of health sector reform in Cambodia, serious efforts have been made to improve health systems and health care financing, through an increase in the level of government expenditure based on improved information on costs, improved allocation of resources to priority areas and efforts to increase formal revenues at the provider level. The current pressure is to reach a more adequate, stable and efficient health care financing system that will promote improvement in quality in the delivery of an appropriate volume and mix of health services and remove financial barriers to seeking health care. The measures taken within the framework of health sector reform and through other efforts of the Ministry of Health are described below, with comments on their current constraints and problems.

Increase in government budget for health care

From 1979 to 1996, public health services were provided free of charge to the Cambodian population. Government spending on health in 1996 was low and could not cover basic health care needs as well as public health functions and maintenance of the public infrastructure. The total amount spent on health was $16.6 million dollars, or $1.51 per person. By 1999, government expenditure on health had doubled to $32.73 million, or $2.80 per person. For 2003, the requested government budget is close to $ 50,000,000 or $3.50 per person.

The share of government expenditure on health as a proportion of total government spending is increasing, and reached 10.9% in 2002. As with government's rising expenditure on education, agriculture and rural development, the increase in this proportion is made possibly to some extent by the decrease in government spending on defence and security (from 37.1% in 2000 to 24.7% in 2002.

By 2002, government sources accounted for 9% of total health care expenditure, or $2.9 per person. External funding was estimated to cover 19% of expenditure or $6.3 per person. The bulk of health care expenditure, 72%, or $24 per person, came from private sources, as out-of-pocket expenditures by households.

The actual increase in government spending has not necessarily solved basic budgetary problems. With only 33% of the total Ministry of Health budget allocated to provincial and district health facilities, these providers remain under-funded. Health professionals, including doctors and nurses, earn a monthly salary of between $20 and $30 in public service. The allocation of the increased government budget for health did not result in any significant increase in public health worker salaries. Necessary additional income to meet the increasing cost of living in Cambodia has to come from second and even third jobs, and from private practice. A conservative estimate of income needs of a household in rural areas is $100 per month, and at least $200 in the urban areas.

The low salary level of public health workers is even more striking if compared with the minimum wage of unskilled garment factory workers, which is now $45 per month and the average earnings from wages (including overtime) of these workers are currently $65 per month. Semi-skilled workers in other productive enterprises, such as the breweries, report $300 as the average monthly salary of their workers.

At the same time, actual recurrent expenditures have been below budgeted levels in recent years. Of the revised Ministry of Health budget for 2001, only 88% was spent. The amount of the budget allocated to salaries constituted 12%, which could be considered a low proportion. The low salary levels may explain this. Yet the percentage spent of that allocation only reached 75%. It is difficult to conclude the reasons for what in fact constitutes under spending of the budget at central level and on priority issues. One reason may be over-reliance on cost recovery through other financing methods, such as formal user fees, at the provincial and district levels.

User fees

As part of the Health Sector Reform agenda, The Ministry of Health of Cambodia has been piloting official user fees for selected health services in health centres and referral hospitals since 1997, following approval by the Council of Ministers in 1996 of the National Health Financing Charter (NHFC). The main purpose of introducing official user fees was to reduce under-the-table payments and improve public accountability among health care providers. The Charter provided the legal framework and guidelines for the introduction of user fees at public health facilities. It introduced mechanisms for regulating personnel and management practices at provider level and raise revenues at local facility level to cover operational costs and staff motivation. In accordance with the NHFC, 99% of the revenues from fees are kept in the facility, and 1 % is channelled to the National Treasury. Of the funds kept at the facility, 50% are to be used for operational costs, including drugs and supplies, while 49% are to be distributed as salary supplements or incentives to the staff.

The NHFC gave considerable independence to the local facilities regarding the level and structure of the fees, and the Health Economics Task Force in the Ministry of Health approves the proposed fees. This Task Force is responsible for technical assistance and monitoring of the user fees, implemented in September 2000.

After over three years of piloting the official User Fee Schemes in 143 facilities (128 health centres and 14 referral hospitals), an evaluation was carried out in 2000 on the effects of the fees on access, equity and provider practices. The main findings related to equity and access showed that utilization of health care has increased, possibility due to increased staff attendance and greater availability of medicines. However, the study noted that current utilization reflects irrational prescribing and poly-pharmacy. Revenues from user fees indeed depend on the volume and type of services provided, and it is not surprising that health workers are motivated to generate demand. The easiest way to increase user fee revenue at the health centre level is to generate demand through the prescription of drugs, which are available in the health centre, do not require any referral and are perceived as being "good care" by the Cambodia population. At the hospital, additional revenues from user fees are generated by more sophisticated technologies, such as x-ray and laboratory examinations.

At the same time, revenue from user fees has not increased the income of the staff in the public health facilities to a substantial or satisfactory level. It would appear that in the best case, income from user fees could double the salary level but not bring it to the level considered adequate to meet living expenses.

The user fee system was introduced without social safety nets, through defined social assistance, for those who cannot afford the fees. The NHFC provided clear guidelines on exemptions, but there was no allocation of funds to cover these services at the local provider level. That is, the local provider did not receive any remuneration for the patients exempted from user fees. The evaluation indeed revealed that exemptions were not regularly granted to the poor, particularly for hospital care. Even when a patient was exempted at the primary health care level, the exemption was not transferred or respected at the secondary level.

As concluded by the study, “paying for health care, particularly secondary or tertiary care is still a major cause of destitution among the poorest sections of the community. High user fees in referral hospitals have often resulted in the poor having to sell productive assets (e.g. land, livestock), or going into debt to pay for treatment, thus increasing their vulnerability”

Other problems with the user fee system are related to the short-term use of the fees collected. At the local health centre level, the money collected is usually kept by one of the health centre staff during the week, and spent at the end of the week. There are no arrangements for depositing the revenues and accumulation of amounts that could facilitate spending according to priorities, or with the advantages of economies of scale for the bulk purchase of drugs and supplies. Drugs purchased at low prices, and possibly

low quality, will be sold to the patients at the same fee as higher priced drugs. There is low compliance with the quarterly reporting system on the user fee yield and use of funds. Special studies at the facility level generally show that a significant proportion of the fees collected are used for "other operational costs" and overtime payment to the health workers.

Equity funds

More recently, several development partners have proposed Equity Funds as an interim measure to cover health care expenditures for indigent households. The current Joint Donor Health Sector Support Project (HSSP) has defined some activities for such funds, under the term Social Protection Funds, to be included in the project components in the target areas and populations. The HSSP partners are the World Bank and Asian Development Bank, which will provide support through loans, and the Department for International Development (UK) (DFID) which will provide support through a grant to be disbursed over the project period of five years.

As set out under Sub-component 1.22 of the Project Implementation Plan, the social protection funds will be introduced in up to 6 districts. The funds would essentially serve as financing for social assistance, to cover the costs of health care of the poorest families. The plans for use of these funds note the need to avoid fee-for-service payment to providers in the use of the funds and propose capitation or case payment. The relatively high costs of identifying the poorest and most vulnerable families are recognized by both the HSSP partners and by UNICEF, which has also proposed Equity Funds in two districts.

1.2 SOCIAL HEALTH INSURANCE IN CAMBODIA

The only social health insurance experience to date in Cambodia is the micro health insurance pilot initiated by GRET, the Research and Technological Exchange Group. This French non-government organization (NGO) has been active in the development of agriculture, water and sanitation as well as micro-credit schemes in rural areas in Cambodia since 1988. GRET launched a micro-finance program in 1991 that progressively turned into a financially viable, legally recognized micro-finance institution called EMT (Ennatien Moulethan Tchonebat), which now covers over 75,000 clients in 9 provinces of rural Cambodia. A micro-credit impact study conducted by GRET in 1995-96 confirmed that health expenses are a key factor in the vicious cycle of poverty. In 1998, GRET reached the decision that an insurance product could be relevant to protect poor rural households against severe health expenses, as a complement to micro-credit. GRET therefore launched an experimental rural health insurance project covering two Cambodian provinces (Kandal and Takeo) in that year.

These pilots are designed within the framework of voluntary and community based health insurance (CBHI), with primary health care and hospital-based benefits, and using existing public health facilities for the provision of these benefits. All family members registered in the Family Book are included in the family unit. Payment to providers is

based on capitation contracts with health centres and district hospitals, while insured persons receive small cash benefits in specific approved cases (mainly as funeral grants). Prior to the finalization of capitation contracts, the insured were reimbursed for payment to hospitals according to the type of service. In Zone 1 and Zone 2, the contracted hospitals send a doctor to the health centre for consultations every two weeks.

An external evaluation in November 2002 concluded that the pilots launched in two zones demonstrated the advantages of social health insurance schemes in: (a) providing rural families with safety nets to avoid poverty resulting from high health care expenditures and (b) generating an additional health care financing source for the public health care system in Cambodia. The project has been extended to an additional pilot area, Kirivong, resulting in an increase in the number of insured households, extension of benefits and contracts with new health care providers and NGOs working in all three pilot areas. In August 2003, a total of 240 households were covered in the three zones, including 54 households in the new pilot in Kirivong (Zone3).

The contribution rate was recently increased to 1,000 per person per month (except in Zone 3 which has a lower household income), following analysis of acceptance of contributions rates to date, current household spending on health, cost estimates for primary health care and hospital in-patient days and target utilization rates. The flat rate amount of 1,000 riel (R) as a monthly contribution could be compared with the cost of 1 kilo of rice per person, or 3 cans of beer for a household with 5 persons. The increase is also linked to proposals for the use of these contribution revenues, both by the schemes and the providers. (The exchange rate in September 2003 is R 4,200 = US$ 1.00.)

While the current contribution rates still require subsidization by GRET to meet all operating expenses, a gradual increase over the next three years has the potential to add substantial funding to the providers, particularly the health centres. The current GRET subsidization to the scheme comes in the form of capitation payment for an inflated number of insured persons. This is done to encourage improvement in the quality of care and provider satisfaction. There is no subsidization or reduced contribution at the household level. Gradual increases in contribution rates are also designed to reduce the level of the NGO subsidization until the schemes become sustainable through contributions alone.

Another important change in the GRET pilots is the shift from 6-monthly cycles of registration and contribution collection to enrolment throughout the year, with increased involvement of community members in promotion. That is, social marketing methods are applied to voluntary CBHI to promote enrolment at times of interest and convenience. Members of the community management committees are increasingly used to promote the schemes.

In addition to these changes, GRET is currently focusing on developing an information system to facilitate monitoring of utilization, quality of care and financial management. In the next phase, attempts will be made to include outreach to the health centres by the contracted district hospitals to allow the insured persons to consult doctors in the health

centre, before and after referral to hospital. The main purpose of this form of outreach is to improve diagnostic capacity at the primary health care level. This should result in patients seeking care at earlier stages of illness than in current patterns.

Attempts to reach a capitation contract with the Takeo Hospital, which is the tertiary hospital for two of the pilot zones, have been complicated by a planned increase in user fees in that hospital.

GRET plans to reach approximately 4,000 people at the end of 2004 and more extensive upscaling (such as to an entire district with approximately 30,000 insured) is envisaged if partnerships with the zone's health care structures can be strengthened. A population of 4,000 or close to 800 families with one network of providers (district hospital and health centres) would enable significant revenue from health insurance at the provider level and allow for financial sustainability of the scheme, with the exception of the costs of monitoring and evaluation by the NGO.

Upscaling would therefore be important to achieve financial viability and demonstrate the effectiveness of health insurance in Cambodia to the Ministry of Health and all development partners. GRET is interested and has the capacity to develop schemes in additional areas including urban areas, and to undertake this expansion in partnership with other development partners. GRET is also willing to use its existing schemes in practical training for new CBHI schemes.

1.3 PRIVATE FOR-PROFIT HEALTH INSURANCE

For-profit private or commercial health insurance is limited to a relatively small population. Several large enterprises and many NGOs have purchased health insurance from private insurance companies, mainly to cover work injuries for their staff. Four commercial companies now sell health insurance: the state owned CAMINCO, and three private international firms, Indochine, Asia Insurance and Forte. The premiums for work injuries are higher than expected for the same occupational risks due to the poor working conditions in most factories. The current cost of a work injury policy is set according to the level of total indemnity to an injured worker. Indemnity ranges from up to $700 to $10,000 during the one-year insurance period, and annual premiums in the state-owned insurance company range from $9.00 to $63 per worker. Premiums are higher in the three private companies.

In all cases, the system does not reflect equity in worker benefits. Health insurance for non-work related risks is purchased mainly for top management of multi-national companies, joint ventures and non-government organizations, and generally only covers employees and not their dependents. Some companies reimburse workers or directly pay contracted providers for non-related health care expenditure, but this is done on a voluntary basis. The insurance companies noted above are general insurance companies that provide insurance for other non-life contingencies (for example, fire and theft) for the same clients.

1.4 NEW SOURCES OF FUNDING FOR HEALTH

The amount of money available for health care and related social services could change dramatically if the grants received from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) are considered within the financial resources available. Approved projects total over $40 million over the next two years. If approval is given for other requested projects, the total amount for the three diseases could reach an average of $20 million per year over the next five years. These funds are allocated for activities in specific projects dealing with various aspects of prevention, diagnosis and treatment but may not directly facilitate access to primary health care, including the basic preliminary investigations leading to the confirmed diagnosis of the three diseases. As with most health conditions, access to primary health care is an essential element in effective intervention.

Given the high prevalence and incidence of the three diseases in Cambodia, there may be some opportunity to utilize the funds for prepayment mechanisms to provide access to primary health care, without prior limitation to patients diagnosed as having one or more of the diseases. Access to primary health care without financial barriers could have a significant impact on health behaviour, particularly the current tendency to delay seeking formal health care. Early detection would not only enable prompt and less expensive treatment, but also prevent the spread of infectious diseases.

1.5 SUMMARY OF THE HEALTH CARE FINANCING SITUATION

While coverage of primary health care services across the country has improved through health sector reform, the results are mainly infrastructure development and training rather than actual increase in access without financial barriers. Utilization of health services remains low (at 0.3 contacts/person/year in the public sector) and the quality of care in public facilities is considered low. Paradoxically, the low quality is reflected in over-prescribing and unnecessary use of injections and intravenous fluids, while public dissatisfaction is often based on the lack of "good" drugs in the health centres. It is difficult to estimate the scale of unnecessary expenditure on drugs, and the negative health consequences of the over-use of drugs, including substandard or counterfeit drugs.

These issues, as well as relatively slow economic development and increased poverty, may in part explain the lack of major improvement in health status among the Cambodian population. Health indicators are still among the worst in Asia. In 2000, life expectancy was estimated at 57, infant mortality was 95 deaths per 1,000 live births; child mortality was 124/1,000 children under 5 years while maternal mortality was 437 per 100,000 live births. The fertility rate of 4 in 2001 is considered high for the region, while the use of contraceptives remains low at 19% of women in that age group (15-49 years). In 1999, 56% of children under 5 years were defined as chronically malnourished, and 44% of children in this age group had moderate to severe stunting. Current estimates are that 30% of the population has access to safe drinking water, and 18% to adequate sanitation facilities.

On the socio-economic side, the proportion of the population living below the poverty line has increased over recent years, and is now estimated to reach 36. % Out-of-pocket payment for health care, to both public and private providers, is the leading cause of poverty. A recent Oxfam study confirmed that health expenses are the second reason why farmers sell land. Marriage was stated as the reason for selling land in 23% of respondents, while 22% cited health care expenses as the reasons. According to this same study, 43.7% of farmers that recently lost their land had sold them because of health expenses in their family.

In 1997, the estimated total per capita spending on health care was $29 per person per year. A 1998 Health Care Demand Survey found that households are the main contributors, covering 82% of total health care expenditures. On average, these expenditures then constituted 22 % of total household expenditures, with households in the lowest wealth quintile paying a higher percentage (28%) of income on health care. More recent estimates are $24 spent on health per capita by households, or 9% of the per capita GDP of $283 in 2001. This constitutes a very heavy burden on families, particularly as the payments are made at the time of illness and reduced earning capacity.

The data from the Cambodia Demographic and Health Survey 2000 show that households reported spending an average of $20.7 to receive health care following injury or illness in the past month. For that episode, 94% of the amount was spent on health services while 6% was spent on transport.

For the most part, the household expenditure is in the form of user fees to public and private providers at the time of use or the direct purchase of medicines from private pharmacies or drug vendors. Over time, the population has increasingly sought health care from private providers, not necessarily at higher quality. Private consumption includes consultations with public system health workers, who are dependent on extra revenue to meet living costs. The purchase of drugs from a wide range of sources, from licensed pharmacies to travelling drug vendors, accounts for a major proportion of private health expenditure. In addition to the costs of health care, the costs of transport and of borrowing money to pay for care create additional financial barriers to seeking care.

According to the perception of the population, the new user charges in the public health facilities did not lead to visible improvements in quality, as reflected by the attitudes of the health workers and the availability of drugs. A possible reason for limited ability of the user fee mechanism to impact on improvement in quality is the way in which the money collected is spent. As noted above, the portion allocated for current expenditures at the local facility level is generally not accumulated and therefore not used for major acquisitions of equipment or bulk purchasing of supplies. As user fee revenues allocated to operating costs (50%) are generally spent within the week on drugs and supplies, the use of the money loses effectiveness in dealing with needs for procurement of equipment and more expensive items than drugs for a short period. This system also encourages the procurement of small quantities of drugs at low prices to meet short-term (weekly) needs.

The impact of the excessive burden on the family imposed by health care expenditures in the public and private sectors is increasingly recognized. Health care financing has therefore remained a major stumbling block in balanced health system development to meet multiple health needs, provide reasonable remuneration for health workers and facilitate efficient planning and operation. The government still provides only 9% of the current health expenditures, development partners provide around 19% while the rest – now around 72% - comes through household out-of-pocket payment for care, at the time of use.

Given the low implementation rate of the government budget for health care, and the competing needs of other government agencies dealing with social services, it is unlikely that government spending on health will increase. More effective collection and use of the user fees are also unlikely to provide a solution to the level and method of funding. The actual posted fees are no longer nominal amounts, particularly for secondary and tertiary health care. The fees increase as more cost information becomes available, and providers attempt to recover all costs. Neither the providers nor the population will have the advantages of stability and protection through prepayment as opposed to payment at the time of use.

Even if the now proposed Equity Funds enable effective exemption of the very poor from the user fees, the vast majority of the population will face financial barriers at the time of paying for care. It is also questionable whether indeed use of the Equity Funds to cover health care costs of the very poor will contribute to equity. The non-paying patients may face discrimination, while the number of almost poor families pushed below the poverty line because of high payments for care is likely to continue to rise and thereby increase the population requiring social assistance. There is also the danger that Equity Funds will encourage a dole-out mentality, with families pleading poverty to avoid paying for health care while they use their own money for non-essential goods and services.

1.6 CURRENT INTEREST IN SOCIAL HEALTH INSURANCE

Recent initiatives

Interest in social health insurance has grown significantly in the Ministry of Health in recent years. From 1999, WHO and the French Cooperation conducted seminars for senior government officials, while GTZ conducted a feasibility study in 2000. The recommendations following the GTZ feasibility study included piloting health insurance in two rural areas, Kampot and Kampong Thom, in collaboration with other GTZ-support activities in these areas and to carry out further studies on health insurance. GTZ now expects an appraisal mission to arrive in October 2003, to begin activities towards development of the two pilot schemes and conduct a workshop.

In 2001, two senior officials from the Ministry of Health undertook a study tour to the Philippines on community-based health insurance. The interest was further stimulated by GRET, which continually shared its experience and information with key persons in the Ministry of Health.

Recognition to develop alternative health financing schemes is given in the Five Year Implementation Framework of the Ministry of Health for 2003-2007, under Strategy 15 in Section 5 of the Framework dealing with Health Financing. The listed activities to introduce health insurance include the setting up of a Health Insurance Committee at central level, development of a long term health insurance plan, development of health insurance guidelines, development of a plan to expand and pilot in a few provinces including Phnom Penh and monitoring and evaluation. The Health Insurance Committee was appointed at the end of 2002, with the following terms of reference:

- To review in-country and regional experiences with developing health insurance including feasibility study reports, lessons from pilot projects, research findings.
- To outline strategic objectives and principles for developing social health insurance systems for Cambodia particularly in achieving social protection, equity and accessibility to health care.
- To propose a process that enables the Ministry of Health and other stakeholders to discuss and explore insurance development in different sectors including development of legislation, financing and regulatory measures.
- To coordinate and direct on-going or new pilot schemes including guidance to technical assistance, on social health insurance for low-income populations in both urban and rural areas.

The Health Insurance Committee has 15 members, and is chaired by a Director General of the Ministry of Health. In addition to the 8 officials from various departments of the Ministry of Health, the Committee includes representatives of the Cambodia National Insurance Company (CAMINCO), WHO, UNICEF, MEDICAM (the association of NGOs in Cambodia), GTZ, MSF Holland-Belgium and the French Cooperation. The Director of the Social Security Department of MOSALVY and the Insurance Office, Department of Financial Industry, Ministry of Economy and Finance, are invited as associate members. The Health Insurance Committee is required to meet quarterly and two meetings have been held to date.

Also at the end of 2002, the Ministry of Health requested WHO to provide technical assistance to develop a master plan for health insurance in Cambodia and this document is the first stage in that endeavour.

Most recently, the Department of Planning and Health Information of the Ministry of Health submitted a formal project proposal to GTZ to pilot social health insurance schemes.

The Ministry of Health is now committed to serious examination of the potential of social health insurance as a major health care financing mechanism.

2. DETERMINANTS OF SOCIAL HEALTH INSURANCE IN CAMBODIA

Towards developing the Master Plan, this section covers the basic situation and trends in the areas that may be termed the determinants of social health insurance development. These are areas that need to be taken into account in developing the components of social health insurance schemes, and areas that may pose risks or threats to successful and sustainable implementation and extension of coverage.

2.1 DEMOGRAPHY

The estimated total population of Cambodia was just over 13 million in 2001. The data on the composition of household population are taken from the Cambodia Demographic and Household Survey of 2000 and provide information on age structure and household size:

Table 1: Age distribution of the Cambodian population

Age group	Percentage of population
< 15	42.7
15-64	53.6
65 +	3.6

Table 2: Household composition in urban and rural areas

Characteristic	Urban %	Rural %	Total %
Sex of head of household			
Male	72.1	75.0	74.6
Female	27.9	25.0	25.4
Usual number of household members			
1	1.8	1.9	1.9
2	4.7	6.3	6.1
3	10.3	12.2	12.0
4	16.6	17.5	17.4
5	17.6	18.3	18.2
6	14.5	16.2	16.0
7	14.5	11.8	12.2
8	8.9	8.0	8.1
9 +	11.0	7.6	8.1
Mean size of households	5.7	5.3	5.4

The persons living in the household do not necessarily comprise a nuclear family. Family members registered in the official "Family Book" in Cambodia may include

dependent elderly parents, orphans of deceased siblings, or relatives from other parts of the country living in the household permanently. There may also be temporary household members, such as relatives living in the urban household for purposes of study or work. Social health insurance is optimally designed for all members of the family, defined as parents and dependent children up to age of 18 years. In voluntary insurance, it is extremely important to take the family approach, rather than allowing individuals to enrol. Individual enrolment is likely to increase adverse selection while family enrolment can minimize adverse selection. The approach taken by GRET has been to include all family members registered in the Family Book. In the long run, a decrease in fertility and small family as well as household size can be expected in Cambodia, but the current figure of 5.4 persons per household should form the basis for health insurance scheme design.

2.2 LABOUR FORCE AND EMPLOYMENT

According to the Labour Force Survey of 2001, the economically active population was then estimated at 6.8 million, of a total population of 13.1 million.

Of the total employed population about 46% were family members working without regular pay in their own family operated farms or businesses. About one million workers reported that they were self-employed. Of the formal salaried population, 350,000 worked in enterprises with over 10 workers, and about 200,000 of these are in the garment industry. In that industry, women account for 87% of all workers. The number of workers reported in these factories ranges from around 30 to 2,500. The data for salaried workers, including for the garment industry, probably reflect under-reporting, as casual workers are not included. The survey also does not provide accurate data on the number of enterprises or workers in enterprises with less than 10 workers.

Current estimates are that civil servants number around 150,000 persons, excluding defence and police.

2.3. CURRENT SCOPE OF SOCIAL SECURITY IN CAMBODIA

At present, Cambodia has no social security system at all. Occupational accidents and diseases are covered only by a Labour Law, which provides no risk sharing among employers or enterprises. The Labour Law was last amended in 1997, to replace the previous Labour Law of 1992, which was drafted by the Department of Labour Wages of the Ministry of Planning. Responsibility for implementation was transferred to the Ministry of Social Affairs and Labour created shortly after passage of that Law. In 1996, the Ministry was expanded to be responsible for three social sectors: Affairs, Labour and Veteran Affairs, and is known as MOSALVY.

Health and safety of workers are dealt with under Chapter 8 of the 1997 Labour Law. The provisions cover all enterprises except workshops where only family members are employed. Article 238, Chapter 8, stipulates that enterprises and establishments covered

by the Law must provide primary health care to their workers. The services are to be provided by Labour Physicians, who may serve more than one enterprise. According to Article 242, enterprises with over fifty workers are required to have a permanent infirmary on the premises, run by a physician and assisted by nurses. According to Article 244, enterprises with more than 200 workers are required to have facilities to treat sick or injured workers until they can be transferred to hospital if necessary. All the costs of operating the infirmaries are the responsibility of the employer.

Articles 248 to 257 of the Law cover work related accidents and diseases, while reporting procedures are covered by regulations (Prakas) issued in September 2002. Accidents are recognized as work accidents if they occur at work or on the way to and from work. The benefits include cash compensation and medical treatment, including hospitalization, surgery and prosthesis required after an accident.

An interesting feature of the provision of this Law is that the same liability for work-related accidents applies to the personnel of private hospitals, employees of professionals, workers in craft shops other than family members, domestic workers and workers in agricultural enterprises. The inclusion of these workers should ultimately simplify reaching coverage of all workers through social security schemes.

Civil servants are the only salaried workers that currently have old-age pensions. This is a non-contributory system and government funds these pensions. Despite the low salaries and essentially inadequate pension amount, civil service is still perceived as preferred employment because of the pension scheme. The de facto job tenure through working life in the civil service may be another factor in this preference. However, there appear to be signs of change in favour of jobs in the private sector, as the gap between public and private sector salaries increases and the traditional fringe benefits in civil service are reduced. Cambodia has also embarked on a civil service reform, which will lead to a gradual increase in salary levels and apply some streamlining in the public sector workforce, including change in tenure arrangements.

New Social Security Law

The Government of Cambodia has recently initiated steps to introduce social security, beginning with a work injury programme and old age pensions. A Law on Social Security Schemes for Persons defined by the provisions of the Labour Law was passed in September 2002. Article 1, Chapter 1, General Provisions, defines these 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 created will be under the National Social Security Fund (NSSF), which will be a public self-financing establishment separate from a government ministry. It will be governed by a Board, with tri-partite representation. As currently planned, the Board members representing government will include the Ministry of Health.

This is an important development step for Cambodia and will allow for risk pooling across worker populations, at least for occupational accidents and diseases. The Law

does not cover civil servants, but this sector, as well as other contingencies such as health care, can be covered through a sub-Decree.

The Social Security Law is a framework law and does not contain any details on contribution levels. However, the old age pension benefits will only be given to workers registered with the NSSF for 20 years. The inclusion of health care (for non-work related accidents and diseases) for both the worker and his/her dependents is therefore likely to add significant value to the system. Health care (for non-work related illness) is a short-term benefit that is likely to be used at least once a year by each insured person (worker or dependents). This is far more attractive than the prospect of paying contributions for a long-term benefit with a 20-year qualifying period.

The new Department of Social Security in MOSALVY is well aware of this approach and therefore keen to consider inclusion of health care. One possibility is to include all health care benefits (excluding cash payments as allowances or compensation) for both work-related and non-work-related health needs, in one benefit branch.

The Department of Social Security of MOLSALVY has very recently requested the support of the International Labour Organization (ILO) in accelerating implementation of the Law. The NSSF should be established in 2004, and the provision of benefits, beginning with the work injury programme, could begin in 2005. The inclusion of health care through a sub-Decree would not hold up this process and could be done within a short period. That could allow planning for the implementation of health insurance at the same time as the work injury programme.

Annex 1 of this Master Plan provides a draft proposal for the text of a sub-Decree to cover health care under the new Social Security Law.

2.4 MAJOR HEALTH ISSUES

As noted above, the health status of the Cambodian people is among the lowest in the region. The high maternal mortality rate and patterns of morbidity and mortality of children deserve particular attention.

Childhood mortality rates have increased over the past ten years. The increase is mainly with post-neonatal mortality, which has increased from 35 per 1,000 live births in 1990 to 58 in 2000, and at present, constitutes 61 % of IMR and 46% of U5MR. On the other hand, neonatal mortality has decreased steadily from 44 per 1,000 live births in 1990 to 37 per 1,000 live births in 2000. The major direct causes of morbidity and mortality among Cambodia's 1.6 million children are diarrhoeal diseases, acute respiratory infections (ARI) and vaccine-preventable diseases, particularly measles. Together these three causes are estimated to account for over half of under-five deaths in the country. The prevalence of ARI is high but less than 40% of children are taken to appropriate health providers. In limited geographic areas, dengue fever and malaria are significant additional causes of child morbidity and mortality. Improper infant feeding practices also contribute to high mortality rates. Severe malnutrition compounds the effects of these

illnesses and further increases under-five mortality rates and malnutrition rates are highest in the rural populations, which include over 80% of children under five in Cambodia. Deficiencies in micronutrients, including vitamin A, iron and iodine, are widespread.

Coverage rates for basic child survival interventions are relatively low. Although 67% of children are still being breastfed at six to eight months, the rate of exclusive breastfeeding at three months is very low, at 16%. Vaccine coverage at the age of one year was estimated in 2000 to be 71% for BCG, 49% for DPT3, 52% for polio, and 55% for measles. Only 40% of children had received all vaccines, and this ranged from a high of 61% in Phnom Penh to as low as 14% in isolated provinces.

The introduction of social health insurance should address the serious problems in maternal and child health, particularly in safe pregnancies and deliveries, infant and young child feeding and nutrition, diarrhoea and acute respiratory infections, and immunization coverage. Social health insurance essentially should allow access to health care without financial barriers. However, the planned allocation of health insurance revenues could be designed to address specific health problems, including investment at the community level.

2.5 HEALTH SYSTEM ISSUES

2.5.1 Health care delivery system

Within the health sector reform carried out in Cambodia, a Health Coverage Plan (HCP) was launched in 1996, dividing the country into 73 operational districts (ODs) in Cambodia's 24 provinces. Each OD covers a population of 100-200 000 and includes a referral hospital and 10-20 health centres with catchment areas of approximately 10 000. Health centres are expected to deliver a Minimum Package of Activities (MPA) that includes basic curative, preventive and promotional services provided both in the facility and through outreach. A manual on provision of the MPA was developed in Khmer in 1997 and distributed to Health Centres, while District Hospitals have been given a manual on the complementary package (CPA).

To date, about 60% of the HCP has been implemented. Sixty-seven referral hospitals have been established, 30% of which offer basic surgical services. Seventy-three percent (628) of the 929 health centres created by the HCP have been either newly constructed or renovated and are currently equipped to provide the MPA. Various forms of contracting-in and contracting-out have been applied, to improve the level of management and health care delivery. The implementation of the HCP in a district is therefore likely to contribute towards the success of establishment of a health insurance scheme.

2.5.1 Human resources

While significant improvement has been achieved in the public health care delivery system, several factors related to the health workers staffing these facilities constitute a major hazard in the development of social health insurance. These factors are:

- Very low salary levels, leading to preference to work in areas with opportunities to increase income from other sources;
- Imbalances in deployment, with some overstaffing in urban areas and severe understaffing in remote rural areas;
- Inadequate skills levels, as most health centres are staffed by primary and secondary nurses and in some cases, midwives, with very low availability of medical assistants and medical doctors;
- Lack of continued education opportunities;
- Lack of outreach to the community health centres by higher level professionals;
- For the health workers in health centres, isolation and lack of supervision of higher level professionals and
- Weak management capacity.

These factors are interlinked, and strongly related to the quality of care provided. If the ability to generate additional income from patients is taken away, motivation of these staff may decrease further. For the insured patient, regular prepayment into a social insurance scheme essentially would eliminate the need for direct additional payment to the provider. Unless each health worker involved sees the immediate financial benefit of this financing mechanism, he/she is unlikely to contribute towards its success or even acceptance. Patients may be given minimal care, in an unfriendly atmosphere. Social health insurance also requires some limitation of benefits, as for example, the limitation to drugs on an appropriate essential drug list. Health workers' hostility to the health insurance scheme can lead them to discredit the quality of the benefits and attempt to push patients to purchase services outside of these benefits.

The design of social health insurance has to deal with these factors. The requirements may be difficult but will probably be necessary to implement both compulsory and voluntary social health insurance on any significant and sustainable scale.

2.5.2 Private health sector

The demand for formal and informal private care may be due to a combination of factors: high expectations for a fast "cure" from the public health system which are not realized, and pressure from the private sector seeking additional income outside the public health system. An additional factor is the credit regarding payment for health services given by private providers. The current user charge system in public health centres and hospitals does not enable any credit.

It is difficult to quantify the growth of the private health care sector in Cambodia. This sector includes a wide range of health professionals, many of them government health

workers, doing private practice to supplement their income. There are no registration or licensing requirements for such private practice. Private clinics are opening in increasing numbers in the capital and in provincial towns, and again there are no licensing requirements. Some of these clinics have a small number of beds, and some even carry out surgery. Many are owned and operated by senior level health professionals working in the public sector.

The new term of "autonomous hospital" is still not well defined. The largest facility in this category is the Calmette Hospital in Phnom Penh, initially built and equipped with funds from France. This hospital is on the one hand a public hospital, and non-paying or indigent patients occupy about 40% of its 286 beds. The Ministry of Health pays a flat amount of $26 per admission for the non-paying patients. Together with the revenue from paying patients, the hospital is able to meet its operating expenditures. Health worker earnings are much higher than in government tertiary care hospitals, such as the provincial hospitals. The relatively high incomes of the health professionals are derived from salaries and are not directly dependent on the volume of services, as is the case in the provincial hospitals. The fees in Calmette Hospital are relatively high for Cambodia, such as $200 for a surgical procedure (excluding drugs, laboratory, x-ray and room and board charges). However, Calmette Hospital permits discounted fees for patients who cannot afford the posted fee.

It is also difficult to predict the growth of the private health sector in the near future. To address the problems of inadequate staffing and low civil service salaries in public health centres, the Ministry of Health has been piloting a strategy in which private contractors manage the health services in selected ODs.

The implications for the development of health insurance are that this sector should be included as contracted providers, under the same conditions as public providers. These conditions include accreditation based on Ministry of Health standards, and the same provider payment mechanism covering the same health care benefits.

Given the overall lack of health care facilities in the urban areas, it would be preferable to integrate them into the insurance system rather than ignore them. The lack of cash in the Cambodian population to support a large private sector is likely to promote acceptance of the conditions, particularly if the non-medically necessary components (such as accommodation in single hospital rooms) can be covered by supplementary insurance or as permitted patient charges.

2.6 CULTURAL FACTORS

As expected, there is little knowledge of social security, health insurance or any other form of insurance in Cambodia. There are also few informal solidarity mechanisms within communities. The GRET experience demonstrated that an insured population understands the concept of prepayment guaranteeing access, and not involving payment at the time of illness or use of services. Insured persons do not seem to exert unnecessary demand for benefits, and the tendency for newly enrolled families to immediately seek

care for minor illness may reflect some testing of the system. They seek assurance that indeed their prepayment does mean that they will not be asked to pay at the time of use.

Current health behaviour and knowledge about health seem to be based more on expectations of rapid recovery from acute infectious diseases, rather than on demanding benefits because of prepayment. Patients who perceive that recovery is too slow tend to seek care outside the public health centre or hospital, rather than return to these facilities to demand additional services. Reference to a Health Centre Manual by the staff may not be appreciated as patients expect the attending staff to know what to do just by observation. There is little understanding of the etiology of disease, particularly chronic conditions. Slow or no progress in the patient's condition may be attributed to external forces in this highly superstitious environment, and the advice of traditional healers is frequently sought. Patients equate multiple drugs with good care, and intravenous administration of the drugs is considered particularly effective. On the other hand, there is no assurance of good compliance with recommended drug regimens.

A more complex issue is the current lack of trust in government services and structures. It is reported that most people, including managers of private enterprises, are more likely to support regular contributions for future benefits to a fund that is outside the government framework rather than to a government institution. This has implications for the administrative structures and fund holding agencies in the development of social health insurance, both compulsory and mandatory.

The lack of trust or confidence is not limited to government institutions. Cambodians are reluctant to deposit money in the bank, and the banking sector is indeed poorly developed. Social health insurance schemes will therefore need a credible administrative structure and a period of confidence building.

2.7 MOTOR VEHICLE ACCIDENTS

The treatment and rehabilitation of injuries caused by motor vehicle accidents are typically not covered by social health insurance. In most countries, the costs of such care may be covered by motor vehicle insurance. Motor vehicle accident injuries, however, can be a major reason for health care utilization. In the absence of such insurance and in new social health insurance schemes, the newly insured population expects to be covered for this contingency while the costs can be a considerable burden on the new scheme.

Studies on road accidents in Cambodia indicate that the rate of accidents and injuries is rising rapidly. Paradoxically, the increase comes with improvement in roads and economic growth, as more vehicles are purchased and new roads encourage higher speed. According to data on road accidents taken from the Cambodia Demographic Survey of 2001, motor vehicle accidents accounted for 39,954 or 36% of all 111,308 reported in 2001. Of these, 29,179 accidents (73%) occurred in rural areas and 6814 (17%) in urban areas.

The data on the numbers of injuries and deaths due to traffic accidents are probably underestimated, as reporting in Phnom Penh and the provinces is generally poor. The data from the Ministry of Public Works and Land Transport reported only 5194 road traffic injuries and 459 fatalities in 2001. National Health Statistics for 2001 reported 15,369 hospital in-patient admissions due to traffic accidents. This too may represent under-reporting of the cause of admission.

There are two important issues of relevance to health insurance development: First, the number of traffic injuries on Cambodia's roads is increasing at an alarming rate. Second, there is no alternative financing arrangement to cover traffic accident injuries of drivers, passengers or pedestrians. Compulsory motor vehicle insurance applies only to 4-wheel vehicles, and has recently been extended to 2-wheel vehicles used for commercial purposes. Compliance is low even with the 4-wheel vehicles. More importantly, the insurance currently does not cover bodily injury of vehicle drivers, passengers or pedestrians. Commuting accidents are covered through the work injury insurance purchased by private companies. Motorcycle injuries are covered only if the injured driver wore a helmet.

Despite the growing commercial insurance industry in Cambodia, it is unlikely that compulsory insurance including medical care will be extended to all types of vehicles in the coming several years. Insurance expenditure in Cambodia for all types of non-life insurance was $ 0.20 per capita in 2002. In neighbouring Viet Nam, this expenditure was $ 2.00 per capita.

The implications for social health insurance in Cambodia are that the schemes should cover traffic accident injuries, at least till alternatives can be developed through the commercial insurance sector. Financing should not be dependent only on social health insurance contributions, but also on a special fund, which can be created for the purpose.

2.8 TRANSPORT

The cost of transport and other indirect costs of hospitalization constitute barriers to in-patient admission. Patients referred to hospital from the village may be asked to pay as much as R 50,000 for transportation by motor-wagon to the district hospital. Transportation for regular passengers or goods on the same vehicle may cost R 5,000 for the same distance. Transport costs are indeed recognized as an additional financial barrier to seeking care, particularly for rural villagers referred to district and provincial hospitals. During evaluation of the GRET experience, health centre personnel reported that insured persons were more likely to carry out referral for hospital care, as they were not faced with the unpredictable and high costs of care in the referral hospital.

The implications for social health insurance are that transport may need to be included in the benefits of the new health insurance schemes in selected areas. The inclusion of such benefits will need to avoid methods requiring reimbursement to patients but attempt to find ways to contract with transport providers.

3. RECOMMENDATIONS FOR THE DEVELOPMENT OF SOCIAL HEALTH INSURANCE IN CAMBODIA

3.1 OBJECTIVES OF SOCIAL HEALTH INSURANCE IN CAMBODIA

It is essential to recognize multiple objectives in the establishment of social health insurance in Cambodia. This method can serve to bring additional financing to the health care system, through fair and affordable contributions from families. It can thereby provide social protection and reduce the risk of poverty due to high and unpredictable costs of health care. At the same time, good social health insurance design can channel the additional revenues in a manner that encourages the insured population to seek care at an early stage, and reduce the use of unnecessary health services and products. Good design with a stable flow of funds into the health care facilities can improve the quality of health care and enable the delivery of appropriate care to meet changing needs. Furthermore, the inclusion of preventive health care in social health insurance benefits, including those that serve populations and not only individuals, can make a significant contribution to the prevention of disease and disability and to the promotion of health.

The objectives of social health insurance in Cambodia can therefore be summarized as:

- **STABLE FINANCING MECHANISM**
  Predictable revenues from defined contributions at insurance scheme and accredited provider levels

- **PROMOTION OF EQUITY**
  Equity in access to health care for all population sectors, through the extension of health insurance through contributory mechanisms in which payment is based on means and use is based on need for those can contribute and social assistance for populations that cannot contribute themselves.

- **RATIONAL HOUSEHOLD EXPENDITURE ON HEALTH CARE**
  Affordable regular prepayment rather than unpredictable payments at time of illness, with coverage of all family members in their own right.
  Prevent poverty due to payment for health care
  Change in health seeking behaviour to encourage early consultation and examination and increased use of prevention and health promotion services.

- **IMPROVEMENT IN THE HEALTH SYSTEM**
  Efficient administration allowing for identification of all insured persons, contribution collection and the utilization of benefits.
  Provider payment systems that allow effective planning of services to meet the current and changing needs of the insured populations
  Improvement in the quality of care through quality assurance programmes
  Building of confidence in the formal health care delivery system
  Increased patient and provider satisfaction

3.2 TARGET SOCIAL HEALTH INSURANCE COVERAGE

The target of the proposed social health insurance policy should be to reach universal coverage within a reasonable period. This period may be between 8 to 10 years, depending on the growth of the economy and the formal labour sector, as well as the development of national and local institutions to manage social health insurance. The development approach should be pluralistic through the establishment of different types of schemes for the different population sectors:

For Cambodia, this pluralistic approach would include:

- Compulsory social health insurance through the social security framework for the public and private salaried sector workers and their dependents. Social health insurance for this sector may be supplemented but not replaced by private (for-profit) commercial health insurance for enterprises or individuals who wish to purchase supplementary insurance for non-medically essential benefits.

- Voluntary insurance through the development of community based health insurance (CBHI) schemes sponsored by different development partners, national non-government organizations in the initial stage and health care providers for non-salaried workers' families that can contribute on a regular basis. Social health insurance for this population sector should include all family members registered in the Cambodian Family Book.

- Social assistance through the use of equity funds and later government funds to purchase health insurance for non-economically active and indigent populations.

All CBHI schemes should be accredited, regardless of sponsorship, to enable the creation of a network of schemes following the same core principles, and allow for eventual merging of schemes to increase risk pooling and enable portability between schemes.

The compulsory and voluntary schemes should be developed in parallel, with maximum similarity in design, particularly regarding benefits and provider payments systems. Public sector health workers and their dependents could be encourage to seek membership in the CBHI is their area, on a voluntary basis, until the social security schemes covers civil servants.

The major differences between compulsory and voluntary schemes will be the type and level of contribution, management of the schemes and priority regarding extension of coverage. The similarities should facilitate the eventual merger of schemes towards broader pooling among population sectors in the social security and community framework to cover the entire population, first at district, provincial and eventually national level. During the period of extension of coverage, the formal salaried labour sector is expected to grow, while a significant part of the informal sector should shift to a formal self-employed sector with registered businesses. Mandatory social health insurance could then be considered for all population sectors.

3.3 STAGES TO REACH UNIVERSAL COVERAGE

Table 3: Activities and timeframe to cover the population sectors

Population Sector	Mechanism/ Activity	2004	2005	2006-8	2009-12
Compulsory Scheme for Formal labour sector	Inclusion of health care as a benefit in Social Security Law Inclusion of public sector workers	Set up NSSF	Launch/ Provide benefits in Phnom Penh	Launch/ Provide benefits in 3 Provinces Enrol retired workers	Extend to rest of country.
Voluntary CBHI Schemes	Expansion of existing schemes New schemes through accreditation process Enrolment of public sector health workers in CBHI schemes	Expand GRET schemes Begin urban scheme Begin 2 GTZ schemes Begin 2 other NGO schemes	Expand GRET Schemes, Include urban area. Expand CBHI Schemes	Reach 80% coverage in 5 – 10 districts Reach 50% coverage in 1 -2 Provinces	Merge schemes at district level, then provincial level
INDIGENT AND NON-ECONOMICALLY ACTIVE POPULATION	Collaboration with Equity Funds	Begin 1 -2 schemes using Equity Fund to subsidize all families in Community Begin 1 -2 schemes using Equity Fund to purchase HI cards for vulnerable families	Expand use of Equity Funds for social health insurance according to experience	Begin Shift from Equity Funds to government funding for health insurance for the indigent populations	Legislate government funding through legislation to fund health insurance for indigent population
Universal coverage	Assure uniform design, through network, plan for eventual merging of schemes	Monitor, Adapt, Begin network regulations	Monitor, Expand network	Draft legislation for compulsory Universal coverage	Legislation

4. RECOMMENDATIONS TO DEAL WITH OPTIMAL DESIGN

4.1 BENEFITS

It is recommended that social health insurance schemes offer a comprehensive range of health care benefits, including primary health care in the community and hospital based outpatient and inpatient care. This approach is recommended rather than the defining a "minimum benefit package". Care may be limited to those services available in the Province, that is, referral to central or national level services would be excluded in the initial stage and included in a later stage. Health care benefits should be the same for the salaried labour sector and dependents, covered by the National Social Security Fund, and for the populations covered by the CBHI schemes.

The health care benefits should cover preventive, curative and rehabilitative services. While the preventive services covered by health insurance will generally be personal rather than public health services, health insurance revenues should be available for campaigns aimed at the control and early detection of disease as well as health promotion, through education or other means, to the benefit of both insured and non-insured persons in the target population.

Prescribed drugs should be limited to those on the national Essential Drug List of the Ministry of Health, at health centre and hospital levels. A mechanism for the inclusion of new drugs and diagnostic services as health insurance benefits should be set up, with annual renewal by the Health Insurance Policy and Implementation Unit in the Ministry of Health with the Medical Division of the NSSF.

Home care should be included, to prevent extended hospital care for patients requiring mainly nursing services. This should not include long-term rehabilitative care, which may need to be funded through an additional insurance contribution at a later stage.

It is strongly advised that areas that are typically excluded, such as diagnosis and treatment of mental health conditions and sexually transmitted infections should be covered. The prevention, diagnosis and treatment of HIV/AIDS and tuberculosis are now covered through Ministry of Health. However, care should be taken to assure benefits for other conditions for insured persons. To avoid duplication as well as gaps in services, funding from specific malaria, tuberculosis and HIV/AIDS and other relevant funded disease programmes, including reproductive health, could be channelled to the provider level, to complement the comprehensive provision of necessary care. For example, if funds are available for home care for HIV/AIDS patients, these funds should be channelled to covered insured patients as well as non-insured. This applies to immunization services for children, which are currently funded by the Ministry of Health and development partners.

The collaboration between the social health insurance and the disease programmes funded by other sources is essential to ensure that social health insurance does not replace government funding but supplements it.

At this stage, it is recommended that the treatment of injuries caused by all accidents be covered. At a later stage, when appropriate motor vehicle insurance is developed, the coverage of motor vehicle or traffic accidents may be reconsidered.

The coverage of dental care should be deferred to a later stage, after more information is available on the supply of qualified dental practitioners and equipment.

In addition to health care benefits, specific cash benefits should be included, according to local conditions:

- Payment for transport to referral hospital, preferably to be paid directly to the provider of transport, at set tariffs arranged by contract.
- Cash maternity benefit on completion of a Safe Motherhood Protocol.
- Cash funeral grant in CBHI schemes, in the event of death of an insured person.

The above benefits should not be limited according to the volume or cost of health care required or used by an individual insured person or household. Time limitations may be imposed, such as a maximum of 45 days of inpatient hospital care in one year.

The benefits are summarized in the Table below:

Table 4: Social Health Insurance Benefits

MEDICAL CARE:

Consultations, examinations, procedures
Preventive - Curative – Rehabilitation services
Diagnostic - therapeutic services
Primary, secondary, tertiary level services
Local, district and provincial levels - National level after 2-3 years
Ambulatory, inpatient hospital care and home care

PHARMACEUTICAL DRUGS AND SUPPLIES:

Prescription drugs on Essential Drug List adapted for SHI
Traditional medicines
Blood and blood products
Medical supplies (e.g., syringes, X-ray film)

DENTAL CARE:

Preventive care, Fillings and extractions, prostheses – at a later stage

CASH BENEFITS

As benefits for specific contingencies: maternity, funeral grant
As payment for transport services to referral hospital

4.2 CONTRIBUTIONS

Percentage of salary for the compulsory formal labour sector scheme:

For the formal salaried workers to be covered by a compulsory national social security system, the monthly contribution should be a percentage of salary, to be shared by employer and salaried employee (with employer contributing at least 50%). The actual rate, the contribution base and ceiling will need to be determined in consideration of prevailing wage conditions. While the sharing between employer and employee should be defined in the Law, the actual contribution rate should be included in the Regulations. The Law will also need to define the process to change the contribution rate and avoid frequent changes. This approach would be in conformity with the recently passed Social Security Law regarding work injuries and pensions.

For civil servants, it may be necessary to increase salaries to compensate for any deduction of social health insurance contribution from the low wages. This would be preferable to funding by employer (government) only, as it is important to introduce the contributory element into health care financing for civil servants.

Flat rate contributions for the voluntary CBHI schemes:

For the population that could be covered by voluntary insurance, through expanded and new micro or CBHI schemes, a flat rate contribution amount is recommended. The amount should optimally be about 4% of family income, with the same amount for all households in the same scheme. That is, assessment of individual household income in the non-salaried labour sector should not be attempted in order to set the CBHI scheme contribution level. In addition, large families should not be discouraged from membership. The following recommendations apply to contributions for CBHI schemes:

- The amount set should be affordable for the majority of the population
- Contributions should be made for households, including all family members in the Cambodia Family Book.
- Discounts should be given for households with a large number of members (above 7 persons). The shortfall in revenues due to these discounts could be covered by the contingency payment.
- Alternatively, flat rate amounts can be set for 3 – 4 levels of family size: single, standard family of up to 6 persons, large family of 6 persons and very large family with over 8 members.
- Advance contribution payments covering 3 months should be applied for the first two years (or until adequate monthly collection mechanisms can be developed).
- Increases in contribution level should be limited to not more than one change in 2 – 3 years, unless benefits are added to justify the changes.
- Compliance with contribution payment should reach 85% in the first year and 95% by the end of the second year.

Registration and Contribution collection mechanisms

It is strongly recommended that enrolment in CBHI schemes be made possible throughout the year. The monthly or continuous enrolment facility could be located in the contracted health centre or in the home of a Management Committee representative and may vary by CBHI scheme. Remittance of the cash contribution revenues to the CBHI Office should be possible immediately (within one day). Where feasible, existing microfinance institutions could be contracted to carry out the registration and contribution collection tasks, for a small fee.

A possible facilitator in contribution collection in the future could be the micro-finance institutions developed in the recent years. These include the existing EMT developed by GRET and the ACLEDA now well established in many parts of the country. These institutions have useful experience in registration, collection contribution and banking of cash collected from households, through credit agents reaching villagers.

Each CBHI will need to examine the opportunities for contribution collection. The facilities for payment or deposit of cash through existing mechanisms are extremely limited in rural Cambodia. Even in provincial and district towns, there are very few banks. Suppliers of utilities such as electricity collect money in cash from clients, not necessarily on a regular basis. There do not appear to be any existing commercial or public services that could collect health insurance contributions on a regular basis.

Co-payments

It is strongly recommended that the compulsory and voluntary schemes do not apply co-payments at the time of use. Every effort should be made to demonstrate that prepayment does indeed cover the costs of care at the time of use.

Payments for services or conditions outside the list of benefits and categorized as not medically necessary may be requested by the provider. Typically, such services will only be available in provincial hospitals and may include items related to "private" accommodation. These conditions, and the list of services for which payment may be requested need to be clearly presented to the insured populations, or members of CBHI schemes.

4.3 PROVIDER PAYMEMT

It is recommended that capitation be used as the provider payment mechanism, to the extent possible, and for all services included as health insurance benefits at the primary and secondary care levels. The referral hospital may sub-contract with a provincial hospital for tertiary care needs. There are advantages in this method for all the partners in social health insurance schemes:

- For the scheme itself, capitation means predictable expenditures on benefits (the major part of the budget). Administration is simple, as the payments to providers are

made at regular intervals, based on and corrected for the number of individuals enrolled in the scheme for the period of payment covered. This is particularly important when administrative capacity to control costs is limited. While there is no claims review to support payment, there is still a need for utilization review to support negotiations regarding changes in the capitation amount.

- For the provider, capitation means predictable revenue, which facilitates planning of budgets and better resource allocation. Administration is simple with regular transfers between the fund and the provider. Patients need to show proof of entitlement to health insurance benefits rather than availability of cash to pay for care.

- For the insured population, capitation means that there is no need for an initial outlay of funds in the case of reimbursement by the scheme, or verification of utilization as may be needed in schemes where providers directly bill the insurance fund. Although there is no real opportunity for choice of health care provider (health centre and referral hospital), capitation can create some dependency on patient satisfaction. All schemes need to convey to the insured population that it is important for them to express satisfaction and report dissatisfaction. It is essential that providers know that satisfaction with their services is monitored, according to indicators acceptable to all the parties.

The disadvantages of capitation are recognized. Particularly after a period with user charges, the providers may seek to preserve capitation revenues by under-serving patients, that is, they may try to limit services to insured patients. It is perhaps not a major threat, as user charges in Cambodia are now lower than current costs, and the capitation amount should be higher than expected through user charges for the same population.

However, the possibility of under-use always exists if providers feel they will not be financially rewarded for giving more services. Actual use of major procedures and services should therefore be monitored by a simple quality assurance system, based on a simple information system and procedures for review. The cost of processing this information can be considered minor compared to the potential risk of uncontrolled expenditure in a fee-for-service or even case payment system, in which providers can generate demand for unnecessary services. The cost of a quality assurance programme to monitor utilization will certainly be less costly than a claims utilization review for each contact, with several items of service.

In the absence of adequate data on past utilization (that is, at an acceptable level reflecting that health care needs are met on time), it is suggested that the capitation amount be based on expected utilization levels and cost estimates that the providers recognize. The list of benefits included under capitation at each provider level will be defined. In addition, a list of services and procedures that are not covered by capitation will be defined and updated regularly.

Optimally, the capitation amount for all the insured population should be channelled through the OD level. The OD level should then allocate the appropriate amounts to the health centres and hospital. This should facilitate better planning, and use of the revenues for items, such as adequate supplies of drugs and medical equipment, that may require substantial amounts. The Ministry of Health may need to be consulted regarding the current internal allocation of health insurance revenues within each facility: 50% for recurrent costs, 49% for salaries and 1% for the Ministry of Health. This allocation could be maintained, but spending on an annual rather than monthly base would be more efficient.

4.4 ALLOCATION OF HEALTH INSURANCE REVENUES

The allocation of health insurance revenues should facilitate the provision of the health care benefits with improved quality, attention to special health and health system issues, and a reasonable level of reserves. Administrative costs should be kept to a minimum, but expenditures for information systems and training should be budgeted. In the initial set-up stage, part of the administrative costs, including investment in information systems and training, may be funded from other sources.

The table below is a proposal for an allocation formula for the budgeting of health insurance revenues in CBHI schemes. The proposal does not include any allocation for the purchase, rent and maintenance of property to manage the CBHI schemes. The actual allocation will depend too on local conditions, such as the need to include transport and home care in the health care benefits.

Table 5: Allocation of health insurance revenues

Health insurance benefits		**77.0 %**
Primary health care (including health centre and home care)	45.0%	
Secondary level hospital care (including outreach to health centres)	17.0%	
Tertiary level hospital care	10.0%	
Transport	2.5%	
Cash benefits (funeral grant, maternity grant)	2.5%	
Management Functions		**23.0%**
Administration (including information system)	8.0 %	
Training	2.0%	
CBHI Scheme Promotion	1.5 %	
Public benefits fund	2.5 %	
Contingency fund	4.0 %	
Non compliance allowance	5.0 %	
Total:		**100.0 %**

At a later stage and depending on the steady expansion of the schemes, an allocation of 1% of contribution revenues to support the CBHI Network activities could be considered. This may be at the done when the needs for expenditure on public benefits and promotion decrease.

The above allocation includes several components that need further detail:

- Administration – should include all the registration or enrolment procedures, collection of contributions, contracting with providers, information system tasks, organization of promotion activities and follow-up of utilization, and remuneration of CBHI scheme staff at all levels. The costs will include printing of all materials (cards, forms), staff transport and communications.

- Training:
  - Training of CBHI staff in all aspects of operation (about 0.5%)
  - Training of community leaders and agents (about 0.5%)
  - Training of health worker staff in selected areas, including the use of protocols for diagnosis and treatment, information on new technologies, new health problems and training on procurement and maintenance in the health care facility (about 1%).

- Promotion:
  - Development and updating of a brochure detailing the contributions, benefits, enrolment procedures and entitlement to benefits to be handed out to the target population
  - Development of posters, providing directions for enrolment
  - Development of audio-visual material for display at relevant sites
  - Health insurance events at the village level including talks on relevant health issues, stories of insured individuals who benefited from membership, health insurance scheme enrolment conditions
  - Development of materials on rational health seeking behaviour, importance of adherence to diagnosis and treatment protocols by health centre staff, and rational drug prescribing, particularly regarding use of anti-biotics, injections and intravenous fluids.
  - Prominent placing of the CBHI logo in contracted health centres and hospitals, indicating affiliation.

- Public benefits
  - Facilities to store drugs purchased in bulk
  - Facilities, equipment for patient comfort
  - Facilities for health worker comfort
  - Health events for the community, with IEC components
  - Health components for schools with significant coverage

Decisions on which public benefits to provide should be made with input from the community and provider representatives in each location. The benefits, which should

have high visibility as provided by the CBHI scheme, could include components that are only available for insured persons and others which benefit the entire community. Preference should be stressed for the use of the funds for prevention of disease and health promotion. The use of health insurance contributions for public goods in other countries was successful in stimulating enrolment. These may include, for example, improved waiting areas in outpatient departments of contracted hospitals, and fans and washrooms in patient wards. The funds could also be used to improve water supply and sanitation in populations in which the major proportion of morbidity is attributable to the lack of such facilities. In all cases, these "public benefits" should be clearly marked as contributions from the social health insurance fund.

The use of health insurance funds for such public benefits may also help to acquire matching funds from government, local NGOs and from development partners. For example, if the priority and community agreement is to use public benefit money for safe water and latrines in the target population, the appropriate development partner could be approached. If the decision is to use the funds for a waiting area for families of hospital inpatients with adequate cooking and toilet facilities, local government could be requested to add funding. The type of activities will very much depend on local initiatives and the ability to define priorities and reach consensus. Public benefits should generate community pride through shared contributions to improve health.

4.5 ADMINISTRATIVE STRUCTURES

Compulsory formal labour sector scheme

As stated in the Social Security Law, the National Social Security Fund (NSSF) will be the administrative structure responsible for the formal sector. The health insurance branch will need a separate technical division, at central and provincial level, as the NSSF develops to cover all active and retired workers and their dependents. The Health Care Division should be supervised by a Medical Board, at the level of Technical Council in the NSSF Board. The Medical Board will need representatives of the Ministry of Health, providers of health care and insured persons.

The Ministry of Health should retain responsibility for overall health insurance policy, which includes the setting of priorities regarding extension of coverage, contracting with private sector health care providers, and the extension or introduction of new benefits. There are certain basic conditions which should ensure harmony and a constructive relationship between the NSSF and the Ministry of Health and other government agencies involved in the policy, establishment and monitoring of social health insurance. These include:

- Financial separation of the social health insurance from government budgets, to ensure that contributions are used only for health care benefits and administration of the scheme and not for the direct support of Ministry of Health functions;

- Creation of a strong policy-making body in the Ministry of Health or relevant government agency to ensure adherence to the continued objectives of the social insurance scheme, changes to deal with new needs and immunity to current political issues in achieving health care goals;
- Strong control functions in both organizations
- Professionalism at operational level, and avoidance of political appointees to senior health insurance scheme positions.

From the viewpoint of the contributing partners, the employers and workers, it is important that the independent and transparent nature of the NSSF be maintained at all levels, and that the NSSF not be seen as another government institution. The Regulations of the Social Security Law need to assure complete separation of the contribution revenues by benefit branch at all levels. Given the overall prevailing lack of trust in "public funds", it will be particularly important to assure that health care contributions will not be used for other contingencies. Since the pension benefits require 20 years of registration with the NSSF, there is no immediate danger than health care revenues would be borrowed to fund pensions. The merging of contributions for both work-related and non-work-related health care could also help avoid any perception of misuse of funds.

However, the main issues to be conveyed to the insured population are that:

- The NSSF, including the Health Care Division, does not have an exaggerated budget for administration.
- Health insurance contributions are indeed used only for health care benefits, with visible improvements in the quality of care and the range of benefits
- Health care reserves cannot be borrowed by external agencies, including government agencies.
- All insured persons are able to express their satisfaction and dissatisfaction with the health insurance system, with regard to all aspects of operations, registration by employers, deduction of contributions from salary and the provision of benefits.

Voluntary CBHI Schemes

In the case of voluntary health insurance schemes, the administrative structure may vary in the different schemes. The CBHI may be set up and managed by a defined community organization, international or nation al NGO, cooperative or associations of individuals with a common affiliation. An example of such an association would be an association of market vendors in an urban area. A public provider institution as manager and fund holder is not recommended at this stage. There may also be other options, linked to the initiators or sponsors of the scheme. Whatever management structure is chosen, it must have the following components:

- Registration as a legal entity according to national legislative requirements (NGO, cooperative or non-profit enterprise) conforming to regulations of the Ministry of Interior and Ministry of Economy and Finance.

- Supervision by a CBHI Management Committee, with representatives of the insured members and contracted providers.
- Accreditation and affiliation with the network of CBHI schemes
- Reporting of quarterly and annual reports to the network of CBHI schemes
- Acceptance of all households in the target population that apply for membership, without rejection of households or individual members due to existing health conditions.

The tasks involved in setting up and maintaining a CBHI scheme are complex and will require technical assistance. These major tasks include:

- Tasks to promote the concept and reach acceptance among the target population, through Focus Groups Discussions with community members, and health workers in the facilities in the area.
- Tasks to establish administrative capacity (registration procedures, contribution collection, development of information systems, structure and staffing of the health insurance administration).
- Tasks to establish financial capacity and control including remittance of contributions and banking of funds.
- Tasks to enable the provision of health care benefits (including negotiations with providers and finalizing contractual agreements).

At this point, it is suggested that new schemes be established as pilots if a minimum of 100 families demonstrate interest and willingness to register. It is too early to set minimum and maximum CBHI size levels, as the financial and managerial viability of the schemes will depend more on sound administration and steady support by a sponsor (development partner) over the first 3 to 5 years than on the number of enrolled families. During that time, financial and managerial independence should be achieved. CBHI schemes may also be expected and encouraged to merge, to enable broader risk pooling.

4.6 USE OF EQUITY FUNDS

A major objective of social health insurance in Cambodia is to reduce poverty caused by paying for health care, and to prevent already vulnerable rural families from falling into deeper poverty when facing health problems. Under current conditions, the non-economically and very low-income population indeed cannot maintain membership in the CBHI schemes.

It is proposed that collaboration between the Ministry of Health and the development partners enable use of the planned Equity Funds to serve as the social assistance funds to purchase health insurance cards for the vulnerable populations that cannot regularly pay all or part of the regular contribution from household income.

The use of the Equity Funds would cover the poorest populations through the same prepayment mechanism as contributing families, and thereby facilitate equity in access to

health care. The cards of contributing and non-contributing CBHI membership would be the same, so that social stigma of poverty can be avoided. Through membership in the CBHI, provider payment for the poor would be the same as for all insured persons, that is, through capitation. Such partnership would also enhance the Equity fund's cost-efficiency by reducing the cost of the care for the poorest through fee-for-service billing. Furthermore, the Equity Fund could reduce its operational expenses, as it would not need to review claims and pay providers. The administrative costs, including identification of the poorest families, inspection and claims processing, can reach up to 40% of the amount available for disbursement through the Equity Fund. Cash transactions in the management of the Equity Fund at local level would also be minimized

Equity Funds could be used in two ways, in conjunction with social health insurance:

a) In communities in which less than 25% of the population have incomes below the poverty line:
   The Equity Fund could be used to purchase health insurance cards for the identified poorest families, at the same contribution level as other households enrolled in the CBHI scheme.

b) In communities in which around 50% of the population have incomes below the poverty line:
   The Equity Fund could be used to subsidize all households, without prior identification of the poorest, through a uniform subsidy, which will be reduced and replaced by household contribution over a period of five years. That is, the contribution burden would be shared, with an increasing share for the households over time and as household income increases.

At the risk of subsidizing a very small number of "wealthy" households in the community, the second method proposed is preferred. It would stimulate a significant level of participation in the CBHI scheme, with minimal administrative costs to the Equity Fund. It would prevent "competition" among households to be identified as poorest and would allow introduction of reasonable cost-sharing by even the very lowest income households. A proposal for the sharing is given in Table 6 below. This method may also be more practical as Equity Funds are likely to be applied first in communities with a significant proportion of very poor households.

Table 6: Contribution subsidization through Equity Funds:
Percent of contribution to be covered by each partner

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Household	20	30	40	60	80	100
Equity Fund	80	70	60	40	20	0

4.7 UNIFORMITY OF CBHI DESIGN

To the extent possible, there should be uniformity in social health insurance design for all population sectors. This is particularly important in the voluntary community schemes, which should all be part of a network of community schemes. To ensure and coordinate this uniformity in basic social CBHI schemes, a Health Insurance Policy and Implementing Unit should be established in the Ministry of Health, which may benefit from collaboration with GRET in the expansion of CBHI schemes. Some variation is encouraged to deal with specific issues in some locations, but basic principles should be strictly adhered to:

- Registration as a CBHI according to regulations on NGO, non-profit associations, cooperatives or enterprises.
- Participation in training coordinated by the Health Insurance Policy and Implementation Unit of the Ministry of Health.
- Contribution levels that are affordable for the majority of the population
- Coverage of all members of the household or family
- Ambulatory and hospital in-patient care benefits
- Equal benefits to all insured persons regardless of pre-existing or new chronic diseases or conditions.
- Regulations on qualifying periods to define entitlement to benefits according to the period of contribution payment and regulations on the cessation of entitlement when contribution payment is discontinued.
- Earmarked allocations for the use of contribution revenues, with provision for activities that will contribute to the improvement of the quality of care and control of major causes of morbidity in the insured population.
- Partnerships through contracts with local public health care facilities, including health centres and referral hospitals, through the local health authorities and relevant NGOs.
- Regular outreach by the contracted referral hospital to health centres
- Provider payment in advance and on a regular basis through capitation, except for defined services excluded from the list.
- Management Committee with composition adapted to local options
- Involvement of all stakeholders in the development, operation and adaptation
- A uniform information system covering registration and membership, contribution payment, the utilization of health care and cash benefits, and select health indicators.

The uniformity of CBHI schemes, with sound design, will also mean that re-insurance by external agencies should not be necessary. At a later stage, when each CBHI reaches financial stability and target population coverage, agreements regarding portability may be arranged between schemes. The umbrella organization itself may be financially supported by small allocations from the contribution revenues of each scheme. All these measures will contribute to eventually reaching universal coverage in a cohesive way.

4.8 INFORMATION SYSTEM REQUIREMENTS

The information system will be a crucial element in the development of social health insurance. The following does not represent a detailed plan but defines the minimum functions requiring regular information for management and quality assurance based on utilization review in a social health insurance scheme.

- Management of the membership data base
  - Enrolment and contribution payment
  - Tracking of continued membership
  - Family membership card with CBHI scheme identification, location (health centre, OD, Province)
  - Period of entitlement or validity

- Financial and management functions
  - Revenues from contributions
  - Revenues from other sources
  - Payments for management activities (printing, cards, utilities, transport, communications, etc)
  - Payment to providers
  - Payment for other activities, including promotion
  - Payment of cash benefits to insured persons
  - Payment to CBHI scheme staff

- Management of utilization information
  - Family folder at health facility enabling recording of health care benefits provided at the health centre level
  - Regular recording of referrals, admissions, transfers and discharges including reasons for referral/admission
  - Records of major outpatient and inpatient procedures
  - Records of duration of inpatient admissions and discharge status
  - Records of referrals and discharge reports from secondary and tertiary facilities
  - Discharge diagnosis according to ICD 10 at a later stage

- Management of high risk insured persons
  - Card recording prenatal and post-natal care of pregnant women
  - Card for insured with chronic/regular drug regimen, noting drugs and date of dispensing

In addition, it would be very useful to have some measurement of initial health status of the insured population. The possibility of using indicators and measurements that are simple to record at first and then periodically on annual enrolment could be considered. An option, which needs to be tested, is to record height and weight to reach body mass index (BMI) and skin fold. To assess the impact of health insurance, proxy indicators at

the health care provider level could be developed. These could include, for example, as the percent of surgical cases admitted as emergencies and as planned admissions.

To facilitate all the above, computerization at the local CBHI level should be considered. In the first stage, it is recommended that computers be introduced at the OD level and in contracted provincial hospitals, to assure information on admissions, transfers and discharges as noted above. When the insured population affiliated with a health centre reaches 2,000 members, and local conditions are favourable (regular supply of electricity, secure location to install and operate the equipment), computerization at health centre level should be considered.

4.9 RECOMMENDATIONS TO DEAL WITH SPECIAL PROBLEMS

Section 2 of this Master Plan covers the determinants of social health insurance and notes several risks, health and health system problems that may require special attention. Some of these issues may be dealt with by sound health insurance design and targeted allocation of health insurance revenues. However, other areas may require additional activities, collaboration with other health sector areas or collaboration with agencies outside the health sector. Such areas are covered in the following section.

4.9.1 HEALTH CARE DELIVERY SYSTEM

In the first stage of expansion of CBHI schemes, priority should be given to Operating Districts (OD) in which the Health Coverage Plan has already been implemented. Among these ODs, priority should be given to those in which Equity Funds can be used to complement health insurance, through the mechanisms proposed above.

In all areas, including Phnom Penh and Provincial Towns, and in both the compulsory and voluntary schemes, the referral hospital should be encouraged to have outreach programmes, with their doctors going to the health centres at least once a week. In addition to patient consultations, the doctor should engage in some training, possibly beginning with reviewing knowledge and use of the MPA Manual, and identifying shortcomings in knowledge and patient care.

The ODs should be should be represented in the Management Committee and encouraged to play a role in promoting health insurance, through various means. The OD could also assist in mobilizing additional funds for projects or programmes to complement the CBHI scheme activities, such as for Safe Motherhood or water and sanitation. The OD Director is likely to be better informed than the CBHI team regarding the availability of such programmes in the district.

When an accreditation system is applied, the OD will be responsible for reviewing standards in health centres to assess whether the facilities in the District meet the defined criteria. There should also be OD involvement in eventually seeking possibility to expand and merge CBHI schemes to reach broadest possible coverage in the District. For

all these reasons, the Director and senior staff of the OD, as well as all staff of the hospital and health centres, should receive the essential training on social health insurance and the establishing of CBHI in their district.

4.9.2 Health workers

The critical element to deal with the various problems related to health worker level and job satisfaction is to demonstrate that health insurance will increase income in a predictable and significant way. It also needs to be demonstrated that the amount of additional income that can come through health insurance revenues is directly related to the number of insured, and that improved quality of care and health worker attitude are key factors in attracting new members.

The non-remunerative aspects of CBHI schemes should also be stressed. Health workers should be appreciative of the fact that patients are likely to come at earlier stages of disease and show better compliance with drug regimens. In addition, they should have less accounting procedures to do and fewer arguments with patients regarding the payment of fees or qualification for exemptions.

The outreach programme should have some positive impact and reduce the feeling of isolation. At a later stage, when the number of insured households grows to around 250 families, there may be at least one hospitalized patient at any given time. The health centre staff should be encouraged to follow the patient and be involved in discharge in more complicated cases. An allocation for continued training could be considered for health centre staff when the insured population grows to 250 households, and to hospital staff when membership grows to 1,000 households.

If home care is introduced, for example in a population with a significant number of HIV/AIDS patients, a small incentive payment could be considered, as long as the health worker does not request additional payment from the patient.

4.9.3 Private health care providers

The Ministry of Health is concerned with quality assurance and criteria for the application of accreditation of both public health facilities. In the hope that such criteria will soon be available, and that an accreditation system can be put in place, the private health care providers should be encouraged to contract with both the compulsory social health insurance and the CBHI schemes. The benefits and capitation payment should be the same as for the public sector. The private sector is likely to obtain additional income from charges for non-medically essential services, particularly in urban areas.

Both the NSSF and the CBHI schemes should avoid contracts with very small private hospitals that offer only a limited range of services, even they are accredited by the Ministry of Health. It is too early to set the criteria, but in general, contracts should not be made with hospitals that have less than 50 beds and do not have separate services for

the four main clinical areas: internal medicine, surgery, paediatrics and obstetrics-gynaecology.

4.9.4 Private for-profit health insurance

The new Social Security Law fortunately applies to all employers and salaried workers, and does not exempt enterprises that have purchased private for-profit health insurance for all or some of their workers. The companies now selling private health insurance will not be put out of business as the major part of their revenue is from other insurance products. They should also retain the market for health insurance for foreigners residing in Cambodia. In the future, they may promote supplementary health insurance for those Cambodians in those companies, organizations and individuals who seek greater patient comfort than is usually available in the public hospitals.

4.9.5 Maternity Care

Social health insurance generally has a qualifying period for maternity benefits in order to avoid women joining only for the period of predicted use of services. The qualifying period may be 6 months contribution of the last 10 months, or 12 months contribution, which may be preferred for voluntary insurance.

In view of the very high maternal mortality rate in Cambodia, and the goal of increasing attended deliveries, it is suggested that the qualifying period be waived, that is, hospital delivery should be covered after three months contribution.

Furthermore, it is strongly recommended that the CBHI developed a Safe Motherhood programme in collaboration with the Reproductive Health programmes of the development partners (WHO, UNFPA) and the Ministry of Health. This could include the following elements:

- Protocol entitling women to all maternity services if they follow the protocol (including a minimum of 3 antenatal visits, recorded on a card issued to each insured pregnant woman, and referral of high risk pregnancies).
- Improvement of the current hospital facilities to absorb a higher number of consultations and hospital deliveries, with appropriate birthing conditions to satisfy cultural preferences
- Training of midwives and placement in health centres
- Provision of essential drugs, micronutrients and other products relevant to safe pregnancy.
- Provision of a maternity grant as an incentive for full participation in the protocol of the Safe Motherhood programme for insured families.

4.9.6. Motor vehicle accidents

In the initial stage of health insurance in Cambodia and until medical care can be included in motor vehicle insurance, such injuries should not be excluded from the health insurance schemes. It is suggested that the expenditures be covered by a special fund, which will cover the expenditure through direct payment to hospitals, on a no-fault basis. That is, the hospital will claim expenditures from the Special Traffic Accident Fund, and receive payment according to an agreed tariff for defined services.

This fund could be created by the addition of 5 - 10% to the annual Road Tax. Vehicle owners are now required to pay the tax to the Ministry of Public Works and Land Transport and compliance is reported to be better than for motor vehicle insurance. Minimal extra expenses would be required for the collection of the additional amount, but the collecting Ministry could retain a reasonable percentage of the amount collected for management. Decisions on the use of the Fund and tariffs would be the responsibility of a Board, including representatives of the Ministry of Health, the NSSF when established, the Department of Insurance of the Ministry of Economy and Finance and health care providers. A small fixed proportion of the Fund could be allocated for road safety, while the bulk of the Fund would be spent on covering costs of health care of accident victims. The Board could decide on the inclusion of specific services, such as rehabilitation.

The existing data on motor vehicle accidents as a reason for hospital care probably reflect underuse, as the current user fees may deter some injured persons from seeking care. If this recommendation is considered, it is recommended that a study be carried out through a rapid patient census, to determine the number and characteristics of patients receiving emergency room and inpatient care with motor vehicle accidents as the reason for admission. Findings from such a study could assist in determining the optimal percentage to be added to the Road Tax.

Table 7
Summary of proposals to deal with risks and special problems

Risk/Problem	Proposed intervention/arrangement/condition
Major health problems	Facilitate use of existing protocols and treatment guidelines (MPA and CPA) at health facility level. Use "public benefit" health insurance budget allocation for training on selected health problems and health education to the public. Include outreach in provider contracts to assure higher trained levels of health workers to provide consultations and training in the health centres.
Cultural factors	Carry out repeated campaigns to inform community leaders and all community members of the potential benefits of membership and compliance with contribution payment. Demonstrate the "safety" of the members money by transparent management of money In the initial stage, use seed money to assure supplies of drugs, other items, and demonstrate availability of services for patients who have prepaid.
Public Health workers	Allocate revenues to health worker incomes and stress the regularity of the increment Include outreach programmes to bring hospital doctors to health centres, and encourage follow-up of hospitalized patient by health centre staff. Conduct training in health centres in Plan continued education at later stage Include health workers in Management Committee.
Maternity care	Provide incentives for Safe Motherhood Programme through Link with Safe Motherhood programme
Private health providers	Promote Ministry of Health activity to register and accredit all formal private health care providers
Private health insurance	Encourage the continuation of private health insurance companies for foreigners not covered by the national schemes, and for supplementary benefits.
Motor vehicle accidents	Develop special fund for treatment of accident victims on no fault basis Promote activities for compulsory motor vehicle insurance including treatment of all victims on no fault basis
Uniformity in CBHI Schemes	Coordination of CBHI Schemes through a network developed by the Ministry of Health Unit on Health Insurance Policy and Implementation The uniformity should facilitate comparison among schemes and constructive competition in reaching coverage targets.

5. NEXT STEPS

5.1 DISCUSSIONS IN THE MINISTRY OF HEALTH AND WITH DEVELOPMENT PARTNERS

Following the presentation of this Master Plan on Social Health Insurance for Cambodia, it is recommended that the contents be discussed within the Ministry of Health, and then with the development partners assisting in health sector reform. On the basis of the decisions and commitment of the government, a detailed Plan of Action can be developed, defining the role of each partner based on a declaration of willingness to provide technical and/or financial support. At this point in time, it is not recommended that additional studies be undertaken.

WHO can assist in preparation of the Plan of Action for the initial phase and collaborate with the bilateral donors to mobilize financial support.

WHO can assist in identifying potential partners for collaboration in specific aspects of the extension in the next stage, and assist in negotiations with the partners to reach achievement of the goals of each partner. Such partnerships should be sought with the funded Disease Programmes and the managers of Equity Funds.

5.2 DISCUSSIONS AT INTER-MINISTERIAL LEVEL

Both the Ministry of Health and MOSALVY are interested in collaborating to reach the inclusion of health care and extension of coverage to the public salaried sector in the Social Security Law passed in 2002. The next step would be dialogue between the relevant Ministries, and with the Ministry of Economics and Finance. This dialogue should take place as soon as possible, and before the arrival of the ILO mission in October, requested by MOSALVY to accelerate development of the NSSF and to draft the Regulations for the Law. To facilitate the dialogue, a proposed draft of the necessary Sub-Decree to include health care is appended to this Master Plan, as Annex 1. WHO can collaborate with ILO in a project to develop the NSSF administration and functions.

It may be necessary to review the need for amendment to the Constitution or the Health Financing Charter to enable social health insurance. In addition, legislative action may be required with regard to existing commercial insurance laws. The Department of Insurance in the Ministry of Economics and Finance is responsible for the commercial insurance sector in Cambodia. The sector is governed by an Insurance Law which stipulates that income tax is payable on insurance contributions. The current law does not include any waiver of income tax on social insurance contributions. It would be advisable and indeed necessary to assure formal exemption from the existing law through a special amendment. In the first stage, this would advisable for the voluntary health insurance schemes that will be governed by regulations rather than legislation. The legislation that will be required for the compulsory social security system should include

the exemption from this Insurance Law. Steps to assure this exemption should be taken before expansion of the CBHI schemes.

5.3 ESTABLISHMENT OF A HEALTH INSURANCE POLICY AND IMPLEMENTATION UNIT IN MOH

The Ministry of Health has already established a Health Insurance Committee with fairly broad representation. In addition, and to accelerate the Plan of Action, it is recommended that the Ministry of Health create a Health Insurance Policy and Implementation Unit. The Unit should be staffed with permanent full time staff, including at this stage at least one senior level officer, with knowledge in the relevant fields of health care administration and financing, epidemiology, sociology and health behaviour. It is suggested that the funding for the first 5 years of operation of the Health Insurance Policy and Implementation Unit be requested from external sources.

The tasks to be carried out by such a Coordinating Unit include:

- Liaison with the Department of Social Security, MOSALVY, the Civil Service Administration regarding compulsory social health insurance for the formal labour sector.
- Assistance in criteria and selection of new target populations for CBHI. Schemes
- Development of training programmes, with the assistance of GRET and other development partners for new CBHI schemes.
- Accreditation and documentation of all new CBHI initiatives, launching and standard annual reports
- Advice on adaptation of the basic scheme for local conditions in new CBHI schemes.
- Advice on the allocation of seed money for the establishment of new CBHI schemes
- Development of standard administrative tools, such as information systems, contracts with providers and quality assurance programmes
- Coordination with opportunities to utilize Equity Funds and other mechanisms to extend health insurance to non-economically active and disadvantaged populations.
- Coordination with Disease Programmes to utilize funds from others sources to strengthen prevention and promotion and to provide access to basic health care (GFATM Funds, reproductive health programmes)
- Capacity building within the Ministry of Health, through study tours and training using regional and international experience.
- Capacity building at Provincial and District level of the Ministry of Health through training at relevant levels using country experience.
- Development of appropriate promotion and IEC methods
- Monitoring of all schemes through data collection, analysis, report generation and policy dialogue to improve design and implementation

- Measurement on the impact of social health insurance on the quality of health care and health status.
- Documentation and publication of reports on the development of social health insurance in Cambodia

5.4 TIMEFRAME

Table 8: Timetable for Major Next Steps

	Oct-Dec 2003	Jan-March 2004	April-June 2004	July-Sept 2004	Oct-Dec 2004
Discussion of Master Plan: MOH and Development Partners	**XXX**				
MOH-MOSALVY Discussion on Social Security Law	**XXX**				
Inclusion in ILO/WHO Technical Assistance	**XX**	**XXXXX**	**XXXXX**	**XXXXX**	**XXXXX**
Establishment of MOH SHI Policy and Implementation Unit	**XXXX**	**XXXXX**			
Development of Project Plan		**XXXX**			
Request for funds for Plan		**XXX**			
Prepare training materials: CBHI Public health workers	**XX**	**XXX**	**XXXXX**	**XXXXX**	**XXXXX**
Develop information system For CBHI	**XX**	**XXXXXX**			
Select new pilot areas Begin activities to launch And provide benefits	**XX**	**XXXXX**	**XXXXX XXXXX**	**XXXXX XXXXX**	**XXXXX XXXXX**

ANNEX 1 – PROPOSED LEGISLATION ON HEALTH CARE WITHIN THE SOCIAL SECURITY LAW

Section …

Health Care

Article 1. *Family coverage*

Entitlement to health care benefits will be given to the insured workers and legal dependants (spouse and children). Children are covered until the age of 18, or until the age of 22 if they are in full-time and continuous education. They are covered indefinitely if they are severely handicapped.

The worker who wishes to obtain health care coverage for other members of his family, such as dependant parents residing in the same household, and who are included in the Cambodian Family Book, may apply for voluntary insurance, under the conditions defined regarding voluntary coverage.

Article 2. *Duration of insurance*

Entitlement to health care benefits is subject to the condition that the insured worker has contributed for at least 3 months within a 12 months period ending 3 months prior to the date of the claim for care. This condition is waived in the case of emergency care, which could not be foreseen.

The insured worker and the protected family maintain the right to health care for 6 months after the worker ceased to pay contributions under this Law or to receive sickness benefit. The health care benefit shall in any case be extended until the end of treatment of a life-threatening condition.

Article 3. *Entitlement of pensioners*

Pensioners, who pay contributions for health care based on their pension, are covered for themselves and their legal dependants, in the same way as workers. No minimum insurance condition applies. Retired workers who do not receive pensions may contribute to health insurance on a voluntary basis.

Article 4. *Services covered*

The eligible persons are entitled to health care, including preventive, curative and rehabilitative services. These services include maternity care and the treatment of employment injuries and diseases. Health care includes services provided in health centres, hospitals and home. The services include diagnostic services, including laboratory and imaging services, and pharmaceuticals and medical supplies according to an approved list, as in the Regulations.

The health care does not include services or products essentially meant for cosmetic purposes.

The NSSF may also provide funding for health promotion and health education, according to Regulations it issues to that effect.

Coverage of transportation costs will be dealt with under Regulations.

Article 5. *Qualifying period*

The qualifying period for all covered persons (insured worker and dependent) will be one month of contribution for outpatient services and two months of contribution for hospital inpatient services.

Article 6. *Acceptable services*

The health care services have to fulfil the following conditions:

a) They have to be provided or prescribed by a physician or other health care worker licensed to practice in the country; apart from the provisions of international agreements, the Regulations may stipulate when care can be provided or prescribed by foreign physicians;

b) They have to be provided by a health care provider co-operating with the NSSF by contract and accredited by the Ministry of Health; the Regulations may stipulate under which conditions and to which extent care supplied by a person or institution without an agreement with the NSSF may be taken into account.

Article 7. *Care given abroad*

Apart from the provisions of international agreements, health care services are only taken into account if they are provided within the country.

Care provided abroad is nevertheless paid for:
a) In cases of emergency, needing hospitalization, through reciprocal agreements with social insurance institutions of other countries;
b) For medical reasons, under special permission given by the NSSF.

The Regulations determine the conditions of the benefit payable for such services.

Article 8. *Provider Payment*

The health care providers will be paid for a defined list of services on a capitation basis per covered person. The amount of capitation payment will be agreed with the Ministry of Health as the health care provider. The same capitation amount will be paid to accredited private providers if such providers are established, licensed and accredited by

the Ministry of Health, according to the same standards as Government providers.

In addition, the NSSF will reimburse the providers for a defined list of specialised high cost services outside the capitation list. The NSSF will reimburse the insured person for services provided in case of emergency care in a hospital that is not the contract hospital.

Article 9. *Agreements with providers of health care*

The NSSF will sign contracts with the main contract hospitals on an annual basis, for the capitation payment. This payment will be transferred by the NSSF directly to the contract hospital on a quarterly basis, at the beginning of each quarter.

If the main contractor subcontracts with another hospital for the treatment of referred patients, the transactions will be between the hospitals.

Arrangements for adjustment of the capitation amount, linked to a defined index, the list of specialised services and conditions for the authorization will be covered in the Regulations.

Article 10. *Additional payments*

Additional payments may be charged to patients by the hospital to cover part of non-medical costs of in-patient accommodation, according to the Regulations.

Regulations may provide for payment by patients for dental prostheses.

Article 11. *Reimbursement*

In emergency cases, where capitation payment cannot be applied, the patients pay the full price to the supplier and receive reimbursement from the NSSF, according to rates determined by the Regulations. The Regulations determine the documents to be delivered by the providers to the patients, in order to make the reimbursement possible. The NSSF will reimburse within the delays determined by the Regulations. If reimbursements are late, interest has to be paid at the current commercial interest rate.

Article 12. *Registration with a selected provider*

In order to receive health care, every covered person has to be registered with a main health care provider, who supervises all care given to the insured person, and keeps records of it.

Except in cases of emergency, no payment is made for services if the beneficiary has not first consulted the selected provider or when they are not reported to this selected provider.

The selected provider has to arrange for a permanent availability of the patients' records,

if necessary in combination with other providers or with a specialised institution. The agreements provide for adequate compensation for the supervision of care and for the keeping of records.

The covered person may change provider after six months, by application to the NSSF, which notifies the former and the new provider of the change. The records are then immediately transferred to the new selected provider.

Article 13. *List of products*

The supply of pharmaceutical drugs, prostheses, appliances and all other products may be subject to their inclusion in a list of products requiring prescription, established by the Ministry of Health, on the advice of a technical committee. The list of pharmaceutical products should include the Essential Drug List adopted by the Ministry of Public Health. Pharmaceutical drugs and products not requiring prescription or drugs purchased over the counter will not be covered. The Technical Committee should meet at least once a year to update the list of products.

A product outside the list may be provided by special permission of the NSSF, to be requested by the beneficiary or by the provider. The permission is given when the product cannot be replaced in a satisfactory way by a listed product.

Article 14. *Quality control*

The NSSF has to guarantee the quality of the care provided.
Quality assurance will be carried out on a regular basis through a defined Quality Assurance Programme, based on an adequate information system. All providers co-operating with the NSSF will transfer the relevant information to support the quality assurance programme and will be provided with feedback on performance. The Quality Assurance Programme will provide an annual report to the NSSF Board of Directors.

Article 15. *Management and Supervision*
The health care benefits will be managed by a Health Care Division in the NSSF, and supervised by a Medical Board, at the level of Technical Council in the NSSF Board. The Medical Board will have representatives of the Ministry of Health, providers of health care and insured persons.

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