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Assessment of the Cambodian National Social Security Fund's health insurance schemes

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Acronyms and abbreviations

CD	communicable disease
CPA	Complementary Package of Activities
GS-NSPC	General Secretariat of the National Social Protection Council
HEF	Health Equity Fund
HSPIS	Health Social Protection Information System
IPD	inpatient department
M&E	monitoring and evaluation
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MPA	Minimum Package of Activities
NCD	non-communicable disease
NGO	non-governmental organization
NSPC	National Social Protection Council
NSPPF	National Social Protection Policy Framework
NSSF	National Social Security Fund
OPD	outpatient department
SMEs	small and medium-sized enterprises
SOPs	standard operating procedures
SSR	Social Security Regulator

Executive summary

Introduction

Since the beginning of the twenty-first century Cambodia's health profile rapidly improved, as demonstrated by several key indicators, including life expectancy at birth and the share of deaths caused by communicable diseases. Still, the country is characterized by high rates of infant and maternal mortality, increased but low life expectancy, undernutrition, and a double-disease burden with prevalent communicable diseases and emerging noncommunicable diseases.

At the present time, the Cambodian social health protection landscape includes social health insurance for the public sector (civil servants, former civil servants, and veterans) and for the formally employed workers in the private sector, as well as subsidized health access through the Health Equity Fund (HEF) for those who are eligible (generally those living in poverty). Overall, there has been remarkable progress made in the social health protection system, but despite this progress, an estimated 70 per cent of the population have no access to social health protection.

The objective of this study is to analyse the design, operation and achievements of the health insurance schemes of the National Social Security Fund (NSSF), and to propose options and ideas for improvement. The research was conducted in consultation with NSSF departments, the NSSF Board and other key stakeholders. This review includes an assessment of the organization and administration of the NSSF's health insurance schemes, and includes an analysis of:

i. The framework of the schemes – consisting of an assessment of the legal architecture, scheme design, achievements in regard to coverage and adequacy, and the financing policy.

ii. The management and operations – consisting of an assessment of the organizational structure and the core operational functions.

The study also benefits from the results of a survey of NSSF health insurance beneficiaries and in-depth interviews with healthcare providers, allowing for an investigation of the perceived strengths and weaknesses of the NSSF health insurance schemes from the perspective of insured members and health facilities.

Framework, design and achievements

The main legal document on contributory social protection in Cambodia is the 2019 Law on Social Security Schemes, which defines the regulation and design of the mandatory health insurance regimes for the public and private sector, as well as providing for the future establishment of a voluntary regime for the self-employed. Several sub-regulations to the Law have been issued, though some others are yet to be developed and promulgated. The multiplicity and occasional lack of regulations has resulted in a need for increased clarity by further simplifying and unifying the legal and regulatory framework. Overall, there are several gaps and areas to be reviewed and updated.

In 2021, 1,533,330 workers were actively enrolled in NSSF healthcare schemes. Among them, 19 per cent (292,295) were from the public sector and 81 per cent (1,241,035) from the private sector. The ratio between the total number of employees and active contributors is 41 per cent, which points at the wide social security gap in the country. Data gathered by the NSSF show that between 60 per cent and 75 per cent of the scheme contributors are women. This is largely due to the demographics of the manufacturing sector (particularly the manufacture of garments, footwear and luggage), which is the largest sector in terms of registered members (accounting for 80 per cent of all NSSF members).

According to the preliminary results of the 2022 Economic Census, Cambodia has 753,670 establishments.[1] Of these, 735,456 are micro-establishments,[2]. leaving 18,214 small, medium and large establishments. The vast majority of establishments in Cambodia – 87.6 per cent - are not registered with the Ministry of Commerce, though this is not the same across establishments of different sizes, as 100 per cent of large establishments and 94 per cent of small and medium-sized enterprises (SMEs) are registered. However, only 10.3 per cent micro-establishments are registered with the Ministry of Commerce. The total number of enterprises registered with NSSF grew by 8 per cent annually over the period 2018–21, from 9,389 to 11,944.

Among enterprises registered with NSSF, 92 per cent (on average) actively contribute to the healthcare scheme every year. In 2021, 869 enterprises did not actively contribute to the scheme, which caused delayed or missing contribution payments for 152,503 workers (11 per cent of registered members). The largest share of registered enterprises (about 30 per cent) operate in the manufacturing sector and have on average 500 employees each. There is significant potential for the NSSF to actively promote and increase registration of employers and workers in other employment sectors.

The benefit package for healthcare services is the same in schemes for both the public and private sectors. The schemes cover preventive and curative health services, including outpatient and inpatient care, maternity care, family planning, medium surgical interventions, and transportation. Pharmaceuticals and medical devices are also covered, but limited to what is included on the essential drugs list published by the Ministry of Health. The current benefit package is deemed to be rather comprehensive, and efforts have been made to harmonize the benefits covered under each of the two schemes.

While the provision of medical care services is similar between the public and private scheme, the cash benefits packages do differ significantly in design and financing. For example, daily allowances for sickness leave correspond to the full salary in the case of public sector employees and there is no qualifying period. In the private sector NSSF sickness benefits are restricted to qualifying workers who have paid contributions for 2 consecutive months (or 6 months) in the preceding 12 months. In these cases, the allowances are delivered to workers being hospitalized (by law) or having received approval to heal from home (in practice) for a duration of at least eight days[3] and correspond to 70 per cent of the average insurable wage of the preceding 6 months. Thus, sickness benefits and the qualifying conditions to access them appear more restrictive when it comes to private sector beneficiaries.

[1] The 2022 Economic Census covered all establishments excluding those in the "agriculture, forestry, and fishery" and "household activities" economic sectors. The census also excludes national/local government offices, including military quarters and diplomatic offices.

[2] The size of enterprises is determined by the number of employees. Microenterprises: no more than 10; small enterprises: 11–50; medium enterprises: 51–100; and large enterprises: over 100.

[3] Before eight days paid sick leave is an employer liability.

The outpatient department (OPD) services rate has increased over time, and seems to be in a relatively good range, that is, not showing underconsumption neither overconsumption, given the rather healthy profile of private sector NSSF members. However, the inpatient department (IPD) services rate is relatively high. Further analysis on causes of hospitalization, length of stay and referral patterns would be necessary to identify possible health preventive actions or detect potential fraud in this space. For instance, the provision of sickness benefits only in case of hospitalization may trigger demands for unnecessary hospitalization. The impact of the NSSF schemes on the reduction of catastrophic health expenditures cannot be documented, due to the absence of specific studies and data.
NSSF members can access all public health facilities and an increasing network of contracted private facilities. As the result of a policy choice, there is no referral system across levels of care, and therefore members can access any contracted health facility without needing to receive a referral for more specialized care. While this measure makes access easier for members by giving them a broader choice of providers, the disruptions on the health system may become significant over time as the level of coverage increases. Allowing patients to bypass lower levels of care may overburden higher levels of care for illnesses that could have been treated at lower levels. It may also contribute to crowding out lower health facilities, depriving them of necessary resources.

The healthcare scheme contribution rate for the civil servants is set at 1 per cent of the payroll salary, borne equally by the State and the worker (50/50). In the private sector, the contribution rate is 2.6 per cent of the payroll salary, and is borne exclusively by the employers, although the legal framework recommends an equal distribution between employer and worker. The insurable earnings monthly ceiling is considered relatively low, as it is very close to the minimum wage. This low ceiling is depriving both schemes of additional revenues and from promoting intragenerational equity across different levels of earning.

In the private sector, revenues from contributions have grown from 361 billion riel in 2018 to 425 billion riel in 2021. The scheme's expenditures reached 286 billion riel in 2019, significantly increased to 326 billion riel in 2020, and then regained the level of 287 billion riel in 2021. On average, the private sector healthcare scheme has been generating an average surplus of 115 billion riel over the period 2017–21, or cumulatively about 576 billion riel.

In the public sector, 2021 revenues from contributions attained 34 billion riel. The expenditures have been increasing each operating year and reached 51.8 million riel in 2021. It is assessed that the public sector scheme had an average annual deficit of 12 billion riel in 2019–21, and the 2021 deficit corresponded to more than 50 per cent of the scheme's revenues from contributions, showing an increasing trend over the four years of operations. How this deficit is financed is not specified.

A comprehensive actuarial analysis is needed to effectively analyse the current financial situation of the NSSF healthcare schemes and estimate future trends. It would also allow for simulations of several policy options aimed at extending coverage and adequacy of benefits. In particular, the actuarial analysis should look at the:

- Ceiling on contributions.
- Contribution rate level.
- Difference in contribution rates between civil servants and private sector workers (considering the difference in sickness and maternity benefits).
- Possible extension of coverage to dependents and its implication on the contribution rate and level of reserves.
- Financial impact of extending the network of private health facilities contracted with the NSSF.

Review of operational functions

The current organizational structure of the NSSF includes a substantial number of departments and units to carry out its strategic functions. The structure is hierarchical. Some functions appear fragmented, with different departments in charge of similar tasks. Departments and units seem to operate in silos, with limited coordination and communication. This results in bureaucratic inefficiencies. For instance, it was observed that within the NSSF departments the coordination and information flow across the units are weak.

Concerning engagement with the public, an identified gap in communication and sensitization is the absence of prioritization of awareness-raising among non-registered enterprises. Increasing coverage among enterprises that are not yet registered with the NSSF would require the implementation of regular and sizeable awareness-raising activities and registration events. While at present no communication activity in field of health and prevention is undertaken, it is foreseen that in 2024 the focus will shift to health awareness.

Concerning registration procedures, despite significant improvements, legal and operational challenges prevent the NSSF from significantly boosting employer and worker registration numbers and contribution collections. A major identified bottleneck was the absence of systematic information sharing on newly registered enterprises between the Ministry of Commerce, the Tax Authority, and the NSSF. However, the NSSF's Department of Registration and Contribution Collection just started in Q3 of 2023 to receive information from the Ministry of Commerce and the Tax Authority to systematically identify non-registered enterprises. At that time, the NSSF registration system started integrating with other relevant databases through the Cambodia Data Exchange (CamDX) system. This is expected to enable the NSSF to access enterprises information, and on this basis to significantly scale up registration and inspection efforts. Furthermore, the 2022 Economic Census of Cambodia collected relevant information for more than 750,000 establishments. These data are planned to be connected to the CamDX database in the future, significantly increasing the information available.

Further improvements can be achieved in contribution collection and compliance. Few procedures are automated, including, for instance, reconciliation, which prevents systematic checks on contribution compliance. In case of detected non-compliance with registration or payment, sanctions are applied to enterprises based on the duration of their period of non- or underpayment. In practice, the Inspection Department first proceeds with awareness and education interventions before applying sanctions, but there are no standard operating procedures or guidelines to guide the Inspection Department's work.

The NSSF strategy to facilitate access to services includes the contracting of private healthcare providers. There is only weak regulation on the contracting of private facilities, which the Government seeks to address through the implementation of the 2022 Sub-Decree No. 160 on Social Security Regulation.

The NSSF pays private facilities with higher rates, ranging between 130 and 150 per cent of the rates applied to public facilities. While this allows the NSSF to provide members with complementary services, it may also act as an incentive for members to use private facilities to the detriment of public services. This may lead to a vicious cycle whereby public facilities are getting less resources, and therefore providing poorer quality of care, which in turn further demotivates the populace from using these services. This may result in a two-tier health system where lower income Cambodians mostly use public facilities of lower quality, and the wealthier use private services providing relatively better quality of care. In addition, while contracting private healthcare providers is part of an effort to facilitate NSSF members' access to quality services, it may have an impact on the financial situation of the healthcare schemes in the short to medium term, given the higher fees being paid to private facilities.

Processing the claims of health facilities is still a largely manual process and involves multi-step control processes. At the facility level, practices vary on how claims are administered. Based on responses received from interviewed healthcare providers, there is no formal case management procedure for NSSF beneficiaries. Healthcare providers who have their own MIS rely largely on it to capture medical and billing records for both their NSSF and non-NSSF clients. Re-entering such data in the NSSF claims system after they have already entered the same in their MIS introduces an extra burden.

To promote quality of service, the NSSF has the right to pay between 80 per cent and 120 per cent of the standard fee, according to the level of service quality achieved, but this is not actually done in practice.

The NSSF's Department of Social Security Policy is responsible for producing monitoring and evaluation (M&E) reports consolidating data from all other departments. This function is severely limited by the current low-level statistical capacity of the Department and the lack of ownership over the M&E framework. Furthermore, the secondary data commonly supplied by other departments does not allow the Department of Social Security Policy to elaborate reports of consistent quality and depth.

Recommendations

1. Promotion and communication of healthcare insurance

The communications strategy currently under development should define goals and targets that go beyond the number of individuals and enterprises reached.

The current strategy of reaching out only to registered enterprises is not adequate to meet the goal of extending coverage, suggesting there is a need for broader communication and promotion methods. Overall, the NSSF could pose itself the ambition of fostering a social security culture among the general population of today and future generations.

2. Harmonization and revision of healthcare benefits and services

Revisions of benefit packages should be based on a defined process that includes clear institutional responsibilities, takes an evidence-based approach (including actuarial valuations), and prioritizes the role of social dialogue.

Future revisions of benefit packages should consider covering medical conditions that are currently explicitly excluded from coverage.

The harmonization of benefits packages across different health insurance schemes should be considered, as it can create an incentive mechanism to participate in social security while avoiding the creation of inequalities in treatment.

Benefits should be, at the very least, aligned with international minimum standards so as to provide adequate care to members and to be attractive to prospective members.

Hospitalization patterns – particularly causes, length of stay and referral patterns – should be analysed in order to identify possible health preventive actions as well as to detect potential fraud, given the high rates of inpatient care observed in recent years.

3. Extension of healthcare insurance coverage

It is recommended that efforts to extend coverage start by enhancing compliance in the formal economy. A recommended pathway to achieving this is to fully implement partnerships with the Ministry of Commerce and the Tax Authority to allow for automatic sharing of information on newly registered enterprises. In the medium-term, automatic registration with the NSSF should be bundled with the registration of enterprises with the Ministry of Commerce.

Beyond enforcing compliance in the formal sector, it is suggested to evaluate the opportunity for extending coverage to NSSF members' dependents. Such an extension is expected to make the scheme more attractive to members and allow for Cambodia to move closer to universal health coverage targets. Evidence from around the world demonstrates the ineffectiveness of voluntary regimes. Thus, there is a case for reconsidering the voluntary nature of the scheme for the self-employed. This could be done through a gradual sector-by-sector approach, in which selected sectors gradually move towards compulsory coverage.

4. Compliance for increased coverage

Now that is linked with CamDX, the NSSF should consider developing an operational plan to register the large volume of enterprises that currently in CamDX but not yet registered with the Fund (about 30,000). Consideration should also be given to collaborating with employers' organizations, trade unions, and non-governmental organization (NGOs) to promote registration, collection of contributions and sensitization.

The review suggests enhancing the capacity and authority of the Social Security Inspection Department and enhancing collaboration between the NSSF and the Ministry of Labour and Vocational Training (MoLVT) in the area of inspection.

The NSSF should enhance its reporting system with the objectives of measuring performance at each level, monitoring the progress of every activity, identifying the strengths and weaknesses, and reporting to top management and the board.

5. Complaints and grievances

It is suggested that the NSSF advocate for the rapid development of the sub-regulations on dispute settlement from the Social Security Regulator.

In addition, the NSSF should consider commissioning an independent regular assessment of members', employers', and health facilities' satisfaction with NSSF services. This work could be complemented by the development of an index to monitor achievements and progress as part of building a performance culture at the Fund.

6. Operational efficiency

As part of modernization efforts, it is suggested that the NSSF carry out a complete review of its core operational processes. The objective of the review should be to increase administration efficiency and improve members' experience with NSSF services. The review could include the following four aspects: (i) a situation analysis; (ii) identification of bottlenecks preventing optimal business processes and information flows; (iii) drafting updated procedures; and (iv) informing piloting priorities and implementation and measuring performance gains.

7. Financial management

Improve the quality of financial reporting and disclosure to provide better accountability of annual budget projections and actual expenditures. This will strengthen the budgeting process and improve the financial sustainability of and trust in the NSSF.

Advocate for stronger legal or regulatory provisions for ring-fencing funds and make clear provisions on the fungibility of funds across schemes.

Consider creating separate funds for the healthcare schemes, maternity benefits and sickness benefits, due to their different natures. The actuarial valuation could be instrumental in defining the exact costs and benefits for each branch (see below).

Based on the newly updated standard operating procedures (SOPs), develop an internal audit manual and regularly implement auditing exercises to ensure administrative compliance.

Strengthen effectiveness by automating checks and controls on: contributions collected as compared to expected amounts, and unexplained variations in numbers of workers or insurable earnings from month-to-month.

Carry out periodic, comparable and reliable actuarial analyses of the healthcare scheme to assess its financial situation. In particular, actuarial valuations would support financial projections and **assess the impact of policy options regarding contribution rates, coverage of dependents and benefit packages**. It is suggested that the actuarial analysis should look at the following parameters:

- Contribution ceiling.
- Contribution rate.
- Harmonization of contribution rates between the public and private sector schemes (taking into account differences in the financing of maternity and sickness benefits).
- Conditions to extend coverage to dependents.
- Timpacts of contracting private healthcare providers at higher rates.

An actuarial valuation is also necessary to evaluate the actual level of reserves compared to the target level, as well as whether the target level is in fact appropriate.

Progressively build the internal capacity of the NSFF to carry out actuarial analyses, including in regard to staffing, training and data management.

8. Purchasing

Conduct simulations in the actuarial analysis to measure the impact that increasing the network of private facilities contracted with the NSSF might have on the financial sustainability of the health insurance schemes.

Develop a strategy for the provision of private healthcare services, with due consideration of financing mechanisms (long-term impact on the scheme financial balance, possible introduction of copayments at private health facilities, and so on) and equity concerns.

Initiate an evidence-based review of payment rates.

Reinforce capacities to conduct medical auditing of claims in order to detect possible risks related to: (i) providers limiting access to care for patients with serious diseases that are more costly to treat; and (ii) inefficient referral of such patients to tertiary level hospitals.

Consider ways of digitalizing claims processing.

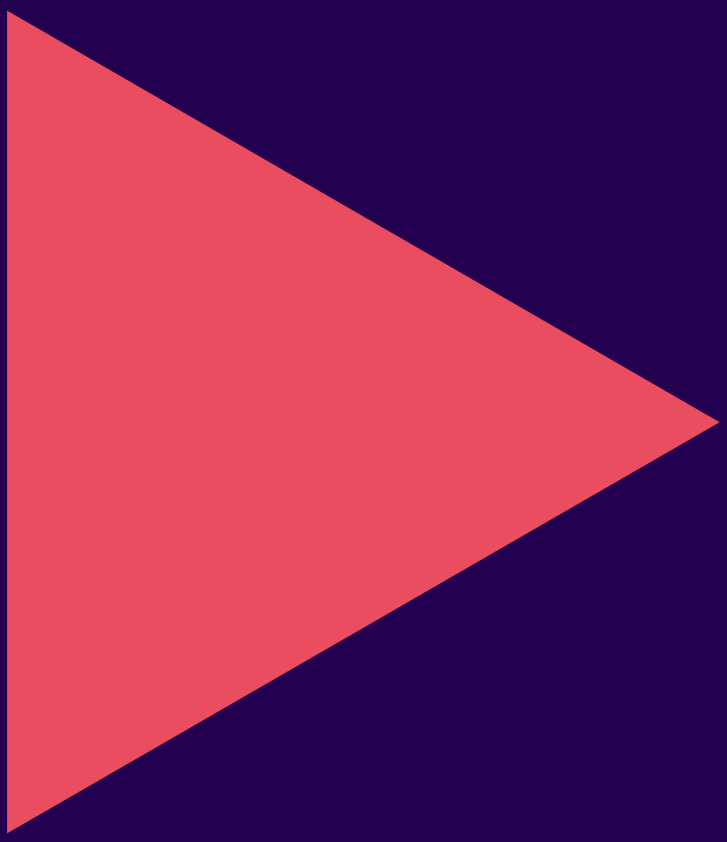
Measure the average time for payments to be made to providers, and use this information to set targets, monitor performance, generate reports and publicize achievements.

Consider implementing a referral system (except in case of emergencies), at least for national and provincial hospitals, both to preserve the overall balance of the health system and for cost control purposes.

9. Data analysis

Enhance monitoring and evaluation capacities across all departments, including staff capacities to retrieve data from information systems, produce and publicize comprehensive annual reports, and use data for decision-making.

Data security and use should also be improved, with stronger guidelines on data sharing within and across institutions.



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Country context and overview of the social health protection system

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1.1. Socio-economic context

Cambodia is a country of approximately 17 million people with an estimated per capita gross domestic product (GDP) of US$1,552 in 2020 (World Bank 2022). Cambodia is currently a lower-middle-income country. After transitioning to the open market economy in the 1990s, Cambodia has seen sustained economic growth, with an average growth rate of 10 per cent until 2011 and subsequently averaging 7 per cent until 2021. In 2021 the country suffered a recession due to the COVID-19 pandemic global crisis. The value of Cambodia's national currency – the riel – has stayed relatively stable at around 4,000 riel to US$1.

As of 2022, economic growth recovery remains uneven across economic sectors. Construction and tourism, historical drivers of growth, remain under pressure, while the garment sector continues to expand. While the share of the population living below the poverty line (2.15 PPP US$ a day) is falling (World Bank, n.d.-a), inequalities are growing, and the effects of the pandemic have accelerated this trend.

Starting in the 1990s, multilateral and bilateral donor agencies and international non-governmental organizations (NGOs) played a major role in the country's reconstruction through economic, infrastructural and social programmes, with the objective of strengthening subnational democratic development, such as through the development of fiscal transfer systems and the introduction of administrative and governance laws. Despite significant advances in the systems of governance, infrastructure and human resources, challenges remain in regard to strengthen government administration.

Since the beginning of the 1980s, Cambodia's population has more than doubled, which has also coincided with the doubling of the urban population, which is now 26 per cent of the total. As a result of the sustained economic growth and increasing urbanization, the age structure is slowly changing. While the population still remains young overall, with the highest share of population being children and adolescents (30 per cent under 15 years of age in 2015), Cambodia is slowly transitioning towards becoming an ageing population country, and is expected to complete the transition by 2050 as the share of people aged 65 or older continues to rise and death rates continue to fall.

1.2. Health profile

The country's health status has substantially improved since the beginning of the twenty-first century. Improvements can be observed via several key indicators, such as life expectancy at birth and the share of deaths caused by communicable diseases. Moreover, disparities between urban and rural districts have been diminishing. However, Cambodia's health status is still characterized by high rates of infant and maternal mortality, increased but low life expectancy, undernutrition, and a double-disease burden with prevalent communicable diseases and emerging noncommunicable diseases. Even though Cambodia's health status is improving, it remains relatively poor compared to neighbouring countries.

▶ **Table 1. Health indicators, latest available year**

	Cambodia	Thailand	Lao PDR	Vietnam
Population (million)	16.7	69.8	7.0	97.3
Crude death rate (per 1 000)	5.9	7.9	6.3	6.4
Life expectancy at birth (years)	70.0	77	68	75
Infant mortality rate (per 1 000 live births)	22	7	35	17
Maternal mortality rate (per 100 000 live births)	160	37	185	43
Prevalence of deaths caused by NCDs (%)	68.0	77.0	65.0	65.0

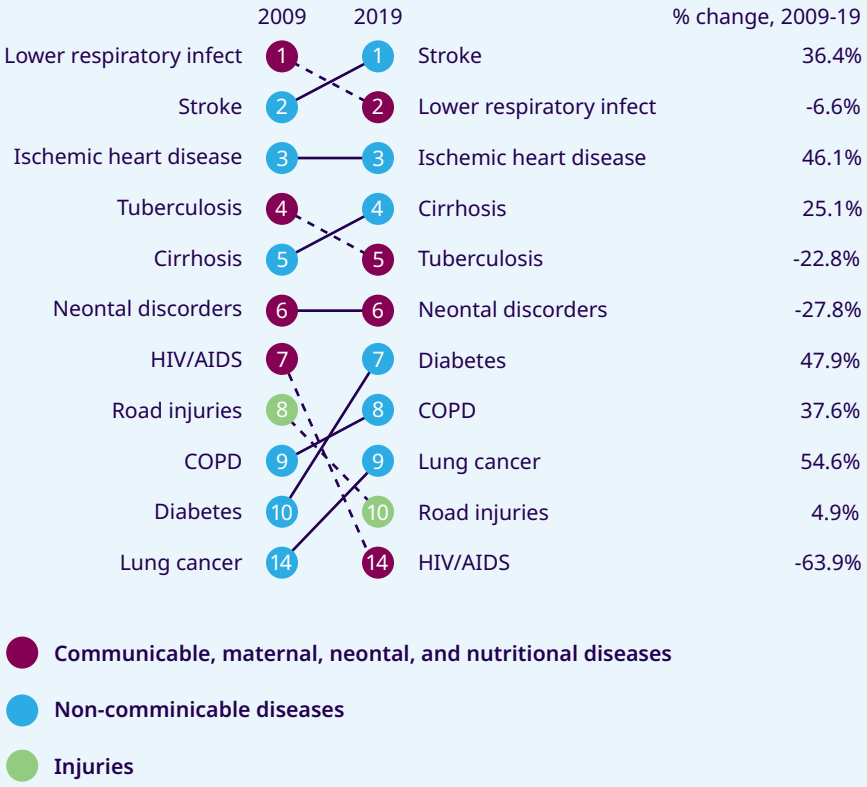
NCDs = non-communicable diseases; Lao PDR = Lao People's Democratic Republic
Source: World Bank, n.d.-a.

Main causes of death and risk factors

The main trend observed since the beginning of the twenty-first century and that has increased during the last 10 years is the shift from prevalence of death from communicable diseases (CDs) to noncommunicable diseases (NCDs). NCDs account today for more than 68 per cent of all deaths, up from 39 per cent in 2000 and 57 per cent in 2010 (World Bank, n.d.-a). As of 2019, the five most common causes of death were strokes (NCD), lower respiratory infections (CD), ischemic heart diseases (NCD), cirrhosis (NCD), and tuberculosis (CD). Other causes of death such as diabetes, cancers and car accidents are also common (figure 1).

The main risk factors due to CD affecting health status are tuberculosis, malaria, unsafe drinking water and lack of sanitation facility, dengue fever, HIV/AIDS, and more recently COVID-19. Overall, the main factors affecting health status are behavioural risks such as tobacco consumption, alcohol use and dietary risks. These are followed by metabolic risks, including high systolic blood pressure, fasting plasma glucose, LDL cholesterol, and body-mass index.

▶ Figure 1. Leading causes of death in Cambodia, 2009 versus 2019



Source: IHME, n.d.

Maternal and child health

Maternal and child health have improved since 2000, and the maternal mortality rate (indicating the number of deaths per 100,000 live births) has fallen by more than 60 per cent, going from 488 in 2000 to 184 in 2020 (World Bank, n.d.-a). The proportion of births attended by skilled staff has risen to almost 90 per cent in the last few years, up from just 16 per cent in 2004 (World Bank, n.d.-b). The Cambodian Demographic Health Survey indicates that child mortality has declined across the country due to better education of mothers and the increasing wealth of households. However, child mortality rates remain relatively high compared to neighbouring countries, and they are significantly higher in rural areas of Cambodia. In 2010, the proportion of children under five with moderate to severe malnutrition or with acute respiratory infection was more than twice as high in rural areas and among those in the lowest wealth quintile (compared to the highest quintile) (APO 2015).

The main causes of death among children up to five years of age are lower respiratory infections (CD), premature birth (CD), neonatal encephalopathy (CD), congenital heart conditions (NCD), and neonatal sepsis (CD). In recent times, the country has seen a decrease in deaths from malnutrition and diarrheal diseases, as well as a sharp decrease in deaths due to measles and tetanus thanks to increasing vaccination coverage (The Lancet 2019).

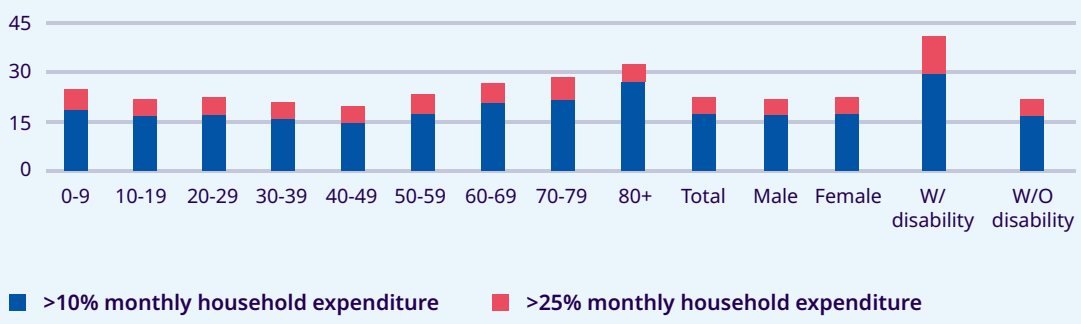
Overall, the health status of Cambodia is slowly improving in tandem with growing economic development and the related wealth creation. Economic development and the ageing of the population are the underlying factors for the epidemiological transition from CD to NCD, and most health indicators are improving. However, the health status of the country is still poor compared to international benchmarks and neighbouring countries, and the differences between urban and rural areas are still substantial.

Catastrophic health expenditure

Health shocks are an important contributing factor to poverty and vulnerability in Cambodia. Current health expenditure in Cambodia has been increasing in absolute terms in recent years. However, the main component are out-of-pocket payments by health service users. These constituted 64 per cent of health expenditure in 2019 (WHO, n.d.-a) – compared to an average of 40 per cent in low- and middle-income countries – and in absolute terms out-of-pocket payments have been increasing. These payments are mostly spent in private sector services at pharmacies and clinics, mainly for the purchase of medicaments.

High out-of-pocket expenditure implies that the main burden of health expenditure directly falls on households. This has a significant impact on poverty and vulnerability. The dynamic is visible when assessing two common indicators of catastrophic health expenditure in Cambodia. Around one in five households in Cambodia (18 per cent) spend more than 10 per cent of their total expenditure on healthcare, and 5 per cent spend more than 25 per cent of their total expenditure on healthcare. Levels of catastrophic expenditure are higher for persons with disabilities, and elevated for older persons and, to a lesser degree, for young children. There are minimal differences between men and women; however, this measure at the household level is not sensitive to the question of who pays for health expenditure within a household (see figure 2).

▶ Figure 2. Share of households experiencing catastrophic health expenditure by age group, sex and disability status, 2019–20 (%)



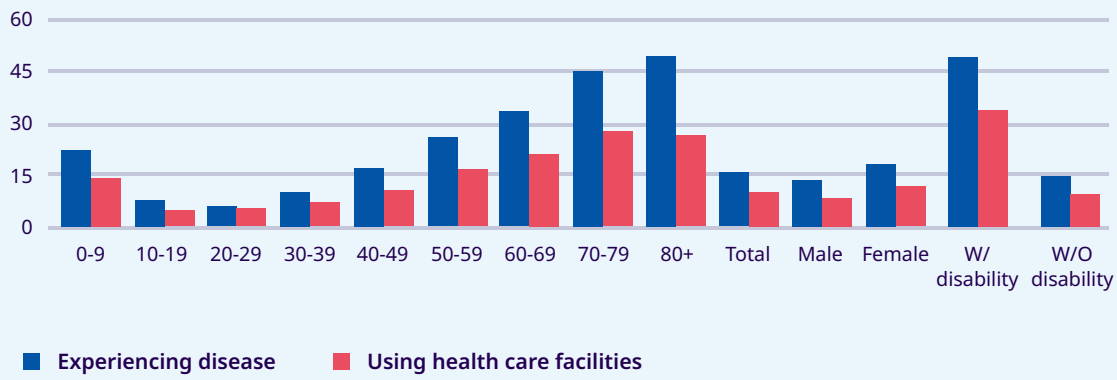
Source: ILO, forthcoming.

Health events and expenditure are strongly linked to life-cycle risks. The age disaggregation (see figure 2) shows that children and older persons are more likely to live in households with catastrophic health expenditure. This is associated with higher incidence of disease and higher healthcare utilization for persons at these stages of life.

Health risks across the life cycle

Incidence of disease is more common at younger and older ages. Notably, increases in disease incidence begin significantly earlier than typical definitions of retirement age (for example, age 60, see figure 3). Incidence of disease is also significantly higher among persons with disabilities, with half (49 per cent) reporting diseases compared to 15 per cent among those without a disability. It is also notable that women report lower health status than men and a higher rate of health facility utilization.

▶ Figure 3. Share of the population experiencing disease and utilizing health facilities in the last 30 days, by age group, sex and disability status (%)



Source: ILO, forthcoming.

The impact of ill health on people's capacity to engage in the labour market contributes to poverty and vulnerability. In the absence of sickness benefits, short-term illnesses can lead to absences from work that reduce a family's earning capacity. This issue has been put into sharp relief globally and in the Asia region in the context of COVID-19, with the requirement to quarantine or self-isolate having significant implications on income security. The impact of ill health on the ability to engage in the labour market relates strongly to other life-cycle risks, particularly disability and old age. Conversely, effective treatment and care can reduce the severity and duration of illnesses and can support a healthy and productive labour force.

1.3. Social health protection system

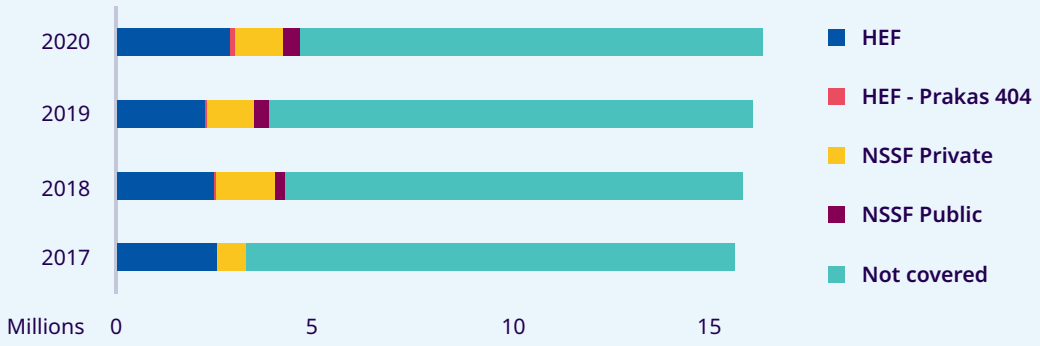
Financial protection, as well as comprehensive, safe and effective access to health services are the two first strategic objectives of the Health Sector Plan (2016–2020).[4] Presently, the Cambodian social health protection landscape includes:

i. Social health insurance for the public sector and formally employed workers in the private sector.

ii. The Healthy Equity Fund (HEF), a social assistance scheme for the eligible population.

Overall, there has been a remarkable progress in the social health protection system with regards to achieving set goals. Despite this progress, however, an estimated 70 per cent of the population have no access to social health protection schemes.

▶ Figure 4. Population covered by the social health protection system, by scheme



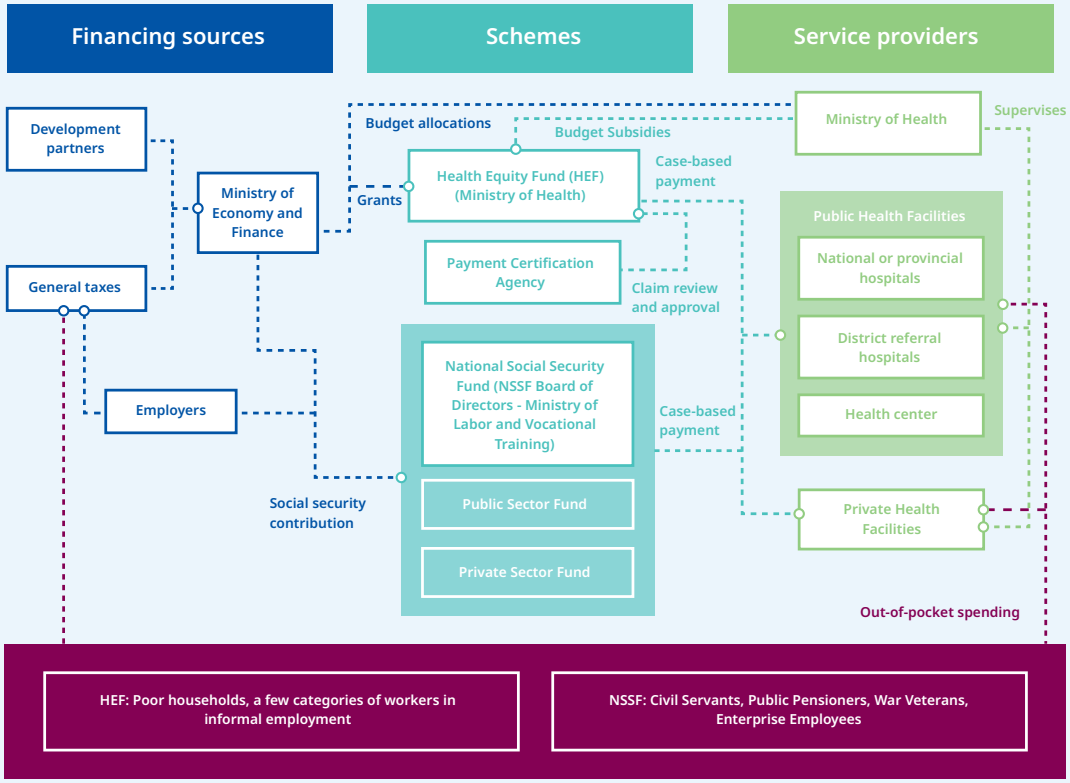
Source: ILO, forthcoming.

The progress of social health protection in Cambodia is part of the broader development of comprehensive social protection policies that began in1997 with the enactment of the Labour Law, which granted maternity and sickness cash benefits to employees in the formal sector. An additional major milestone was the first pilot of the HEF in the early 2000s. The Ministry of Health (MoH) officially launched the HEF scheme in 2006 to cover the population living in poverty, and rolled it out in several provinces, progressively reaching nationwide coverage in 2015. In parallel, between 2005 and 2016, various models of community-based health insurance were piloted and served as a learning experience for the development of the National Social Security Fund health insurance schemes.

The National Social Security Fund (NSSF), under the Ministry of Labour and Vocational Training (MoLVT), manages the civil servants' and formally employed workers' schemes. The NSSF began its operations in 2008, and in 2017 the Fund launched the social health insurance schemes for private sector workers and for active and retired civil servants and veterans.

[4] The new Health Sector Plan 2021–2030 is under development.

▶ **Figure 5. Overview of social health protection system in Cambodia**



Source: ILO 2021.

The HEF scheme is non-contributory. Financing comes from the Government's general revenues, allocated through the Ministry of Economy and Finance (MEF), and from development partner grants. The Health Equity and Quality Improvement Project (H-EQIP) finances up to US$6 million per year in user-fee reimbursements for health services provided to poor beneficiaries, and the balance is paid from the national budget. In 2019, total user-fee reimbursement attained US$18.4 million. The HEF is operated by the Ministry of Health (MoH), but claims and payment verification are under the responsibility of the semi-autonomous Payment Certification Agency.

HEF eligibility is primarily determined at the household level through the targeting mechanism IDPoor, which is operated by the Ministry of Planning and uses community-based proxy means testing. Pre-identification accounts for about 92 per cent of enrolment. This mechanism is complemented by a post-identification procedure enabling enrolment at the point of service delivery; post-identification accounts for the remaining 8 per cent of enrolments.

In 2017 the MEF, MoH and MoLVT issued Interministerial Prakas No. 404 on the Implementation of Healthcare Scheme through the Health Equity Fund System for Informal Workers. This joint legal directive extended HEF coverage to a relatively small number of informal workers defined as part-time, seasonal or casual workers.

By January 2021 the HEF covered 2.8 million people targeted via equity cards (that is, through IDPoor) and 172,875 were targeted via the priority card (where patients are identified as poor at health centres). In total this represents 21 per cent of the population. The population covered under the HEF has increased with the expansion of coverage of the IDPoor system. In response to the COVID-19 pandemic an estimated 15 per cent of persons with moderate or severe disabilities received some form of cash benefit. Most of these benefits were provided by the NSSF for the public sector (10 per cent), with the remaining 5 per cent provided by the Cash Transfer for Persons with Disabilities mechanism. Coverage of male persons with moderate and severe disabilities is significantly higher (at 26 per cent) than females (at 6 per cent). This is primarily because most recipients of disability benefits are men under the veterans' scheme.

02

Methodology

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This study relied on a number of approaches to gather to gather essential information and insights about the NSSF's health insurance schemes. These included:

i. A desk review of key documents and data sources.
ii. Interviews with key personnel at the NSSF.
iii. A survey of NSSF members.
iv. In-depth interviews with healthcare providers.

The desk review focused on the following key documents and data sources:

- Cambodian laws, decrees, sub-decrees, prakas[5] and other legal documents referring to social security and the NSSF healthcare schemes.
- Strategic plans of the NSSF.
- Benefit package details and payment rates under different schemes.
- Descriptions of the claims management system and a sample claims form.
- Sample contracts of service providers.
- NSSF Annual Reports for the years 2018–22.

The researchers had the opportunity to meet with key department directors and deputy directors of the NSSF. These included representatives from the:

- Department of Social Security Inspection
- Department of Administration and Human Resource
- Department of Budget Management, Finance, and Accounting
- Department of Registration and Contribution
- Department of Social Security Benefits
- Department of Health Facility Services
- Department of Information Technology
- Department of Social Security Policy
- Department of Customer Services and Public Relations

These meetings provided valuable insights into the inner workings of each department and allowed for productive discussions regarding the NSSF's operations and policies.

Additionally, a survey of NSSF members was conducted to gain insight into their awareness of and experiences with various aspects the NSSF healthcare schemes.

[5] A prakas is a ministerial level decree that is promulgated by either a single ministry or jointly by multiple ministries (as an interministerial prakas).

The selection of participants for the NSSF members' survey was conducted through a systematic process. Angkor Research collaborated with the NSSF to obtain a list of all digitized NSSF records from January to December 2020. From this list, beneficiaries were randomly chosen from the records of NSSF-supported treatments at various health facilities. The NSSF then provided contact information for the selected beneficiaries. A total of 722 survey participants were included in this study. The selection of participants aimed to capture diverse perspectives. To that end, the survey included both private sector and public sector workers, ensuring comprehensive representation of both NSSF health insurance schemes.
The initial aim was to generate a survey sample that was nationally representative by surveying NSSF members from each province in proportion with each province's share of total claims filed in 2020. However, this was ultimately not practicable, in large part because the available information in the NSSF database on claims was incomplete, largely due to many provinces handling and recording claims entirely through paper-based processing, which can be seen in the provinces with few or no registered claims in table 2 below. In addition, there were challenges involved in obtaining up-to-date contact information for NSSF members, which meant that 13 provinces could not be sampled. While there was no specific target for gender balance or rural–urban ratio in the survey sample, efforts were made to include a wide range of participants to enhance the representativeness of the sample.

The survey took place in 2021, and was conducted using computer-assisted telephone interviewing (CATI). This approach allowed for efficient data collection while ensuring the participation of beneficiaries across various locations. A mix of open-ended and multiple-choice questions was utilized during the survey. This approach provided participants with the opportunity to provide detailed responses while also allowing for efficient data analysis. This approach aimed to capture recent experiences while considering potential limitations in recall accuracy.

▶ **Table 2. NSSF member survey sample composition: Intended versus actual**

Province	No. of claims (2020)	Proportion of total claims (%)	Sample (Intended)	Sample (Actual)	Proportion of sample (Actual) (%)	Delta (p.p.)
Banteay Meanchey	30 920	4.0	28	31	4.3	+0.3
Battambang	7 768	1.0	7	7	1.0	–
Kampong Cham	72 947	9.3	65	27	3.7	-5.6
Kampong Chhnang	77 717	9.9	70	32	4.4	-5.5
Kampong Speu	187 663	24.0	168	133	18.4	-5.6
Kampong Thom	2 819	0.4	3	2	0.3	-0.1
Kampot	20 777	2.7	19	16	2.2	-0.5
Kandal	400	0.1	–	1	0.1	–
Kep	–	–	–	–	–	–
Koh Kong	–	–	–	–	–	–
Kratie	24	0.0	–	–	–	–
Mondulkiri	83	0.0	–	–	–	–
Oddar Meanchey	1 160	0.1	1	15	2.1	+2.0
Pailin	–	–	–	–	–	–
Phnom Penh	52 934	6.8	47	128	17.7	+10.9
Preah Sihanouk	1 111	0.1	1	13	1.8	+1.7

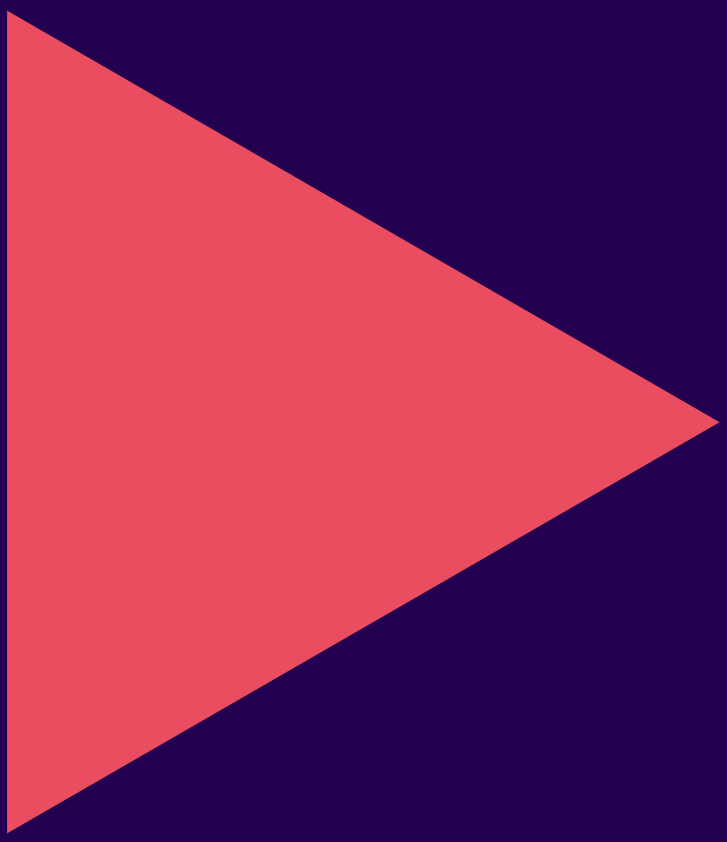
Preah Vihear	–	–	–	–	–	–
Prey Veng	40 726	5.2	36	33	4.6	-0.6
Pursat	10 086	1.3	9	10	1.4	+0.1
Ratanakiri	–	–	–	–	–	–
Siem Reap	41 573	5.3	37	70	9.7	+4.4
Stung Treng	–	–	–	–	–	–
Svay Rieng	97 210	12.4	87	82	11.4	-1.0
Takeo	136 448	17.4	122	122	16.9	–
Tboung Khmum	–	–	–	–	–	–
Total	782 366	100	700	722	100.0	

– = nil.

The healthcare providers selected for in-depth interviews were chosen from a comprehensive list of NSSF-contracted health facilities (see table 3). To ensure a diversity of healthcare providers, the facilities were selected based on their sector (private/public), facility level (district/commune), and service specialty. In total, nine in-depth interviews were conducted to gather valuable perspectives from these selected healthcare providers.

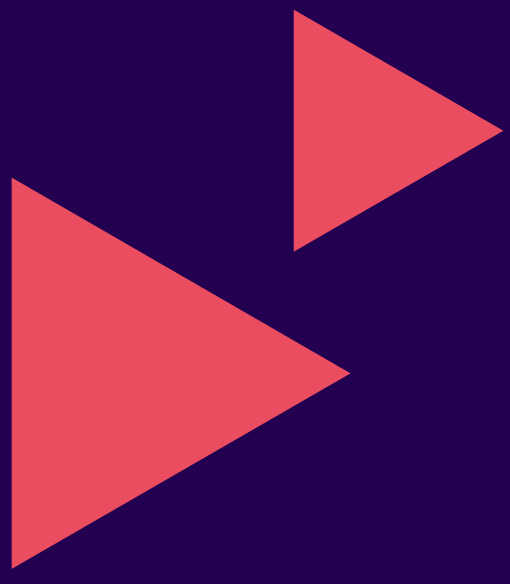
▶ **Table 3. Anonymized overview of the health facilities interviewed**

Health facility	Location	Sector	Facility type
1	Phnom Penh	Private	Hospital
2	Pursat	Public	Health centre
3	Svay Rieng	Private	Hospital
4	Takeo	Public	Referral hospital
5	Svay Rieng	Public	Referral hospital
6	Phnom Penh	Private	Maternity care
7	Kandal	Private	Maternity care
8	Phnom Penh	Private	Clinic
9	Kandal	Private	Clinic



03

Review of the design and achievements of the health insurance schemes



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3.1. Legal, regulatory and policy framework

The legal framework on social health protection

Citizens' right to healthcare in Cambodia is ensured by article 72 of the Constitution of 1993, which states, "The health of the people shall be guaranteed. The State shall pay attention to disease prevention and medical treatment. Poor people shall receive free medical consultations in public hospitals, infirmaries, and maternity clinics. The State shall establish infirmaries and maternity clinics in rural areas."

In 1997, the Government of Cambodia promulgated the Labour Law (later amended in 2007 and 2018), which covers employment and labour rights, union rights, labour inspection and labour dispute resolution. The Labour Law defines the coverage scope as applying to workers and employees of all private sector enterprises/institutions, including social organizations, non-governmental organizations (NGOs), religious organizations, independent professions, and domestic workers as well as staff of public, semi-public or mixed public–private institutions/ventures. This law also establishes the right to paid vacation leave and paid maternity leave, and identifies employers as being responsible for paying the contributions for occupational risk insurance to the NSSF.

In 2002, the Government promulgated the Law on Social Security Schemes for Those Who Are Defined by the Provisions of the Labour Law. The NSSF itself was established by Sub-Decree No.16 SD/PrK, dated 2 March 2007, which states the functions, limits and responsibilities of the Fund. Sub-regulations were subsequently issued during 2008–17, including the Sub-Decree on Creation of Social Security Healthcare Scheme to complement the occupational risk insurance scheme (introduced via Sub-Decree No. 1 ANKr. BK of 2016, which was amended by Sub-Decree No. 140 ANKr.BK of 2017).

The current main legislation regulating contributory social protection in Cambodia is the Law on Social Security Schemes, adopted in October 2019. This Law abrogates the former 2002 Law on Social Security Schemes (article 106). Alongside old-age and occupational risk insurance schemes, the 2019 Law on Social Security Schemes regulates the healthcare scheme. The Law defines the regulation and design of the mandatory health insurance regimes for the public (Chapter V, section II, subsection I) and private sector (Chapter V, section II, subsection II), as well as providing for the future establishment of a voluntary regime for the self-employed (Chapter V, section III).

Several sub-regulations operationalize the Law on Social Security Schemes; although several more have not yet been developed and promulgated. Some of these are being drafted by the NSSF and are to be finalized and approved. The current lack of regulations has created a lack of clarity within the legal and regulatory framework. Table 4 below presents a list of regulations called for under the current legal framework but that have not yet been put in place, which has been extracted from the ongoing ILO study "Review and Development of Social Protection Legal Architecture in Cambodia". This study encompasses a comprehensive analysis of the social protection legal framework to identify critical gaps in the existing architecture to inform the development of relevant legal instruments for the effective functioning of the social protection system. The study identifies several potential gaps and areas to be reviewed and updated, and for the sake of the review of the contributory health insurance schemes, these are summarized below.

▶ **Table 4. Regulations missing and required under current legal framework**

Requirement	Concerned matters	Remarks	Source
Sub-Decree	Determination of other persons in the public sector to implement the 2019 Law on Social Security Schemes	A sub-decree would be required if the Government wants to include local and subnational elected councillors and village administrative agents under social security coverage for the public sector. Also, another sub-decree would be required to provide social security coverage for judges and prosecutors. This sub-decree is being drafted by the MoLVT.	Article 3 of the 2019 Law on Social Security Schemes. See articles 3 and 5 of Royal Decree No. NS/ RKT/ 0217/078 of 2017 on Social Security Schemes for Employment Risks Insurance Scheme for Public Servants, and Healthcare Scheme for Public Servants, Former Government Servants and Veterans. See Royal Decree No. NS/ RKT/ 0710/595 of 2010 on Social Security Schemes for Veterans.
Sub-Decree	Healthcare social security scheme and voluntary contribution scheme for healthcare for self-employed persons	Requirement not met. This sub-decree is being drafted as of April 2023	Articles 6 and 56 of the 2019 Law on Social Security Schemes.
Sub-Decree	Composition, qualification, organization and functioning of a Social Security Trustee Council	This sub-decree is being drafted by the MoLVT.	Article 16 of the 2019 Law on Social Security Schemes. MoLVT Prakas No. 108 KB.BrK, dated 20 May 2014 on the Creation of a Committee on Investment of Social Security Fund of NSSF

Sub-Decree	Contributions to the healthcare scheme (public and private sectors)	Transitional – Existing regulations (as listed below) determine these issues and remain applicable until new prakas issued. ▶ Sub-Decree No. 59 SD.E, dated 08 May 2018 ▶ Prakas No. 449 LV/PrK. NSSF, dated 10 November 2017 Not applicable for the voluntary regime.	Article 40 of the 2019 Law on Social Security Schemes.
Sub-Decree	Revision of provider payment methods for healthcare scheme by other methods	Requirement not met.	Article 43 of the 2019 Law on Social Security Schemes.
Sub-Decree	Organization and functioning of the Social Security Medical Council	Requirement not met.	Article 47 of the 2019 Law on Social Security Schemes
Prakas	Conditions, formalities and procedures for: ▶ Providing medical care services ▶ Rehabilitation services ▶ Determination of services or excluded medical care services ▶ Health prevention services ▶ Determination of chronic disease list	Transitional – Existing regulations determine these issues and remain applicable until new prakas issued. ▶ Prakas No. 109 LV/PrK, dated 17 March 2016 ▶ Prakas No. 184 LV/PrK. NSSF, dated 25 April 2018 ▶ Prakas No. 238 LV/PrK, dated 21 June 2016 ▶ Prakas No. 049 LV/PrK. NSSF, dated 7 March 2017	Article 48 of the 2019 Law on Social Security Schemes
Prakas	Regulation of funeral grant	Requirement not met. This sub-decree is being drafted as of April 2023	Article 51 of the 2019 Law on Social Security Schemes

Sub-Decree	Eligibility for healthcare services among persons in the public sector	Requirement not met. This sub-decree is being drafted	Article 52 of the 2019 Law on Social Security Schemes
Prakas	Conditions, formalities and procedures for providing daily allowance for sick leave (private sector)	Transitional – Existing regulations determine these issues and remain applicable until new prakas issued. ▶ Prakas No. 184 LV/PrK. NSSF, dated 25 April 2018	Article 54 of the 2019 Law on Social Security Schemes.
Prakas	Conditions, formalities and procedures for providing maternity allowance (private sector).	Requirement not met This sub-decree is being drafted as of April 2023	Article 55 of the 2019 Law on Social Security Schemes.
Prakas	Organization and functioning of the Dispute Settlement Committee	Transitionally, existing regulations determine these issues and remain applicable until new prakas issued. ▶ Praks No. 177 LV/PrK, dated 18 August 2010	Article 91 of the 2019 Law on Social Security Schemes.

Source: Authors and ILO, forthcoming.

National Social Protection Policy Framework

The National Social Protection Policy Framework (2016–2025) recognizes the important role of social health protection in achieving universal health coverage. According to the NSPPF, universal health coverage policy development is required to be led by the four principles of "good governance, effective spending, accountability and financial sustainability" (Cambodia, Government of Cambodia 2017, 29). The NSPPF frames the fragmentation of the current social health protection system as a challenge and provides a vision that aims at the establishment of a single operator managing four separate funds:

i. The HEF
ii. Health insurance for public officials
iii. Health insurance for workers/employees under the provisions of the Labour Law
iv. Health insurance for the informal sector

The NSPPF specifies that the "organization and functioning of the NSSF will be revised to allow this agency to play a role as single operator" (Cambodia, Government of Cambodia 2017, 33).

While administrative fragmentation remains by consequence of the existence of several health protection schemes, the NSPPF has supported progress towards greater coherence in the social protection sector. One notable feature of the NSPPF is that, while the health protection system includes both non-contributory schemes (the HEF) and contributory schemes (the NSSF schemes), the Framework locates health protection wholly within the remit of social security. This is distinct from the treatment of other risks, such as disability, old age and maternity. In practical terms, this has involved the development of a conceptual basis for comprehensive reform of the health sector to achieve universal health coverage by 2030.

A Universal Health Coverage Road Map is currently being developed by the Government. It is expected to provide strategic direction for the extension of social health protection in the country, moving it towards a more integrated approach. While the options and level of integration may vary, the Road Map should seek to address the risks inherent in fragmentation, such as: inclusion and equity; incentives and perceived fairness; and financial sustainability.

Furthermore, as of October 2022, an overarching legal instrument – the Social Protection Law – is at the drafting stage. The objectives of this law are to:

- Determine the management structure of the entire system
- Determine the roles and responsibilities of all stakeholders
- Establish monitoring and evaluation mechanisms and processes within the contributory and non-contributory schemes.

The development of this law could be a positive initiative leading to a solid foundation for the newly consolidated system. It is expected that this new legislation will be firmly based on the vision set out by an updated version of the NSPPF and fed by more detailed technical work on governance (ILO, forthcoming).

A revised Social Protection Law can be the appropriate legal instrument to establish the foundations of the institutional framework. A core aspect of good governance in social protection is that programmes and implementing institutions must be enshrined and defined in national legal frameworks and supported by a national strategy and plan of action. The most successful experiences of social protection systems are those grounded in legal instruments that create an entitlement to social protection benefits, ensure the permanence of these initiatives, and give rights-holders the legal ability to invoke their rights (ILO, forthcoming).

International labour standards

As part of its normative mandate in regard to social security, the ILO has adopted a range of Conventions and Recommendations providing standards and principles to guide Members States in the development of their social protection systems. The main ILO social security standards relevant to Cambodia's current health system are set out in the:

- Social Security (Minimum Standards) Convention, 1952 (No.102)
- Medical Care and Sickness Benefits Convention, 1969 (No. 130)
- Maternity Protection Convention, 2000 (No. 183)

Cambodia has yet to ratify these Conventions. A comprehensive review of laws and practices related to the requirements of these Conventions would be necessary if Cambodia was to consider ratification of these Conventions. Such a review could potentially be conducted with ILO support.

3.2. Governance

Over the past decade, Cambodia has progressively developed the governance framework that is necessary to ensure good governance of social protection, including health insurance.

Coordinators and policymakers

Under the 2019 Law on Social Security Schemes (article 10), "all operations of social security schemes shall be coordinated, monitored and oriented in line with policy levels and strategies of the National Social Protection Council". The National Social Protection Council (NSPC), its Executive Committee, and its General Secretariat (GS-NSPC) have critical decision-making, stewardship, oversight and coordination roles in five policy areas: (i) social assistance; (ii) social security; (iii) supervision; and (iv) general affairs; and (v) conflict resolution and beneficiary protection.

The NSPC works to accelerate progress on priority areas while ensuring optimal performance and efficiency of all social protection schemes. The Minister of Economy and Finance chairs the Council, which is comprises ten other ministers, including the Minister of Health and the Minister of Labour and Vocational Training. The same ministries also have high-level representation on the Executive Committee of the Council. The main duties of the Executive Committee are to coordinate the technical and policy level, monitor the implementation of the strategic plans, and create subcommittees and working groups. The GS-NSPC has a full-time technical team.

The development of the Universal Health Coverage Road Map (by the GS-NSPC) and the development of the new Health Sector Plan (by the MoH) are expected to provide strategic orientation on future social health protection governance and the institutional model, increasing coherence and efficiency in the delivery of the social health protection. The HEF is currently regulated differently and separately from the NSSF, with the main actor being the MoH (see box 1).

▶ Box 1. Governance of the Health Equity Fund

The MoH manages the HEF for poor and near-poor households, and its extension for informal workers (Prakas No.404 LV/Prk.NSSF), through the Department of Planning and Health Information (DPHI) and the Department of Budget and Finance. The governance of the HEF is overseen by the Health Financing Steering Committees at the provincial and district levels, chaired by the vice-governors of the respective localities. The Steering Committee for Phnom Penh is the final referral point for any decisions or problems that cannot be resolved at a lower level.

The Payment Certification agency monitors and assesses HEF utilization and Service Delivery Grant implementation, identifies issues, and recommends solutions. In addition to monitoring and assessing the quality of the health services used by HEF beneficiaries, the Payment Certification Agency was established to review and verify payment and audit claims received from all public facilities.

Regulator

Within the GS-NSPC sits the Social Security Regulator (SSR), established in 2022 through the Law on the Organization and Functioning of the Non-Banking Financial Service Authority. The objective of the SSR is to ensure compliance, transparency, accountability and financial sustainability in regard to the social security system through the issuance of regulations, operating standards, guidelines and other prudential measures. However, at the present stage, the SSR still has to develop the necessary frameworks, regulations, standards and guidelines such that will be able to fulfil its role of supervising the social security system and achieve its mandated objectives.

Operator

As the social security operator, the NSSF manages the social health insurance scheme for the public sector and the social health insurance scheme for private sector employees, with technical oversight from the MoLVT and financial oversight from the MEF.

The NSSF is governed by a tripartite Governing Body composed of:

- One representative from the MoLVT (as President)
- One representative from the Office of the Council of Ministers
- One representative from the MEF

- One representative from the MoH
- Two representatives of employers
- Two representatives of workers
- The Director-General of the NSSF

In addition to being a member, the NSSF Director-General also reports to the Governing Body.

The NSSF's work is supported by five councils and commissions that are in charge of technical operations such as dispute settlements, public procurement, state inventory, medical definitions, and general technical support in social security (see Annex 1).

One of the five commissions of the NSSF is the Medical Council, regulated by Sub-Decree No. 109 ANKr. BK dated July 2021, which as the following duties:

- Monitoring the implementation of contractual agreements and undertaking quality assessments of the services of health facilities.
- Examining and advising on the conditions and advantages of health facilities that have requested to sign an agreement with the NSSF.
- Studying, preparing and editing the schedule of permanent incapacity for work risk.
- Examining and deciding on the determination of the level of permanent incapacity for the members of the NSSF suffering from occupational risks that are not listed in the schedule of permanent incapacity, at the request of a doctor recognized by the NSSF.
- Studying, researching and proposing the preparation of legal documents on the classification of occupational diseases.
- Supervising and deciding on the disabilities and chronic diseases of survivor pensioners.
- Studying and deciding on occupational disease classifications.
- Studying and determining the general conditions or situations that require caregivers.
- Studying, preparing, examining and advising on the payment mechanism for the provision of medical services and medical care.
- Reviewing and advising on the selection of medical doctors accredited by the NSSF.
- Performing other duties as determined by the Director-General of the NSSF.

3.3. Population coverage

3.3.1. Eligibility

Insured persons are defined by the 2019 Law on Social Security Schemes (article 38) as follows: "Persons under public sector;[6] persons defined by the provisions of the Labour Law, including personnel serving in air and maritime transportation as well as domestic workers [see box 2]; and the self-employed."

[6] The scope of the Law (article 3) further defines the categories of persons covered in the public sector. It includes retirees from the public service and veterans. It specifically excludes the Royal Cambodian Armed Forces.

▶ Box 2. Persons defined by the provisions of the 1997 Labour Law

The 1997 Labour Law governs relations between employers and workers resulting from employment contracts to be performed within the territory of Cambodia, regardless of where the contract was made or what the nationality and residence of the contracted parties are.

The Law applies to every enterprise or establishment of industry, mining, commerce, crafts, agriculture, services, and land or water transportation, whether public, semi-public or private, non-religious or religious; whether they are of professional education or charitable characteristics; as well as the liberal profession of associations or groups of any nature whatsoever.

The Law also applies to every personnel member who is not governed by the Common Statutes for Civil Servants or by the Diplomatic Statutes, as well as officials in the public service who are temporarily appointed.

"Workers", in the sense of the Labour Law, include all persons of all sexes and nationalities who have signed an employment contract in return for remuneration, under the direction and management of another person, whether that person is a natural person or legal entity, public or private. To clearly determine the characteristics of a worker, one is not to take into account either the jurisdictional status of the employer or that of the worker, as well as the amount of remuneration.

Source: 1997 Labour Law, articles 1, 3.

Enrolment is mandatory for the two first groups of persons and it is foreseen as voluntary for the Self-employed. The conditions and procedures of the Voluntary Health Care Scheme for the self-employed are to be defined by sub-decree. Initially, private companies with fewer than eight workers were not mandated to register with the NSSF, but since 2017 mandatory registration has been extended to all enterprises regardless of their size.

NSSF members are covered on an individual basis and dependents are not covered. This limits the potential of the NSSF to expand coverage to a more significant share of the population. The NSSF is piloting the extension of coverage to domestic workers (under the mandatory scheme) and to *tuk-tuk* drivers, under a voluntary pilot scheme, with the support of the NGO GRET (Group for Research and Technology Exchanges). It will soon start a pilot for further categories of workers yet to be identified, with the support of the ILO. These pilots are expected to offer key lessons on the extension of coverage in Cambodia, with specific attention paid to the promotion of the healthcare scheme and the design of a voluntary scheme.

Previous experience in Cambodia with community-based health insurance proved that voluntary registration is not a valid pathway for the extension of coverage. Voluntary registration commonly translates into very low coverage and high adverse selection. A separate scheme of this nature would not allow for efficient risk pooling and equity in financing.

3.3.2. Legal and effective population coverage, and achievements versus targets

Based on NSSF data, 1,533,330 workers were actively enrolled in healthcare schemes in 2021. Among them, 19 per cent (292,295) were from the public sector and 81 per cent (1,241,035) from the private sector.

The ratio between the total number of employees and active contributors is 41 per cent, which points at the wide social security gap in the country. Also, some specific groups of civil service employees are not yet covered by the public sector scheme. Overall, the quality of data reported in the NSSF Annual Reports for 2018–2021 does not allow a careful assessment of performance indicators related to coverage.

▶ Table 5. Selected indicators of coverage among private and public sector employees, 2019

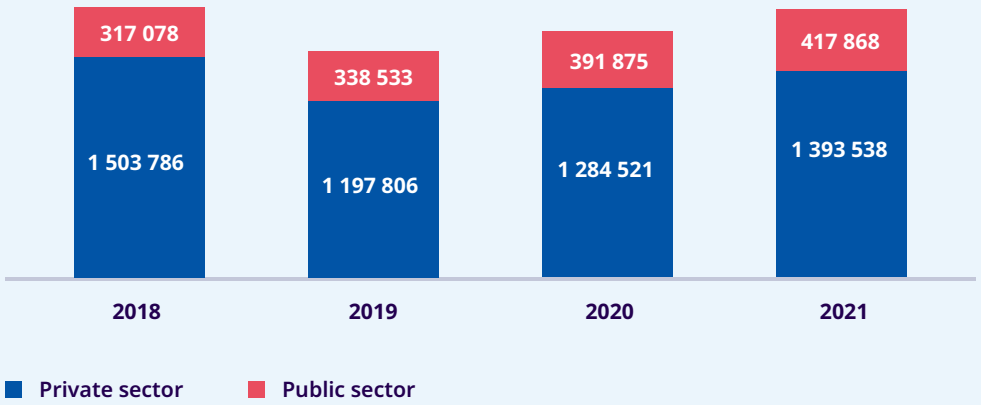
Sector	Total employees*	In the formal sector*	Registered members^	Active contributors^	Active contributors as a % of total employees#
Private sector employees	3 200 714	1 113 197	1 197 806	1 321 249	41
Public sector employees	568 801	568 801	338 533	23 910	39
Total	3 769 515	1 529 015	1 536 339	1 545 159	41

Note: # Ratio between data from different sources.

Source: * Cambodia, NIS 2021; ^ Cambodia, NSSF 2021.

Membership increased relatively rapidly once schemes were established. By 2018, the total number of members had already reached 1,820,864, which roughly corresponds to the total number of members in 2021 (1,811,406). Membership saw a substantial decline in 2019 (-20 per cent), but bounced back in 2020 towards a growth trajectory (see figure 6). Despite the challenges caused by the COVID-19 pandemic, the nominal coverage of social security was not negatively impacted in 2020 and 2021.

Figure 6. NSSF currently registered members, 2018–21



Source: Elaboration of NSSF Annual Reports 2018–2021.

3.3.3. Profile of members

Data gathered by the NSSF since 2016 show that between 60 and 75 per cent (depending on the year and enterprise) of contributors are women. This is largely due to the demographics of the manufacturing sector (particularly the manufacture of garments, footwear and luggage), which is the largest sector in terms of registered members (see table 6). Workers in manufacturing accounted for about 80 per cent of all NSSF members in 2018–19, followed by workers in financial and insurance activities, administrative and support service activities, and accommodation and food service activities. There is potential for the NSSF to actively promote and increase registration of employers and workers in other employment sectors. Data on the distribution of members by age and income were not available.

Table 6. Share of contributing workers by economic sector (excluding the public sector) (%)

Economic sector	2018	2019
Agriculture, forestry and fishing	0.6	0.6
Mining and quarrying	0.1	0.0
Manufacturing	76.1	75.0
Electricity, gas, steam and air conditioning supply	0.0	0.0
Water supply; sewerage, waste management and remediation activities	0.2	0.2
Construction	0.7	1.0
Wholesale and retail trade; repair of motor vehicles and motorcycles	1.4	1.5
Transportation and storage	0.6	0.6
Accommodation and food service activities	3.1	3.0
Information and communication	0.8	0.7
Financial and insurance activities	4.9	5.0
Real estate activities	0.3	0.4
Professional, scientific and technical activities	0.6	0.8
Administrative and support service activities	3.9	4.0
Public administration and defence; compulsory social security	0.1	0.1
Education	1.3	1.4
Human health and social work activities	0.2	0.2
Arts, entertainment and recreation	2.3	2.4
Other service activities	1.5	1.5
Activities of extraterritorial organizations and bodies	1.4	1.5
Total	100.0	100.0

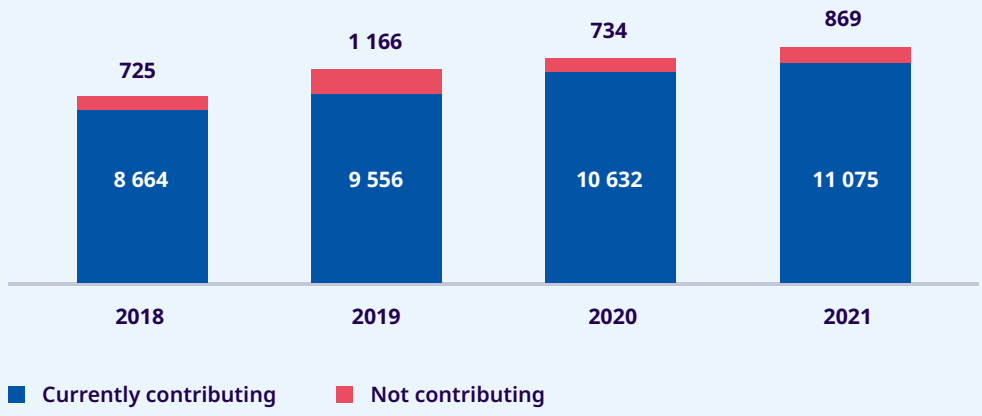
3.3.4. Enterprise registration

According to the preliminary results of the 2022 Economic Census, Cambodia has 753,670 establishments.[7] Of these, 735,456 are micro-establishments, which leaves 18,214 small, medium and large establishments.[8] Under the Law on Commercial Rules and Register, establishments in Cambodia are required to register with the Ministry of Commerce, but the vast majority – 87.6 per cent – have not done so. This lack of registration is not the same across establishments of different sizes, as 100 per cent of large establishments and 94 per cent of small-and medium-sized enterprises (SMEs) are registered. However, only 10.3 per cent of micro-establishments are registered.

The total number of enterprises currently registered with the NSSF has grown by 8 per cent annually in the period from 2018 to 2021, from 9,389 to 11,944. This significant and positive rate of growth can be explained by the onset of the private sector social health insurance scheme. Before the start of the health insurance scheme, the growth rate was positive overall, but declined to 2 per cent in 2017. Thus, it is expected that the growth rate will soon be declining again if no actions are implemented to further encourage NSSF registration.

Among the enterprises currently registered with the NSSF, 92 per cent actively contribute to the healthcare scheme every year on average (see figure 7). In 2021, 869 enterprises did not actively contribute to the scheme, which caused delayed or missing contribution payments for 152,503 workers (11 per cent of registered members).

▶ Figure 7. Number of enterprises registered with the NSSF, by contribution status



Source: Elaboration of NSSF Annual Reports 2018–2021.

[7] The 2022 Economic Census covered all establishments excluding those in the "agriculture, forestry, and fishery" and "household activities" economic sectors. The census also excludes national/local government offices, including military quarters and diplomatic offices.

[8] The size of enterprises is determined by the number of employees. Microenterprises: no more than 10; small enterprises: 11–50; medium enterprises: 51–100; and large enterprises: over 100.

The largest share of registered enterprises (about 25 per cent) operate in the manufacturing sector and have on average 500 employees each (see table 7). The second largest share of registered enterprises are involved in accommodation and food service activities and administrative and support service activities, and have, on average, 31 and 39 employees, respectively.

▶ Table 7. Share of contributing enterprises by economic sector (excluding the public sector) (%)

Economic sector	2018	2019
Agriculture, forestry and fishing	1.1	1.0
Mining and quarrying	0.1	0.2
Manufacturing	25.5	24.1
Electricity, gas, steam and air conditioning supply	0.1	0.0
Water supply; sewerage, waste management and remediation activities	0.2	0.2
Construction	2.2	2.4
Wholesale and retail trade; repair of motor vehicles and motorcycles	5.6	6.3
Transportation and storage	0.8	0.7
Accommodation and food service activities	16.1	15.1
Information and communication	1.4	1.6
Financial and insurance activities	2.6	2.5
Real estate activities	1.6	2.1
Professional, scientific and technical activities	4.3	5.4
Administrative and support service activities	16.2	16.6
Public administration and defence; compulsory social security	0.0	0.0

Education	5.3	5.4
Human health and social work activities	1.6	1.8
Arts, entertainment and recreation	3.0	2.9
Other service activities	5.0	5.2
Activities of extraterritorial organizations and bodies	7.2	6.7
Total	100.0	100.0

Source: NSSF.

Overall, there is a need for the NSSF to strengthen its statistical, monitoring and research capacities. This would allow the NSSF to better understand the profiles of both uncovered workers and enterprises that have not yet registered, including the sectors they are operating in, and to develop a strategy for extension on this basis.

3.4. Service coverage

3.4.1. Benefits covered

The NSSF's benefits can be divided into two broad types: (i) in-kind benefits; and (ii) cash benefits.

3.4.1.1. In-kind benefits

The benefit package for healthcare services is the same for both the public and private sectors, as specified in the 2019 Law on Social Security Schemes (article 53). Conditions, formalities and procedures for providing medical care services, providing rehabilitation services, determination of services or excluded medical care services, health prevention services, and determination of chronic disease list shall be regulated by prakas. During the current transition period before the promulgation of these new regulations, prakas[9] issued before the promulgation of the 2019 Law on Social Security Schemes are still valid. Although formulated differently in these prakas, the list of services covered is very similar for both public and private sector members.

[9] Namely:

- Prakas No. 109 LV/PrK, dated 17 March 2016;
- Prakas No. 184 LV/PrK.NSSF, dated 25 April 2018;
- Prakas No. 238 LV/PrK, dated 21 June 2016;
- Prakas No. 049 LV/PrK.NSSF, dated 7 March 2017.

Services covered

In-kind benefits cover preventive and curative health services, including outpatient and inpatient care, maternity care, family planning, medium surgical interventions, and transport. Pharmaceuticals and medical devices are also covered. Currently, reimbursement of drug costs is limited to pharmaceuticals included on the essential drugs list published by the MoH.

Health services and medical goods covered by the benefit package include:

1. Inpatient care (up to 180 inpatient days within 12 months): treatment and care services with medical professional technics, diagnosis, laboratory, and other medical screening services; surgical equipment and other medical equipment in the need of treatment; prescribed medicines; room (standard) and food provided by health facilities.
2. Outpatient care: treatment and care services with medical professional technics, diagnosis, laboratory, medical imaging and other medical screening services; surgical equipment and other medical equipment needed for treatment; prescribed medicines.
3. Delivery and prenatal and postnatal services
4. Physiotherapy and kinesitherapy services
5. Emergency medical services
6. Health prevention services[10]
7. Patient transport services and corpse transportation
8. Rehabilitation services

The list of chronic diseases covered by the NSSF (as defined in Prakas No. 238 of 2016) includes 14 diseases:

1. Cardiac failure
2. Cardiomyopathy
3. Chronic hepatitis B
4. Chronic hepatitis C
5. Chronic renal disease
6. Liver cirrhosis
7. Coronary artery disease
8. Diabetes mellitus types 1 & 2
9. Arrhythmias
10. Multiple sclerosis
11. Schizophrenia

[10] These include: rabies vaccination, antirabic serum, anti-tetanus serum, antivenom immunoglobulin, blood test for goiter including TSH (Thyroid-Stimulating Hormone), free T3 (free triiodothyronine), free T4 (free thyrozine), and blood tests for tumour markers after cancer treatment by surgery, chemotherapy, and/or radiotherapy.

12. Systemic lupus erythematosus

13. Hypertension

14. Thalassemia

In order to facilitate continuity of coverage, particularly for seasonal workers, the NSSF maintains coverage of its members for a given period of time following their last contribution. The duration of this period depends on the number of months of contributions.

Exclusions

The 2019 Law on Social Security Schemes defines the above list of includes services, while Prakas No. 184 LV/PrK.NSSF, dated 2018, and Sub-Decree No. 134 of 2017 define the excluded medical care services for both private and public sector members. The excluded services, which are the same for both groups of members, are as follows.

1. Free services as stipulated in the public health policy

2. Dental care (cleaning, filling and implanting)

3. Sexual surgery and care

4. Organ transplantation

5. In vitro fertilization

6. Self-treatment

7. Plastic surgery

8. Contact lenses, glasses, and eye laser-therapy

9. Drug abuse treatment

10. Fertility treatments

11. Cataract surgery

12. Coronary and heart surgery

13. Haemodialysis

14. General health check-ups

The current benefit package is rather comprehensive, and efforts have been made to harmonize the benefits covered under each of the two health insurance schemes.

Future revisions of the benefit package could consider covering conditions that are currently explicitly excluded. Such revisions should be informed by costing exercises, actuarial valuation and analysis of the burden of diseases, and led with a public health objective in mind. For instance, cost analysis for high-cost treatments such as coronary and heart surgery, haemodialysis and chemotherapy, as well as non-covered chronic diseases could inform progressive reform towards the development of a more comprehensive package over time. Moreover, the increasing burden of non-communicable disease would justify the inclusion of regular medical check-ups. Moreover, the progressive reduction of global funding to vertical programmes on tuberculosis, HIV and malaria would justify the progressive coverage of the associated treatments by the NSSF. Consultations with partners through social dialogue is also a necessary condition to address priority demand and to discuss the conditions associated with an increased package of benefits.

Level of financial protection

There are no copayments for medical services covered by the NSSF. This is a good practice that maximizes financial protection and facilitates access to services. It is also in line international labour standards, as per ILO Convention No. 102 (Article 10), which states that when a beneficiary may be required to share in the cost of the medical care "the rules concerning such cost-sharing shall be so designed as to avoid hardship".

The NSSF reimburses contracted health facilities for the medical services they provide to NSSF members. This third-party payment mechanism is also an important element to facilitate access to care, as beneficiaries do not need to advance the required amount of money before accessing care. The NSSF has specific measures in place in case of the need for emergency care, whereby the patient is allowed to use health facilities not contracted with the NSSF. In such cases, the NSSF reimburses patients upon claim submission.

Even so, the qualitative research provides some indications that NSSF members still incur out-of-pocket expenditures. More research is needed to understand better the origin of these out-of-pocket expenditures.

Qualifying period

International labour standards recognize the role of a qualifying period "to limit abuse" (Convention No. 102, Article 11), but the conditions governing the qualifying period should not deprive members of the right to access benefits (Convention No. 130, Article 15). According to the 2019 Law on Social Security Schemes, eligibility criteria for workers in the public sector to access healthcare/medical services will be regulated by sub-decree. A new sub-decree has not been issued since the passage of the 2019 Law on Social Security Schemes, though Sub-Decree No. 134 of 2017, which is still in effect, does not require any qualifying period. The 2019 Law on Social Security Schemes does not mention any eligibility criteria for persons defined by the provision of the Labour Law to access healthcare benefits. However, a qualifying period is defined in a previous prakas (No. 184 of 2018): to get access to medical care services, a worker shall have paid contributions during a qualifying period of at least 6 months in the 12 months preceding healthcare problems or delivery. This period is rather long, and consideration could be made to reduce it so as to not prevent effective access to healthcare services, particularly emergency services (which are less prone to abuse) and child deliveries.

Revision of the healthcare services package

There is no prescribed methodology for defining and revising the healthcare benefits package. Currently, NSSF technical departments draft and submit proposals to the NSSF's Department of Policy for review and inputs. Decisions relating to the benefit package or provider payment mechanisms are done in consultation with the MoH. The final decision on any policy change remains with the NSSF Governance Body. The NSSF's Medical Council has a consultative role only.

3.4.1.2. Cash benefits

Benefits and conditions for access

Article 39 of the 2019 Law on Social Security Schemes defines the cash benefits NSSF members are entitled to. These benefits are (i) daily allowances for hospitalization (sickness benefits); (ii) maternity allowances; and (iii) funeral grants. While the provision of medical care services is similar between the public and private schemes, the cash benefits packages do differ significantly – both in design and in financing (see table 8).

For workers in the public sector the funeral benefits are granted, although the amounts are not defined in the Law or a prakas. In the subsection regulating benefits for workers in the private sector (Chapter V, section II, subsection II), there is no provision concerning funeral grants, but funeral grants of 2 million riel were ultimately introduced in early 2023 via Prakas No. 166 LV/PrK.MLVT (2023).

Maternity allowances differ too. There is no contributory qualifying period for public sector workers; while workers in the private sector must pay contribution for a minimum of 9 months in the 12 months preceding giving birth. Also, the maternity allowance for public sector workers is equivalent to their full salary; while in the case of private sector employees, the benefit corresponds to 70 per cent of the insurable wage (and thus is capped at 70 per cent of the ceiling of about US$300 per month).

Daily allowances for sick leave correspond to the full salary in the case of public sector employees, and there is no qualifying period. In the private sector, sickness benefits are restricted to workers having paid contributions for 6 months in the preceding 12 months (including at least 2 consecutive months before falling ill). For private sector members, sickness allowances are delivered only to workers who are hospitalized, and correspond to 70 per cent of the average insurable wage of the preceding 6 months.

▶ **Table 8. Comparison of cash benefits by sector**

Benefit	Public sector	Private sector
Maternity allowance	**Qualifying period:** n/a **Amount:** Full salary. **Duration:** 90 days.	**Qualifying period:** Paid contributions for at least 9 months within the last 12 months before the date of delivery. **Amount:** 70 of insurable wage. **Duration:** 90 days.
Daily Allowance for sick leave	**Qualifying period:** n/a **Amount:** Full salary. **Condition:** n/a	**Qualifying period:** Paid contributions over a period of 2 consecutive months (or 6 total months) within the last 12 months. **Amount:** 70 of average insurable wage over the preceding 6 months. **Condition:** Only provided in case of hospitalization of at least 8 days (by law) (Fewer than 8 days: Employer liability)
Funerary grant	**Amount:** Not defined. **Condition:** Death due to nonwork-related sickness or contingent accidents.	n/a

n/a = not applicable.

Source: Law on Social Security Schemes (2019).

By providing 90 days of maternity benefits at 70 per cent income replacement rates to workers defined by the Labour Law, the 2019 Law on Social Security Schemes is compliant with the standards of ILO Convention No. 102 (12 weeks at 45 per cent) for workers whose salary is equal or below the ceiling of the insurable earnings. However, as regards persons defined by the Labour Law, these provisions alone are not fully compliant with the more advanced standards on maternity protection provided by Convention No. 183, which provides for a duration of at least 14 weeks with at least 2/3 of previous earnings. Alongside the provisions of the 2019 Social Security Law, the 1997 Labour Law (article 183) establishes that during maternity leave employees are entitled to half of their wage paid by the employer. The two provisions together mean that women may receive 120 per cent of their wages during maternity, an uncommon practice which increases the labour and opportunity costs of hiring reproductive age women. In other words, this may create a barrier and disincentive for employers to hire women, promoting discriminatory hiring practices. The establishment of a contributory social security mechanism should instead effectively serve as a substitute for the employer liability to maternity leave. In addition, article 8 of Interministerial Prakas No. 404LV/PrK.NSSF establishes that workers delivering children in public health facilities shall receive a lump sum allowance of 400,000 riel (doubled in case of twins, and tripled in case of triplets). The lump sums are to be paid by the NSSF and financed via the state budget.

By providing income replacement rates of 70 per cent (private sector) and 100 per cent (public sector) for sickness benefits, the 2019 Law on Social Security Schemes is also compliant with provisions of both Convention No. 102 (at least 45 per cent) and Convention No. 130 (at least 60 per cent) in regard to workers whose salary is equal or below the ceiling of the insurable earnings. In terms of duration, the Law also goes beyond the minimum requirements of the international labour standards, which specify in Convention No. 102 that "the benefit shall be granted throughout the contingency, except that the benefit may be limited to 26 weeks in each case of sickness" (Article 18); while the minimum is 52 weeks under the more advanced standards of Convention No. 130 (Article 26).

While international labour standards allow for a qualifying period can be prescribed for sickness benefits (to preclude abuse) or for maternity benefits (so long as it can be satisfied by a majority of women), the duration should not be such that it precludes access.[11] As such, consideration should be given to reducing the current waiting period that applies to sickness benefits for private sector workers (eligibility below 8 days) and to paid maternity leave, as a strategy to facilitate recovery and to improve maternal and child health.

Qualifying conditions for sickness benefits for persons defined under the Labour Law appear restrictive. The legislation should mention the provision of sickness benefits regardless of the need for hospitalization, so long as a medical certificate has been acquired. By providing income protection to a sick worker paid through collective financing mechanism (rather than employer liability), comprehensive sickness benefits enable workers to rest and recover faster, hence avoiding complications and accidents at the workplace. As such, health expenditures decrease and productivity improves. This prevents the spread of contagious disease too, as demonstrated by the COVID-19 crisis. Ultimately, such conditionalities are detrimental to public health and generate additional costs to the social security system and the society.

[11] Concerning access to maternity cash benefits, Convention No. 183, Article 6 states: "Each Member shall ensure that the conditions to qualify for cash benefits can be satisfied by a large majority of the women to whom this Convention applies."
Concerning access to healthcare services, Convention No. 130, Article 15 states: "Where the legislation of a Member makes the right to the medical care referred to in Article 8 conditional upon the fulfilment of a qualifying period by the person protected or by his breadwinner, the conditions governing the qualifying period shall be such as not to deprive of the right to benefit persons who normally belong to the categories of persons protected."

Conventions No. 102 (Article 18) and Convention No. 130 (Article 26) both contain provisions that authorize an initial period of suspension of earnings during which a sickness benefit is not paid, but such a period should not exceed three days.

Evolution of provision of cash benefits

The number of benefits delivered and the amount expended on these benefits are only available – through NSSF Annual Reports – for the benefits delivered to private sector members (see table 9). The Annual Reports also include expenditures lines for "medical care benefits", which correspond to emergency care claims provided in facilities not contracted with the NSSF. It should be noted that there has been a sharp increase – by a factor of nearly four – in the number of daily allowances from 2020 to 2021. This may be explained by the return to work in 2021 during the COVID-19 pandemic. On the other hand, maternity benefits, which had been provided to roughly 70,000 women per year before COVID-19, reduced by 12,000 in 2021.

▶ **Table 9. Number of benefits provided in the private sector**

Year	Daily allowances for hospitalization	Medical care benefits	Maternity benefits
2018	10 315 (0.7)	698 (0.05)	69 061 (4.6)
2019	17 446 (1.5)	709 (0.06)	69 061 (5.8)
2020	14 653 (1.1)	382 (0.03)	71 781 (5.6)
2021	54 363 (3.9)	184 (0.01)	59 054 (4.2)

Note: Percentages in parentheses are relative to the total number of registered members.
Source: Elaboration of NSSF Annual Reports 2018–2021.

In the general population, the birth rate per 1,000 people is 21.56 in Cambodia (for reference, it is 22.66 in the Lao People's Democratic Republic and 9.99 in Thailand) (The Global Economy, n.d.). Higher rates within the NSSF were expected given that 75 per cent of the membership is female.

3.4.2. Adequacy of benefits

While population coverage is often the main focus of policymakers globally, it is equally important to measure the adequacy of benefits covered. Adequacy of benefits encompasses two complementary dimensions, both in law and in practice:

i. The range of services covered must be comprehensive and meet criteria of availability, acceptability, adaptability and quality.

ii. the level of financial protection effectively enjoyed by the covered population.

Concerning the range of services covered: as mentioned above, a revision of the benefit package could be considered so that it includes additional services, particularly services focusing on prevention and easily justifiable from a public health perspective. A set of proxy indicators can be used to inform accessibility, acceptability, affordability and quality. However, the available indicators are mostly available for the total population only, and are not specific to the NSSF. The utilization rates data are only available for private sector members, and are summarized in table 10.

▶ **Table 10. Healthcare services utilization rates**

	2018	2019	2020	Lao PDR	Vietnam
OPD utilization rate (%)	109	172	175	79.80	129
IPD utilization rate (%)	17	31	19	7.7	16

Lao PDR = Lao People's Democratic Republic.

Source for Cambodia: Authors elaboration of data from NSSF Annual Reports.

Source for Lao Peoples Democratic Republic: Data set provided by National Health Insurance Bureau.

Source for Viet Nam: Thuong 2020.

In 2020, each NSSF member had on average 1.75 OPD visits, while 19 per cent were hospitalized. The OPD rate has increased over time, and seems to be in a relatively good range, that is, not showing underconsumption or overconsumption, given the rather healthy profile of the private sector members. The IPD rate is relatively high. Further analysis on causes of hospitalization, length of stay and referral patterns would be necessary to identify possible preventive health actions or to detect potential frauds. For instance, the provision of sickness benefits only in case of hospitalization may trigger demands for unnecessary hospitalization.

Indicators to measure the adequacy and predictability of benefits, as well as availability and accessibility are, as in most countries, not readily available for specific groups of the population. Some selected indicators are presented in table 11 below, with it noted when they are not specifically applicable to NSSF members.

▶ Table 11. Performance indicators of benefits

Adequacy and predictability	
Universal health coverage service coverage index – Coverage of essential health services (range 1–100; SDG 3.8.1)1	61 (2019) Note: Entire population, but equally relevant for NSSF members, as most services are provided by public facilities
Skilled health staff density per 10,0002	10.94 (2014) Note: As above.
Application of user fees at the point of payment	No (in theory, see qualitative analysis below)
Proportion of population spending more than 10 of household's consumption or income on out-of-pocket payments for healthcare ()[3]	15.3 (at the 10 threshold) and 5.2 (at the 25 threshold) (2014) Note: Entire population, data specific to NSSF members are not produced.
Availability and accessibility	
Utilization of services	OPD utilization rate: 1.75 in 2020 (private sector only). IPD utilization rate: 19 in 2020 (private sector only).
Satisfaction	Satisfaction surveys are not done on a routine basis by the NSSF, and no satisfaction index is calculated.

Sources: Compiled by the authors, including from: 1 WHO and World Bank 2021; 2 WHO, n.d.-b; 3 WHO and World Bank 2019.

Regarding the level of financial protection: legal financial protection is high for NSSF members, as no copayment is required at the point of service. The qualitive survey conducted for this study suggests that a very limited number of NSSF members still incur out-of-pocket expenditures. Additional research is needed to understand whether these are the results of payments for services excluded from the NSSF benefit package or payments at non-covered facilities.

At the national level, out-of-pocket payments account for 64 per cent of current health expenditures (WHO, n.d.-a), and 15.3 per cent of the population suffers from impoverishment due to health expenditures (at the 10 per cent threshold) (WHO and World Bank 2021). It is likely these indicators are driven by the population groups that do not benefit from any form of social health protection (neither the NSSF nor HEF); mainly the population relying on work in the informal economy for a living. Further studies would be necessary to define the level of financial protection that NSSF members are enjoying. The referral rate was 5.6 per cent. Because the number of first and follow-up visits cannot be measured with the current payment and reporting system, we cannot provide an opinion on the achieved referral rate.

3.4.3. Patients' experience on adequacy of benefits

This section draws on the qualitative survey of 722 NSSF members conducted for this study to examine members' experiences concerning the adequacy of the benefits they are entitled to. The surveyed NSSF members were asked about their experiences in accessing healthcare and using their NSSF insurance.

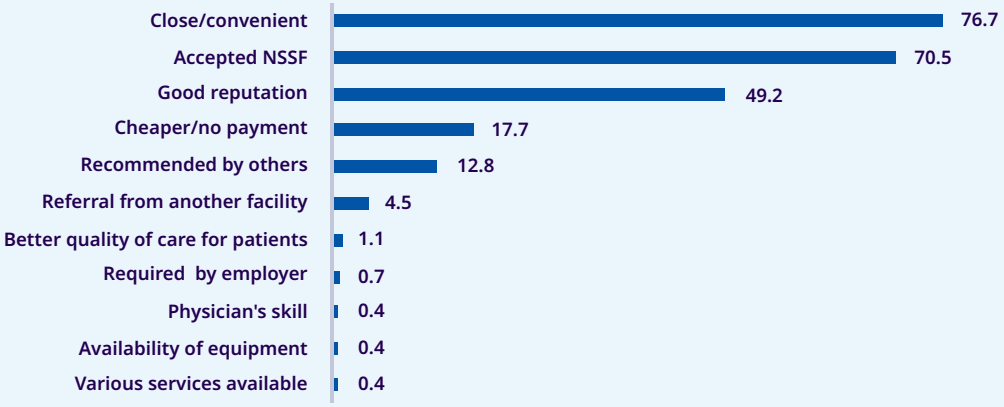
Ease of access to health facilities and use of NSSF insurance

Overall satisfaction with choice and ease of access to facilities accepting NSSF insurance was high among survey respondents. The mean satisfaction with health facility choice was 8.4 out of 10, indicating overall satisfaction with the availability. Likewise, the same mean score of 8.4 out of 10 was given for ease of access to facilities.

This translates into common usage of NSSF health facilities by NSSF members. In terms of using NSSF cards, members reported a mean score of 8.5/10 for the likelihood of using their insurance whenever they get sick and seek treatment. The 722 NSSF members surveyed overwhelmingly accessed outpatient health services using their NSSF insurance at public health facilities (N=711, or 98 per cent). Among the 320 beneficiaries with inpatient experience, nearly all (97.4 per cent) reported seeking treatment using their NSSF insurance at a public health facility. Maternity care through public facilities were comparably accessed, with 96.2 per cent of maternity care beneficiaries (N=263) reporting as much.

The decision to seek outpatient services at the selected health facilities was primarily made as a matter of convenience/proximity by three-quarters of beneficiaries, taking precedence over the need for acceptance of their health insurance (70.5 per cent) and the reputation of the facility (49.2 per cent).

▶ **Figure 8. Reasons for selecting outpatient care facility (N=642) (%)**



Note: Survey respondents were allowed to provide more than one response.

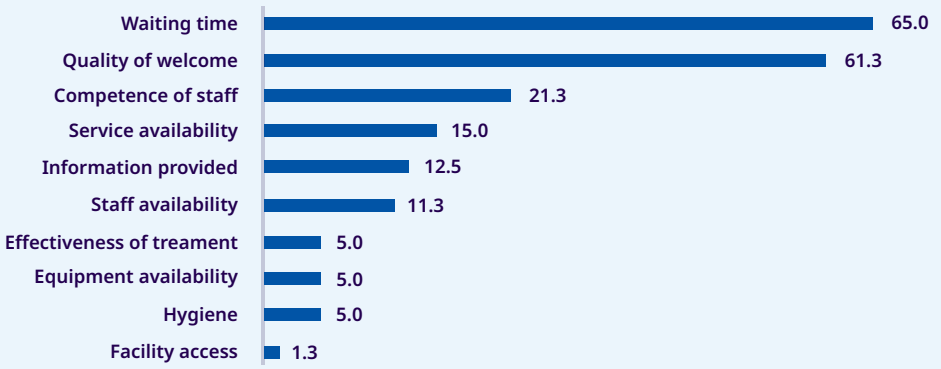
Source: Study survey.

Perceived quality of care

The NSSF has yet to establish satisfaction targets. In absence of a benchmark, appreciation of the survey's results remains subjective. However, we can observe that in general, satisfaction with the healthcare services among respondents to the study survey is high. Satisfaction with inpatient care came to an average of 8.7/10; while respondents' satisfaction with outpatient care is 7.5/10 and 8.8/10 for maternity care, scores ranging from 2 to 10. Ninety-three per cent of respondents indicate that the healthcare services for inpatient care adequately met their needs. Regarding maternity services, members' needs were largely met during their most recent maternity healthcare visit, with 97 per cent reporting that all of their needs were addressed. The respondents who had accessed maternity care declared that health facilities provided all of the necessary equipment for successful treatment. Beneficiaries did report, however, that in a few instances the health facilities were missing echocardiography and surgical equipment.

Only 10 per cent of outpatient care respondents reported experiencing issues. The most common issue with OPD services was waiting time (65.0 per cent), followed closely by quality of welcome (61 per cent) (figure 9). Nonetheless, the average waiting time reported was 18.2 minutes, with nearly all outpatient respondents having waited less than an hour to receive care. This does not seem unreasonable given the absence of a medical appointment system and current human resources deficits. Although they appear lower in the ranking of stated issues, concerns about staff competency and availability remain high (21 per cent and 15 per cent, respectively).

▶ **Figure 9. Most common issues experienced in outpatient care (%)**



Note: Survey respondents were allowed to provide more than one response.

Source: Study survey.

Distance

When asked about their proximity to NSSF-contracted health facilities, 85 per cent reported living within 5 kilometres, and only 4 respondents did not know the distance. The mean reported distance from the nearest NSSF-contracted health facility was 3.9 kilometres. When accounting for locality, large variations were observed (see table 12 for a comparison between rural and urban respondents). Regardless of locality, respondents were more likely to report that they lived closer to a non-NSSF health facility than an NSSF-contracted facility, with this being the case for nearly all respondents living in urban areas (95 per cent), compared to 80 per cent of rural respondents.[12] This scenario could prove detrimental to NSSF members in the event of an emergency.

[12] Not all of the survey respondents were certain whether or not their closest health facility was contracted with the NSSF. This was the case for 17 urban beneficiaries and 24 rural beneficiaries.

Table 12. Distance to NSSF-contracted health facilities: Urban versus rural beneficiaries

Area	No. of survey respondents	Distance (in km)		
		Min	Max	Average
Urban	182	<1.0	14.0	3.3
Rural	536	<1.0	90.0	4.1

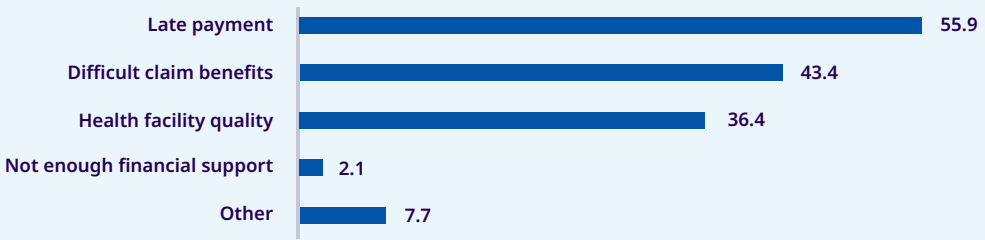
Note: Four respondents did not know the distance to the closest NSSF-contracted health facility.

Source: Study's survey.

Stated satisfaction with NSSF health insurance cover

Overall, satisfaction with currently available insurance services is positive. Respondents rated the overall NSSF scheme 8.8 out of 10, indicating positive reception of the aspect(s) of the insurance scheme that they had accessed in the last two years. Generally, the social health insurance schemes seem to be meeting the expectations of respondents, although the dissatisfaction of 12 per cent of the members surveyed must be addressed.

Figure 10. Issues experienced by survey respondents attributed to NSSF support (N=143) (%)



Note: Survey respondents were allowed to provide more than one response.

Source: Study's survey.

One in five beneficiaries (19.8 per cent) reported having some issue with the NSSF support they received. The most frequently reported issue was late payments, accounting for more than half (55.9 per cent) of beneficiary issues. The second most common issue reported was difficulty claiming benefits (43.4 per cent), which was more clerical in nature: beneficiaries who reported difficulty claiming benefits said that this involved challenges related to the procedures for using their NSSF coverage. The prevalence of late payments is likely due, in part, to these reported difficulties in claiming benefits. In addition, issues related to a lack of friendliness among NSSF staff when contacted for support (1.4 per cent) and no compensation from NSSF despite being disabled (0.7 per cent) were reported.

Other reported issues were less about the NSSF, and more closely related to issues experienced with the health facilities and their staff. Concerns about health facility quality were common (36.4 per cent). This is likely a reflection of perceived quality of health centres, which were commonly used for treatment. Other issues reported involved unfriendly health facility staff (4.9 per cent), and the belief that using NSSF coverage led to differential treatment (long waiting times, mistreatment by staff, and poor quality of welcome – 5.6 per cent, collectively).

Coverage of dependents

Four in five respondents (80 per cent) reported having dependents of some kind – 2.3 dependents per respondent on average, with 1.6 dependents on average being minors (under 18 years). Coverage for dependents is rare enough that only 8.6 per cent of respondents reported their dependents having insurance coverage. Among those who do, these persons were covered through the HEF (45.9 per cent) or through private insurance (44.3 per cent), with only 11.5 per cent being covered via NSSF. Given the higher proportion of HEF coverage over other types of insurance, most dependents with coverage are likely under the age of 18 and living below the poverty line or are informal workers with a similar socio-economic status.

▶ Figure 11. Insurance types for NSSF members dependents (%)

Note: Survey respondents were allowed to provide more than one response.

Source: Study's survey.

On top of the low coverage, the need for social health protection appears high for dependents of NSSF members. More than 85 per cent of respondents report that during the six months preceding the survey their dependents needed medical attention at some point. Among those who did, the treatment received was outpatient in more than 90 per cent of cases. Inpatient services were far less common, only accounting for 6.6 per cent of treatment received.

Treatment of dependents was rarely covered by insurance of any kind, with this reportedly being the case in only 3.8 per cent of instances. Overwhelmingly, dependents' treatment was an out-of-pocket expense for 90 per cent of respondents reporting such circumstances. The absence of health insurance cover for dependents resulted in personal costs, but also created the need for some beneficiaries to seek outside funding from family and friends (5.2 per cent) and even borrow via loans (0.5 per cent) to finance treatment. In the rarest instances, there was no cost incurred, but this only applied to treatment at Kantha Bopha Children's Hospital.[13] When asked about the total cost of dependents' treatment in the last six months, beneficiaries noted that the average cost was 632,400 riel (about US$150).[14] The absence of coverage for dependents underscores a wide gap that could be addressed.

▶ Box 3. NSSF members suggestions to improve coverage and health services

Among the 722 beneficiaries surveyed, 296 (37.3 per cent) proposed recommendations to improve the NSSF health insurance schemes. More than half of beneficiaries with suggestions noted that, in their experience, health facility staff either neglected them, communicated using immoderate language, deprioritized them as NSSF cardholders, or they experienced disparity in quality of care compared with non-NSSF beneficiaries. Indeed, the most reported issue experienced by beneficiaries was discrimination by healthcare professionals during healthcare visits (52.7 per cent).

There was a common interest, among beneficiaries in enhancing services, including coverage of more illnesses, provision of better medical equipment, and the inclusion of more private health facilities. Due to challenges regarding documentation, beneficiaries also reported wanting to see better support for documenting procedures because the current mechanism is time-consuming. Beneficiaries experience difficulties with the process and as a result, there is a call for NSSF to provide support for medical forms to claim benefits. In some instances, beneficiaries report issues with diagnostic skills of healthcare professionals, with one stating that they only received paracetamol, irrespective of the diagnosis received.

In terms of coverage, though uncommonly mentioned, some beneficiaries would also like to see NSSF benefits extended to family members. One beneficiary recommended a grace period for coverage when beneficiaries leave their current place of employment, allowing for consistent coverage and time to transition. The final recommendation provided by beneficiaries was an interest in NSSF arranging for [presumably] non-emergency transportation to health facilities for poor beneficiaries.

Source: Study survey.

[13] Kantha Bopha is a children's hospital that waives fees and charges to treat children in Cambodia.

[14] Median: 200,000 riel (US$48.78).

3.5. Financing

3.5.1. Financial management

The NSSF's Department of Budget Management, Finance, and Accounting is responsible for the consolidation of each department's budget proposals. The proposals are accounted into the annual budget and sent to the Governing Body for approval. At least by 30 September every year, the Governing Body is to approve the NSSF annual budget planning and development programme. The programme and plans shall be submitted to the MoLVT and the MEF for approvals and recommendations.

In case of budget overruns, a reserve fund is used to cover the expenses, although minimum reserves for each scheme are stipulated. The NSSF can incur a deficit, and its sustainability is granted by the State. The NSSF can also incur debt and secure loans with the approval of the MEF and MoLVT.

Investment of the funds and their returns should be recorded in separate accounting books. The sub-decree regulating the Social Security Regulator (SSR) requires the development of Guidelines on Social Security Fund Investments. Currently, the Department of Social Security Funds Investment Management is at the stage of preparing investment guidelines and plans, but a timeline for this task is not available. The 2019 Law on Social Security Schemes states that each social security scheme's funds should be deposited in respective banks accounts, meaning that the healthcare insurance scheme for persons under public sector, the healthcare insurance scheme for persons defined by the provisions of the Labour Law, and the voluntary healthcare scheme should each have separate bank accounts. However, no specific legal provision guaranteeing the ring-fencing of the funds or the potential for fungibility across funds has yet been specified.

In the case of the healthcare insurance fund(s), the 2019 Law on Social Security Schemes specifies a reserve-to-expenditure ratio (RER) of one year.[15] It is a good practice to set a reserves requirement in law, and to express it with regards to level of expenditures, as well as to publicly disclose the reserve amount. Moreover, there is a need for a financing policy and an actuarial valuation. The actuarial valuation is necessary to provide input into the level of reserves compared to the target and whether the target level is in fact appropriate.

The 2019 Law on Social Security Schemes specifies that annually an actuarial review of the healthcare scheme must be carried out, and the current drafted SSR Sub-Decree establishes that: "NSSF shall conduct actuarial valuation to ensure financial sustainability of each social security scheme in accordance with the existing laws and regulations, and shall submit to the SSR the results of the actuarial valuation within one (01) month after completing the calculation". However, the sub-decree does not specify that parametric reforms shall be evidence-based and backed-up by the results of periodic actuarial valuations. Despite the commitment and legal requirement to perform annual actuarial review of the healthcare scheme, the NSSF currently does not have the internal capacity to do so, and development partners are sought to provide support through technical collaboration activities. The NSSF has not yet carried out the first actuarial valuation of the healthcare schemes although it is expected that a valuation will be completed by the end of 2023.

[15] Medical care benefits, maternity benefits and sickness benefits are all administered under the healthcare schemes.

The 2007 Law Establishing the NSSF (article 17), and 2019 Law on Social Security Schemes (article 96) provide that the NSSF shall comply with financial accounting in accordance with public accounting principles and accounting rules set by the MEF; approve annual financial reports; and be monitored and audited by the National Audit Authority. In practice, this process is yet to fully take place, and at present the NSSF is not fully capacitated to produce comprehensive financial reporting, including annual budgeting and financial statements. It has to be noted that, in order to perform actuarial reviews and assessments, the consolidation of flows and stocks in standardized financial statements is a prerequisite for quality and an accelerator for timeliness. Eventually, the publication and dissemination of financial reports serves as a transparency tool that fosters trust and credibility in social security institutions.

3.5.2. Revenues

According to the 2019 Law on Social Security Schemes, the NSSF health insurance schemes can originate revenues from members' contributions, returns on investments, and other donations or legacies and other legal sources. The 2019 financing mix of the overall NSSF was largely based on revenues from members' contributions (95 per cent), followed by returns on investments (3 per cent), and subsidies and donations (2 per cent).

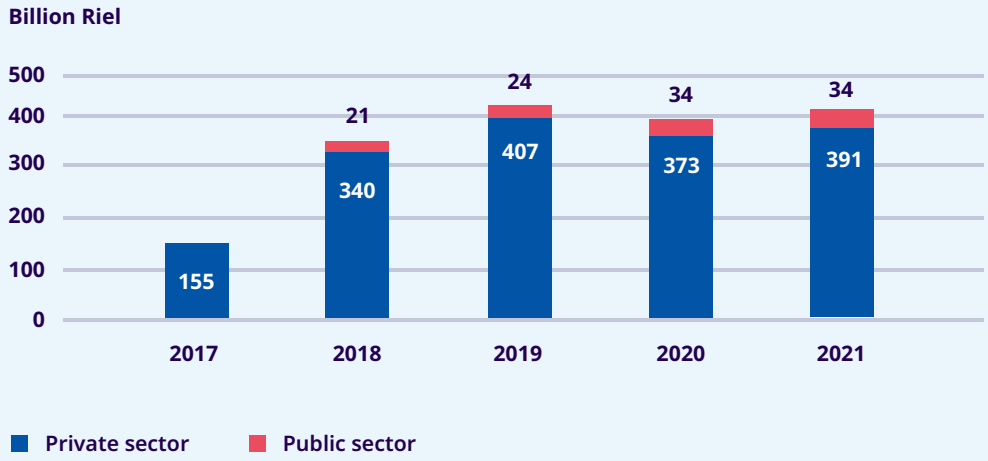
Social security contributions

The 2019 Law on Social Security Schemes states that both the employer and the worker must pay contributions (article 6), with workers not contributing more than 50 per cent of the total mandatory contributions (article 9). In the transitional Sub-Decree No. 59 SD.E, dated 8 May 2018, the healthcare scheme contribution rate for the civil servants' is set at 1 per cent of the worker's salary, borne equally by the State and the worker (50/50). In the case of the private sector, the contribution rate is transitionally defined by Prakas No. 449 LV/PrK.NSSF, dated 10 November 2017, at 2.6 per cent of the gross wage, entirely borne by the employer.

A ceiling of 1.2 million riel, or approximately US$300, is applied to the monthly insurable earnings for both schemes. This should be considered relatively low, as it is very close to the minimum wage, and therefore deprives the schemes from additional revenues and better risk pooling. Indeed, in the private sector scheme, the current ceiling is slightly above the average wage – about 1 million riel in 2019 (Cambodia, NIS 2021) – while it is a common practice throughout social security institutions globally to set it as a multiplier of the average wage so as to promote intragenerational equity across different levels of earning.

Since the onset of the schemes in 2017, revenues from contributions grew to 361 billion riel in 2018 and 430 billion riel in 2019, before slightly decreasing in 2020 and then recovering to 425 billion riel in 2021 (see figure 12). In 2021, contributions from the public sector accounted for 8 per cent of total contribution revenues. On average, the monthly contribution of workers was 26,258 riel in the private sector and 9,790 riel in the public sector.

▶ **Figure 12. Revenues from social security contributions**



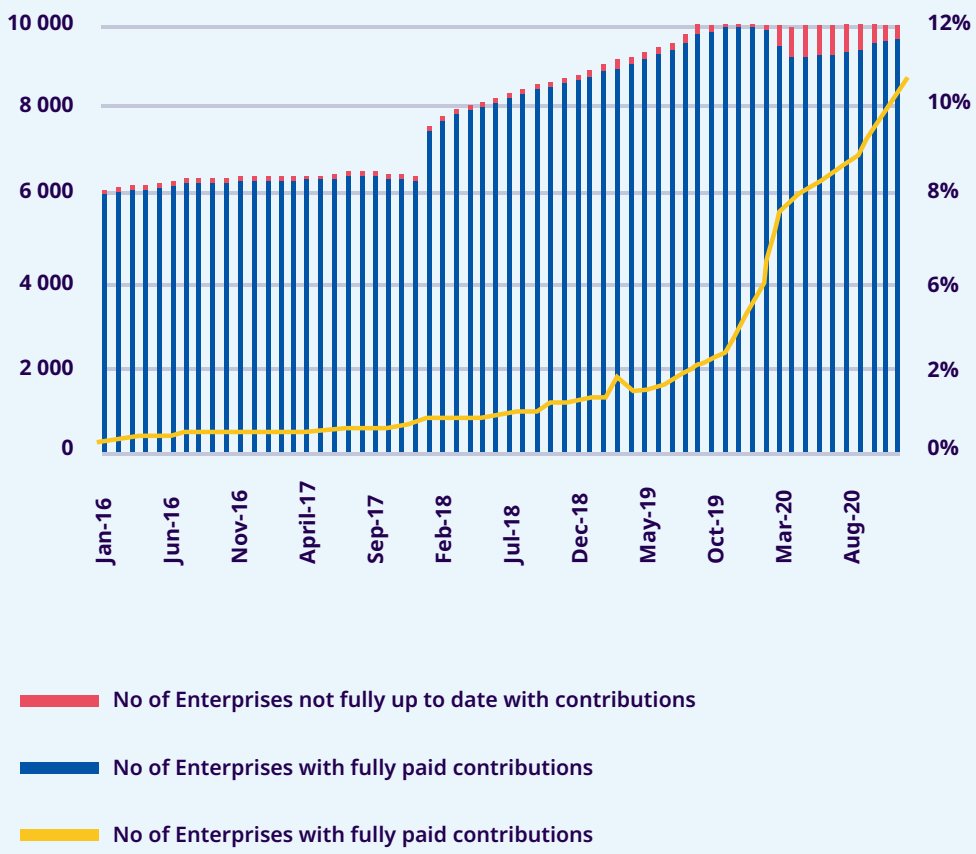
Note: Elaboration of NSSF Annual Reports 2018–2021.

In the public sector the budget credit for contributions borne by the State is planned in the annual budget package of MoH, which in turn transfers the budget to the NSSF account on a monthly base. Every month, the Ministry of Civil Service shares with the NSSF and MoH updated data on public sector employees. The NSSF, based on the data shared by the Ministry of Civil Service, bills to the MoH the corresponding budget credit required.

In the private sector, monthly contributions should be paid no later than the 15th day of the following month. Employers of enterprises/establishments who do not comply with the contribution payment by the deadline or who submit the incorrect number of workers are considered liable to a fine of 10 to 30 times the daily base wage. Enterprise compliance with payment of contribution remained relatively good during the two first years of scheme implementation, with the percentage of non-compliant enterprises remaining below 2 per cent until the third quarter of 2019 (see figure 13). Non-compliance started to increase from the last quarter 2019, with a steep increase from January 2020. This could be a result of the measure concerning on-demand temporary suspension of contributions to the social security fund as an attempt to alleviate the financial burden on enterprises suffering from the COVID-19 crisis.[16] Members were still granted access to benefits during this period. The directive had no provision for the future reimbursement of such contributions from enterprises.

[16] As per MoLVT Instruction No. 045/20 K.B/S.N.N.Kh.L on Employment Contract Suspension and Suspension of NSSF Contribution Payment for Factories, Enterprises, Establishments in the Garment and Tourism Sectors Severely Affected by COVID-19.

Figure 13. Evolution of enterprises compliance and non-compliance with regard to contributions



Source: Authors elaboration of NSSF Data.

In the period 2016–19 the economic sector that contributed the most to the NSSF (all schemes) was the manufacturing industry. This sector accounted for about 80 per cent of all collected contributions, followed by financial and insurance activities (5 per cent annually) and administrative and support service activities (3–4 per cent), with the remaining share distributed across other sectors (see table 13).

▶ **Table 13. Share of contributions by economic sector (%)**

Economic sector	2016	2017	2018	2019
Agriculture, forestry and fishing	0.4	0.2	0.5	0.6
Mining and quarrying	0.1	0.0	0.1	0.1
Manufacturing	80.7	90.1	74.8	73.0
Electricity, gas, steam and air conditioning supply	0.0	0.0	0.0	0.0
Water supply; sewerage, waste management and remediation activities	0.2	0.1	0.3	0.3
Construction	0.4	0.2	0.6	1.0
Wholesale and retail trade; repair of motor vehicles and motorcycles	0.9	0.5	1.4	1.5
Transportation and storage	0.7	0.3	0.7	0.7
Accommodation and food service activities	2.1	1.0	2.6	2.8
Information and communication	0.9	0.4	1.0	0.9
Financial and insurance activities	4.7	2.2	6.5	6.5
Real estate activities	0.2	0.1	0.3	0.4
Professional, scientific and technical activities	0.3	0.2	0.6	0.8
Administrative and support service activities	2.9	1.6	3.6	3.9
Public administration and defence; compulsory social security	0.1	0.1	0.1	0.1
Education	1.0	0.5	1.2	1.3

Human health and social work activities	0.2	0.1	0.2	0.2
Arts, entertainment and recreation	1.9	0.9	2.7	2.8
Other service activities	0.9	0.6	1.4	1.5
Activities of extraterritorial organizations and bodies	1.6	0.7	1.6	1.7
Total	100.0	100.0	100.0	100.0

Source: NSSF.

3.5.3. Expenditures

The 2019 Law on Social Security Schemes does not specify what the authorized expenditures of the health insurance fund are. Revenues from mandatory health insurance contributions and the state budget subsidy are used to finance the NSSF's regular activities, that is, payments to healthcare providers according to the terms of contracts, payment of maternity allowances, daily allowances for sick leave, and funeral grants. Revenues are also used for administration of the NSSF and compensation for some NSSF workers, such as contract staff.

Total private sector healthcare fund expenditures are detailed in the NSSF Annual Reports 2018–2021. After the onset of the scheme in 2017, and following the increasing enrolment of members in 2017–19, expenditures reached 286 billion riel in 2019, before significantly increasing to 326 billion riel in 2020, and then regaining the level of 287 billion riel in 2021 (see table 14).

Claims from contracted health facilities annually account for about half of total expenditures. The remainder is spent on cash transfers to NSSF members, such as maternity benefits (43 per cent in 2021), daily sickness allowances (11.8 per cent), and medical care benefits (members' direct claims) (0.05 per cent). It shall be noted that there was a sharp increase – by a factor of more than six – in expenditures for hospitalization daily allowances from 2020 to 2021. This may be explained by increased hospitalizations and length of stay during the COVID-19 pandemic.

▶ **Table 14. Expenditures for the private sector scheme (billion riel, nominal)**

Year	Daily allowances	Medical care benefits	Maternity benefits	Contracted facilities	Rehabilitation services	Total
2017	1.07	0.07	10.91	14.50	0.0	26.55
2018	8.87	0.33	81.77	73.22	<0.01	164.20
2019	6.87	0.29	143.26	135.17	<0.01	285.59
2020	5.81	0.18	147.81	172.63	<0.01	326.43
2021	33.87	0.13	122.21	130.99	<0.01	287.20

Source: Elaboration of NSSF Annual Reports 2018–2021.

Comparing the expenditure amounts with revenues, the private sector healthcare scheme may have been generating an average annual surplus of 115 billion riel over the period 2017–21, or cumulatively about 576 billion riel (these values do not take into account monetary inflation). The public sector scheme's expenditures have been increasing each operating year and reached 51.8 billion riel in 2021, with the main expenditure item being "Formal Hospitals" (see "reimbursement to the contracted health facility" in table 15 below). Compared with the scheme's revenues, it is assessed that the public sector scheme has run an average annual deficit of 12 billion riel in 2019–21. The 2021 deficit corresponds to more than 50 per cent of the scheme's revenues from contributions, and deficits show an increasing trend over the four years of scheme operation. The NSSF Annual Reports do not mention the source of funding for addressing the current deficit, nor do they provide the annual amount of the scheme's reserves.

A comprehensive actuarial analysis is needed to analyse the current financial situation of the NSSF healthcare schemes. Such an analysis would allow one to carry out simulations of several policy options aimed at extending the coverage and adequacy of benefits. In particular, the actuarial analysis should look at the:

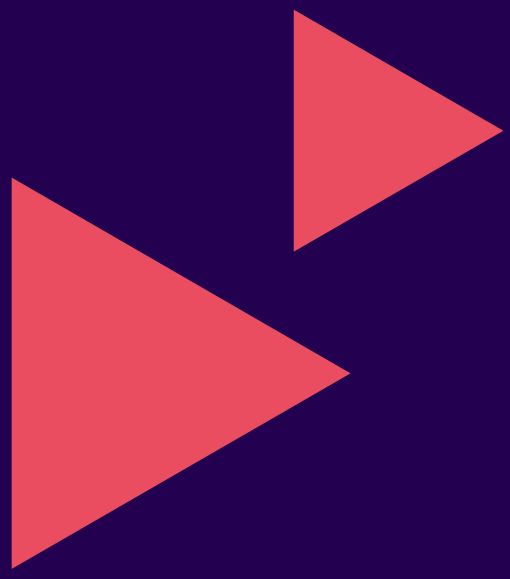
- Ceiling on contributions
- Contribution rate level
- Difference in the contribution rate between civil servants and workers defined by the Labour Law (taking into account the difference in sickness and maternity benefits)
- Possibility of extending coverage to dependents
- The implications of the contribution rate and level of reserves.

Table 15. Expenditures for the public sector scheme (billion riel, nominal)

Year	Referral services (emergency cases)	Reimbursement to the contracted health facility	Rehabilitation services	Total
2018	0.32	2.79	0.01	3.12
2019	0.45	22.14	8.35	30.94
2020	0.10	44.42	0.00	44.52
2021	0.08	51.04	0.70	51.82

04

Review of core operational functions



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4.1. Organizational structure

The NSSF has a central office in Phnom Penh and has decentralized part of its operations to 25 service points spread across Cambodia, which include offices in Phnom Penh and each of the 24 provinces.

The current NSSF organizational structure is outlined in figure 14 below. At the top of the organizational structure is the NSSF's tripartite Governing Body. The Director-General reports to the Governing Body and is also a member of the Governing Body. Under the Director-General there are 13 departments/ units namely:

- Department of Social Security Inspection
- Department of Administration and Human Resource
- Department of Budget Management, Finance, and Accounting
- Department of Registration and Contribution
- Department of Social Security Benefits
- Department of Health Facility Services
- Department of Information Technology
- Department of Social Security Policy
- Department of Customer Services and Public Relations
- Department of Social Security Funds Investment Management;
- Department of Rehabilitation
- Procurement Unit
- Internal Audit Unit

The Department of Health Facilities Services is in charge of several core functions pertaining to the operationalization of the healthcare schemes. These include:

- Contracting health facilities
- Processing reimbursements to contracted health facilities
- Settlement of payments for emergency cases handled at health facilities not contracted with the NSSF
- Payment of daily allowances for hospitalization
- Quality assurance
- Data management
- Member satisfaction

The department is divided into several divisions, including: Medical Care, Health Facility Agreement, Accreditation, Health Promotion and Health Marketing. Interestingly, the NSSF has set up within the department the Health Prevention Division, which identifies from the Fund's information management system HSPIS (or Health Social Protection Information System) the main health risks and issues members are facing. The division proposes preventive measures and intends to develop interventions on this basis.

Table 16 below summarizes the main responsibilities of the core divisions involved in the management and implementation of the health insurance schemes.

▶ Table 16. Main divisions involved in delivering healthcare schemes

Year	Main responsibilities
Medical Care Division	▶ Financial division ▶ Settles payments to health facilities ▶ Pays daily allowances ▶ Data management
Service Quality Monitoring Division	▶ Quality assurance ▶ Manages data of facilities ▶ Works on costs of services together with the MoH ▶ Makes proposals on signing new agreements ▶ Carry out service needs assessments
Health Prevention Division	▶ Studies preventive health, health risks, and prevention measures ▶ Proposes measures ▶ M&E
Health Facility Agreement Management Division	▶ Contracting ▶ Monitoring service use ▶ Complaints ▶ Data management ▶ Customer satisfaction service, including with 6 agents at the hospital level ▶ Member education
Health Marketing Division	▶ Data management and collection (for research purposes) ▶ Budget planning ▶ Human resource planning ▶ M&E ▶ Inventory

Source: Authors.

The current organizational structure of the NSSF includes a substantive number of departments and units to carry out its strategic functions. The structure is hierarchical and functionally fragmented. As a result, the different departments and units often operate in silos with limited coordination and communication. This results in some bureaucratic inefficiencies. For instance, it was observed that there is weak coordination between the NSSF departments and insufficient information flow across the units. The description of the roles and responsibilities of the departments/units appears in MOLVT Prakas No. 016 LV/PRK.NSSF, but this prakas appears to be partially outdated as it describes roles and responsibilities of the Department of Services Reimbursement, which does not exist in the current organogram.

4.2. Review of the core operational functions

4.2.1. Awareness and sensitization

4.2.1.1. NSSF interventions

The Department of Customer Service and Public Relations, through its Education and Dissemination Division, oversees raising awareness on benefits, contributions and related procedures. The Department's Customer Service Division operates a hotline (call centre) receiving members' questions and complaints. The International Cooperation Division facilitates communication with international stakeholders; while the Public Relations Division deals with questions and complaints raised through social medias. The Department oversees the elaboration of annual workplans that operationalize and mirror the five-year NSSF strategic plans.

Communication activities in the field mostly aim at reaching out to enterprises registered with the NSSF. Although not written, the strategy is to first focus on the largest employers, starting with enterprises with more than 500 workers, the second target is enterprises with more than 300 workers, and then those with more than 100. Awareness-raising and ad hoc registration among smaller enterprises (when these have more than 60 workers) is done upon request. In 2022, these activities were strongly focused on the newly introduced pension scheme.

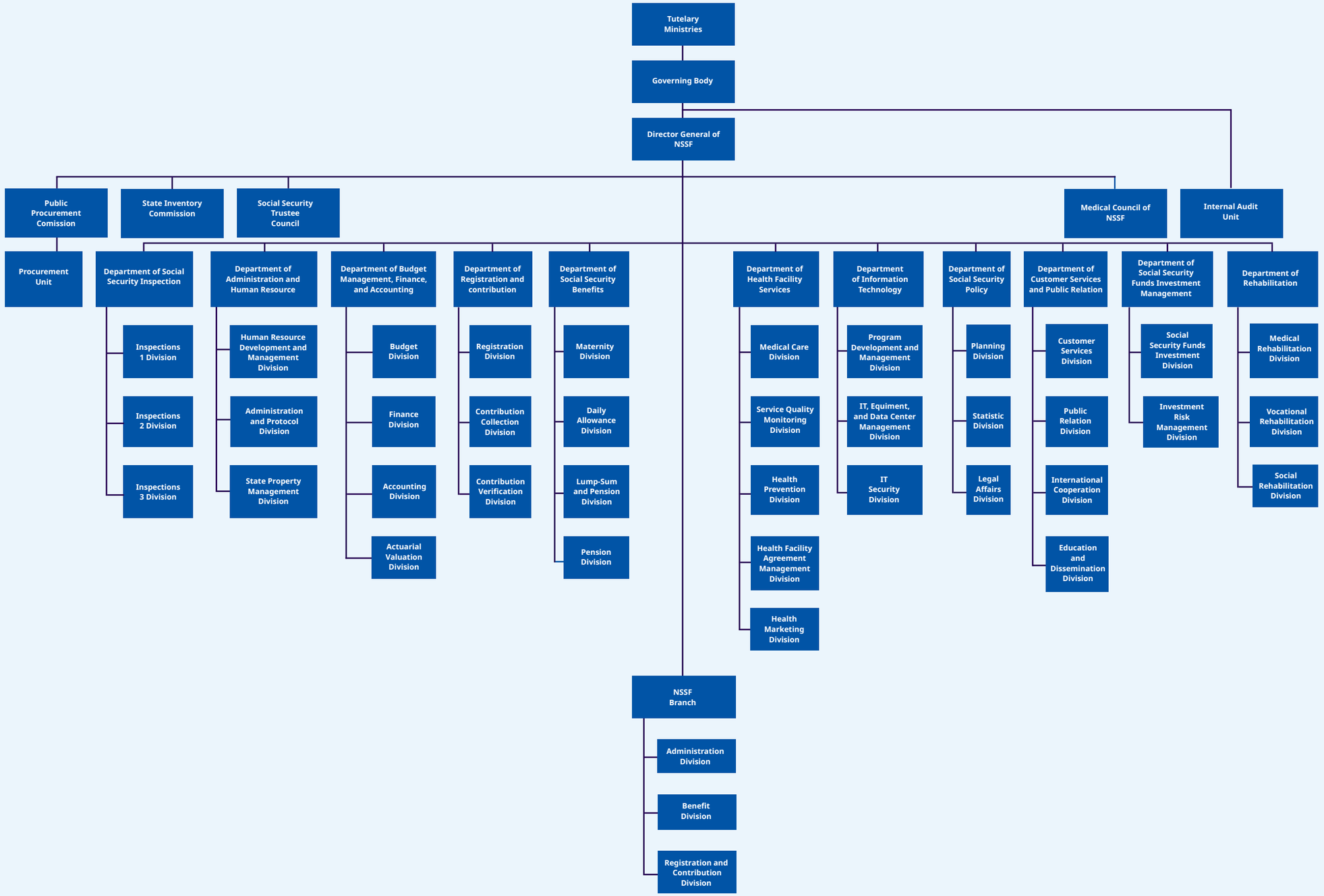
An identified gap is the absence of prioritization of awareness-raising among non-registered enterprises. Increasing coverage among enterprises that are not yet registered with the NSSF would require the implementation of regular and sizeable awareness-raising activities and registration events. Nationwide events giving high visibility to compliant enterprises could be organized as an incentive to promote good practices.

While at present no communication activities in the field of health and prevention are undertaken, it is foreseen that in 2023 the focus will shift to health awareness. Two departments are currently in charge of similar activities: the Department of Customers and Services Relations (Education and Dissemination Division) and the Department of Health Facilities (Health Prevention Division). The former plans to implement health promotion and education programmes, which are expected to first focus on traffic laws (one of the main causes of employment injury) and nutrition. The latter plans to develop and implement health prevention programmes based on the diseases most frequently identified in the Hospital Management Information System (HMIS). Synergies between the two could be further explored to avoid redundancy and to maximize the use of resources allocated to education and prevention programmes.

4.2.1.2. Members' knowledge and awareness on benefits

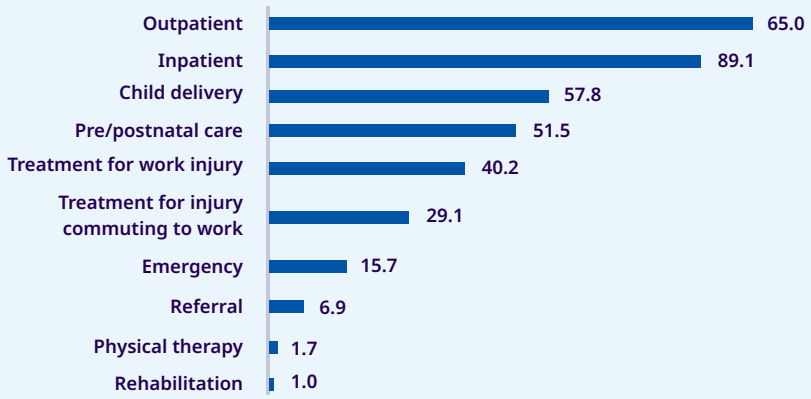
The study's survey shows that, on average, beneficiaries have been enrolled in the NSSF for more than four years. Despite this duration, there still are knowledge gaps about the services covered by the health insurance schemes. Beneficiaries were most aware of the NSSF providing outpatient services (99.9 per cent), followed by inpatient services (89.1 per cent) (see figure 15). More than half were reportedly aware that delivery, surgery and pre/postnatal care services are included in the NSSF schemes. Two-fifths of beneficiaries (40.2 per cent) were aware of NSSF's provision of services for work injury or illness. Very few beneficiaries were aware of the NSSF providing beneficiaries with referral (6.9 per cent), physical therapy (1.7 per cent) or rehabilitation services (1.0 per cent). On the matter of where to take advantage of one's NSSF benefits, nearly all beneficiaries (92.2 per cent) stated that they aware of the name of the nearest health facility that accepts their NSSF insurance.

▶ Figure 14. Current NSSF structure



Source: NSSF.

Figure 15. Survey respondents' awareness of various services (%)



Note: Respondents were allowed to provide more than one response.

Source: Study survey.

Service awareness appears to be closely linked with the services sought, reinforcing the suggestion that beneficiaries do not know what services exist until seeking treatment. This is best illustrated by the difference of only 6.3 percentage points between awareness of child delivery and awareness of pre/postnatal care, or the 0.7 percentage point difference in awareness between physical therapy and rehabilitation service coverage, as these services are likely to be sought in close timing to each other and by the same beneficiaries.

Respondents were also asked about the extent of coverage in different scenarios, that is, whether services were fully, partly or not covered by their NSSF health insurance. Most respondents reported that the following were fully covered:

- Treatment with medical professionals (70 per cent)
- Testing and diagnosis (65 per cent)
- Medical prescriptions (80 per cent)
- Inpatient stays (75 per cent)
- Child delivery (65 per cent)

The service with the lowest reporting of full coverage was surgery, at 40 per cent. Overwhelmingly, most respondents believe that all of the services in figure 15 above are covered under the NSSF in some capacity (either fully covered or partially covered). In all instances, it was highly unlikely for respondents to believe that any services were not at all covered. On the matter of knowing which health facilities accept their insurance, 90 per cent of respondents reported knowing the name of the nearest health facility that has an active contract with the NSSF.

When asked about awareness of how long their NSSF benefits would be available to them, two-thirds of respondents reported being aware. When asked for further information, respondents who reported being aware either replied that benefits would be available as long as they are employed, or that the availability of their benefits is contingent upon remaining with their current employer.

The results of the survey indicate that if a majority of members have a good knowledge about the benefits covered, there is ample space for increasing awareness to reach a situation where at least 90 per cent of members are aware of the categories of services that are fully covered before they actually reach a situation of being in need of healthcare. Full awareness on the level of financial protection provided to them is indeed required for members to make full use of their entitlements.

Sources of information

Nearly two-thirds (62.6 per cent) of beneficiaries reported receiving information about their NSSF insurance benefits through health insurance agents, with health facilities being the second-most common source of information (37.7 per cent). Based on the concentration of responses, it is fair to suggest that most knowledge and awareness of health insurance benefits is obtained on an interventive basis (as opposed to preventive). As NSSF insurance agents do not call beneficiaries to discuss benefits unprompted and health facilities provide information to beneficiaries on an ad hoc basis, inquiries were likely made in response to a present need. More than one-quarter reported receiving information from administrators (non-governmental) and one in ten received information from familiars (that is, co-workers, friends, neighbours and relatives).

4.2.2. Registration of enterprises and workers

Registration of beneficiaries is a key operational function of the NSSF. The registration process is laid out by Prakas No. 448 LV/PrK.NSSF, dated 7 March 2017. Standard operating procedures (SOPs) have been developed, but these will require updates to take into account process changes that have recently been implemented. The registration process and type of access is different for enterprises and workers, due to specific information required of workers. Nonetheless, the registration process is a duty of both enterprises and workers. Once an enterprise is registered, its employees are responsible for going to NSSF offices to complete the registration process.

Employers are required to provide staff and enterprise details, their company identification number, and their certificate of incorporation issued by the Ministry of Commerce. The employer shall declare a list of all employed workers. Upon verification, the enterprise receives a unique employer serial code from the NSSF. This is the "Certificate of Enterprise / Establishment Registration".

As noted above, employees are also required to register themselves with the NSSF. The procedure consists of filling in forms with personal information and the employer's information and submitting these to the NSSF, generally either online or at an NSSF office. The customer services desk at the NSSF office then takes a portrait photo and the fingerprints of the worker, and then releases the NSSF card on spot. While individuals currently can pre-register online, the procedure cannot be fully digital because of the collection of fingerprints. Enterprises may ask the NSSF to register their employees at the workplace. Some workers do not have ID cards (or only expired ID cards), which is a relatively minor but persistent problem, and is more common among under-age workers, which can create legal issues related to child labour.

The NSSF card includes the insurance number, which is used by health facilities to check the bearer's insurance status when they check in for treatment. Health facilities can verify a patient's insurance status through the NSSF portal. In case of doubts or uncertainty, health facilities can also call the hotline for further verification.

The registration process has been significantly improved over the years, with efforts made to reduce reliance on paper and to cut down the time needed to register. Enterprises are now immediately registered (until recently it required seven days) and can complete some of the steps online. If documents are missing on the registration day, they can be shared digitally, making it so the employer does not have to go back to the NSSF office to complete the registration process.

The NSSF has also engaged a modernization process through the development of digital processes. A mobile application for members has been introduced, and it allows members to track employers' contribution payments, the validity status of their NSSF card, and identify the closest health facilities. An online portal for employers has been put in place, and its functions include registration, making contribution payments, sending alert messages on contribution payments, and tracking contributions. These new applications can enable faster and easier connections with the NSSF and are also expected to provide better quality service to NSSF members while building stronger trust in the system.

Despite the improvements mentioned above, legal and operational challenges have prevented the NSSF from significantly boosting employer and worker registration and contribution collection. A major bottleneck had been the absence of systematic information sharing on newly registered enterprises between the Ministry of Commerce, the Tax Authority, and the NSSF. However, the NSSF's Department of Registration and Contribution Collection just started in Q3 of 2023 to receive information from the Ministry of Commerce and the Tax Authority to systematically identify non-registered enterprises. At that time, the NSSF registration system started integrating with other relevant databases through the Cambodia Data Exchange (CamDX) system. This is expected to enable the NSSF to access enterprise information, and on this basis to significantly scale up registration and inspection efforts. Furthermore, the 2022 Economic Census of Cambodia collected relevant information for more than 750,000 establishments. These data are planned to be connected to the CamDX database in the future, significantly increasing the information available.

Another issue is that the NSSF does not have a mechanism to identify workers who are not registered by the enterprise that employs them. This is currently the role of the MoLVT's Labour Inspection Department, which is tasked with visiting enterprises and enforcing compliance. Non-compliant factories, when identified, can be visited for educative purposes before applying sanctions. However, this is not a rule or a procedure, and it is up to the Labour Inspection Department to decide.

Despite the on-going progressive digitalization, the actual registration process is still manual in the majority of cases, with NSSF officers processing forms, performing data entry, scanning forms, handling validation, and printing certificates and membership cards. Consequently, the process still requires significant human resources, warehousing and document destruction, as well as capital costs related to procuring, maintaining and replenishing cards, card printers and ribbons.

4.2.3. Collection of contributions

The Department of Registration and Contributions is in charge of monthly revenues collection and reporting. The NSSF has successfully moved away from cash payments, and contribution payments are made exclusively through bank transfers.

The contribution collection process starts with payments from employers via bank transfers. Subsequently, employers submit certifying documents (workers' registration forms, payroll ledgers, contribution payment receipt, employer's verification letter, and the bank slip) to the NSSF head office or branch. The documentation can be submitted via email. The NSSF contribution department then verifies and issues a slip of contribution payment. Contribution reconciliation is a manual process, and there is no automated system that checks to ensure that contributors have contributed during the previous months.

The NSSF's Inspection Department periodically conducts employer audits to verify the number of active contributors on the payroll. The Verification Division oversees the process and transfers any information on noncompliance with payments to the Inspection Department. The Inspection Department is then in charge of issuing letters and carrying out site visits. In case of noncompliance with registration and contributions payments, sanctions are applied to the enterprise based on the number of days of delay. The 2019 Law on Social Security Schemes provides for penalty levels that depend on the attitude of the enterprises and the discussion held with the Inspection Department. A decision to apply sanctions is made by the Inspection Department, though usually the department first proceeds with awareness and education interventions before applying sanctions. There are no SOPs or guidelines to guide the Inspection Department's work.

The Inspection Department produces monthly reports with key statistics to the management of the NSSF. These reports include the number of enterprises that are not up to date of their contributions. However, the report does not provide the estimated number of workers for whom the contributions are not being paid, nor the estimated value of the missing contributions. Neither of these two indicators are calculated, and there are no automatic flags on underreporting, such as deviations from the expected number of employees, level of salaries, and so on. In a context of a rapid increase of nonpayment – such as was seen in 2019–20 – it becomes urgent to improve the management of unpaid contributions, in close collaboration with the Inspection Department.

4.2.4. Purchasing healthcare services

4.2.4.1. Network of providers

The 2019 Law on Social Security Schemes specifies that "medical care service shall be provided by the health facilities recognized by Ministry of Health and signed the agreement with NSSF" (article 45). Both public and private facilities can be contracted, as long as they are licensed by the MoH. The NSSF has contracts with all public facilities, and they are the backbone of the NSSF healthcare scheme network. Selective contracting of public providers is not allowed, as defined in Interministerial Prakas No. 291 LV/PrK on Agreement on Health Service Consumption and Provision for Health Care between the National Social Security Fund and Health Facility.

Selective contracting is allowed with private providers registered by the MoH after assessment of their service quality by the NSSF. The NSSF is allowed to sign contracts with a private health facility only if necessary to complement public provision of care. This is assessed based on the necessity for specific services, geographical location and the adequacy of its infrastructure and equipment. For instance, many private facilities have been contracted to facilitate access to reproductive and maternity services, given that the large majority of NSSF members are women. Many private providers are located near manufacturing areas where public services may be limited. Most facilities contracted by the NSSF are concentrated in Phnom Penh.

In 2021, the NSSF had contracts with 1,456 health facilities, including: 1,344 public health facilities (national hospitals, referral hospitals, other health facilities) and 119 private health facilities (clinics and polyclinics). As shown in table 17 below, the number of contracted public health facilities has remained relatively stable over time. The extension of the healthcare providers network has rather been due to the contracting of private health facilities.

▶ **Table 17. Evolution of the number of NSSF-contracted health facilities, 2018–22**

Year	National hospitals	Referral hospitals	Health centres	Private health facilities	Total
2018	5	113	1 184	50	1 352
2019	5	115	1 189	85	1 394
2020	5	117	1 209	107	1 438
2021	6	118	1 220	112	1 456
2022	n/a	n/a	n/a	119	wn/a

n/a = not available.

Source: Elaboration of NSSF Annual Reports 2018–2021.

The population per facility ratio is relatively homogenous across provinces, with the expected exception of Phnom Penh. Another exception lays in the low number of facilities in Tbong Khmum given the number of inhabitants in that province. This may be explained by the relatively recent creation of the province, which came about due to the split of Kampong Cham province in 2013, and the overall lack of infrastructure. As noted above, the distribution of health facilities can be an important factor in NSSF members' decision to utilize a particular provider, with distance/convenience being the most commonly cited factor in selecting a health facility.

▶ Table 18. Number of health facilities per province

Province	CPA-1	CPA-2	CPA-3	MPA	Other	Total	Inhabitants/ facility
Tbong Khmum	–	1	1	5	–	7	110 757
Phnom Penh	–	–	8	27	–	35	60 839
Preah Sihanouk	–	–	–	14	–	14	21 635
Kampong Speu	1	2	–	54	1	58	15 038
Stung Treng	–	–	1	11	–	12	13 297
Kampong Thom	–	2	–	51	1	54	12 542
Battambang	1	2	1	77	–	81	12 190
Pailin	–	–	–	6	–	6	11 933
Banteay Meanchey	2	2	1	71	–	76	11 310
Takeo	4	1	1	76	1	83	10 837
Svay Rieng	3	1	1	44	–	49	10 705
Kampong Chhnang	2	–	1	47	–	50	10 519
Kep	–	–	–	4	–	4	10 450
Siem Reap	2	3	1	91	–	97	10 376
Kandal	12	1	1	102	–	116	10 306
Kratie	1	1	2	33	–	37	10 076

Kampot	–	3	1	60	–	64	9 263
Prey Veng	6	2	1	106	–	115	9 195
Pursat	4	–	1	40	–	45	9 150
Preah Vihear	–	–	–	27	1	28	8 977
Koh Kong	1	–	1	13	–	15	8 241
Oddar Meanchey	1	–	–	27	7	35	7 464
Mondulkiri	–	–	–	–	13	13	6 819
Ratanakiri	–	1	1	27	1	30	6 801
Kampong Cham	6	4	1	148	–	159	5 634
Total (simple average)	46	26	25	1 161	25	1283	16 574

– = nil. CPA = Complementary Package of Activities; MPA = Minimum Package of Activities.
Note: Totals may differ from official statistics.

CPA-1 hospitals: 40–60 beds, provide basic obstetric care, but with no major surgery (no general anaesthesia) and no blood bank or blood deposit.

CPA-2 hospitals: 60–100 beds, provide CPA-1 services plus emergency care, major surgery and other specialized services such as blood transfusion.

CPA-3 hospitals: 100–250 beds, provide major surgery and more activities than CPA-2, including various specialized services; all eight national hospitals located in Phnom Penh, and 24 provincial hospitals are CPA-3 hospitals.

MPA: consists mainly of preventive and basic curative services, supplemented by specific activities for vertical programmes.

Source: UNDP, n.d.

4.2.4.2. Contracting process

The NSSF signs individual contracts with each facility, using standard templates developed for each level of care, in accordance with the aforementioned standards of the MoH (MPA, CPA, and so on[17]), and as per the official standard forms provided by the aforementioned Interministerial Prakas No. 291 LV/PrK (see section 4.2.4.1 above). The Prakas covers the basic conditions for contracting public and private facilities, references to payment of service in line with dedicated prakas, and service quality monitoring. The contract templates appendixed to the Prakas provide for the roles and responsibilities of both parties, the services covered under the contract, the modalities of payment, and reference to payment mechanisms in line with relevant prakas. The Prakas also includes a specific section on payment related to performance.

It is mandatory for public health facilities to contract with the NSSF. As for contracting private providers, a contracting process has not been defined in detail in regulations. In practice, however, it starts with the submission of proposals by private providers, followed by a preliminary examination by the NSSF. The Government is currently seeking to address the lack of regulations on the contracting of private facilities through the implementation of the 2022 Sub-Decree No. 160 on Social Security Regulation.

4.2.4.3. Provider payment mechanisms

The NSSF manages the claims processes and reimburses public facilities. The reimbursement rates are prescribed by Inter-Ministerial Prakas No. 173 LV/PrK (2016)[18] and are uniform across facilities at the same level. The drafting of this Prakas was the responsibility of the Medical Commission of the NSSF, but there is no clearly defined methodology for payment model developments and revisions. The 2019 Law on Social Security Schemes and the 2016 Prakas do not specify how or how often the rates should be readjusted. A revision of the provider payment mechanism is planned, but so far has been postponed.

The 2019 Law on Social Security Schemes defines "case-based payments" and "fees for services" as the two allowed payment mechanisms. Case-based payments are expected to cover the cost of all provided medical and paraclinical services that the health facility must provide, as stipulated in the benefit package defined by the Prakas on Healthcare Benefit and the contract between the NSSF and the health facility. The case base is defined by the discharge. This may create incentives for health facilities to unnecessarily refer patients to services that charge a higher case base. Moreover, in the case of a referral, both facilities are paid a case-base rate. This may lead to over-referring of patients to limit spending in one facility.

[17] See Annex 3 for more details about each of the levels of care under the MoH standards.

[18] More precisely, rates are set out in Annex 1 (case base) and Annex 2 (fees-for-service) of Interministerial Prakas No. 327 LV/PrK on Revision of Annex 1 of Inter-Ministerial Prakas No. 173 LV/PrK., dated 05 May 2016, on Provider Payment Methods for Healthcare.

The fee-for-service payment method is used for "special cases". These include:

- Acute haemodialysis (chronic haemodialysis is not covered)
- Magnetic resonance imaging (MRI) scans
- Computerized tomography (CT) scans
- Radiotherapy
- Pathologist's examination of a sample of tissue taken from a patient's tumour
- Osteosynthesis material
- Room with air conditioning
- Patient or victim referral/transportation
- Corpse transportation
- Rehabilitation services
- Trepanation
- Heart and vein surgery
- Cardiac emergency cases

Fee-for-service payments follow a unique schedule per level of care (hospital, polyclinic, clinic), which is applied throughout all facilities, with the exception of Calmette Hospital.

The current use of case-based rates and fees for services requires sound a medical audit capacity to ensure there is not abuse for over-referral (case-based) or over-prescription (fees for services) particularly for MRI and CT scans. To this end, systematic monitoring of the use of MRI and CT scans should be considered, in addition to conducting random spot checks on patients' files.

Balancing easy access, financial sustainability and equity

To access medical care benefits covered by the NSSF, there are no user fees at the point of service provision, and no waiting periods, copayments, ceilings or deductibles. The absence of these barriers facilitates access to healthcare services and is in line with international labour standards.

NSSF members are not required to seek a referral in order to access more specialized care, and this absence of a referral system is the result of a policy choice. Members can access any contracted health facility of their choosing, and while this measure makes access easier for members by allowing a broader choice of providers, the disruptions on the health system may become significant over time, particularly as the covered population increases. Allowing the bypassing of lower levels may overburden facilities that provide higher levels of care, as they will end up handling illnesses that could have been treated at lower levels. It may also contribute to crowding out lower-level health facilities, depriving them of necessary resources.

[18] More precisely, rates are set out in Annex 1 (case base) and Annex 2 (fees-for-service) of Interministerial Prakas No. 327 LV/PrK on Revision of Annex 1 of Inter-Ministerial Prakas No. 173 LV/PrK., dated 05 May 2016, on Provider Payment Methods for Healthcare.

The NSSF strategy to facilitate access to services also includes contracting private providers. Although higher payment rates are allowed for private healthcare providers[19] in order to provide NSSF members with complementary services, these may act as an incentive to use private facilities to the detriment of public services. This may lead to a vicious cycle whereby public facilities get fewer resources, which in turn leads to them providing poorer quality of care, which in turn further demotivates the population from using public services, and so on. This may result in a two-tier health system where lower income Cambodians are mostly using public facilities of lower quality, and wealthier Cambodians are using private services that provide relatively better quality of care. In addition, while the contracting of private providers is done in order to facilitate members' access to quality services, it may have an impact on the financial situation of the healthcare schemes in the short-to-medium term, given the higher fees being paid to these private facilities. Strengthened regulations on contracting, as well as costing and actuarial analysis, are necessary to inform an NSSF provider network extension strategy.

The non-harmonization of rates being paid to providers – both by the various schemes (NSSF and HEF) and by the general public – may lead (or already leads) to a hierarchy in the way patients are attended to, prioritizing those who are more likely to generate higher revenues for the facility, and ultimately leading to discrimination and inequity in access.

4.2.4.4. Claim administration

The NSSF claims process requires the healthcare provider to prepare and batch together a series of claims forms on a monthly basis. These documents are submitted to the NSSF for reimbursement through the HSPIS portal. A batch number is generated in the web portal for these batched claims. The healthcare provider (except national hospitals) then prepares the physical files and scans for submission against the appropriate batch number. The physical files are brought to the relevant NSSF branch office for submission.

Clerical officers at the Department of Health Facility Services receive the claims, and if these satisfy the minimum standards, they are approved and forwarded to the accountant for payment processing. Claims verification is extremely demanding, as incorrect provider coding on diagnosis or procedures requires clinical reviewers to carry out a detailed review of each claim and to modify the coding to reflect the actual treatment.

In the event that a claim lacks the required documentation, it is rejected and cancelled. The healthcare provider is sent a rejection notice, which includes the reason(s) for the rejection, and is given the opportunity to re-open the claim through an appeal process.

According to the Agreement of Service Consumption and Provision, the NSSF has right to reject a claim if:

- The service(s) provided are suspected to be disproportionate to the actual health problem or sickness conditions.
- The intervention, treatment method, or diagnosis are not in pursuance of procedures or principles of the MoH.
- The medical service was of poor quality, counterfeit, or performed by an entity without a license recognized by MoH, or if the prescription was inappropriate.
- The health facility has provided fraudulent or false information.

[19] The NSSF generally pays private facilities a higher rate, ranging between 130 and 150 per cent of the rates applied to public facilities.

Fraud analysis is carried out retrospectively when patterns in the claims data for a certain period are analysed by an NSSF technical team. A comprehensive assessment of the claims process was carried out in 2021 by the World Health Organization (WHO) (Beichl, unpublished). The assessment report concluded that the clinical reviews of the claims are "highly effective", and that "the NSSF works diligently to ensure accurate provider coding, case rates, and additional fee-for-service payments per contract, going so far as to correct an incorrect invoice rather than send back to the provider for modification". The clinical claim audit concluded that no monies were wrongly paid, which is extremely rare.

The claims process is still significantly manual and involves multistep control processes. While a part of the claim submission process is done online, specific tasks related to the generation and submission of claims still rely on manual processes, where both providers and the NSSF incur costs related to transportation, storage and procurement.

At the health facility level, practices vary on how claims are administered. Based on responses received in the healthcare provider survey conducted for this study, there is no formal case management procedure for NSSF beneficiaries. The NSSF does not appear to hold any policy regarding the appointment of an NSSF focal point in the health facility. Healthcare providers who have their own Hospital Management Information Systems (HMIS) rely largely on these to capture medical and billing records for both their NSSF and non-NSSF clients. The re-entering of such data in the NSSF claims system after they have already entered the same in their HMIS, which is currently the case, therefore introduces an extra burden for health facilities.

Efficiency gains and reduction of errors could be obtained in harmonizing the services codes. The current coding is relatively rudimentary, and therefore a new system would need to be developed using a standard diagnosis, procedure and pharmaceutical coding.

The NSSF must pay providers within 30 days from the submission of a claim. Information on current payment timelines was not available. In the qualitative survey for this study, healthcare providers' feedback varied, with a few reporting delayed payments. Overall, the claims process does not collect a comprehensive set of data that can be useful for decision-making. Medical (diagnoses and procedures) and billing codes and their related details are not prescribed. For this reason, data on diagnosis, medicines, investigations and prescriptions cannot be analysed automatically, and this denies the NSSF access to the types of data needed to take further action on preventive care. The aforementioned WHO review of clinical claims provides a full set of recommendations to bolster the NSSF's capacity to improve data quality and availability in order to inform preventive actions.

4.2.4.5. Pay for performance and quality assurance

The NSSF has introduced a pay-for-performance system to encourage and reward care providers for good performance and to empower and incentivize continual improvements. In the absence of a national framework for quality control that would assess compliance with national medical protocols, the pay-for-performance system has been kept relatively simple. The indicators are summarized in table 19 and the indexation scores are presented in table 20.

▶ **Table 19. Pay for performance indicators**

Indicator	Target	Means of measurement	Frequency
Waiting time for patients is less than 30 minutes for emergency cases	90	Report from the NSSF team	Every 6 months
Staff with proper uniforms	90	Report from the NSSF team	Every 6 months
Hygiene in general and in rooms	90	Report from the NSSF team	Every 6 months
Service satisfaction among patients	80	Report from the NSSF team	Every 6 months
Report on good behaviour of health facility staff towards patients	90	Report from the NSSF team	Every 6 months
Patients visited by staff of health facility at least twice per day	90	Report from the NSSF team	Every 6 months
No payments under the table in all cases	100	Report from the NSSF team	Every 6 months
No asking or requiring the NSSF member to buy medicine except when it is set in the regulations	100	Report from the NSSF team	Every 6 months

Source: Contracts form annexed to Inter-Ministerial Prakas No. 291 LV/PrK., dated 25 July 2016, on Agreement on Health Service Consumption and Provision between the National Social Security Fund and Health Facility.

▶ **Table 20. Service quality indicators assessment for determining the rate of service payment**

Service quality score	Payment rate (% of full rate)
>90	120
>85 to 90	100
>70 to 85	80
>60 to 70	70
>50 to 60	60
Equal to 50 or less	Cannot sign the agreement

Source: Contracts form annexed to Inter-Ministerial Prakas No. 291 LV/PrK., dated 25 July 2016, on Agreement on Health Service Consumption and Provision between the National Social Security Fund and Health Facility.

The NSSF's Accreditation Team Division oversees the performance assessment and reports to the Fund's Medical Council. However, the NSSF Accreditation Team has not been trained in assessing the performance of the facilities. This capacity could be developed via a training prepared by the MoH and acknowledged by health facilities.

To promote quality of service, the NSSF has the right to pay more or less than the fee charged by the health facility (between 80 per cent and 120 per cent) according to the level of service quality. The level of quality is assessed based on performance criteria annexed to the health facility's contract with the NSSF. In reality, however, payment adjustments based on performance are not actually made, since the Health Equity and Quality Improvement Project (H-EQIP) provides similar incentives to health facilities.

The MoH has created the Quality Improvement Working Group (QIWG) to coordinate quality improvement policies and implementation. The group is currently in the process of endorsement of the Cambodian Primary Healthcare Accreditation Standards and endorsement of the Cambodian Hospital Accreditation Standards Implementation Guide. These are expected to directly benefit NSSF members though improved quality of services in public facilities.

4.2.4.6. Views of health providers

This section presents findings from interviews conducted for this study with nine public and private healthcare providers. See Section 2 above for further details concerning the providers interviewed.

Claims and auditing

In in-depth interviews for this study, healthcare providers reported that claims information is typically submitted at the end of the month, which suggests that a high volume of cases is processed in the same period. Reports of auditing procedures are conflicting. Some health facilities report there being no auditors, with others reporting that auditors are present at times. The different experiences with regard to auditing may be due to there being a degree of randomness or differences of circumstance determining auditors' visits to different health facilities. For instance, if a health facility is unable to present documentation of their cases when they are due, an auditor may visit. In other instances, NSSF auditors just happen to be stationed on duty at the health facility registration desk. If there are inconsistent reports of auditing among healthcare providers, it is reasonable to suggest that an absence of claims process problems begets an absence of auditing.

Patients' medical history

On the matter of discharge summaries, all of the interviewed healthcare providers reported providing them for beneficiaries following each visit, apart from one private health facility that reported withholding them for long-term treatments (that is, patients are required to continue with health monitoring and follow-up evaluations, and the discharge summary is provided upon completion of the course of treatment).

According to the interviewed providers, the transition of care to other health facilities is seamless, but can be detrimental to the continuity of care. No mechanisms are described for transferring the medical records of NSSF beneficiaries looking to change healthcare providers. The interviewed providers state that they are unaware of whether beneficiaries are seeking healthcare elsewhere and are only cognizant of cases where beneficiaries are transferring care to their own health facilities. In other words, the absence of medical records and going by beneficiaries' word of mouth on pre-existing conditions presents a notable issue in regard to the quality of care received.

Other issues

From the perspective of healthcare providers, NSSF beneficiaries are sometimes working against their own health outcomes. Providers report a propensity among beneficiaries for additional screenings: rather than focusing on the healthcare provider's diagnosis and testing procedures to confirm a diagnosis, beneficiaries are allegedly asking for services outside of the scope of treatment for the concerns specified when they arrived. Allegedly, there is also opposition from beneficiaries when providers recommend inpatient stays for health monitoring, and beneficiaries also often request courses of medication longer than the prescriptions are intended to be.

Another issue is beneficiaries frequently forgetting their NSSF membership cards, presenting a significant challenge when these beneficiaries have traveled a great distance to visit the health facility. When patients forget their NSSF cards like this, health facilities report having no option other than issuing a payment exemption because their membership cannot be verified at the time of service. As this issue was commonly shared by providers, it suggests there is a potential risk of abuse by beneficiaries.

Concerning medical services coverage offered to NSSF beneficiaries, healthcare providers report that the insurance schemes have improved since their inception, or since their earliest engagements with them. Healthcare providers support the current trajectory as the scope and scale of the NSSF schemes continue to expand. The main issue cited by healthcare providers is the absence of insurance cover for crucial surgeries and procedures. Regarding improvements, providers would like to see payment delinquency issues resolved. One private health facility reported wanting to set a limit on the number of visits allowed per beneficiary per health facility. For these frequent visitors, the concern is likely rooted in delayed payments and claim rejections, impacting the financial wellbeing of health facilities. Lastly, to expedite the process of validating NSSF memberships, one health facility shared an interest in scanner installations to quickly verify active coverage.

4.2.5. Data management and monitoring and evaluation

4.2.5.1. Data management

The NSSF relies on several information systems to manage its operations and monitor its performance. Registration and contribution collection for all branches is done through a specific management information system. Members' individual information are imported to another health information system, the aforementioned Health Social Protection Information System (HSPIS). The HSPIS is used to collect and process health facilities' claims and to check membership eligibility.

The HSPIS also allows for the collection of comprehensive data on health service utilization. Tracking of individual utilization data is in principle possible, since members' information is imported from the information system managing registration and contribution collection. The HSPIS collects a comprehensive set of information:

- Member data, including: name, gender, age, address (province, district, commune), contribution information (active or not), employer name, national ID, social security ID, marital status, number of children, type of contract (public or private), starting date of employment with current employer, and employment history (list of previous employers). Family information is, however, only captured at registration time and not updated unless the member proactively asks for it through the Registration and Contribution Collection Department. Salary information is accessible from the registration and collection system.

- Utilization data are captured, using a digital "treatment form" embedded into the system. It captures essential information such as the following:
  - Type of visit (new case, second case)
  - Type of disease: personal accident or disease
  - Category: OPD, IPD, and so on
  - Sub-category: general consultation, and so on
  - Diagnostic (usually more of a list of symptoms)
  - Ward and service name

- Payment to health facilities: automatic display of case-based rates as set in configurations. The system also automatically displays the equivalent amount that would have been paid if the facility was paid following the official user fees schedule.

- Prescribed drugs: type, name, prescribing ward.

- Cash benefits: captures information on emergency, maternity, sick leave and transportation benefits. The system also has two data functions built into it that are not currently being used by the NSSF:
  - Medical history: there is functionality to register members' medical histories.
  - Payback function: to adjust for over-payment of contributions resulting from workers contributions being paid by several employers at the same time.

The HSPIS can generate automatic reports on utilizations and claims and membership on demand. Concerning utilizations and claims, such reports include:

i. Utilization by health facility by level of care

ii. Average cost by health facility

iii. Report on drugs

iv. Overconsumption

v. Top ten diseases

Although membership reports are usually generated by the Registration and Contribution Collection Department through their information system, the HSPIS can generate automatic reports, including:

i. Eligibility lists

ii. Membership monitoring reports

iii. Enterprise membership monitoring reports

iv. Total members by age group and province (among others)

Health facilities reports are generated to track total cases in a given month, and can be grouped by type of case and by unit price (by type and total). It can also produce additional reports based on an SQL request model, which requires the intervention of a trained staff member.

Overall, the HSPIS seems rather comprehensive and in line with the needs of the health insurance schemes when it comes to managing the claims process, monitoring utilizations and membership, and producing necessary operational and management reports. However, at the organization level, data are kept in silos. While there are some reports that tracks NSSF performance, these processes are not IT enabled and are time-consuming.

4.2.5.2. Monitoring and evaluation

The Department of Social Security Policy is responsible for producing monitoring and evaluation (M&E) reports that consolidate the data from all other departments within the NSSF M&E framework structure. This function is severely limited by the limited statistical capacity of the Department, and the lack of ownership of the M&E framework. Furthermore, the Department's officers receive secondary data from other departments, which does not allow them to elaborate reports of consistent quality and depth.

The NSSF produces annual reports on achievements and action plans. These annual reports include both statistical data on coverage and benefits, as well as information on activities, challenges and priority actions for the following year. However, the annual reports also showcase some caveats and inconsistencies. A new structure of the presentation of statistical information as well as the addition of some coverage, benefits and financial indicators would enable an easier analysis of performance over multiple years and against targets.

4.2.6. Complaints and appeal and member satisfaction

As mentioned, the NSSF's Customer Service Division operates a hotline receiving members' questions and complaints, and the Public Relations Division deals with questions and complaints raised through social media. Notably, the operations to collect feedback and manage complaints do not proceed on the basis of updated SOPs. This may cause longer delays in relation to complaint management and problem-solving.

The hotline is mainly used as a channel for members' questions and complaints, but health facilities also use the hotline to verify members' eligibility when doubts arise at the stage of checking patients' documentation (that is, their NSSF card). When an issue cannot be immediately resolved, the hotline filters it to the department in charge of the matter.

Using the information collected from the hotline and social media, the Department of Customer Service and Public Relations produces monthly reports on challenges and support needed from management. However, these are not automated outputs, and require intense work to be produced. Customer satisfaction surveys are not conducted regularly, and when they are conducted, they are not based on a standard format. Instead surveys are performed on ad hoc basis when issues arise.

Complaints management is handled through a complaints information system. This system helps with allocating duties to solve the corresponding issue through a notification system. The complaints system does not allow for keeping track of the decisions made to address the issues raised, nor does it generate reports. This prevents a systematic analysis of the complaints process (for example, capturing the most common complaints and verifying the effective closure of complaints that have been raised).

The 2019 Law on Social Security Schemes provides for dispute settlement mechanisms. Disputes/complaints should first be reported to the Dispute Settlement Committee of the NSSF. If the Committee does not address the dispute/complaint to the satisfaction of the member, a lawsuit can be filed with the Social Security Regulator (SSR) in first instance. However, the SSR – though established – has not yet put in place the necessary procedures for handling such disputes/complaints. In addition, the prakas on the organization and functioning of the Dispute Settlement Committee (as stipulated in article 91 of 2019 Law on Social Security Schemes) has not yet been issued, and it is understood that the pre-existing Prakas No. 177 LV/PrK, dated 18 August 2010, is the legal instrument currently regulating the committee. The absence of an active regulator and these gaps in the regulatory framework deprive members of the right to appeal in case of refusal of benefit or complaints concerning the benefits paid.

Members experience with grievance mechanisms

The study's survey of NSSF members reveals that the redressal mechanism is rarely utilized by beneficiaries, with only 14 of the 722 survey respondents reporting making any complaints. Of the 14 respondents who reported making complaints, 10 complained directly to the health facility that treated them. Only four respondents complained directly to the NSSF – three via social media and one via the call centre. Two of the four beneficiaries who submitted complaints to the NSSF reported receiving replies: one of them receiving a reply one week later and the other one month later. Across all 14 complaints made to both health facilities and the NSSF, only three beneficiaries had their issues completely resolved (21.4 per cent); six had their issues partially resolved; and five received no resolution at all.

4.2.7. Inspections

The Social Security Inspection Department is in charge of monitoring the implementation of the social security law, searching for new enterprises not yet registered, raising awareness on NSSF, encouraging registration, checking on contribution payments when issues are raised, and finally supporting the solving of complaints. In addition to inspectors based at headquarters, the NSSF has inspection staff members at the branch level, assigned by district or commune, whose role is to locate newly established enterprises through neighbourhood visits, social media searches and information provided by local district and commune authorities (main channel). The Department has connections with the Ministry of Commerce and the Tax Authority at the national and provincial levels, but does not automatically receive a list of new enterprises.

Results of inspection visits are manually compiled into reports and then summarized in Excel. The Department does not have a management information system (MIS) that would allow for easy management of inspection activities, findings and follow-up actions. The Inspection Department should seek to gradually move away from manual reporting and move towards more advanced tools and systems in line with changes in technology.

A sub-decree on social security inspections is expected to be issued soon and to give more powers to inspectors to carry out their duties than the current prakas. NSSF inspectors sometimes work with the MoLVT Inspectorate through joint visits when relevant or for difficult cases, but there is no systematic coordination.

The Department currently has 46 contractual staff, including inspectors and administrative staff. The MoLVT Labour Inspection Department has 438 inspectors. This means Cambodia exceeds the ILO standard for less developed countries of 1 inspector for every 40,000 workers.[20] If the two inspections teams work closely together and take a strategic approach to compliance, there should be a sufficient number of inspectors to carry out their duties effectively.

[20] The employed population of Cambodia is estimated at 7.9 million in the Labour Force Survey 2019 (Cambodia, NIS 2021), which would indicate a need for approximately 200 labour inspectors based on the standard for less developed countries.

05

Recommendations

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The recommendations provided below cover selected design features and operational aspects of the NSSF's health insurance schemes. The recommendations are expected to provide concrete directions for the NSSF to improve its organizational efficiency, extend coverage and enhance benefit adequacy. Ideally, the selection of priority recommendations by the NSSF should be informed by its strategic plan. There are several areas of intervention for which the next strategic plan can define goals and activities to implement. Overall, these goals and activities should be developed in consideration of the current National Social Protection Policy Framework, the upcoming one, and relate to the current development of the Universal Health Coverage Road Map undertaken by the GS-NSPC. The main areas addressed below include administrative modernization, extension of coverage, establishment of a member-focused organization, and the development and retention of human resources.

Legal and regulatory framework

A number of prakas and sub-regulations are missing, which creates gaps and uncertainties in the implementation modalities for several policy areas as well as in relation to entitlements (such as benefit packages). It is recommended that these prakas and sub-regulations be developed in the short term. Additionally, it is recommended that the NSSF update its web legal archive with all the relevant legal instruments (laws, decrees, sub-decrees, prakas, and so on).

Additionally, further discussions between the MoLVT, MoH and other related institutions may be considered to specify the distribution of roles within the definition of policies relating to social health protection, including in relation to benefit packages, provider payment mechanisms, and so on.

Promotion and communication of healthcare insurance

The communication strategy currently under development should define goals and targets that go beyond the number of individuals and enterprises reached. The strategy can tailor plans and outcomes to specific categories of workers and employers (for example, through a sectorial approach or a life-cycle approach). Targeted interventions on healthcare promotion can include:

- Awareness-raising field campaigns
- Systematic induction sessions with newly registered enterprises
- Regular engagement programmes with employers for updates on regulations
- Publicity on benefits paid out and actions against wrongdoers

Further, the strategy should envision the human resources and internal capacity that the NSSF aims to develop to enable its communications operations.

The current strategy of reaching out almost entirely to registered enterprises is not adequate to meeting the goal of the extension of coverage. The design of awareness-raising campaigns should include tailored approaches aimed at both registered and non-registered enterprises, delivering key messages on the role of social security for the members, the coverage provided, the rights of the insured, the duties of employers, and the sanctions and consequences of noncompliance.

Overall, the NSSF should set for itself the ambition of fostering a social security culture among the general population of today and coming generations. An example of such promotion is associating awareness campaigns with already attractive events, such as Health Day, by providing free screenings, experience sharing with insured members, and registration booths. Members' experiences can be improved by launching a mobile registration application and online full registration and by moving towards paperless procedures. It is critical that the insured know their rights and entitlements, so that their trust in the NSSF system becomes the promotion backbone of the Fund.

Harmonization and revision healthcare benefits and services

Revisions of the benefit packages should be based on a defined process that includes clear institutional responsibilities, takes an evidence-based approach, and involves social dialogue. In line with the Universal Health Coverage Road Map, the role of the MoH in the process of designing the package can be reinforced. This would allow for a more harmonized approach to defining levels of service coverage across the different healthcare schemes currently provided.

Future revisions of the benefit packages can consider covering conditions that are explicitly excluded at present. Revisions of the benefit packages should be informed by costing exercises, periodic actuarial valuations, and analyses of the burden of diseases. Cost analysis for high-cost treatments such as coronary and heart surgery, haemodialysis, and chemotherapy, as well as non-covered chronic diseases could inform progressive policy changes towards the development of more comprehensive packages. For instance, the increasing burden of non-communicable diseases can justify the inclusion of regular medical check-ups in the package. Moreover, the progressive reduction of global funding to vertical programmes on tuberculosis, HIV and malaria can justify the progressive coverage of associated treatments for these diseases.

Harmonization of the benefits packages across different schemes should be considered as an incentive mechanism to spur participation in social security, while avoiding the creation of inequalities in treatment. The current discussion over the harmonization of services between the HEF and NSSF should be based on the fundamental principle of equity. A step forward can be tying a few key additional benefits to the social security scheme to maintain its attractiveness and to incentivize contributions. The definitions of these benefits should be established such that they do not create inequalities in relation to conditions to accessing healthcare services, nor should these benefit definitions create differences in the quality of services accessed.

Benefits should, at the very least, be aligned with international minimum standards in order to be both attractive and adequate. Regarding sickness benefits for persons defined by the provisions of the Labour Law, it is suggested to: (i) facilitate access by reducing eligibility criteria; and (ii) extend coverage to all episodes of sickness, not only instances of hospitalization. Regarding maternity benefits for persons defined by the provisions of the Labour Law, it is suggested to: (i) facilitate access by reducing eligibility criteria; and (ii) consider increase of duration of benefits to comply with ILO Convention No. 183.

Further analysis on causes of hospitalization, length of stay and referral patterns would be necessary to identify possible health preventive actions and to detect potential fraud, given the high IPD rates among NSSF members in recent years.

Extension of healthcare insurance coverage

It is recommended that the extension of coverage starts with enhancing compliance in the formal economy. A core step towards developing an extension strategy is to generate evidence through sectorial research and to analyse findings from ongoing pilot programmes. NSSF efforts to reach out to more and different sectors of employment will also be a determinant in developing its capacity to increase membership. Sectorial strategies need to include the development of integrated approaches based on partnerships with other structures, such as the Ministry of Commerce and the Tax Authority. The alignment of different institutions can enhance compliance and create conducive environments for participation.

Beyond enforcing compliance among workers in the formal sector, it is suggested to evaluate the **opportunity for extending coverage to NSSF members' dependents**. This can be done through the elaboration of options and scenarios to be simulated in the upcoming actuarial review of the scheme, as the extension of coverage to dependants should be evidence-based and aimed at ensuring the social and financial sustainability of the scheme. Such extension is expected to make the scheme more attractive to members and allow Cambodia to move closer to universal health coverage targets.

The available evidence points to the ineffectiveness of voluntary regimes, and thus there is a case for reconsidering the voluntary nature of the health insurance scheme for the self-employed. Changes to the voluntary nature of this scheme could be considered through a gradual sector-based approach in which coverage would be made mandatory in selected sectors. Although anchored in the 2019 Law on Social Security Schemes, the voluntary scheme for the self-employed lacks a sub-decree to define its design criteria and to make it operative. This opens a window of opportunity for a cautious reflection on the design of the scheme. The global and national evidence available point at the low capacity of voluntary schemes when it comes to extending effective coverage, in addition to posing risks related to adverse selection and financial sustainability. The way in which this scheme is going to be operationalized will determine the type of medium-term strategic efforts to be made in extending social security coverage to the missing middle.

Compliance

The review suggests enhancing the capacity and authority of the Social Security Inspection Department. To improve compliance, the NSSF should devise strategies that involve a mixed approach of incentives and sanctions. The Inspection Division can set targets and identify interventions on prevention, detection (including visits but also "smart detection") and deterrence (that is, by emphasizing incentives for compliance before applying sanctions). This process should coordinate with ongoing and future efforts to extend coverage, as well as with the Labour Inspectorate operated by the MoLVT.

Following the recent successful linkage with CamDX and in partnership with the Ministry of Commerce and the Tax Authority, the NSSF should consider developing an operational plan to register the large volume of enterprises that are currently in CamDX but not yet registered with the NSSF (about 30,000). In the medium-term, automatic registration with the NSSF could be bundled with the registration of enterprises with the Ministry of Commerce.

Enhance collaborations between the MoLVT and NSSF in the field of inspection. The roles and responsibilities of NSSF inspectors and of labour inspectors, although different, are complementary. Thus, it is necessary to carry out an analysis of:

- What is currently in place and of any gaps regarding the mandate of the NSST Social Security Inspection Department and its relation to that of the MoLVT's Labour Inspectorate
- Their powers to execute their respective mandates
- The human resources available
- The need for training and re-training, risk management, supporting systems and tools, and strategy development

It is further recommended to enhance the **reporting system** with the objectives of:

- Measuring performance at each level
- Monitoring the progress of every activity
- Identifying the strengths and weaknesses
- Reporting to the top management and the board

Reports should be produced with the objective of identifying the root causes of any problems that have occurred. These reports can then be used to take corrective measures, formulate strategies and enhancement initiatives, prepare budgets and training plans, and to some extent identify performers and non-performers and give acknowledgment and recognition where it is deserved.

Operational efficiency

As part of the modernization project, it is suggested that NSSF carries out a complete review of its core operational processes, possibly starting with health-related processes. The objectives of this review should be to increase administrative efficiency and to improve members' experience with NSSF services. The review could include the following four aspects:

1. **Conducting a situation analysis** in order to better update business rules and sequences, including roles and responsibilities of users and agents involved, as well as information requirements and practices (for example, directives, manuals, forms and ledgers that are currently paper-based). Core processes to update could include registration, contribution collection, contracting, the claims process, M&E, complaints and satisfaction management. The processes to be streamlined as part of the modernization of the information system should be prioritized.
2. **Identification of bottlenecks leading to suboptimal business processes and information flows**. This requires identifying the issues preventing efficient information flows and procedural effectiveness and consistency, including in forms and tools used for data collection and claim management.
3. **Drafting enhanced and updated procedures**. Revised procedures should aim at facilitating access to the social security system by NSSF users (employers, workers and contracted public/private health facilities).
4. **Informing piloting priorities and implementation, and measuring performance gains**. The obtained results shall be monitored and evaluated to decide on the effectiveness of proposes SOPs.

Financial management

It is recommended that the quality of financial reporting and disclosure be improved to provide better accountability of annual budget projections and actual expenditures. This will strengthen the budgeting process and improve the financial sustainability of and trust in the NSSF.

Consideration should be given to advocating for stronger legal and/or regulatory provisions for ring-fencing funds, with clear provisions on funds' fungibility.

Consider creating separate funds for the healthcare scheme, maternity benefits and sickness benefits due to their different natures. The actuarial valuation could be instrumental in defining the exact costs and benefits for each branch (see below).
Based on the newly updated standards operating procedures (SOPs), develop an **internal audit manual** and regularly implement auditing exercises to ensure administrative compliance.

Strengthen effectiveness by automating checks and controls on: (i) contributions actually collected as compared to expected contributions; (ii) unexplained variations in the numbers of workers in a particular establishment from month-to-month; and (iii) unexplained variations in insurable earnings from month-to-month.

Carry out periodic, comparable and reliable actuarial analyses of the healthcare scheme to assess its financial situation. In particular, such analyses would support financial projections and assess the impact of policy options regarding contribution rates, coverage of dependents and benefit packages. It is recommended that the actuarial analysis should look at the following parameters:

- Contribution ceiling
- Contribution rate
- Harmonization of contribution rates between the public and private sector schemes (taking into account difference in the financing of maternity and sickness benefits)
- Conditions to extend coverage to dependents
- Impacts of contracting private providers at higher rates

The actuarial valuation is also necessary to provide input into the actual level of reserves compared to the target level, and whether the target level is in fact appropriate.

Progressively build the internal capacity of the NSFF to carry out actuarial analyses, including through staffing, training and data management. This can include sponsoring formal education processes to one, or more, individuals who commit to employing their capacities for the NSSF. The field of actuarial work is a narrow area of expertise that requires specific certifications, and experts are highly in demand in the private labour market. It is therefore suggested to evaluate the opportunity to develop this internal capacity, as it can lead to ownership of a better understanding of data requirements and storage and the value of evidence-based decision-making.

Purchasing

In order to strengthen the efficiency of the purchasing function, the following recommendations are put forward:

1. Include simulations in the actuarial analysis to measure the impact that increasing the network of private health facilities contracted with the NSSF might have on the financial sustainability of the health insurance schemes.
2. Develop a strategy for the provision of services by private health facilities, with due consideration of financing mechanisms (long-term impact on the schemes' financial balance, possible introduction of copayments at private health facilities, and so on) and equity concerns.
3. Initiate a review of payment rates.
4. Reinforce capacities to conduct medical auditing of claims in order to detect: (i) possible risks of providers limiting access to care for patients with serious diseases that are more costly to treat; and (ii) inefficient referrals of such patients to tertiary level hospitals.
5. Consider ways of digitalizing claims processing
6. Measure the average time for payments to be made to providers, and use this information to set targets, monitor performance, generate reports and publicize achievements.
7. Consider implementing a referral system (except in case of emergencies), at least for national and provincial hospitals, both to preserve the overall balance of the health system and for cost control purposes.

Reporting and data analysis

Enhance monitoring and evaluation capacities across all departments, including capacities to retrieve data from information systems, analyse this data and report on core indicators. Systematize data use for decision-making. In particular, further build the knowledge of the Policy Department on data availability and analysis, and further improve the completeness, quality and publicity of the Annual Report. This would help to improve the availability of data and to ensure that data can be accessed reliably and in a timely manner by all users. Data security and use could also be improved through stronger guidelines on data sharing within and across institutions.

Strengthen the statistical scope of analysis. This would be required, for instance, to be able to carry out further analysis on membership achievements versus targets, membership movements (dropout rate), member profiles (age, income level) and contribution patterns (accumulated debt, density of contributions). It is also recommended to develop a deeper understanding of enterprise profiles with the objective of defining targets for coverage and determining corresponding interventions to promote and enforce registration.

Complaints and grievances

It is recommended that NSSF advocates for the rapid development of sub-regulations for dispute settlement from the Social Security Regulator.

Within a member-centric strategy, the NSSF could consider commissioning an independent regular assessment on members', employers' and health facilities' satisfaction with NSSF services. This work could include the setting of satisfaction targets, which would be based on the development of an index to monitor achievements and progress as part of building a performance culture at the NSSF.

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Annex 1. Healthcare provision in Cambodia

The Cambodian healthcare market is comprised of a wide variety of providers, including public health facilities, pharmacies, private hospitals and professional medical service providers. The latter typically operate from their own facilities or travel directly to patients' homes. Qualified private providers and pharmacies are mostly available in urban areas. Two-thirds of public health staff also work separately in some private capacity. In addition, a number of NGO-run health facilities and charitable hospitals provide services. In 2015, there were more than 180 NGOs working in the health sector.

Apart from formal healthcare services, informal healthcare providers are common throughout Cambodia: these include vendors selling drugs from shops or markets and traditional birth attendants, as well as traditional healers.

The public sector plays a lead role in promotion and prevention activities for essential reproductive, maternal, neonatal and paediatric health, as well as major communicable diseases control. Public health facilities such as health centres and hospitals have flourished at a notable pace, especially in urban areas in the last few decades. As of 2015, there are 102 referral hospitals, including 9 national hospitals, 25 municipal/provincial hospitals and 68 district-based hospitals across the country. There are also 1,141 health centres and 107 health posts. At the same time, there is also a growing pool of health professionals in different fields.

The public health system in Cambodia has diversified into different categories including in and outpatient care, oncology (treatment of cancer), emergency care, pharmaceutical care, mental healthcare, dental care, rehabilitation and long-term care.

According to the MoH, there were 8,488 private health providers/facilitators in Cambodia in 2015. There are also around 2,156 pharmacies operating across the country. Private health services are usually seen in urban areas, where the population is dense and able to financially support their businesses. Different categories of private health service include nursing care, clinics, polyclinics, hospitals and pregnancy care. However, most high income and some middle-income people seek medical treatment abroad for complex or emergency cases, primarily in Viet Nam, Thailand and Singapore.

Classification of health facilities

Within the framework of the 1995 Health Coverage Plan, the services delivered at government facilities are regulated under guidelines produced by the MoH that define a Minimum Package of Activities (MPA) for health centres and a Complementary Package of Activities (CPA) for referral hospitals.

- The MPA consists mainly of preventive and basic curative services, supplemented by specific activities for vertical programmes.
- The CPAs are graded 1–3 on the basis of the number and composition of staff, number of beds, standard drug kit, standard medical equipment, and clinical activities:
  - CPA-1 hospitals: the lowest hospital level, with 40–60 beds, provide basic obstetric care, but with no major surgery (no general anaesthesia) and no blood bank or blood deposit.
  - CPA-2 hospitals: with 60–100 beds, provide CPA-1 services plus emergency care, major surgery and other specialized services such as blood transfusion.

- CPA-3 hospitals: with 100–250 beds, are the highest hospital level, provide major surgery and more activities than CPA-2, including various specialized services. All eight national hospitals located in Phnom Penh and 24 provincial hospitals are CPA-3 hospitals.

In order to implement payment via the NSSF healthcare schemes, the MoH must evaluate and classify the health facilities, which need to sign an agreement. As part of the evaluation, health facilities are classified into the abovementioned categories – MPA level, CPA-1 level, CPA-2 level, CPA-3 level, mixed level or National Hospital level – according to the scope and the quality of services provided by that health facilities. It should be noted that a health facility may receive agreements for multiple service levels. For example, a single-bed health centre can be classified as CPA-1 for inpatient services, while its other services are classified as MPA. Some CPA-1 hospitals may have major surgery services, in which case the major surgery services may be classified as CPA-2, although other services may be classified as CPA-1. In addition, a health centre located in or under the management of a large hospital will be classified as MPA if the service level of that health centre is no different from that of other MPA level health centres.

Modality and level of decentralization

The administration of the public health system in Cambodia is centralized at the level of the national MoH, with responsibilities for implementation and service delivery assigned to health officials at the provincial and district levels. In 2001, the Government initiated a process of political decentralization through two laws: the Law on the Administration and Management of Communes and the Law on Commune Elections. The first commune elections, open to all parties and candidates, were held nationally in 2002. In 2008 the Ministry of Interior enacted the Organic Law (on Administrative Management of the Capital, Provinces, Municipalities, Districts and Khans), which provided the administrative basis for decentralization and deconcentration. The law gives priority to decentralization of functions that have a direct impact on poverty and livelihoods, including health and nutrition.

The process of decentralization and deconcentration has only begun, and many of the challenges are yet to be recognized. In some cases, this provides an opportunity for the MoH to retain influence by purchasing services through social health protection schemes. In Cambodia, a potential move to demand-side financing as the means to fund local administration health providers may anticipate such a development, if not the need to move funds more effectively to peripheral services.

To operationalize the Organic Law, the National Program for Sub-National Democratic Development was developed for the period 2010–19. The National Program was designed to create a culture of accountable local participation, improve public services and infrastructure, and promote social and economic development and poverty reduction. To avoid major disruptions to service delivery, the Organic Law has been implemented incrementally to enable capacity-building at the subnational level. The first phase aims to align line ministries' oversight; the second phase concerns delegation of the management of funds to subnational administrations; and the third phase relates to the full transfer of specific and mandatory functions.

Under the three-tier health system, MoH activities are administratively decentralized (deconcentrated), but with considerable upward accountability to the central level and limited decision-making discretion at the provincial and district levels. A first step has been to convert almost one-quarter of Health Operational Districts and provincial hospitals to the status of Special Operating Agency. This status was established as one part of the Government's 2006 Policy on Public Service Delivery as a means for providing greater management autonomy to district health and hospital managers through internal contracting arrangements and community monitoring.

Cambodia has a pluralistic health system in which the main health infrastructure and public healthcare are delivered through the MoH; while the disparate private sector provides most outpatient curative care. The MoH was institutionalized under Sub-Decree 67 ANKr.BK, dated 22 October 1997. The Sub-Decree makes the MoH alone responsible for all aspects of healthcare, including the development of strategic plans and the delivery and evaluation of public health services in Cambodia. The public health system is based on a district health system model with three levels of responsibility:

Central Ministry

- Develops policies, legislation and strategic plans
- Responsible for resource mobilization and allocation
- Responsible for monitoring, evaluation and research
- Maintains the national Health Information System
- Provides training and support to provinces and districts
- Coordinates with other ministries and external aid

Provincial level

- Administered by a Provincial Health Department
- Links the central MoH with Health Operational Districts
- Implements the Health Strategic Plan via Annual Operational Plans
- Responsible for the equitable distribution and effective use of available resources
- Supports the development of Health Operational Districts

Operational District level

- Administered by a Health Operational District Office
- Responsible for effective, efficient and comprehensive health-service delivery
- Interprets, disseminates and implements national policies and provincial health strategies

The MoH, which alone is responsible for the delivery of government health services, administers health programmes at the national, provincial and Health Operational District levels. The central MoH has three General Directorates: (i) General Directorate of Health; (ii) General Directorate of Administration and Finance; and (iii) General Directorate of Inspection. These Directorates are responsible for ensuring that the Government's health objectives – defined in the National Strategic Development Plan and the Cambodian Government's overall plan for national development called the Rectangular Strategy – are translated into policies, strategies and guidelines in order to reach their targets.

The role of the General Directorate of Health, which is the most comprehensive of the three general directorates, is the formulation and implementation of MoH policies through its eight departments[21] and to oversee the Provincial Health Departments and their Operational Districts.

Annex 2. Tables on utilizations

In 2019, contracted providers provided 2,575,792 services, with that figure increasing slightly in 2020, during which 2,656,241 cases/patients were served (table A3).

Table A1. Number of services provided in 2019–20

Case / FFS name	2019		2020	
	Cases	Total cost (riel)	Cases	Total cost (riel)
MPA	**702 186**	**7 693 585 200**	**613 811**	**6 878 834 000**
Outpatient	679 946	5 845 736 000	591 955	5 078 185 000
Inpatient	1 599	159 900 000	1 195	119 620 000
Obstetrics	19 755	1 580 760 000	19 802	1 584 640 000
Ambulance	886	107 189 200	764	90 209 000
Other services (FFS)	–	–	95	6 180 000
CPA-1	**147 740**	**5 393 187 000**	**189 355**	**6 990 663 000**
Outpatient	115 760	2 348 338 000	162 569	4 383 567 000
Inpatient	19 482	2 079 025 000	13 931	1 614 230 000
Obstetrics	6 564	667 350 000	6 416	656 120 000

[21] The eight departments are: (i) Planning and Health Information; (ii) Human Resource Development; (iii) Preventive Medicine; (iv) Communicable Disease Control; (v) Drug and Food; (vi) Medical Equipment and Cosmetics; (vii) Hospital Services; and (viii) International Cooperation.

▶ Air-conditioned room	3 022	102 705 000	4 243	144 405 000
▶ Physical therapy	19	285 000	15	225 000
▶ Ambulance	2 893	195 484 000	2 181	192 116 000
▶ Other services (FFS)	–	–	–	–
CPA-2	**70 294**	**3 046 046 000**	**74 418**	**3 302 649 000**
▶ Outpatient	57 075	1 241 810 000	61 070	1 486 230 000
▶ Inpatient	7 543	1 166 770 000	6 359	1 075 940 000
▶ Obstetrics	4 238	522 980 000	4 597	570 820 000
▶ Air-conditioned room	900	43 395 000	1 762	76 805 000
▶ Physical therapy	1	20 000	16	320 000
▶ Ambulance	517	69 871 000	564	89 254 000
▶ Other services (FFS)	20	1 200 000	50	3 280 000
CPA-3	**1 279 677**	**61 728 461 800**	**1 318 580**	**63 746 054 000**
▶ Outpatient	1 072 608	38 705 768 000	1 126 775	40 480 203 000
▶ Inpatient	59 961	13 418 535 000	49 896	13 101 752 000
▶ Obstetrics	14 310	2 588 480 000	15 306	2 867 980 000
▶ Air-conditioned room	129 282	6 431 875 000	121 734	6 396 830 000
▶ Physical therapy	299	3 082 000	1 027	14 913 000
▶ Ambulance	1 714	214 768 000	1 665	369 302 000
▶ CT scan	781	303 080 000	1 063	425 430 000
▶ Laboratory	113	10 565 300	176	18 498 300
▶ Other services (FFS)	609	52 308 500	938	71 145 700
National hospitals	**375 895**	**57 275 103 000**	**460 077**	**73 328 895 000**
▶ Outpatient	263 133	17 345 460 000	267 748	20 048 950 000
▶ Inpatient	34 073	26 422 700 000	37 285	32 039 190 000
▶ Obstetrics	5 476	2 190 400 000	7 759	5 074 000 000
▶ Air-conditioned room	40 517	3 896 318 000	60 689	7 626 420 000
▶ Physical therapy	1 204	33 436 000	4 220	113 828 000
▶ Ambulance	62	23 054 280	73	28 739 300
▶ Radiotherapy	131	17 320 000	258	46 384 000
▶ Chemotherapy	105	8 038 000	7	1 616 000

▶ CT scan	3 122	1 158 685 000	6 237	2 334 331 400
▶ Laboratory	7 423	532 310 440	8 096	654 656 620
▶ Other services (FFS)	20 649	5 647 381 280	67 705	5 360 779 680
Total	**2 575 792**	**135 136 383 000**	**2 656 241**	**154 247 095 000**

– = nil.

Outpatient visits were the most frequent service provided (83 per cent in 2020), followed by inpatient services (4 per cent in 2020) (table A4). Unfortunately, more detailed data on inpatient services (per case-based group) were not available.

▶ Table A2. Most frequent services provided in 2019–20

Type of service	2019		2020	
	Cases	Total cost (riel)	Cases	Total cost (riel)
Outpatient	2 188 522	65 487 112 000	2 210 117	71 477 135 000
Inpatient	122 658	43 246 930 000	108 666	47 950 732 000
Obstetrics	50 343	7 549 970 000	53 880	10 753 560 000
Ambulance	6 072	610 366 480	5 247	769 620 300

In addition to direct payments to contracted health providers for services provided to its members, the NSSF also reimburses services provided by non-contracted facilities for emergency services. The number of such claims grew rapidly between 2017 and 2020.

▶ Table A3. Number of claims for services provided by non-contracted healthcare providers

Description	2017	2018	2019	2020
Number of claims – Healthcare	8 890	55 187	87 132	86 816

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Assessment of the Cambodian National Social Security Fund's health insurance schemes

The Cambodian social health protection landscape includes social health insurance for the public sector (civil servants, former civil servants, and veterans) and for the formally employed workers in the private sector, as well as subsidized health access through the Health Equity Fund (HEF) for those who are eligible (generally those living in poverty). Overall, there has been remarkable progress made in the social health protection system, but despite this progress, an estimated 70 per cent of the population have no access to social health protection.

The objective of this study is to analyse the design, operation and achievements of the health insurance schemes of the National Social Security Fund (NSSF), and to propose options and ideas for improvement. The research was conducted in consultation with NSSF departments, the NSSF Board, and other key stakeholders.

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