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Social Protection Expenditure and Performance Review

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Jean-Claude Hennicot

EU/ILO Project on Improving Social Protection and Promoting Employment

In cooperation with the GIZ Social Health Protection Programme, Cambodia, in the context of the P4H initiative

Social Security Department
International Labour Office, Geneva

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Abbreviations

ADB	Asian Development Bank
ALMP	active labour market policy
CARD	Council for Agricultural and Rural Development
CAMFEBA	Cambodian Federation of Employers and Business Associations
CAMINCO	Cambodian National Insurance Company
CBA	collective bargaining agreement
CBHI	community-based health insurance
CCT	conditional cash transfer
CDC	Council for the Development of Cambodia
CDHS	Cambodia Demographic and Health Survey
CDRI	Cambodia Development Resource Institute
CFW	cash for work
CIDS	Cambodia Institute of Development Study
CIM	Centrum für Internationale Migration und Entwicklung
CMDG	Cambodia Millennium Development Goals
COM	Council of Ministers
CPI	consumer price index
CPP	Cambodian People's Party
CRC	Cambodian Red Cross
CSES	Cambodia Socio-Economic Survey
CT	cash transfer
CTA	Chief Technical Advisor
D&D	Strategic Framework for Decentralization and De-concentration
DLD	Department of Labour Disputes
DP	development partner
DPT	diptheria, pertussis and tetanus
DREF	Disaster Relief Emergency Fund (IFRC)
EC	European Commission
EFAP	Emergency Food Assistance Project
EI	employment injury
EIC	Economic Institute of Cambodia
ESSPROS	European System of Social Protection Statistics
EU	European Union
FDI	foreign direct investment
FFW	food for work
FISIM	financial intermediation services indirectly measured
FUNCIPEC	National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia
GDP	gross domestic product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMAC	Garment Manufacturers Association of Cambodia
GRET	Groupe de Recherche et d'Échanges Technologiques
HEF	health equity fund
HEI	higher education institution
HIP	Health Insurance Project for Garment Workers (GRET)
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HR	human resources
HSSP	Health Sector Support Project
IBRD	International Bank of Reconstruction and Development
IDA	International Development Association
IFRC	International Federation of Red Cross and Red Crescent Societies

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ILO	International Labour Organization/International Labour Office
IMF	International Monetary Fund
IMR	infant mortality rate
IPD	inpatient department
IPEC	International Programme for the Elimination of Child Labour (ILO)
ISSA	International Social Security Association
IT	information technology
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau
KHR	Cambodian Riel
LAC	Labour Advisory Committee
MCH	maternal and child health
MDG	Millennium Development Goal
MMR	maternal mortality ratio
MOD	Ministry of Defence
MOEF	Ministry of Economy and Finance
MOEYS	Ministry of Education, Youth and Sport
MOH	Ministry of Health
MOI	Ministry of the Interior
MOLVT	Ministry of Labour and Vocational Training
MOP	Ministry of Planning
MOSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MRD	Ministry for Rural Development
MRS	most representative status
MTEF	Medium Term Expenditure Framework
NBC	National Bank of Cambodia
NCDD	National Committee for Democratic Development at the Sub-National Level
NCDM	National Committee for Disaster Management
NFV	National Fund for Veterans
NGO	non-governmental organization
NIS	National Institute of Statistics
NPA-WFCL	National Plan for Action on the Elimination of the Worst Forms of Child Labour
NSDP	National Social Development Plan
NSPS	National Social Protection Strategy for the Poor and Vulnerable
NSSF	National Social Security Fund
NSSFC	National Social Security Fund for Civil Servants
NTTI	National Technical Training Institute
OD	Operational [Health] District
ODA	official development assistance
OOP	Out-of-pocket expenditure
OPD	outpatient department
P4H	Providing for Health Initiative
PBCRG	Planning and Budgeting Committee Representative Group
PFM	public financial management
PFMRP	Public Financial Management Reform Programme
PPD	provincial planning department
PRK	People's Republic of Kampuchea
PWP	public works programme
RCAF	Royal Cambodian Armed Forces
RGC	Royal Government of Cambodia
RILGP	Rural Investment and Local Governance Project
SDR	special drawing rights
SESC	Socio-Economic Survey of Cambodia
SEZ	Special Economic Zone
SHI	social health insurance

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SNEC	Supreme National Economic Council
SOA	special operating agency
SOE	state-owned enterprise
SPER	Social Protection Expenditure Review
SPF	Social Protection Floor Initiative
TB	tuberculosis
TOFE	tableau des opérations financières de l'Etat
TVET	Technical and Vocational Education and Training Programme
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's and Education Fund
UNTAC	United Nations Transitional Authority in Cambodia
URC	University Research Council
VRG	Village Representative Group
VT	Vocational Training
WFP	World Food Programme
WHO	World Health Organization

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Executive summary

The Social Protection Expenditure and Performance Review (SPER) presented in this report was carried out under the EU-funded ILO project "Improving Social Protection and Promoting Employment Policies in Cambodia" during 2010 and 2011. SPER is a diagnostic tool developed by the ILO that aims to establish a comprehensive overview of a country's social protection system. It comprises an assessment of the country's demographic, economic, and labour market context, and of the main social protection schemes in terms of coverage, expenditure and benefit levels. The main objectives of the exercise are to assess system financing, to identify coverage gaps, and to discuss policy issues for consideration by national policy-makers.

Cambodia's population is estimated at 13.4 million according to the last population survey undertaken in 2008. With a median age of only 21.0 in 2008, the population of Cambodia is young on average. Children aged under 15 represent about 34 per cent of the total population, whereas the elderly aged 65 or above make up for only about 4 per cent. The total fertility rate is still high at 3.1, although it shows a decreasing trend; the population growth rate is estimated at 1.5 per cent per annum. At 62.5 years on average, life expectancy at birth is relatively low, mainly due to high child and infant mortality rates. The majority (80 per cent) of Cambodia's population still live in rural areas, while only 20 per cent are urban dwellers.

With a high labour market participation rate of about 78 per cent among the population aged 15 and above, Cambodia's economically active population in 2008 was estimated at approximately seven million persons. Total employment that year was estimated at 6.8 million persons, including about 2.9 million unpaid family workers. Among the 3.9 million paid workers in 2008, about 1.2 million were paid employees, whereas the remaining 2.7 million were self-employed or own-account workers. Despite an increasing trend in formal-sector employment, a high share of employment remains informal, with workers uncovered by social protection provisions. The share of employees in the formal economy is estimated at 17 per cent of total employment including public administration and defence. Given the steady expansion of formal types of employment, there is a window of opportunity for the extension of social security through employment-based social insurance provisions. Nevertheless, since employment formalization is a slow and gradual process, informal types of employment will persist and there is also a need to extend social protection provisions for informal workers through targeted or universal benefits.

Cambodia's economy has witnessed a sustained expansion over the past decade. Real GDP expanded during 2002–2010 at approximately 8 per cent per annum. The main drivers of growth were foreign direct investment, a young and fast-growing labour force, and emerging industrialization in the garment and footwear industries. Output in agriculture also expanded due to the increasing employment engaged in agriculture, whereas the services sector benefited from a steady increase in tourist arrivals. The average value added per worker increased by about 5 per cent per annum in real terms over the period 1998–2008. The ongoing increase in labour productivity is expected to result in higher wages, improved livelihoods and an enlarged national tax base. Productivity increases in agriculture will help to improve the livelihoods of the rural workforce and accelerate poverty alleviation among the rural poor. Higher wages overall will increase the capacity of workers and employees to participate in contributory social security systems.

Fiscal revenue collection has improved markedly over the past decade, with total revenues collected reaching 12.3 per cent of GDP in 2010 compared to less than 10 per cent in 2000. Along with sustained economic expansion, new fiscal space is opening up, creating opportunities for new government projects, including those aiming at the expansion of the social protection system.

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The planned costing of priority interventions outlined in the National Social Protection Strategy for the Poor and Vulnerable (NSPS) is expected to create a sound basis for resource-based policy planning with regard to the extension of social protection programmes.

In governance, the ongoing reform process of decentralization and deconcentration (D&D), which aims at strengthening local governance and public service delivery, is creating new perspectives for the delivery of social protection benefits at the community level. The strengthened administrations at subnational level could be instrumental in the future for the delivery of a comprehensive package of social protection benefits. However, any novel approaches will need to be carefully designed and piloted first before they can be mainstreamed on a national scale. Overall, an efficient and effective public administration system is a key requirement for the functioning of a comprehensive social protection system. Further efforts aimed at developing administrative capacities and strengthening national social protection agencies will be required in the future.

Despite ongoing achievements in poverty alleviation, many Cambodians are still poor or live in precarious livelihood conditions, particularly in rural areas. Rural populations engaged in subsistence agriculture are often highly vulnerable to climatic shocks, including droughts and flooding. Other factors contributing to the vulnerability of Cambodians include high levels of poor maternal and child health and nutrition, high seasonal unemployment, income insecurity, health shocks and poor education. Hence the need remains for social protection provisions that cater to basic needs, including food and income security, emergency aid, access to basic primary health care, and child support. The identification of the poor, largely achieved in Cambodia through the ID-Poor project, allows for targeted social protection measures benefiting the poor. The benefits of targeted interventions have been demonstrated by the successful implementation of health equity funds that currently ensure access to basic health care for the majority of the poor.

Cambodia's health status is among the poorest in South-East Asia. A heavy burden of communicable diseases and high child and maternal mortality rates still affects many Cambodians caught in a vicious cycle of ill health, debt and poverty that is delaying the country's development. Although progress has been achieved in strengthening the national health system and improving access to health care for the poor, continued efforts are required to further improve the access to quality health-care services and the protection of households against catastrophic health expenditures. Household out-of-pocket spending for health remains high, at an estimated 55 per cent of total national health expenditure. Furthermore, a high percentage thereof (67%) is spent outside the public health system. Total national health expenditure in the year 2010 is estimated at US$848 million, representing 7.1 per cent of GDP, and an amount per capita of about US$61.

The main social protection provisions and programmes as currently existing in Cambodia have been reviewed based on scope and relevance in relation to the NSPS; they include the following:

- Statutory provisions, adopted in accordance with the fundamental rights to social protection enshrined by the Constitution of Cambodia, and stipulated in the following laws: the Labour Law, the Law on the Common Statute of Civil Servants, the Law on War Veterans, the Law on Pensions for Members of the Armed Forces, the Law on Suppression of Trafficking, and the National Disability Law.
- The National Social Security Fund for Civil Servants (NSSFC), providing social security benefits to around 175,000 civil servants and to their family dependants. Benefits provided include maternity and sickness cash benefits, funeral grant, employment injury benefits, and pensions. In the year 2009, a total of 67,500 pension benefits were disbursed including 28,000 retirement pensions. Total benefit expenditure in 2009 amounted to US$22.7 million.

- The National Fund for Veterans (NFV), established in 2010 and providing social security benefits to members of the armed forces and the national police. The scheme also provides pensions to persons qualifying as war veterans. Total benefit expenditure in the year 2010 is estimated at about US$19.5 million.
- The National Social Security Fund (NSSF), established in 2008 to administer social security benefits for private-sector workers as stipulated by the social security law, 2002. So far only the employment injury branch has been implemented, covering about 600,000 workers mainly in the garment and footwear industries. Total benefit expenditure in 2010 amounted to about US$0.6 million. Other statutory social protection provisions for private-sector workers are stipulated by the Labour Law (1997), including paid sick- and maternity leave, and severance pay for employees dismissed by their employer.
- Social health expenditure, comprising supply-side subsidies to hospitals as funded from the national budget and through ODA grants, and demand-side social health protection schemes including the fee-waiver scheme for the poor, the voucher scheme for maternal health, the health equity funds for the poor, and the community-based social health insurance schemes. Total social health expenditure for the year 2010, including administration costs, is estimated at about US$385 million, including about $4.6 million spent by health equity funds and $1.2 million by community-based health insurance (CBHI) schemes.
- Social assistance or welfare services as provided by the Government of Cambodia through different line ministries, mainly the Ministry of Social Welfare, Veterans, and Youth Rehabilitation (MOSVY), which provides support to orphans, the disabled, the elderly and the poor. The Ministry of Education, Youth, and Sport (MOEYS) runs a scholarship programme to support poor students. Other benefits provided include emergency food assistance as coordinated through the National Committee for Disaster Management (NCDM), and vocational training through the Ministry of Labour and Vocational Training (MOLVT).
- Social protection benefits, as also provided under donor-funded programmes, including the WFP-supported school feeding programme, under which school meals are served and take-home rations are provided to school children. Other interventions comprise public works programmes implemented under the Rural Investment and Local Governance Project (RILGP), and the ADB-funded Emergency Food Assistance Project (EFAP). Total social expenditure under all ODA- and NGO-funded programmes in the year 2010 is estimated at US$68 million.

Total social expenditure in the year 2010, including ODA-funded programmes and subsidies for the health sector, is estimated at about US$634 million, an amount equivalent to 5.5 per cent of GDP. Social spending on health accounted for about 60 per cent of total social expenditure.

Overall, the social protection system in Cambodia is relatively fragmented and there is little coordination between the different stakeholders. The adoption of the NSPS is a positive step towards a more coherent and coordinated national social protection system. The overall coverage of the social protection system is currently still incomplete, and there are few statutory provisions apart from those benefiting public-sector workers. It is recommended that efforts be continued towards the development of a more institutionalized system. This, however, will require the further strengthening of institutional capacity, particularly at the national social protection agencies, including the social security funds catering to workers employed in the formal economy. Along with the development of social security provisions in the formal sector, there is a need to pursue policies and programmes that relieve the plight of the most needy, the poor and the most vulnerable. The introduction of basic social protection provisions for all, as promoted under the global Social Protection Floor Initiative (SPF) launched by the UN family under the lead of the International Labour Organization (ILO) and the World Health Organization (WHO), therefore

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deserves due consideration for the design of social protection provisions within the overall strategic framework defined by the NSPS.

The vast majority of Cambodians remain without coverage under any social health protection scheme and therefore face the risk of catastrophic health expenditures, in particular the near-poor, who still remain largely unprotected. There is a need to move ahead with the implementation of social health insurance for formal-sector workers, both for public and private employees. This could be a critical step forward, resulting in additional demand-side financing for the public health system and improved quality standards through the use of performance-based contracting arrangements between the new purchasers and public health-care providers.

In order to achieve a lasting impact on poverty alleviation and the extension of social protection for the poor, the vulnerable and the non-poor, a strong commitment is required from both government and donors to ensure the allocation of the resources required. Since ODA funding cannot be relied on forever, the allocation of fiscal resources will be indispensable for the extension of social protection coverage in the future. In light of the limited resources available, a gradual and step-wise approach is the only viable option towards the development of a more coherent, institutionalized, and financially sustainable system under the full ownership of the Government. Further efforts to upgrade administrative capacities and to strengthen national social protection agencies will no doubt be crucial; they are a precondition for lasting progress on the path towards universal coverage.

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Introduction

This report was prepared under the EU-funded ILO project "Improving Social Protection and Promoting Employment", covering the countries Burkina Faso, Cambodia and Honduras.[1] Its main purpose is to explore possibilities of fostering social protection and employment policies in those three countries. A core element in the ILO's approach in this broader endeavour is to undertake for each country a social protection expenditure and performance review (SPER) and to compile its social budget (SB).

The approach pursued in Cambodia reflects ILO standard methodology applied for SPER/SB exercises, but not to the full extent. Due to the incomplete and fragmented state of Cambodia's social protection system and the gaps in consistently compiled expenditure data, the full exercise could not be completed. The report therefore aims foremost at providing contextual background information, an in-depth review of the different schemes, and a critical assessment of the overall social protection system in Cambodia. It also presents for each scheme all the financial data that could be made available.

It should be kept in mind, however, that data compiled in a consistent manner and systematic format (i.e. data extracted from a management information system), can only be expected to exist after a social protection system has been implemented and institutionalized. In other words, given the state of development of Cambodia, it is not surprising that the available data is limited and/or fragmented. Along with the future development and implementation of a comprehensive social protection system, the need for an efficient and effective administration system will arise. In conjunction, there will be a need for a more consistent management of information and data to ensure good governance, monitoring and evaluation of different programmes, and stewardship of the overall system. For the time being, policy-makers and administrators in the field of social protection will have to live with a certain degree of "visual impairment".

Notwithstanding the data limitations, a number of reliable information sources are available in Cambodia, notably the results of the statistical surveys undertaken by the National Institute of Statistics (NIS) that are of national importance. Other sources include project reports of development partners, financial reports on state budget execution, and the information compiled by the different programme administrators, most of whom demonstrated commitment and cooperation in sharing information and programme data.

The report is organized as follows:

Chapter 1 presents the demographic context, including population figures, development trends and related indicators.

Chapter 2 presents a general overview of the labour market in Cambodia and provides a detailed picture of labour force and employment composition.

Chapter 3 provides an overview of the macroeconomic context and recent development. It also addresses fiscal space and social spending from the government budget.

Chapter 4 presents the poverty and vulnerability profile of Cambodia, and provides an overview of the ID-Poor targeting mechanism and national poverty estimates.

[1] EC project code: DCI-HUM/2009/215230; ILO-code INT/09/06/EEC.

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Chapter 5 provides background information on the health status of Cambodians and an overview of the public health system and financing arrangements.

Chapter 6 presents the governance context in Cambodia and information regarding systemic reforms that may have implications for the design and implementation of future social protection provisions.

Chapter 7 provides a comprehensive overview of existing social protection provisions in Cambodia, including legislative provisions, statutory schemes, government-funded social services, and major donor-funded interventions. Expenditure data, where available, is provided for each scheme.

Chapter 8 presents the overall conclusions of the report and provides recommendations regarding the future development of social protection provisions in Cambodia.

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1 Demography

1.1 Population

According to the last population census (NIS, 2009a), Cambodia's population was estimated at 13.4 million persons for the year 2008, accounting for 2.3 per cent of South-East Asia's population.[2] Cambodia's current demography is similar to that of most other countries in the region, featuring a youthful population, a declining total fertility rate and declining mortality rates, including a marked decline in infant, child and maternal mortality rates. Life expectancy has been increasing rapidly despite a HIV/AIDS prevalence rate estimated at 0.7 per cent.

The historical development of the total population since 1920 is shown in table 1.1. It can be observed that the country's population grew five-fold over the period 1920–2008. Despite this rapid growth, war and genocide took their toll on Cambodia's population during the 1980s. It is estimated that up to two million Cambodians died during the Khmer Rouge period (1975 to 1979).

Table 1.1 Total population by sex, 1920–2008

Year	Population			Source
	Total	Male	Female	
1920	2 600 000			Unknown, see Hang (2009)
1962	5 728 771	2 862 939	2 865 832	Population census 1962
1980	6 589 954	3 049 450	3 540 504	General Demographic Survey, 1980
1993/94	9 870 000	4 714 000	5 156 000	Cambodia Socio-economic Survey, 1994
1996	10 702 329	5 119 587	5 582 742	Demographic Survey of Cambodia, 1996
1998	11 437 656	5 511 408	5 926 248	General Population Census of Cambodia, 1998
2004	12 824 000	6 197 000	6 627 000	Cambodia Inter-censal Population Survey 2004
2008	13 395 682	6 516 054	6 879 628	General Population Census of Cambodia 2008

Sources: Population Census 2008, NIS (2009a); Hang (2009).

Over the decade 1998–2008 the total population increased by about 1.96 million persons, with the annual growth rate estimated at 1.6 per cent on average.[3] At this rate a population doubles more or less every 44 years. The average population density in Cambodia increased during that decade from 64 to 75 persons per square kilometre.

The 2008 Census counted 6,516,054 males (48.6 per cent) and 6,879,628 females (51.4 per cent). A higher share of women than men is a common observation in most countries; in Cambodia this phenomenon is compounded as a consequence of the Khmer Rouge period, during which the death toll for men was higher than for women. As can be noted in table 1.2, the discrepancy between the population shares of males and females increases with age. This is most striking at ages of 50 and above, i.e. among those who were of age 17 or above in 1975.

[2] Author's calculation based on UN population estimates (UNDESA, 2010),
[3] The annual growth rate declined from 2.5 per cent in 1998 to about 1.5 per cent in 2008 (NIS, 2009a).

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Table 1.2 Population share by gender and age group, 2008

Age group	Share of total population (%)		
	Male	Female	Total
0–4	51.2	48.8	100.0
5–9	51.2	48.8	100.0
10–14	51.4	48.6	100.0
15–19	51.5	48.5	100.0
20–24	48.9	51.1	100.0
25–29	49.1	50.9	100.0
30–34	48.3	51.7	100.0
35–39	48.3	51.7	100.0
40–44	46.7	53.3	100.0
45–49	45.7	54.3	100.0
50–54	39.9	60.1	100.0
55–59	41.5	58.5	100.0
60–64	42.0	58.0	100.0
65–69	41.7	58.3	100.0
70–74	40.2	59.8	100.0
75–79	39.6	60.4	100.0
80–84	38.3	61.7	100.0
85–89	37.0	63.0	100.0
90–94	35.5	64.5	100.0
95 +	35.7	64.3	100.0

Source: Author's calculations based on 2008 Census data (NIS, 2009a).

The sex ratio in the total population is 947 males per 1,000 females. The same ratio among the elderly (65+) stands at only 675 men per 1,000 women; hence women make up an estimated share of about 60 per cent of the elderly. This indicates that women live longer than men, in Cambodia as in most other countries. The low male-to-female ratio contributes to the problems related to the low coverage of old-age social protection provisions in Cambodia. As women generally have lower average lifetime earnings and savings opportunities, they are more likely to retire with little means or income security; elderly women therefore represent a particularly vulnerable population group.

The population pyramid of Cambodia is shown in figure 1.1 for the year 2008. It can be observed that the population is fairly young on average; about 33.7 per cent were aged 14 or younger, while those aged 65 and above accounted for only 4.3 per cent. As a consequence, the introduction of universal cash transfers for the elderly would be less costly in relative terms than universal cash transfers for children. Furthermore, the overall cost of providing for social health protection should be relatively low by international comparison, as the population is comparatively young on average.

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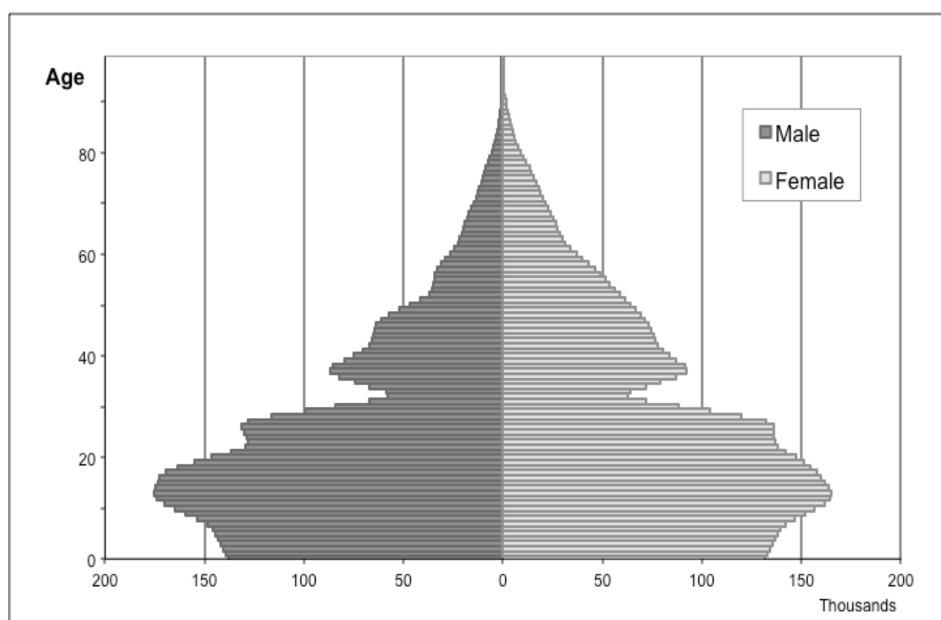
Figure 1.1 Population pyramid of Cambodia, 2008



Sources: Population Census 2008 (NIS, 2009a) and ILO Population Model.

In 2008 the average age of the population of Cambodia was low at only 26.3 years (25.0 years for males and 27.5 years for females), while the median age was only 21 years. The overall young age profile has implications for the dependency ratios; in 2008 the child dependency ratio was 54.3 per cent whereas the old-age dependency ratio stood at only 6.9 per cent.[4] The overall dependency ratio shows that there were on average 61.2 persons aged younger than 15 years of age or aged 65 years and older per 100 persons of working age (15–64 years). During the period 1950 to 2000 this ratio had been higher at around 80–85 per cent. The child dependency ratio observed (54.3 per cent) is more than twice as high as in most developed countries. This has obvious implications for the financing of education and social protection for children, such as food security, health care, and cash benefits targeting children. As a consequence, the total resources required, fiscal and other, for financing basic public services for children and youth are substantial in Cambodia.

1.2 Fertility rates

According to the last Census the gross total fertility rate stood at 3.1 children per woman in 2008. The total fertility rate is significantly lower than a generation ago when women still had 5–6 children on average. The net reproduction rate in 2008 was estimated at 1.3, implying that, with mortality rates assumed constant at current levels, a generational cohort of 1,000 women would replace itself with a daughter generation of 1,300 women. This means that the population increases by 30 per cent from one generation to the next. Therefore, despite the continuous decline in the total fertility rate, the Cambodian population is still on a relatively high growth path. It can be shown that, under conservative assumptions regarding future fertility, mortality and

[4] The child dependency ratio is given by the population ratio of children aged 0–14 to the working-age population aged 15–64. The old-age dependency ratio is given by the ratio of the elderly (aged 65+) to the working-age population (15–64). The total dependency ratio is given by the sum of these two ratios.

(net) international migration rates, a visible ageing of the population will only materialize after the middle of the century.

The mean age of child-bearing in 2008 was estimated at 28.7 years (NIS, 2009a). As in most countries of the region, better education for women and their improved livelihood conditions and employment opportunities are shifting the average child-bearing age upwards.

With respect to the figures on fertility presented above, it must be noted that a complete vital registration system does not exist in Cambodia. The absence of comprehensive data on births from birth registries cannot be fully substituted by survey or census data. Therefore, a number of demographic techniques had to be applied for estimating fertility rates from the census and survey data available in Cambodia (see NIS, 2010).

1.3 Life expectancy at birth and mortality rates

Based on the 2008 Census data, life expectancy at birth was estimated at 60.5 years for men and 64.3 years for women (ibid.). For both sexes combined, the average life expectancy at birth was estimated at 62.5 years in the same year. The pace of improvement in life expectancy at birth has varied in the past. Until the end of the 1970s, life expectancy at birth stagnated at about 40 years. During the first half of the 1980s it increased significantly by more than ten years, and, as of then, it has increased more or less steadily by another decade. There are indications, however, that the improvement in life expectancy is slowing down.

It should be noted that, while life expectancy is comparatively low at birth, it is not much lower than in developed countries once individuals have reached a certain age. Life expectancy at age 60, for instance, is estimated at over 16 years (about 16 years for men and 17 years for women). This, again, underlines the importance of providing income security to the elderly.

During the past decades, the decrease in infant mortality has been remarkable (ibid.), reaching 60 infant deaths per 1,000 live births in 2008. During the early 1950s, infant mortality still stood at 165 deaths per 1,000 live births. Nevertheless, despite the marked decrease achieved, the current rate is still considered too high. The same applies for the maternal mortality rate, estimated recently at 206 deaths per 100,000 births in the year 2010 (NIS, 2011). In developed countries by comparison, the maternal mortality rate is generally less than 10–20 maternal deaths per 100,000 births (see WHO, 2010).

As noted above, Cambodia does not yet have a complete vital registration system in place, and therefore many deaths are not formally registered when they occur. Since demographic techniques had to be applied for estimating infant mortality and maternal mortality rates indirectly, the reported figures should be considered as rough estimates (NIS, 2010).

1.4 Rural versus urban population

The urban population in Cambodia increased from around 2.1 million in 1998 to approximately 2.6 million in 2008. During the same period, the rural population rose from about 9.3 million to about 10.8 million individuals. The share of urban in total population, a common measure of urbanization, increased from 18.3 per cent in 1998 to 19.5 per cent in 2008 (table 1.3).

Table 1.3 Total population, urban and rural, 1998 and 2008

	Population		Share of total (%)	
	1998	2008	1998	2008
Total	**11 437 656**	**13 395 682**	**100 0**	**100 0**
Urban	2 095 074	2 614 027	18 3	19 5
Rural	9 342 582	10 781 655	81 7	80 5

Source: NIS (2009a), p. 26.

Notwithstanding the increase in urbanization as observed during 1998–2008, both current level and pace of urbanization are relatively low in Cambodia when compared to eastern Asia as a whole, where the average urbanization rate is estimated at 46 per cent (UN Habitat, 2009). Urbanization worldwide reached over 50 per cent in 2010, with more than half of the world's current population considered urban dwellers (ibid.). The increase in the urbanization rate observed from 1998 to 2008 in Cambodia thus follows a global trend observed worldwide. Urbanization has implications for social protection and must be taken into account for the design of adequate social protection policies and programmes. Urban dwellers are generally more likely to be employed in the formal economy than rural dwellers, who are often employed largely in subsistence farming. Urban dwellers also have higher earnings on average than rural dwellers and therefore a higher capacity to contribute to statutory social security systems. On the other hand, urban dwellers often have less income security and may live separated from their family or native community. Wage workers employed in the private sector notably face the risk of unemployment in case of retrenchment or illness. Urban dwellers are also more likely to make use of public services, and they are easier to target and enrol under social security and/or social welfare programmes.

The population density by region is shown in table 1.4. It can be observed that in 2008 about half of the total population inhabited approximately 1/7th of the country's surface area in the Plain Region, where the population density was highest at 261 persons per square kilometre, whereas the Plateau and Mountain Region had the lowest population density, with only 22 persons per square kilometre.

Table 1.4 Population density by natural region, 1998 and 2008

	Surface (km^2)	Population	Population density per km^2	
	2008	2008	1998	2008
Total Cambodia	**181 035**	**13 395 682**	**64**	**75**
Plain region	25 069	6 547 953	235	261
Tonle Sap region[1]	67 668	4 356 705	52	64
Coastal region	17 237	960 480	49	56
Plateau and mountain region	68 061	1 530 544	17	22

Note: [1]Area includes the surface of the Tonle Sap lake.

Sources: NIS Population Census, 1998 and 2008 (NIS, 2009a).

There are no indications that the administration and delivery of social protection benefits would face hurdles imposed by geographical conditions or terrain. Furthermore, Cambodia already has a public administration system in place that is branched out to the local level. The ID-Poor programme has made use, without much difficulty, of the local administrative capacity for the

identification of the poor in remote villages.[5] It is relevant here to refer to the current efforts aiming at the decentralization of public services in the context of the ongoing public administration reform. The planned strengthening of administrative capacity at the subnational level with regard to both public service delivery and financial management as pursued under the decentralization and deconcentration (D&D) reform process, should facilitate the delivery of social protection benefits at local level in the future (see section 4.2.1).

1.5 Conclusions

The demographic profile of a country is one of the key determinants for the design and implementation of a social protection system. The main features of Cambodia's demography can be summarized as follows:

- With a median age of only 21, Cambodia has a young population, which is expected to age in the future. Under conservative assumptions, advanced ageing as witnessed in developed countries is not expected to occur in Cambodia before the middle of this century.

- The fertility rate of Cambodia surged in the aftermath of the Khmer Rouge regime, but has since been on the decline. With a total fertility rate estimated at 3.1 (year 2008), fertility is still high by international comparison but clearly on the decline in line with a general trend observed worldwide.

- Infant and child mortality rates are still high in Cambodia, mainly due to poor sanitation, malnutrition, a relatively high incidence of communicable diseases, and limited access to quality health-care services. With access to health-care services improving, particularly for the rural poor, the declining trend observed for infant and child mortalities is expected to continue.

- There is much room for a further reduction of age-specific mortality rates, particularly for younger age cohorts. As a consequence of decreasing mortality rates, life expectancy at birth will continue to increase, but probably at a reduced pace.

- The high fertility rate and high child dependency ratio indicate that a sizable allocation of fiscal resources is required to ensure adequate public services for children, in particular basic education and health care. Since children represent the country's future, it is relevant to consider expanding social protection provisions for children to ensure improvements in their health status, education, and access to opportunities for gainful employment.

- With an old-age dependency ratio estimated at only 6.9 per cent, population ageing is not a major issue in Cambodia. As a consequence, resource requirements to finance social protection provisions for the elderly are comparatively low at present and will remain low in the short- and medium-term future. Since the elderly population comprises a high share of women who often lack income security, there is a need to expand social protection provisions for the elderly.

- With a total population of 13.4 million, Cambodia's population is relatively small, and most areas of the country are easily accessible. The implementation and administration of social

[5] See http://www.ncdd.gov.kh/projects/ncddprojects/gtz/ID-Poor/117-ID-Poor

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protection benefits at local level should therefore not face hurdles due to geographical conditions or terrain. The main challenges for the expansion of benefit delivery at local level are tight fiscal resources and limited administrative capacities. The strengthening of administrative capacities at the subnational level as planned in the context of the D&D reform process should facilitate the delivery of social protection benefits at local level in the future.

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2 Labour market

2.1 Overview

The labour market situation has important implications on the design of a country's social protection system. In Cambodia no periodical labour force surveys have so far been undertaken.[6] Although data on employment status is collected during the population census, a data bias cannot be excluded due to seasonal variations in employment and variations in the phrasing of the relevant census questions. Nevertheless, the labour force statistics available from the population census provide a useful overview of the labour market situation for the assessment of the social protection system. Employment and labour market balance have been established from the 2008 Census data and other secondary data sources, together with projections for the years 2009 and 2010 (see Annex table A.2). The table shows labour supply, employment by type and gender, and residual unemployment. Little statistical information on wages is available in Cambodia. NIS reports contain some data on wages for the 1990s until the year 2001, but no comprehensive wage data are available for subsequent years.

2.2 Labour force

In the year 2008 Cambodia's labour force or active population totalled almost seven million persons, out of a total working-age population of 8.9 million.[7] The female labour force represented 51.2 per cent of the total, not surprisingly however, as women make up 52.7 per cent of the working-age population (aged 15 or above). From 1998 to 2008 the labour force increased by 1.9 million, or on average about 3.3 per cent per annum – an impressive growth rate which contributed to the sustained economic growth witnessed during the decade. It must be stressed, however, that the number of persons reported as unpaid workers increased by one million or about 4.4 per cent annually during the same period.[8]

2.2.1 Labour market participation rate

The total labour market participation rate for the population aged 15 and above increased from 77 per cent to 78.3 per cent from 1998 to 2008, i.e. by 1.3 percentage points. The breakdown by sex shows that the male participation rate stood at 80.8 per cent in 2008 and the female participation rate at 76 per cent. The labour market participation rate for males decreased by 0.4 per cent during the decade, while the rate for females increased by 2.5 per cent. Disaggregation by sex and age group shows that the increase in the female labour market participation rate took place most prominently in the higher age groups (55 and above).

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[6] The first full-fledged labour force survey was carried out finally in 2011 by the NIS; at the time of writing the survey results had not yet been released;

[7] The working-age population as defined here comprises all persons aged 15 and above;

[8] It is unclear whether the large increase can be related to an expansion of economic activity or to a statistical inconsistency, e.g. a change in interpretation or definition of "unpaid worker" occurred between 1998 and 2008.

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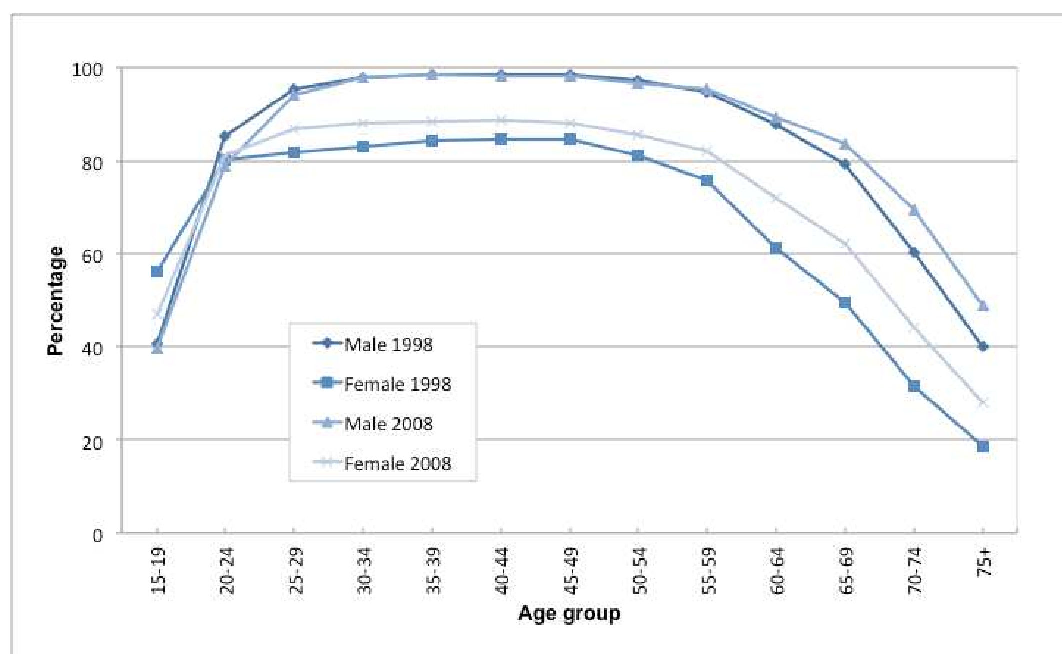
Figure 2.1 Labour market participation rates by sex and age group, 1998 and 2008



Sources: NIS Population Census, 1998 and 2008 (NIS, 2009a); NIS/ILO (2010).

Table 2.1 Changes in labour market participation rates by sex and age group, 1998–2008[1]

Age group	Male	Female
15–19	–1.2	–9.0
20–24	–6.5	1.1
25–29	–1.3	5.1
30–34	–0.1	5.2
35–39	0.1	4.4
40–44	–0.2	4.3
45–49	–0.2	3.5
50–54	–0.5	4.3
55–59	0.6	6.3
60–64	1.8	10.7
65–69	4.6	12.7
70– 4	9.3	12.7
75+	8.9	9.2
Total (15+)	0.6	1.5

Note: [1] Changes in percentage for the respective age cohorts.

Source: NIS (2009a).

Youth

For the younger age cohorts (15–24), the overall labour market participation rate decreased slightly from 60.7 per cent in 1998 to 60.1 per cent in 2008. Young workers represented more than a quarter (25.8 per cent) of the total labour force in 2008. During the decade from 1998 to

2008, the labour market participation rate among the younger age cohorts was persistently higher for females than for males. In general, it can be observed that women tend to enter and exit the labour force at an earlier age than men.

Adults (25+)

For Cambodians aged 25 and above, the overall labour market participation rate increased from 84.7 per cent (nearly 3.8 million) in 1998 to 87.5 per cent (5.2 million) in 2008, i.e. by 2.8 percentage points. The adult labour market participation rate was much higher among men, and that rate remained broadly constant throughout the decade at approximately 94 per cent. From 1998 to 2008 the absolute increase in the male labour force among male adults was almost 668,000, while it was about 722,000 for adult females. The gender gap in the adult labour market participation rate thus decreased throughout the decade from 16.8 per cent in 1998 to 12.1 per cent in 2008.

2.3 Employment

2.3.1 Employment by sex and age group

Total employment in the year 2008 was estimated at 6.8 million for the population aged 15 or above, increasing from 4.8 million in 1998, i.e. by about two million persons, including one million unpaid workers. Out of total employment, slightly over 3.9 million workers were considered as in “paid employment” while over 2.9 million were reported as “unpaid family workers”. Among the 3.9 million “paid” workers, about 1.2 million persons were found to be paid employees, i.e. persons having some form of contractual arrangement and a regular wage, whereas the remaining 2.7 million were reported as self-employed or own-account workers. According to the 2008 Census, about 100,000 children younger than 15 years of age were reported as employed; these included child workers, unpaid family workers and children subjected to child labour.[9]

The employment-to-population ratio in 2008 stood at 77 per cent overall: 79.6 per cent for males and 74.7 per cent for females. These rates are very high by international standards.[10] For youth workers (aged 15–24), the youth employment-to-population ratio increased in 2008 to 58.1 per cent from 53.3 per cent in 1998. In absolute terms, youth employment increased by 623,000 during the period 1998–2008. In general, the employment-to-population ratio was slightly higher for female than for male youth.

The adult employment-to-population rate also increased from 82.2 per cent in 1998 to 86.6 per cent in 2008. In absolute terms, total adult employment increased from 3.7 million to 5.1 million, i.e. by 1.4 million employed. The adult employment ratio in 2008 was higher for males than females; but in terms of growth, the male ratio increased only by 1.5 per cent while the female ratio increased 6.5 percentage points.

[9] The Cambodian Labour Law (1997) provides for the employment of workers aged 12–15 under certain conditions, including restrictions on working hours and type of work allowed (e.g. exclusions for hazardous occupations).

[10] The employment-to-population ratio is defined as the proportion of employed persons within the whole working-age population (aged 15+). Worldwide, employment-to-population ratios vary between around 50 per cent (mainly in the Middle East and North Africa) and around 75 per cent (mostly in East Asia). As reported unemployment is low in Cambodia, the employment-to-population ratio differs only marginally from the labour market participation rate.

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Total employment in absolute terms increased over the decade 1998–2008 by 43.3 per cent, or 3.6 per cent per annum on average. Youth employment increased over the same period by 4.4 per cent per annum, whereas adult employment increased by 3.3 per cent per annum on average.

Unpaid family workers totalled 2.9 million in 2008, including 2.1 million women, or 72.1 per cent. A comparison by age group and sex of the share of unpaid family workers in the total population reveals important differences between males and females (see table 2.2). It can be observed that for males the share of unpaid family workers decreased rapidly with increasing age to below 10 per cent from the age of 35. For females, however, the share of unpaid workers remained high at over 50 per cent up to the age of 49; it decreased only from age 50 to about 15 per cent for those aged 75 and above.

Table 2.2. Unpaid family workers by sex and age group, 2008

Age group	Unpaid family workers (% of population)[1]		
	Male & female	Male	Female
15–19	29.0	27.1	31.0
20–24	44.8	39.3	50.1
25–29	39.6	25.5	53.2
30–34	35.8	14.8	55.5
35–39	32.2	9.4	53.5
40–44	31.8	7.3	53.2
45–49	30.2	6.3	50.4
50–54	29.5	5.4	45.6
55–59	27.2	5.4	42.7
60–64	23.7	6.0	36.5
65–69	21.4	7.2	31.7
70–74	16.4	7.8	22.1
75+	12.3	8.3	14.8

Note: [1] Includes non-incorporated family businesses.

Source: NIS Population Census 2008 (extracted from database).

2.3.2 Employment by education

Among the employed persons aged 15 or older, 75.7 per cent were found to be literate in 2008, an increase of 8.6 per cent since 1998, or two million individuals in absolute numbers. Women particularly benefited from this positive development, with the literacy rate among female employment increasing from 56.3 per cent in 1998 to 69.1 per cent in 2008. During the same period, the literacy rate among male employed increased from 78.3 per cent to 82.7 per cent (NIS/ILO, 2010).

Between 1998 and 2008 the share of employed who had not completed primary school declined from 38.6 per cent to 34.5 per cent. The share of employed who had completed primary school increased from 17.2 per cent to 23 per cent, while those having completed secondary school increased from 7.2 per cent to 13.7 per cent (ibid.).

Similar patterns emerged among the youth and the adult age groups. A striking change was the decline of the number of illiterate women aged 15 or older from 43.7 per cent to 30.9 per cent of the total population in the same age group. But the proportion of employed females who had not completed the primary level of education (36.1 per cent) remained larger than the proportion of

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males (32.8 per cent) in 2008. Furthermore, across the range of all education levels, the share of employed with educational achievements was markedly lower for women than for men, both in 1998 and 2008 (ibid.).

2.3.3 Employment by sector

A large share of total employment (71.1% in 2008) can still be attributed to the primary sector, which includes agriculture, forestry and fisheries. However, a gradual decline has been observed since 1998 (77.4%), due to rapid economic development, diversification, and emerging industrialization (NIS, 2009a). The total number of women employed in the primary sector was larger than the number of men, both in 1998 and 2008, which can partly be explained by the fact that females outnumber males in the overall working-age population (see table 1.2).

Employment in the secondary sector (manufacturing and industry) increased from 4.3 per cent to 8.6 per cent of total employment from 1998 to 2008. This marked increase can be explained by the expansion of the garment and footwear manufacturing industry during the decade. Employment in the tertiary sector (trade and services) also expanded in relative terms from 18.3 per cent of total employment in 1998 to 19.3 per cent in 2008.

2.3.4 Unemployment

The total unemployment rate among those aged 15 or older declined, from 5.3 per cent in 1998 to 1.6 per cent in 2008. The female unemployment rate was marginally higher than the average rate, at 1.8 per cent in 2008. In general, unemployment rates were lower in rural areas compared to urban areas, owing to the large number of workers engaged in subsistence agriculture.

In 2008, the youth unemployment rate stood at 3.3 per cent compared to the adult unemployment rate of 1.1 per cent. Over the decade, the unemployment rate for both sexes among the youth declined significantly, from 12.3 per cent to 3.4 per cent among males and from 12 per cent to 3.3 per cent among females.

As in other countries at a similar stage of economic development, the reported unemployment rate is very low in Cambodia. There are two possible explanations:

(i) the absence of unemployment insurance benefits and therefore heightened economic pressure for the unemployed to accept whatever job is available for the sake of survival;[11] and

(ii) the low level of regulation of the economy and the labour market. Given the scope of the informal economy, wage workers made redundant, if not rehired swiftly in the formal economy, are likely to seek work informally (e.g. as day labourers) or work on their own account (e.g. as petty traders).

2.3.5 Informal employment

Employment in Cambodia is still to a large extent unregulated or "informal". Formal employment relationships governed by employment contracts, the Labour Law or collective bargaining agreements, and subject to entitlements such as work injury insurance coverage are however

[11] For an overview of the potential of unemployment insurance in Asia see for example Scholz et.al. (2010).

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gaining ground.[12] This is notably the case for the expanding employment in the secondary and tertiary sectors (e.g. in garment and footwear manufacturing, the hospitality industry and other service sectors). Informal employment can be attributed largely to the primary sector (agriculture, forestry and fishery), and partly the informal tertiary sector, which includes street vendors, petty traders, tuk tuk drivers and similar trades. These generally operate as own-account workers or family businesses.

Informality of employment is a multidimensional concept which relates mainly to the employment conditions observed in the informal economy (Hussmann, 2004). Informal employment generally refers to precarious forms of employment devoid of labour- and social protection provisions. It also comprises employment situations where employees are protected in principle by labour legislation but are not able to exercise their rights because mechanisms to enforce existing laws and regulations are lacking or deficient. Informal employment may be determined by the existence of a formal contract, the type of this contract, the character of the job (e.g. temporary or permanent), and the actual entitlements to various benefits prescribed by the Labour Law (e.g. sick leave or maternity leave).

Formal-sector employment usually comprises employment of those working in the public sector, in larger corporations, or in smaller establishments where the employer keeps comprehensive records and is subject to the enforcement of labour regulations. These proxy indicators (establishment size, record keeping, and enforcement of labour law provisions) are often used in the absence of information about registration of the enterprise or its compliance with rules and regulations regarding taxation.

In Cambodia no comprehensive data are available on formal/informal employment (NIS/ILO 2010, p. xvi). It can be assumed, however, that all employers registered with the Ministry of Commerce are subject to labour regulations, inspection by the MOLVT, taxation, and registration with the NSSF; hence they can be considered as formal employers in principle. According to the Labour Law, all employers with more than seven employees must have internal company regulations that are subject to scrutinization and endorsement by the MOLVT. These regulations must comprise detailed stipulations regarding working conditions and labour protection.

Self-employed workers and smaller (mostly informal) employers are often subject to licensing requirements, depending on their trade or economic sector in which they operate. This is usually an annual process, but apart from licensing fees there are no requirements to file tax records, declare employees (if any), and/or register with the NSSF. According to the Labour Law (1997), the status of "artisan" is granted to own-account workers and employers employing fewer than eight workers. It is understood that there is an obligation to incorporate and register with the Ministry of Commerce for all business entities in whatever trade that have eight or more regular employees.

According to the last population census (NIS, 2009a), the reported number of paid employees or wage workers totalled 1.2 million, including about 300,000 employees in public administration and defence. It can be reasonably assumed that the remaining 900,000 are regular workers in registered enterprises. This figure is in line with the number of enterprise employees reported in the latest enterprise survey (NIS, 2009b) for enterprises with eight or more employees. Hence, only about 17 per cent of employment may be considered formal-sector employment in Cambodia.

[12] The Labour Law applies in principle only to enterprises with eight or more employees (see section 7.2.2), although there seems to be some ambivalence in interpretation.

2.4 Labour migration

The annual number of internal or domestic migrant workers increased slightly during 1998–2008 from 2.3 million to 2.5 million. In both 1998 and 2008 the majority of them found work in the primary sector, and the number of female migrants was lower than males.

Overseas migration as reported by the MOLVT relates to registered overseas workers only; no information could be made available on economic migrants seeking work abroad on their own. The total number of workers reported as seeking work overseas was highest in the year 2007 (9,476 persons) and fell to 7,340 persons in 2008. Starting from 2004, the total number of women going overseas to work was higher than the number of men. Cambodian workers have been officially authorized to work in Malaysia since 1998, in the Republic of Korea since 2003, in Thailand since 2006 and in Japan since 2007. In the years 2007 (2008), the number of migrant workers reported in Thailand was 5,670 (2,116), in Malaysia 3,219 (2,654), in the Republic of Korea 584 (2,531), and in Japan 3 (39).

Targeted policy efforts by the MOLVT and bilateral and multilateral partnerships aim at increasing overseas employment opportunities for Cambodian jobseekers and at improving the placement system for overseas migrants (see NIS/ILO 2010, box 3). It is unknown to what extent overseas workers of Cambodian origin benefit from social security entitlements in the respective countries where they seek work.

The number of internal migrants (2.5 million) represented about 19 per cent of the total population in 2008 (NIS, 2009a). The high rate of internal migration represents a major challenge for the administration of social protection benefits. This challenge can be successfully addressed only through the cooperation with employers and the development of a national registration system and centralized database allowing for the administration of social protection benefits countrywide.

2.5 Education and vocational training

Cambodia's education system had to be rebuilt almost from scratch in the early 1980s after the devastating Khmer Rouge years, during which an estimated 75 to 80 per cent of teachers and higher education students died or fled the country (see ADB, 1996). Much progress has been achieved since. According to the data from the population censuses, the overall literacy rate increased from 63 to 78 per cent during the decade 1998–2008, while the school attendance rate for children aged 6–14 increased from 60 to 80 per cent during the same period.

Substantial efforts are being made by MOEYS, together with development partners, to achieve further improvements in providing equitable access to education, improving the quality of education and the efficiency of management functions. The main objectives pursued are to reduce repetition and dropout rates, to ensure access for the poor (particularly of girls in rural areas), to increase enrolment in higher education, and to improve the overall quality of the education provided (MOEYS, 2010). The MOEYS also promotes the expansion of early childhood education for children younger than the mandatory school age of six.

The lower education system comprises six years of compulsory primary education (grades 1–6) for children of age 6–11; three years of lower secondary school (grades 7–9), and three years of voluntary higher secondary school (grades 10–12). The net enrolment rates in the school year 2009/2010 stood at 95, 32 and 19 per cent for the primary, lower secondary, and upper secondary

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levels respectively (MOEYS, 2010). There is also a non-formal education system catering mostly to adults, offering literacy programmes and operating community learning centres that offer skills training in 12 different skills.

The demand for higher (tertiary) education has increased markedly in recent years. In this area MOEYS promotes public–private partnerships and the development of private higher education institutions (universities), the number of which continues to increase. In the school year 2009/2010 there were 76 higher education institutions (HEIs), among which 33 were public and 43 private universities. In that academic year total enrolment at HEIs was 145,596 students, among whom 51,596 were female (ibid.). Compared with the figures for the 2005/2006 school year, total enrolment had increased by 60 per cent, and by 80 per cent for females. However, enrolments are still below target, largely due to the limited financing for higher education. The Government is actively mobilizing resources from development partners with the aim of expanding scholarships for poor and outstanding students so as to ensure equitable access to higher education services.

Cambodia's technical and vocational education and training (TVET) system consists of 39 polytechnics and institutes and 25 provincial training centres that operate under the supervision of the MOLVT. Nine institutes conduct training courses at the bachelor and engineer levels and offer a Master's programme. One centre conducts short training courses (Phnom Penh) and two centres offer longer courses. The 25 provincial training centres deliver non-formal training programmes in rural areas whereas the 11 polytechnics and institutes deliver formal technical training courses. There is also a range of non-formal training programmes run by private providers, and about 30–50 non-governmental organizations (NGOs) train between 300 and 500 people per year through short programmes.

The number of TVET graduates increased from 88,367 in 2007 to 113,648 in 2008. Three out of five of the 2008 graduates (59.1 per cent) attended a primary short-term training course in a public institution, while 35.5 per cent studied in a centre run privately or by an NGO or an international organization. Only 2.8 per cent of the 2008 graduates studied for a technical diploma or technician certification. Even fewer, 1.3 per cent, attended a public primary long-term training programme, and 1.2 per cent received vocational training at the post-graduate level.

The continued development of the education system is considered an important pillar of Cambodia's overall long-term development agenda. This relates to both primary and higher education, formal and informal education, and academic and technical education. In the longer term, economic development can only continue at the current pace if it builds on an increasingly educated workforce that will be needed in the future, notably to support the ongoing expansion of the secondary and tertiary economic sectors.

2.6 Industrial relations

The establishment of a contributory social security scheme for private-sector enterprises requires the cooperation of employers' and workers' associations; these should play a prominent role to ensure ownership by all stakeholders, good governance and tripartite stewardship. It is therefore relevant in the given context to assess the state of industrial relations in Cambodia, including representation, legal framework, communication and negotiation channels, and collective bargaining and dispute resolution mechanisms.

Cambodia does not have a long history of industrial relations owing to the low level of industrialization. Emerging over the last two decades, industrial relations have developed

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alongside industrialization itself, particularly during the last five years. Unions began to emerge before the adoption of the Labour Law in 1997. A dispute resolution system was established and now includes conciliation and arbitration mechanisms. Genuine collective bargaining began in the hotel industry in 2004. Workers and employers engaged in regular dialogue, and the Government adopted a policy to promote collective bargaining more broadly.

2.6.1 Legal and regulatory framework

The Labour Law (1997) stipulates the right of enterprise employees to form and join trade unions of their choosing. It also provides for procedures in case of a strike and lockout and contains provisions for dispute settlements and collective bargaining. The law has been supplemented by several regulations covering strikes and strike procedures, union registration, collective bargaining procedures and union representation. In 1999, Cambodia ratified the eight core Conventions of the ILO that cover some of these issues.

Representation

A large number of enterprises and unions have been established since the mid-1990s. Altogether, more than 1,687 trade unions have been registered since the adoption of the Labour Law in 1997. Unions are organized under 42 federations and five confederations as well as some independent or non-affiliated groupings.[13] Given the large number of trade unions and the absence of a representative umbrella organization, trade unions may not yet be in a position to contribute fully to the shaping of labour-oriented and social protection policies, and/or to participate as a united entity in the stewardship of social protection systems on behalf of all workers.

Cambodia's Labour Law and the related regulations define the concept of most representative status (MRS) for trade unions, whereby a union with at least 51 per cent of workers enrolled in an enterprise may be assigned the right to represent all workers in the enterprise for the purpose of collective bargaining. Where multiple unions are allowed to operate, MRS is a key feature in enabling an orderly process of collective bargaining in which the employer can negotiate with a single union. A new regulation issued in 2008 helped to facilitate the certification of MRS unions by the MOLVT, resulting in a 300 per cent increase in new certifications (from nine in 2007 to 36 in 2008), with all MRS certifications totalling 202 by the end of 2009 (see table 2.3). The number of workers represented by all MRS-certified trade unions is not available.

Table 2.3 Most representative status (MRS) for trade unions, certifications

	2002–2006	2007	2008	2009	Total
MRS certifications	122	9	36	35	202

Source: NIS/ILO (2010), table 3.20.

By contrast, the Cambodian Federation of Employers and Business Associations (CAMFEBA), established in 2000, serves as the umbrella organization for the employer community, with more

[13] The MOLVT registers unions, union federations and employer organizations as part of its responsibilities. From 1997 up to the beginning of 2010 the number of unions ever registered totalled 1,725. However, only an estimated one-third, or around 600, were entitled to be active (NIS/ILO, 2010, p. 38). This is because a union registration certificate is only valid for two years, which implies that, at the date of the drafting of this report, unions that registered before around mid-2009 have since expired. In 2009, only 163 enterprise unions applied for a renewal of their registration.

than 900 direct and indirect members. The Garment Manufacturers Association of Cambodia (GMAC) is the oldest employers' organization; it furthers industrial relations and provides dispute resolution services to its members.

The Labour Advisory Committee (LAC), chaired by the MOLVT, is the only statutory national tripartite body. It is the main mechanism for the discussion of national labour policies among tripartite partners.

Dispute and dispute resolution

Cambodia has established a dispute settlement mechanism through the MOLVT's Department of Labour Disputes (DLD), which is responsible for conciliation. Provincial and municipal Departments of Labour carry out similar functions. The DLD also serves as the secretariat for the Arbitration Council. Established in 2003, the Arbitration Council has become an important component of the industrial relations system. It is composed of 30 part-time arbitrators, out of which ten each are nominated by unions, employers and the MOLVT. Arbitrators are mandated by law to resolve collective disputes that cannot be resolved through conciliation. The Arbitration Council has heard more than 900 cases and has gained widespread trust. It has been suggested that the Arbitration Council could be further strengthened through the use of binding arbitration for rights disputes. The number of labour disputes referred to the Arbitration Council has increased in recent years (see table 2.4).

Table 2.4 Labour disputes reported, 2001–2009

Year	No. of disputes	Disputes settled	Referred to Arbitration Council
2001	146	140	0
2002	118	116	0
2003	155	138	15
2004	229	157	72
2005	148	82	66
2006	217	142	75
2007	186	103	83
2008	174	90	84
2009	131	44	87

Source: NIS/ILO (2010), table 3.19.

Strikes in a number of major hotels in 2004 led to collective agreements between unions and management, several of which have been renewed repeatedly. This has helped to build relationships of trust between the parties and has practically eliminated strikes in the establishments that have adopted collective agreements. Figures on strikes and lockouts could not be made available.

Collective bargaining

Collective bargaining has become common practice in the hospitality sector, and is slowly gaining ground in the garment-manufacturing industry. Table 2.5 shows the number of collective

bargaining agreements (CBAs) adopted between 2003 and 2009. Information regarding the number of workers covered by these agreements could not be made available.

Table 2.5 Collective bargaining agreements (CBAs) concluded, 2003–2009

	2003–2006	2007	2008	2009	Total
CBAs	45	19	11	131	206

Source: NIS/ILO (2010), table 3.21.

In 2007, the number of CBAs registered with the MOLVT increased to 19 from an average of 11 during 2003–2006. In 2009 the number surged to 131 and during the first quarter of 2010 an additional 24 CBAs were registered. Most of them, however, dealt with a single contentious issue and were concluded on an ad-hoc basis rather than through a comprehensive collective bargaining process. Hence, only about 30 fully-fledged CBAs were concluded during 2009/2010 by MRS unions across all sectors (including the garment and footwear industry, hotel sector, food and beverage industry, and construction sector).

Minimum wage setting

In 2006, for the first time, all garment sector union federations and the GMAC agreed to negotiate a new minimum wage for workers in the textile and garment sector. Negotiations took place over a four-month period but could not be settled. Nevertheless, the experience was considered positive, creating a basis for improved communications (NIS/ILO, 2010, p. 39). Agreement was finally reached in 2010 and a collective bargaining agreement agreed upon, fixing the minimum wage in the garment sector at 200,000 KHR (~ US$50) per month.[14] The minimum wage in the garment sector was made official via notification by the MOLVT as provided for under the Labour Law.[15] To date, the garment sector is the only industrial sector for which an official minimum wage has been set.

Minimum wage setting at national or sector level is probably the most effective measure against exploitative wage structures when market forces fail. An official minimum wage is an effective social policy tool aiming to ensure a decent livelihood for workers. However, since wage levels affect the competitiveness of export-oriented industries, a minimum wage can adversely affect employment if the level thereof is set too high. Also, if not adjusted regularly to account for price inflation, a minimum wage loses significance over time. International experience suggests that the lack of an indexation mechanism for the minimum wage can also cause the erosion of the real value of social security benefits (e.g. pensions) if the value of benefits is tied to the minimum wage.

2.7 Conclusions

This chapter has presented a review of labour market and employment features in Cambodia. The main findings are summarized below:

[14] The collective bargaining agreement between the GMAC and representative union confederations and federations was signed on 28 September 2010 to come into effect on 1 January 2011; it is considered a landmark agreement for the improvement of labour relations in the industry.

[15] See Labour Law of Cambodia, 1997, described in section 7.2 of this paper.

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- Cambodia has a young labour force totalling about seven million persons. Labour market participation rates have been increasing over the past decade, particularly for women. The labour market participation rate is high for both youth and the elderly. During the past decade the total labour force has been expanding on average by 3.3 per cent per annum in nominal terms.

- Internal labour migration is high in Cambodia; it is estimated that about one-third of the labour force consists of domestic migrants. Internal migration relates predominantly to the primary sector, in particular to agriculture. Migration is a challenge for the effective implementation of a social protection system due to administrative requirements and the need to uniquely identify all beneficiaries in a national database.

- The employment-to-population rate in Cambodia is high by international standards at an estimated 77 per cent. This is partly due to the age profile of the population, with a low share of the population in the higher age groups (see Chapter 1). However, it is noteworthy that total employment comprises a large share of unpaid family workers, the majority of whom are women.

- The majority (71.1 per cent) of those employed work in the primary sector, including agriculture, forestry and fishery; but the share of the primary sector is on a declining trend in relative terms. The share of employment in the secondary (industrial) sector has been expanding to 8.6 per cent of total employment, mainly due to the growth of the garment and footwear industries. Employment in the tertiary sector (trade and services) has also been expanding to reach 19.3 per cent of total employment in the year 2008.

- The vast majority of the employed (83 per cent) can be attributed to the so-called informal economy; they often lack income security and generally have no entitlements to social protection benefits through their employer or occupation (if self-employed). The share of employees in the formal economy is estimated at only 17 per cent including public administration and defence. Given the expanding share of formal employment there is a window of opportunity for the extension of social security provisions in the formal economy through employment-based social insurance. Nevertheless, since employment formalization is a slow and gradual process, informal types of employment will persist and there is also a need to extend social protection provisions for informal workers through targeted or universal benefits.

- The official unemployment rate is low in Cambodia at only 1.6 per cent of the labour force (2008). This can be explained by the absence of unemployment benefits and the scope of the informal economy. Despite the low unemployment rate, under-employment and seasonal unemployment is believed to be high, particularly in the primary sector.

- Labour relations have developed since the adoption of the Labour Law in 1997. Several trade unions have emerged, both in the garment industry and in the services sector, and collective bargaining has been gaining ground. However, due to the high number of trade unions and the absence of an umbrella organization, trade unions lack sufficient representation to fully contribute as a united force to a tripartite dialogue at the national level.

3 Macroeconomic environment

Cambodia's national accounts are not yet fully developed due to the limited availability of primary statistics required for compiling national accounts. Nevertheless, the national accounts provide for a systematic picture of economic activity in Cambodia. They allow for useful insights into Cambodia's overall output (GDP) growth and factor income. GDP is an important indicator as it determines national income, the main financing source for social protection, aside from external financing through official development assistance (ODA). GDP also relates to fiscal revenues and tax income (including income tax, profit tax, value-added tax and/or import taxes). Tax on property is another potential income source for social protection financing, but little statistical information is available on Cambodia's wealth distribution. There is also limited information available regarding government finances, and therefore a detailed assessment of fiscal space issues is not possible here. The data limitations referred to should be kept in mind while reading this chapter. An overview of the Cambodian economy is presented in the following sections based on the data available at the time of writing.

3.1 Economic growth, factor income and inflation

3.1.1 Gross domestic product (GDP)

According to the International Monetary Fund (IMF), Cambodia's GDP for the year 2010 is estimated at KHR 47.8 trillion, or about US$11.7 billion. With the total population estimated at 13.9 million in 2010, this yields a GDP per capita of US$860 per annum, about US$2.40 per capita per day.[16] The composition of GDP shows that the primary sector, i.e. agriculture, fisheries and forestry, still made up for about 36 per cent of total output in 2010, while industrial output decreased to about 20 per cent (see table 3.1). Total output of the tertiary sector, i.e. trade and services, measured at current prices accounted for about 38 per cent in 2010; the tertiary sector thus remains the predominant economic sector.

Table 3.1 GDP and GDP composition at current prices, 2002–2010 (KHR billions)

	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
GDP at constant 2000 prices	16 232	17 613	19 434	22 009	24 380	26 870	28 668	28 107	29 799
Percentage change per annum	6.6	8.5	10.3	13.3	10.8	10.2	6.7	–2.0	6.0
GDP at current prices	16 781	18 535	21 438	25 754	29 849	35 042	45 583	44 841	47 805
Percentage change per annum	7.3	10.5	15.7	20.1	15.9	17.4	30.1	–1.6	6.6
GDP deflator	103.4	105.2	110.3	117.0	122.4	130.4	159.0	159.5	160.4
Percentage change per annum	0.7	1.8	4.8	6.1	4.6	6.5	21.9	0.3	0.6
GDP composition (% current prices)									
Total GDP	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Agriculture, fisheries & forestry	31.1	32.0	29.4	30.7	30.1	29.7	34.9	36.2	35.8
Industry	24.3	25.0	25.6	25.0	26.2	24.9	21.1	18.9	19.9
Trade and services	39.3	38.2	39.3	39.1	38.7	38.5	38.5	39.1	38.4
Taxes on products less subsidies	6.2	5.7	6.6	6.2	6.0	8.0	6.5	6.9	7.0
Less: FISIM[1]	0.9	0.9	1.0	1.0	1.0	1.1	0.9	1.1	1.1

[16] The total population for the year 2010 is projected at 13,890,465 according to the ILO population projection model.

Note: [1] Financial intermediation services indirectly measured.

Source: IMF data; author's estimates.

According to Hang (2009), Cambodia's economic development since 1989 can be divided into three phases:

(i) the rehabilitation phase from 1989 to 1998, witnessing privatization, decollectivization and structural problems similar to those observed in other transition countries;

(ii) the reconstruction phase from 1999 to 2003, characterized by institutional reforms and consolidation of market reforms, including liberalization; and finally

(iii) the high-growth phase from 2004 to 2008, witnessing GDP growth rates at 10.2 per cent per year on average lasting until the onset of the global financial crisis.

During the period 2002–2010, the annual GDP growth rate averaged 7.9 per cent in real terms. Growth rates were even higher before the financial crisis at an average 9.9 per cent per annum for the period 2002–2008. For the same period, real output in the primary sector (agriculture, forestry and fishery) increased on average by 6.8 per cent per year, while industrial output increased at an impressive 11.9 per cent per year. Output growth was also high in the tertiary sector (trade and services) during the same period. at an average of 10.2 per cent per annum (see table 3.2). Despite the rapid expansion of the industrial and service sectors in real terms, agricultural output, when measured at current prices, increased from 31.1 per cent to an estimated 36 per cent of total output due to important price increases of agricultural commodities during the period (2002–2010). The primary sector thus still represents a large share of Cambodia's output and absorbs close to 70 per cent of the labour force (see Chapter 2).

Table 3.2 Annual GDP growth rates by industrial sector at constant 2000 prices, 2002–2010

	2003	2004	2005	2006	2007	2008	Average 2002–08
Overall GDP growth rate	**8.5**	**10.3**	**13.2**	**10.8**	**10.2**	**6.7**	**9.9**
Agriculture, fisheries & forestry	10.5	–0.9	15.7	5.5	5.0	5.7	6.8
Industry	12.1	16.6	12.7	18.3	8.4	4.0	11.9
Trade and services	5.9	13.2	13.1	10.1	10.1	9.0	10.2
Taxes on products less subsidies	0.6	27.5	6.1	7.5	45.8	9.1	15.1
FISIM	8.2	18.4	15.5	11.1	25.0	14.0	15.2

Source: IMF data.

An in-depth look at the respective sub-sectors reveals that the output of agricultural crops grew on average by about 10.7 per cent per year at constant prices from 2002 to 2008. This can be explained by productivity reserves in agriculture and the increase in exports of paddy rice.[17] The sustained growth in agricultural output and, in conjunction, the increase of market prices for agricultural commodities may explain the positive development of the headcount poverty index, which has witnessed a sustained decrease in recent years (see Chapter 4).

[17] The RGC is promoting an increase in paddy rice productivity, which currently stands at only 2.6 tons per hectare per year compared to an annual 4.9 tons per hectare in Viet Nam (IMF, Article IV Report, 2011).

Table 3.3 Annual GDP growth rates and share in total GDP, ranking by sector, 2002–2008

	Annual growth rate[1] 2002–2008	Share in total GDP 2008 at current prices
Agriculture, fisheries & forestry	**6.8**	**32.8**
Crops	10.7	17.9
Livestock & poultry	5.1	4.4
Fisheries	2.7	7.4
Forestry & logging	1.9	3.0
Industry	**11.9**	**22.4**
Mining	17.9	0.4
Electricity, gas & water	13.9	0.5
Textiles, wearing apparel & footwear	13.7	10.3
Construction	13.0	6.1
Other manufacturing	10.2	1.9
Food, beverages & tobacco	3.4	2.2
Wood, paper & publishing	2.7	0.6
Rubber manufacturing	– 1.2	0.4
Trade & services	**10.2**	**38.8**
Finance	18.5	1.3
Other services	15.2	8.5
Real estate & business	12.8	6.4
Hotels & restaurants	9.6	4.5
Trade	7.3	8.9
Transport & communications	7.2	7.4
Public administration	– 0.4	1.8

Note: [1] Increase of value added measured at constant prices.

Sources: IMF data and author's calculations.

In the industrial sector, mining expanded at 17.9 per cent annually but only represented 0.4 per cent of total output in 2010. The labour-intensive garment and footwear industry expanded at 13.7 per cent per year over the period. Representing more than 10 per cent of total output, the sector is an important contributor to employment growth in the formal economy. Value added in the construction sector expanded at 13.1 per cent per annum in real terms during the period and meanwhile represents about six per cent of total output.

In the trade and services sector, financial intermediation was the fastest growing segment, expanding at 18.5 per cent per year in real terms over the period. The steep expansion of value added in financial intermediation can be explained by financial deepening and the rapid growth of credit markets in Cambodia.[18] Other segments also expanded during the period, e.g. hotels and restaurants at 9.6 per cent, and "other services" at 15.2 per cent per annum. There is no doubt that the fast growth of the service sectors benefited from the positive development of the tourist industry, with foreign arrival numbers increasing more than threefold since 2002, reaching an estimated 2.5 million visitors in the year 2010 (Ministry of Tourism, 2011). Total receipts from tourism for the year 2010 are estimated at about US$1.8 billion, an amount equivalent to 15 per cent of GDP (ibid.).

The future prospects for the Cambodian economy are considered as very good, at least for the next two decades, provided political stability can be maintained and foreign investors do not shy

[18] According to IMF data, the total volume of outstanding loans by commercial banks increased by 38 per cent per year during the period 2004–2010.

away from investing in Cambodia. The main constraint for sustained growth may be human capital unless further efforts are undertaken to improve education levels and to further invest in building the capacity Cambodia's future economy will need.

3.1.2 National income

Detailed data on national income could not be made available, notably on compensation of employees and income allocation between production factors (labour, capital, land and enterprise). Based on anecdotal evidence, the labour income share in total income is currently estimated at between 25 and 30 per cent.

3.1.3 Prices

The GDP deflator increased on average by 5.6 per cent per annum during the period 2002–2010. Notably high annual increases were witnessed in 2007 and 2008 due to the worldwide escalation of commodity prices shortly before the advent of the financial crisis. Consumer prices, as measured by the CPI, increased at the even faster pace of about 6.5 per cent on average over the same period. In the year 2008 alone, consumer prices as measured by the CPI increased by 25 per cent year-on-year. However, price pressures have eased since due to the global financial crisis and economic downturn. In 2010, the CPI increased by a moderate four per cent only. With high economic growth and continuing influx of foreign capital, the preservation of some price stability is a major challenge for the National Bank of Cambodia (NBC) and important for sustaining economic momentum in the longer term. High inflation rates can undermine the effectiveness of a social protection system, particularly if benefits are not properly indexed so as to adequately and promptly reflect any erosion of purchasing power as a result of price inflation (see Scholz and Drouin, 1998).

3.2 Labour productivity, wages and social protection

Labour productivity is a critical economic indicator that relates to social protection financing, in particular for contributory systems. Since the introduction or increase of wage-based contributions may result in an increase of labour cost for producers, this can only be justified if the workforce is productive enough to absorb the additional cost, meaning that the increase in labour cost does not undermine the viability of a business rationale.[19] On the other hand, social protection (health care in particular) helps to ensure that workers are healthy and productive, hence there is a reciprocal relationship between labour productivity and social protection. Furthermore, labour productivity usually increases with the skill set of workers, and with higher expertise workers become less fungible, creating thereby increased incentives for employers to enter into long-term employment relationships. This in turn increases employers' willingness to share the additional burden or cost for the workers' well-being. Generally high productivity growth rates indicate that adding financial costs to the production process by way of social security contributions (or personal taxation) is possible as industries become more competitive on a global scale, employees less fungible, and employment more secure.

[19] It has been argued that social security contributions do not increase labour costs but merely substitute for wages, in other words, that workers may accept lower wages if they benefit from social security benefits in addition.

In Cambodia, high productivity growth rates have been observed during the past two decades. Initially this was mostly due to the "peace dividend" unfolding and the resumption of the production process under normal conditions after the end of the civil war. During the past decade the growing influx of foreign capital has resulted in new capital investments and helped to accelerate the sectoral shift of economic activity from the agricultural sector to the secondary and tertiary sectors, where value added per worker is usually higher.

Total value added (GDP) per employee for the years 1998 and 2008 is displayed in table 3.4, both in Cambodian Riels (KHR) and in US dollars (US$).[20] It can be observed that for all sectors combined the average value added per employed increased by 5.8 per cent per annum for prices measured in Riels and 5.0 per cent in US$. The highest rate of increase in value added per worker was observed in the mining and quarrying industry, at over 20 per cent in both Riel and US dollar terms. For the primary sector, value added per worker increased on average by about 1.7 per cent per annum in Riels and 1.0 per cent in US$ respectively. It should be noted however that these figures are indicative only, since no comprehensive data on employment is available.

Table 3.4 Value added (GDP) per employee, by economic sector, 1998–2008 (KRH '000s and US$)[1]

	1998		2008	
	KRH ('000s)	**US$**	**KRH ('000s)**	**US$**
Mining and quarrying	3 637	964	25 341	6 229
Hotels & restaurants	24 378	6 460	22 068	5 425
Construction	9 337	2 474	13 553	3 332
Manufacturing	9 735	2 580	13 339	3 279
Transport and communication	6 042	1 601	10 824	2 661
Electricity, gas and water	15 849	4 200	10 695	2 629
Finance and other services	4 292	1 137	10 096	2 482
Trade	4 156	1 101	4 598	1 130
Agriculture, fisheries & forestry	1 294	343	1 537	378
All sectors (average)	**2 380**	**631**	**4,190**	**1 030**

Note: [1]GDP at constant prices per employed; values displayed should be understood as indices.

Source: IMF data (GDP), NIS data (employment), and author's calculations.

At current prices, the average value added per employee amounted to approximately US$110 per month in 2008. The lowest level of value added per worker was observed for agriculture, fisheries and forestry at only about US$40 per month.

[20] Since data on the capital stock could not be made available, it was not possible to distinguish between productivity contributions of labour and capital respectively.

Table 3.5 Value added per employee by sector, average rate of change, 1998–2008 (percentages)

	Rate of change per annum (%)	
	Riel-basis	**US$-basis**
All sectors (average)	**5.8**	**5.0**
Agriculture, fisheries & forestry	1.7	1.0
Mining and quarrying	21.4	20.5
Manufacturing	3.2	2.4
Electricity, gas and water	–3.9	–4.6
Construction	3.8	3.0
Trade	1.0	0.3
Hotels & restaurants	–1.0	–1.7
Transport and communication	6.0	5.2
Finance and other services	8.9	8.1

Source: Author's calculations based on table 3.4.

For most sectors productivity relates mostly to labour productivity, as capital inputs are low. Since wages are highly correlated to labour productivity, an increase in productivity also means an increase in wages. High labour productivity growth as observed in Cambodia is therefore conducive to the progressive implementation of a contributory social protection system as wage levels continue to rise. Labour productivity also relates to workers' skills and education levels. Hence, in the longer term, sustained increases in labour productivity are only possible if education levels rise in parallel, both for basic and higher technical education; therefore the need to further efforts and investments aiming at improving overall education levels in Cambodia.

In summary, substantial further productivity increases will be required in the future in order to adequately finance a social protection system of national coverage. This will require concurrently a strengthening of the public education system at all levels, including of vocational training. Since higher labour productivity generally means higher wages and thus an enlargement of the income tax base, the increase in labour productivity will also help to generate the fiscal resources required to extend social protection provisions in Cambodia.

3.3 Government finances and fiscal space

3.3.1 Government revenues and expenditure

Between 1994 and 2010, domestic government revenues increased from 8.3 to 12.3 per cent of GDP, i.e. by 50 per cent in relative terms, to reach a total of US$1.47 billion in the year 2010 (see table 3.6). The main revenue item is domestic tax, which currently represents about 60 per cent of total revenues, followed by tax on cross-border trade (mainly customs) at about 20 per cent, and current non-tax revenue (transfers from post and telecommunications, visa and tourists' fees and other commissions and charges, including capital returns) at approximately 18 per cent of total revenues.

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Table 3.6 Government revenues and expenditure, 1994–2010 (% of GDP)

	1994	1999	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total revenue	8.3	9.9	10.0	10.6	9.8	10.3	10.5	11.4	12.1	11.6	11.0	12.3
Tax revenue	5.1	7.2	7.2	7.5	6.8	7.7	7.7	8.0	10.2	9.7	9.3	9.8
Domestic	1.2	4.0	4.8	5.0	4.7	5.3	5.5	5.9	7.1	6.9	7.4	9.8
Tax on foreign trade	4.0	3.2	2.4	2.5	2.1	2.4	2.2	2.2	2.6	2.4	2.4	7.4
Current non-tax revenue	3.2	2.6	2.7	3.0	2.8	2.5	2.2	2.1	1.8	1.7	1.6	2.2
Capital revenue	0.0	0.1	0.1	0.1	0.2	0.1	0.6	1.3	0.1	0.2	0.1	0.3
Total expenditure	14.0	13.6	16.4	18.0	16.1	14.2	13.2	14.1	14.7	14.1	17.0	19.9
Current expenditure	9.3	8.2	9.3	9.7	9.7	8.5	8.0	8.3	8.6	8.3	8.5	10.6
Civil administration	4.9	4.5	6.2	6.8	7.1	5.9	5.7	6.0	6.5	6.5	6.4	8.1
Wages and salaries	4.1	3.9	3.3	3.5	3.3	3.0	2.8	3.2	3.3	3.2	3.3	2.5
Social spending	n.a.	n.a.	2.9	3.5	3.3	3.1	2.8	2.6	2.8	2.6	2.8	2.7
Other civil spending	n.a.	n.a.	0.0	–0.2	0.5	–0.2	0.1	0.8	0.8	0.8	0.3	2.9
Military and security	4.4	3.5	2.7	2.4	2.2	2.0	1.8	1.7	1.0	1.0	1.3	1.8
Interest payments	0.0	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Other current expenditure	0.0	0.0	0.3	0.3	0.2	0.4	0.3	0.4	0.6	0.6	0.6	0.5
Capital expenditure	4.7	5.4	7.1	8.3	6.4	5.7	5.2	5.8	6.1	5.8	8.5	9.3
Balance	–5.7	–3.7	–6.4	–7.4	–6.3	–3.8	–2.6	–2.7	–2.6	–2.5	–6.0	–7.6
Domestic financing	–0.4	–0.2	0.7	0.0	1.4	–0.5	–1.8	–2.2	–2.6	–3.0	–0.3	0.6
External financing	6.1	3.9	5.7	7.4	4.9	4.3	4.4	4.9	5.2	5.3	6.3	7.0

Note: n.a. = not available.

Sources: TOFE (tableau des opérations financières de l'Etat) 2008–2010, in MOEF (2009a, 2010, 2011); Hang (2009).

During the same period, government expenditures increased from 14 per cent to about 20 per cent of GDP. In 2010, current expenditures represented about 53 per cent of total expenditures, while the remaining 47 per cent were capital expenditures. Outlays related to public administration accounted for 76 per cent of current expenditure, and defence and security 16 per cent. Capital expenditures have increased substantially in recent years to reach 9.3 per cent of GDP in 2010 in comparison to only 4.7 per cent in 1994.

The budget deficit reached its highest level in 2010 at 7.6 per cent of GDP. It must be stressed however that the deficit consisted mainly of foreign-funded project financing covered by grants (61%) and concessional loans (33%), these totalling about seven per cent of GDP in 2010. Only a minor share (8%) of the budget deficit incurred in 2010 was funded from domestic borrowing, at about 0.6 per cent of GDP. In 2010, total net borrowing, including concessional foreign loans, amounted to approximately 3 per cent of GDP.

Only limited information was available on fiscal spending by line ministries and their related programmes, with the exception of the health sector (see section 6.3). According to the data provided for the year 2010, about 15 per cent of recurrent expenditures were spent for general administration, 23 per cent under defence and security, and about 35 per cent for "social administrative", which includes recurrent spending of the main line ministries, including the MOH, MOSVY, MOLVT and MOEYS (see table 3.7). Recurrent spending for economic government sectors (including the MOEF) totalled about eight per cent whereas the remainder ("miscellaneous") corresponded to approximately 19 per cent.

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Table 3.7 Composition of government expenditure by sector, 2006–2013 (percentage of total)

	2006	2007	2008	2009	2010^{BL}	2011^{p}	2012^{p}	2013^{p}
General administration	18.9	19.7	30.2	29.7	15.0	14.7	14.4	14.0
Defence and security	22.1	20.7	18.3	30.0	22.9	22.4	21.8	21.2
Social administrative	37.2	34.8	28.9	32.6	35.2	36.2	37.6	38.9
Economy administrative	9.3	8.1	6.5	7.3	8.3	8.4	8.5	8.6
Miscellaneous	12.5	16.8	16.0	0.3	18.6	18.2	17.7	17.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Notes: BL = Budget Law; p = projected.

Source: IMF.

For the sector referred to as "social administrative", it can be observed (table 3.8) that fiscal spending in nominal terms more or less doubled between 2006 and 2010 to reach approximately 3.7 per cent of GDP in 2010. However, since this includes salary costs, overheads and some procurement (e.g. pharmaceuticals), only a minor share is believed to represent transfers benefiting households directly.

Table 3.8 Government expenditure for social and cultural sectors, 2006–2013 (KHR billions)

	2006	2007	2008	2009	2010^{BL}	2011^{p}	2012^{p}	2013^{p}
Total social administrative	**875**	**1 034**	**1 283**	**1 549**	**1 771**	**1 988**	**2 232**	**2 504**
Information	17	18	23	40	41	44	46	49
Public health	261	343	427	525	600	681	774	879
Education, youth and sport	446	491	607	708	825	936	1 064	1 208
Culture and fine arts	15	18	22	25	26	28	30	31
Environment	10	11	16	18	20	21	22	23
Social affairs, labour & VT	108	129	159	197	216	230	243	256
Public worship and religion	5	8	10	12	15	16	17	18
Woman affairs and veteran	13	15	20	24	28	32	36	41

Notes: BL = Budget Law; p = projected.

Source: IMF.

Budget projections for the years 2011–2013 reveal planned increases in social sector spending, notably for health and education, both of which are projected to increase by 46 per cent in nominal terms by 2013 from the year 2010. The total allocation to all sectors labelled as "social administrative" is projected to increase to about KHR 2.5 billion by 2013, reflecting an average increase of about 12 per cent per annum in nominal terms. In relative terms, however, this does not reflect a material increase after accounting for projected GDP growth (at 6–7 per cent per annum) and price inflation (3–4 per cent per annum).

3.3.1 Fiscal space

According to the IMF (2011), government revenues are projected to increase to 14.9 per cent of GDP by 2015. Taking into account the projected growth of GDP, this yields a total increase of fiscal revenues by 107 per cent in real terms up to the year 2015, or an average annual increase of 14.5 per cent in nominal terms (see table 3.9). Although these projections may appear as overly

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optimistic, there is no doubt that new fiscal space will emerge in future years, notably due to the high GDP growth projected for the coming years.

Table 3.9 Government revenue projections (MTEF), 2010–2015

	2010	2011	2012	2013	2014	2015
GDP at current prices (KHR billions)	47 805	53 330	58 984	65 578	73 541	81 965
Projected revenues (% of GDP)	13.0	13.4	13.8	14.2	14.5	14.9
Projected revenues (KHR billions)	6 215	7 146	8 140	9 312	10 663	12 213
Actual revenues	5 869					
Projected increase in revenues (% p.a.)		15.0	13.9	14.4	14.5	14.5

Source: IMF (2011).

The process of long-term budget planning is based on an approach of sectoral programming and resource allocation, taking into account the respective needs and programmatic priorities, a process referred to as the Medium Term Expenditure Framework (MTEF). The first MTEF was prepared in 2002 for the period 2003–2007 and is being piloted by four line ministries, including health, education, rural development and agriculture. The intention of the MTEF is to allow for medium-term resource allocations based on financing requirements for the implementation of priority programmes. In this context, line ministries must provide indicative spending projections by programme area and line items (salary, non-salary, and capital expenses).

So far no long-term financing framework for social protection programmes exists in Cambodia. Since responsibilities for social protection are shared between different line ministries, any long-term financing strategy would require close cooperation between the respective ministries, and coordination of their MTEFs. In this context, the launching of the National Social Protection Strategy for the Poor and Vulnerable (NSPS) in December 2010 has established a new overarching conceptual planning framework, together with modalities for the coordination of line ministries and development partners under the stewardship of the Council for Agricultural and Rural Development (CARD).

A long-term costing of social protection programmes is currently being undertaken by CARD for the priority interventions spelled out in the NSPS.[21] It is understood that the planned assessment of long-term resource requirements for the implementation of the respective NSPS components will establish a long-term planning framework and thereby create a sound basis for informed policy decisions by the Government and donors regarding the extension of social protection in Cambodia. The process underpinning this long-term policy–resources–planning approach as suggested by the NSPS is conceptually similar to the MTEF process. In light of the sizable amount of funding required for the implementation of the programmes outlined in the NSPS, the commitment of the Government to allocating fiscal space for the extension of social protection is deemed critical. Since ODA funding is likely to decrease in the future, the allocation of fiscal resources may be indispensable for the extension of social protection, notably for the financing of basic social transfers targeting the poor and vulnerable.

[21] With technical support provided through the EU-funded ILO project “Improving Social Protection and Promoting Employment”.

3.4 Dollarization

Cambodia's economy is highly affected by dollarization; according to the IMF, Cambodia is the most dollarized economy of South-East Asia.[22] More than 95 per cent of all bank deposits are denominated in US dollars and an estimated 90 per cent of currency bills in circulation are US dollar bills. Vietnamese Dong and Thai Baht are also widely used in the provinces bordering the two countries.

During the years 1975–1980, Cambodia had no monetary system. Private property and commercial exchanges including barter trade were prohibited under the Khmer Rouge regime, and all savings and cash holdings were lost as a consequence. Although the Riel (KMH) was reintroduced in 1980, confidence in the national currency did not fully return; alternative means of exchange were used by the public including gold, rice and foreign currency, mainly the Vietnamese Dong, the Thai Baht, and the US dollar. During the early 1990s, Cambodia witnessed a huge influx of US dollars; under the United Nations Transitional Authority in Cambodia (UNTAC) operation in 1992/93 an estimated US$1.7 billion of aid monies were disbursed. The influx of US dollars continued thereafter as a result of foreign aid, tourism, garment exports and foreign direct investment (table 3.10). Furthermore, remittances from abroad estimated at over US$400 million in 2010 were transferred mostly in US dollars and made up for a high share of all bank deposits (World Bank, 2010a). Although the volume of Riels in circulation also increased, the national currency is used mainly in rural areas as the preferred means of exchange, while the urban economy remains largely dollar-based.

Table 3.10 Total ODA disbursement by donor, 1993–2007 (US$ millions)

Donor agency or country	US$ (millions)	Share of total (%)
UN agencies and international financial institutions	**2 232.6**	**29.3**
United Nations agencies	642.5	8.4
IBRD/World Bank	541.4	7.1
International Monetary Fund	241.5	3.2
Asian Development Bank	745.4	9.8
Global Fund	61.8	0.8
European Union	**1 814.3**	**23.8**
European Commission	467.5	6.1
Belgium	59.5	0.8
Denmark	97.4	1.3
Finland	24.0	0.3
France	450.4	5.9
Germany	228.9	3.0
Netherlands	69.0	0.9
Spain	7.9	0.1
Sweden	230.8	3.0
United Kingdom	178.8	2.3
Other EU Member States	0.0	0.0
Bilateral donors	**2 913.5**	**38.3**
Australia	323.8	4.3
Canada	69.3	0.9

[22] Dollarization refers to the use of foreign currency, often the US dollar, alongside the national tender.

China	303.8	4.0
Japan	1 491.0	19.6
New Zealand	17.3	0.2
Norway	22.4	0.3
Republic of Korea	119.8	1.6
Russian Federation	10.3	0.1
Switzerland	17.5	0.2
United States	514.1	6.8
Other bilateral donors	24.2	0.3
NGOs (core funds)	**652.9**	**8.6**
Total	**7 613.2**	**100.0**

Source: Hang (2009).

Dollarization has both benefits and disadvantages for Cambodia. The benefits include price stability for imported consumer goods and the absence of exchange-rate risk for foreign investors, in particular for export-oriented sectors such as the tourist and garment industries. Since the garment sector is currently the driving force of industrialization in Cambodia, the benefits of dollarization should not be underestimated. The lack of exchange-rate risk also applies to the banking sector, since the balance sheets of domestic banks are largely dollarized in Cambodia. It should be recalled in this context that a major reason why the impact of the Asian financial crisis in 1998/99 was so devastating was that many local investors had financed their investments via foreign currency-denominated loans and suffered tremendous losses as a result of their exposure to exchange-rate risk when Asian currencies massively depreciated.

The problems related to dollarization are mainly the limitations in control over monetary policy by the Central Bank, the loss of seigniorage revenues for the dollarized share of currency in circulation, and the loss of lender-of-last-resort ability.[23] Forgone seigniorage revenues are estimated at around five per cent of GDP, an amount equivalent to approximately 40 per cent of current fiscal revenues (IMF, 2011). Dollarization also limits the range of monetary policy instruments available to the National Bank of Cambodia (NBC) for exerting control over the Riel/US$ exchange rate, the money supply, and price inflation. The main instruments currently used comprise (i) foreign exchange auctions; (ii) setting minimum capital and reserve requirements for commercial banks; and (iii) interventions via standing facilities, including deposit and overdraft facilities, and a refinancing window for commercial banks (Bonnang, 2009). The loss of lender-of-last-resort ability relates to liquidity risk in the banking sector. In case of a bank run, the NBC will have to tap its limited foreign currency reserves (US$) to provide emergency loans to banks that encounter liquidity problems.[24]

It remains to be seen whether the NBC will be able to deal with future shocks and crises effectively, and whether the current level of dollarization can be maintained. Despite the future uncertainties, it is questionable whether a forced de-dollarization would be of benefit for Cambodia given the current impact of foreign direct investment on industrial development in the country. Dollarization may adversely affect the social protection system if the NBC is unable to maintain price stability. High inflation rates can be detrimental to social protection systems if benefits are not adjusted adequately to reflect losses in purchasing power due to price inflation (Scholz and Drouin, 1998).

[23] Seigniorage revenues refer to the revenues generated through currency issuance given the (positive) difference between face value and cost to produce the currency (i.e. the cost of printing bank notes and coins).
[24] Total NBC foreign reserves are estimated at 70 per cent of total foreign bank deposits; this may not be sufficient to prevent a serious financial crisis in case of a major bank run.

3.5 Conclusions

The findings of this chapter can be summarized as follows:

- Over the past decade, Cambodia's economy has witnessed a sustained expansion at approximately 8 per cent GDP growth per annum. The main drivers of growth were foreign direct investment, a young and fast-growing labour force, and emerging industrialization in the garment and footwear sector. Output in agriculture also expanded due to the increasing employment engaged in agriculture. The services sector benefited from the ongoing increase of tourism, with foreign visitor numbers higher than ever before.

- No macroeconomic data is available on the labour income share in Gross National Income. Based on anecdotal evidence, the labour income share is estimated at only 25–30 per cent of total national income.

- The GDP deflator increased at more than 5 per cent over the period 2002–2010. Consumer prices increased during the same period at 6.5 per cent per annum. Due to the worldwide rally in commodity prices witnessed in 2008, the CPI rose at an alarming rate of 22 per cent per annum in Cambodia. However, although high price inflation is a matter of concern for sustained growth in the future, the increase in food prices may have benefited the poor, who are mostly engaged in agriculture and therefore net producers of agricultural crops.

- Over the period 1998–2008, the average value added per worker increased by about 5 per cent per annum in real terms. Further productivity increases will lead to overall higher wages, improved livelihoods and an enlarged national tax base. Furthermore, higher wages will increase the contributory capacity of workers and employees to participate in any future contributory social protection systems. Future productivity increases should be pursued in agriculture to improve the livelihood of the rural workforce and accelerate poverty eradication.

- Cambodia's economy is the most dollarized economy in the region, with over 95 per cent of bank deposits held in foreign currency, mainly US dollars. Dollarization may help to attract foreign investors and protect importers of foreign goods from exchange-rate risk. However, it also results in forgone fiscal revenues from seigniorage benefits and limits the scope of monetary policy instruments available to the NBC for achieving price- and exchange-rate stability. Furthermore, dollarization prevents the NBC from intervening as the lender of last resort in case of a serious liquidity crisis and may therefore constitute a risk for long-term economic stability.

- Fiscal revenues have increased continually over the past decade to reach about 12.3 per cent of GDP in 2010 from less than 10 per cent in the year 2000. According to the MTEF, fiscal revenues are projected to increase further to reach over 14 per cent of GDP by 2015. Along with sustained economic expansion, new fiscal space is likely to emerge in the coming years. In light of the sizable amount of funding required for the implementation of the programmes outlined in the NSPS, the commitment of the Government to allocating fiscal space for the extension of social protection is deemed critical. Since ODA funding is likely to decrease in the future, the allocation of fiscal resources may be indispensable for achieving progress towards the extension of social protection in Cambodia.

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4 Governance

4.1 Background

Before the year 1953, Cambodia had been a French colony for almost a century.[25] Under the first Constitution, adopted under the French in 1947, Cambodia was governed by a monarchy with two generally elected houses, the National Assembly and the Popular Assembly; but all powers emanated from the king. After gaining independence in 1953, Cambodia experienced tumultuous changes in its political and economic regimes during four decades. The second Constitution was adopted in 1957. It granted Cambodians a number of basic rights such as freedom of speech and the right to stand for election to parliament. Under the leadership of Prince Norodom Sihanouk, Cambodia enjoyed during the 1960s economic prosperity and security comparable to its neighbours. Much of the basic infrastructure was constructed during those years, some of which is still in use today.

In the late 1960s Prince Sihanouk implemented a nationalization policy which forced many foreign companies out of Cambodia and seriously disrupted the development of a market economy. A coup d'état by General Lon Nol ousted Prince Sihanouk in 1970 and Cambodia became a republic. Lon Nol, the new President, promulgated the third Constitution that stipulated a multiparty political system and democratic principles. The President held all executive power and commanded the armed forces. Parliament included the National Assembly and Senate, with members elected by general elections. The courts were independent and monitored by a supreme court.

Opposition forces against the new republican government formed the National United Front of Kampuchea with the support of North Viet Nam. Initially allies, the Cambodian People's National Liberation Armed Forces and the Khmer Rouge split soon after. In April 1975 the Khmer Rouge took over Phnom Penh and established a Maoist regime, Democratic Kampuchea, under the leadership of Pol Pot. The three branches of government were unified under a single institution, the Central Committee. The market economy was completely abolished, and no money, trade or private ownership of any kind was allowed. The urban population was forcibly resettled to rural areas to perform agricultural work, and the educated elite was executed. Estimates indicate that more than a million people were killed or starved to death during the Khmer Rouge years.

The regime was toppled in 1979 by Vietnamese troops and Cambodian resistance forces. Khmer Rouge forces continued to occupy areas along the Thai–Cambodian border until 1998. A new government, the People's Republic of Kampuchea (PRK), was established and received major assistance from the former Soviet Union. The regime was controlled by the Communist Party, the People's Revolutionary Party of Cambodia, which later evolved into the Cambodian People's Party (CPP). Cambodian People's Revolutionary Committees at the provincial, district and communal levels were the local governing bodies responsible for implementing the Central Committee's decisions and directives. The Central Committee also set up a court system, and many of the judges and prosecutors appointed during that time are still serving today.

Reconciliation began in 1987 and the last contingent of Vietnamese troops withdrew in 1989. The Constitution was amended again in 1989 and the State of Cambodia emerged. In 1991 the four

[25] Most of this section is based on Chandler (1991).

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main political factions signed the Paris Peace Accords, which laid the groundwork for general elections held in 1993 and the development of a liberal, multiparty political system. The country also embarked on the transition to a market economy in 1989, seeking external assistance from the West after the former Soviet Union collapsed. The new regime permitted limited private ownership of property and private enterprise, and state-owned enterprises (SOEs) were privatized.

The United Nations Transitional Authority in Cambodia (UNTAC) was set up in 1992 to help govern the country until a new legitimate government was established after general elections. General elections took place under UNTAC in May 1993, and a coalition government was formed by the three major political parties: the National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia (FUNCIPEC), the CPP, and the Buddhist Liberal Democratic Party. This political compromise resulted in an uneasy arrangement of two co-prime ministers as well as co-ministers of the interior and defence. The sixth Constitution was promulgated by the National Assembly in 1993. It stipulates the establishment of Cambodia as a constitutional monarchy, where the king reigns officially but does not govern the nation.

The Constitution further provides for a multiparty, liberal democracy in which the people are masters of their country and exercise their powers through the National Assembly, the Senate, the Royal Cambodian Government and the judiciary. The legislative, executive and judicial branches of government are separate and all citizens have the right to establish associations and political parties. The Constitution recognizes the rule of law and human rights as enshrined in the Universal Declaration of Human Rights, and guarantees freedom of expression, freedom of the press (along with the 1995 Law on Press Regime), and freedom of assembly.

According to the Constitution, the State protects citizens' rights to obtain a quality education for at least nine years, with free provision of both primary and secondary education. To this end, the State must establish a comprehensive, standardized educational system throughout the country and adopt curricula based on modern pedagogical principles. The State is also responsible for providing health services and support for the socially vulnerable through the provision of free medical treatment and maternity services for poor citizens. The Constitution also stipulates that the State must support children, mothers, the disabled, and the families of combatants who gave their lives for the nation, and that the State will establish a social security system (see section 7.2.1).

4.2 Current reform

4.2.1 Decentralization

Over the past decade the governance reform agenda has embraced decentralization, referred to in Cambodia as subnational democratic development. Already in 2001 a law on commune/sangkat governance was adopted and commune/sangkat elections were held in 2002 to establish democratically elected commune councils.

In the following years the objectives of the "D&D Reform" were further elaborated in the 2005 Strategic Framework for Decentralization and De-concentration Reforms (the Strategic Framework), which envisages a reform process aiming to (i) consolidate and deepen the process of democratization at the grass roots; and (ii) promote local development and poverty reduction.

The reform entails the establishment of district and provincial councils and the creation of accountable and unified subnational administrations to support these councils.

The guiding principles of the Strategic Framework are spelled out as follows:[26]

- **Democratic representation**: Strengthen local councils that are democratically elected (either directly or indirectly) and expand their powers, responsibilities and resources.
- **Popular participation**: Introduce systems and procedures for people's participation in decision-making at all levels of the subnational governance system.
- **Public-sector accountability**: Strengthen the accountability of public administration at all levels and facilitate people's oversight of the administrative and financial performance.
- **Effectiveness**: Bring providers of services closer to the users and allow users to participate in the planning and monitoring of public services delivery in order to make public services responsive to local needs and priorities.
- **Efficiency**: Improve the administrative system, coordination and management capacity of the subnational governance system to improve quality and access to public services at all levels.
- **Poverty focus**: Enhance the capacity of integrated territorial authorities at all levels to better target public expenditures to eradicate poverty by focusing on vulnerable groups and to achieve Cambodia's Millennium Development Goals.

In 2008, the Council of Ministers and the National Assembly adopted further laws in the context of subnational governance.[27] The Organic Law does not directly assign functions and allocate personnel and resources, but indicates the future steps to do so, and establishes a new National Committee for Sub-National Democratic Development (NCDD), an inter-ministerial body entrusted with overseeing implementation of the Organic Law. In 2009 NCDD formulated the National Program for Sub-National Democratic Development (2010–2019) (the National Program) aiming to operationalize the implementation of the D&D Strategic Framework and the Organic Law over the decade. In 2010, a three-year Implementation Plan (IP3) was developed by NCDD with detailed objectives and activities of the first three years of implementation.

In parallel to the development of the policy and legislative framework, decentralization activities proceeded at the local level. In 2007, the second elections of commune/sangkat councils were held in 1,621 communes and sangkats, and in 2009 elections were organized for provincial and municipal councils.

Along with political authority some resources were decentralized early on during the reform. The Commune/Sangkat Fund (C/S Fund) was established in 2001 as the first step in an intergovernmental fiscal transfer system to finance both administrative and development expenditures to be controlled by commune/sangkat councils. The allocation to the C/S Fund from recurrent revenues has increased each year to reach about 2.8 per cent of overall fiscal revenues in 2010; an average annual budget of about US$15,000 per commune. Since 2003, the C/S Fund budgets earmarked for local development have been topped up through the World Bank-funded Rural Investment and Local Governance Project (RILGP).

The experience of the C/S Fund has been a positive one so far. Using the Fund to provide basic infrastructure and services, commune/sangkat councils have been empowered through a small

[26] See NCDD website: www.NCDD.org.kh.

[27] Law on Administrative Management of Capital, Provinces, Municipalities, Districts and Khans; and Law on Elections of Capital Council, Provincial Council, Municipal Council, District Council and Khan Council.

budget which provides some flexibility and requires participatory planning processes and the need to put in place the downward accountability mechanisms envisaged in the policy framework.

4.2.2 Public financial management reform

Efforts to improve public financial management (PFM) systems, including the provision of technical assistance, began in 1995. However, although reform was regarded as a key element in improving service delivery and resource reallocation, initial reform efforts had little concrete impact, primarily because of constraints associated with a weak and poorly remunerated civil service, lack of political support and technocratic ownership, and weak donor coordination.

In 2002 the Government launched a wide-ranging effort to engage all actors in the diagnosis of problems and difficulties related to PFM in the country. The outcome of these deliberations was documented in the 2003 Integrated Financial Accountability and Public Expenditure Review (IFAPER). Key findings included the need to increase revenue, address the system's high fiduciary risk, link spending more closely to outcomes, and give high priority to civil service reform, including merit-based performance incentives.

In December 2004, the Prime Minister of Cambodia launched the country's 10-year Public Financial Management Reform Programme (PFMRP), which is focused on four development objectives:

- ensuring that the **budget is realistic** and implemented as intended in a predictable manner;
- **implementing the policy agenda** through a comprehensive, orderly and transparent budget process;
- improving **accountability** and internal control systems to strengthen compliance and transparency in the mobilization and use of public resources; and
- motivating civil servants by an effective **incentive system** managed according to meritocratic principles and procedures.

Given the situation on the ground, PFMRP is designed as a step-by-step reform process or platform approach built on four sequenced platforms: (i) a more credible budget; (ii) effective financial accountability; (iii) a fully affordable and prioritized government policy agenda; and (iv) government managers become fully accountable for programme performance.

Initially efforts under PFMRP were focused mainly on Platform One, aiming to achieve a budget that is more credible as an instrument of strategic and day-to-day management of public resources. Ensuring that the budget reflects all significant public resources and their deployment will enable steps in subsequent platforms to hold budget managers more accountable for the proper, efficient and effective use of resources. Most activities set out under Platform One have been completed, although in some areas such as cash management and the streamlining of budget execution considerable work remains. Tangible results achieved to date under PFMRP include improvements in tax administration, revenue collection, expenditure control, cash management and budgeting. While efforts aimed at improvements in these areas are continuing, activities under Platform Two started in 2008.

According to the World Bank (2008), key factors contributing to the successes achieved so far under the PFM reform include the following:

- the use of a sector-wide approach (SWAp) to coordinate development partners' input around an agreed action plan;
- a core of dedicated reformers in the Ministry of Economy and Finance (MOEF) and other key ministries to drive reforms forward;
- merit-based posting of staff in key positions; and
- Good team leadership in the MOEF.

4.3 Implications for social protection

The current social protection system in Cambodia is administered by different line ministries, comprising mainly the MOSVY, MOH, MOLVT and MOEYS. In addition, donor-funded initiatives, in particular those undertaken in the framework of projects, often have their own stand-alone administrative structure. Although the recent efforts of development partners increasingly support a programme-based approach with pooled funding and are aiming at full-fledged budget support in the future, this is not yet the rule and there is still a myriad of different actors implementing activities that are sometimes overlapping or implemented in an uncoordinated manner in the same areas. So far, little inter-ministerial coordination has been attempted. Exceptions are social health insurance where an inter-ministerial body, the Social Health Insurance Council, has been established; and disaster management, where the National Committee for Disaster Management (NCDM) has the role of coordinating the respective line ministries.

The recent adoption of the National Social Protection Strategy for the Poor and Vulnerable (NSPS), prepared under the leadership of CARD, is another attempt to (i) coordinate all actors; (ii) define priority areas of intervention; and (iii) streamline implementation arrangements at a national level. It can be expected that the NSPS will lead to a more coherent and coordinated approach to the field of social protection in the future. However, this will depend also on whether donors are prepared to support the NSPS and whether CARD will have the mandate and leverage to enforce a more coherent programme formulation and coordinated implementation. Since CARD does not have a country-wide implementation structure, much of the responsibility for implementation will remain with the respective line ministries, at least in the near future.

The planned decentralization of public service delivery might have implications for the delivery of social protection benefits at local level, although it is as yet unclear what exactly the interface between vertical programmes administered by line ministries and the new local administration will look like in the future, and notably to what extent responsibility for the delivery of benefits will be delegated to the local administrations. Nevertheless, the commitment of the Government to decentralizing public service delivery, and the ongoing empowerment of local administrations, should open new perspectives and widen the range of policy choices available. It should be obvious that new approaches will need to be carefully planned and piloted before a country-wide implementation can be envisaged.[28]

[28] A pilot project is currently being prepared by ILO, aiming at piloting an integrated social service delivery mechanism (referred to as the "People Service") at the subnational level.

5 Poverty and vulnerability

According to the United Nations, Cambodia is still among the world's least-developed countries. Despite substantial achievements in poverty reduction during the past decade, many Cambodians still live in poverty or in precarious livelihood conditions, particularly in rural areas. In addition to the poor, numerous are those considered as "near poor" or vulnerable; the latter have a high risk of falling into poverty in the event of economic downturns, natural disasters, or other adverse events affecting household income such as ill health, death or unemployment.

With a high proportion of the workforce engaged in subsistence agriculture, food security for many depends on stable weather conditions. Cambodia is therefore highly vulnerable to climatic shocks, including droughts and flooding. This is compounded by insufficient or non-existent infrastructure for controlling water levels in rivers and wetlands, including dams and irrigation systems. As a result, the livelihood of many Cambodians is highly affected by extreme weather events, increasing their need for social protection in case of climatic shocks.

Other factors contributing to the vulnerability of Cambodians include high levels of poor maternal and child health and nutrition, high seasonal unemployment, income insecurity, health shocks and poor education (see CARD, 2010). Given the remaining poverty and vulnerability profile, social protection interventions by the Government and development partners are focused mainly on basic needs, including food security, emergency aid, access to basic primary health care, and child support. The following two sections provide a review of poverty statistics and identification mechanisms in Cambodia.

5.1 Measuring poverty

Since 1994, poverty rates have been estimated in Cambodia by the Ministry of Planning (MOP) with support from development partners, mainly the World Bank. Baseline poverty estimates were prepared initially using data from the first broad consumption survey, the 1993/1994 Socio-Economic Survey of Cambodia (SESC) (see Prescott and Pradhan, 1997). Updated poverty estimates were prepared based on the data from the Cambodia Socio-Economic Survey (CSES), this in 1997, 2004 and 2007, and on a preliminary basis for the years 2008 and 2009.[29] The updated poverty estimates are useful in monitoring Cambodia's success in reducing poverty over time. They are also useful for broadening and deepening our understanding of the changing dimensions of Cambodia's poverty and thereby improving the effectiveness of poverty reduction and monitoring efforts.

Methodologies for measuring poverty have evolved over the years and therefore poverty headcount rates over time have limited comparability, as changes in methodologies can result in variations of estimates. The year 2004 is considered as the beginning of a new period, with poverty measurements based on consumption per capita from that year onwards. However, despite efforts to ensure consistency over time in terms of methodology, household needs and consumption patterns also change over time and setting the benchmark that defines poverty remains a challenging task.

[29] See MOP (1998), and Knowles (2009). At the time of writing, the preliminary estimates for the years 2008 and 2009 have not yet been published nor endorsed by the MOP.

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Poverty estimates in Cambodia are established based on a so-called poverty line, which reflects the amount of household consumption required for procuring a basic benchmark basket of items (food and other) consumed by the average household. Two poverty lines are used in Cambodia: the "food poverty line" and the "total poverty line". The food poverty line reflects the cost of basic nutritional requirements set at 2,100 calories per person per day, based on the market cost of staple foods according to the local dietary composition. The food poverty line thus basically reflects the cost of feeding a person, assuming food is purchased at local market prices. Households with a per capita consumption under the food poverty line are designated as extremely poor. The overall poverty line comprises, in addition to the basic food consumption, the cost of essential goods and services such as clothing, housing, transportation and health care. The poverty line reflects the cost of basic food and non-food consumption, with non-food items representing about 20 per cent of total minimum consumption according to estimates from 2004. Households with a per capita consumption under the overall poverty line are labelled simply as "poor". The two poverty lines have analogies with the class 1 and 2 poverty groups under ID-Poor (see below), although the underlying methodologies differ substantially.

Based on the above methodology, the poverty line for Cambodia was estimated in 2004 at KHR 1,826 (~US$0.45) per person per day, or KHR 9,130 (~US$2.25) per day for a household comprising an average of five persons. About 80 per cent (US$0.36) of the minimum consumption reflected by the poverty line represents cost for food, while the remaining 20 per cent (US$0.09) is for basic non-food items (e.g. clothing and housing). Based on the 2004 poverty lines, the headcount poverty rate (i.e. the poverty prevalence rate) was estimated at 34.7 per cent poverty and 19.7 per cent extreme poverty (see table 5.1).

Table 5.1 Estimated poverty headcount rate, 1993–2009 (percentage of total population)

	1993/1994[1]	2004	2007	2008[2]	2009[2]
Extreme poverty	20.0	19.7	18.0	11.1	7.4
Poverty	39.0	34.7	30.1	20.7	14.6

Notes: [1]Adjusted figures that account for areas excluded from the initial sample. [2] Preliminary estimates prepared by the World Bank.

Sources: MOP (1994, 2004, 2007); and data provided by the World Bank Office, Phnom Penh.

By 2007 poverty had decreased to 30.1 per cent and extreme poverty to 18 per cent. Preliminary estimates from CSES 2009 data suggest that poverty headcount rates may have decreased further to as low as 14.6 and 7.4 per cent for poverty and extreme poverty respectively, if the same consumption basket used in 2004 is applied (World Bank, 2011).[30] According to these preliminary results, the poverty headcount rate is highest in rural areas (17.0 per cent) and lowest in Phnom Penh (1.8 per cent). Regardless of any methodological issues that may remain, estimates clearly suggest that the poverty rate is decreasing rapidly in Cambodia, both for total and extreme poverty. It is unclear, however, to what extent this positive development can be attributed to economic growth versus poverty alleviation efforts.

The evolution of the Gini Index during 1994–2009 suggests that, on average, income disparities increased during the years 1994–2007, but have since been decreasing (see table 5.2.).[31] This

[30] An alternative set of preliminary World Bank estimates using an updated consumption basket (comprising 39.9 per cent non-food items) puts the poverty headcount rate at 30.1 per cent and extreme poverty rate at 7.0 per cent.
[31] It is noted that the estimates shown are based on consumption per capita as a proxy variable for income.

seems to be an indication that recent economic gains have been shared, to some extent, by the poor through trickle-down effects. For rural areas the data suggests, however, an increasing trend in inequalities since 1994, despite a sharp drop in 2008, which may be related to the surge in food prices that may have benefited the poor, given that their livelihood relates mostly to agricultural output (RGC, 2011).

Table 5.2 Estimated Gini coefficient for Cambodia, 1993–2009[1]

	1993/1994	2004	2007	2008[2]	2009[2]
National average	**0.347**	**0.393**	**0.415**	**0.368**	**0.355**
Phnom Penh	0.393	0.367	0.334	0.335	0.347
Other urban	0.439	0.432	0.449	0.352	0.370
Rural	0.265	0.340	0.344	0.302	0.355

Notes: [1]The Gini coefficient is a measure of income inequality, ranging from 0 (no inequality) to 1 (total inequality). The estimates shown are derived from CSES data on real consumption per capita. However, sampling changed over the successive surveys, so that values have limited comparability. [2] Preliminary estimates as prepared by the World Bank.
Source: World Bank (updated estimates).

5.2 Targeting the poor: The ID-Poor project

Identifying poor households on an individual basis through means-testing is important in many ways to support efforts aimed at poverty eradication. It allows not only for a geographical mapping of poverty and henceforth the identification of areas that require priority intervention; it also allows for targeting of poverty relief efforts to benefit individual households that have been identified as poor. The latter is particularly important for the design of social assistance programmes aimed at benefiting individual households in order to lift them out of poverty.

The ID-Poor project was initiated in 2005 by the Government with support from GIZ. Its objective consists in identifying all poor households in Cambodia and determining their respective needs. The programme started the assessment of individual households in specific regions in 2007, and quickly expanded to cover about 2,000 villages in 2009. So far more than 50 per cent of all Cambodian households have been interviewed, out of which more than 1.5 million persons were classified as poor at the end of 2010. Poverty assessments of the remaining households have been ongoing in 2011, and it is expected that the ID-Poor database will include all poor Cambodians by the end of the year 2012. The programme plans a full re-evaluation of all households every two years to ensure availability of an up-to-date set of data on the demographic and economic situation of the poor.

The ID-Poor project is implemented through the MOP. The central office is assisted by two GIZ advisers and works closely with ID-Poor units at provincial planning departments (PPD). The latter liaise with special committees set up in communes, called Planning and Budgeting Committee Representative Group (PBCRG), who collect information from villages. In each village a committee called Village Representative Group (VRG) is established to carry out the poverty assessment and report the results to the PBCRG.

The assessment of households is in itself a participatory process comprising a self-assessment of households through a detailed questionnaire making use of scoring and non-scoring questions. *Scoring questions* relate to the shape of the housing, productive assets (e.g. land ownership,

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fishing equipment), animal husbandry, number of dependent family members per working family member, electronic assets, means of transportation, and food borrowed over the last year; whereas *non-scoring questions* relate to unexpected problems or crises, e.g. schooling missed by children of the household, assistance received from relatives, sickness or deaths among the household,and so on..

The questionnaires are reviewed by the VRG, which then decides upon the classification of households into three groups: (a) the non-poor; (b) those considered extremely poor, i.e. living below the food poverty line (referred to as ID-Poor 1); and (c) those considered poor but whose livelihood is considered above the food poverty line (referred to as ID-Poor 2). The list of households considered poor is displayed in the village for review by the villagers, who can object or make suggestions before the list is finally forwarded to the PBCRG at district level. If unresolved issues remain, the PBCRG will assist with mediation before the list is forwarded to the provincial group, where the data is recorded in the ID-Poor database, including ID of poor household members and poverty classification (ID-Poor 1 or ID-Poor 2). An “equity card” is issued for each household classified as poor and a picture of the household members is recorded in the database.

ID-Poor is a useful mechanism to identify poor households. Once the poor have been identified, the introduction of social protection benefits targeted to the poor (e.g. cash transfers) is realistically possible, provided the resources are available and political commitment is ensured. The lack of an appropriate poverty targeting mechanism is often the main impediment for the introduction of benefits targeted to the poor.

5.3 ID-Poor data

This section presents an overview of the poverty data collected so far by ID-Poor in 14 provinces and a comparison with the respective population figures from the Census 2008.[32] The age distribution of the poor (ID-Poor 1 and ID-Poor 2) is shown in figure 5.1. It can be observed that poverty is high for children and elderly women. Since poverty is assessed on a household basis, it can be concluded that poor households have proportionately more dependants (children and elderly) than households that are not poor.

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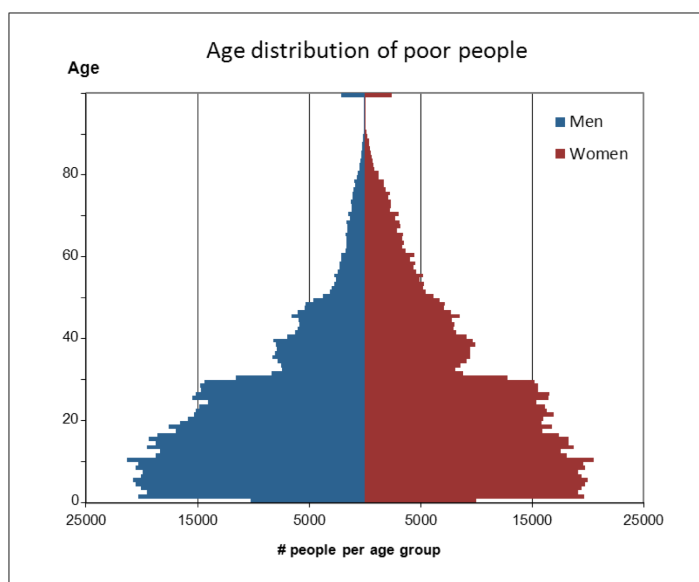
[32] The data provided cover the following 14 provinces: Banteay Meanchey, Battambang, Kampong Cham, Kampong Thom, Kampot, Koh Kong, Mondul Kiri, Prey Veng, Pursat, Ratanak Kiri, Siemreap, Stung Treng, Svay Rieng, Oddar Meanchey.

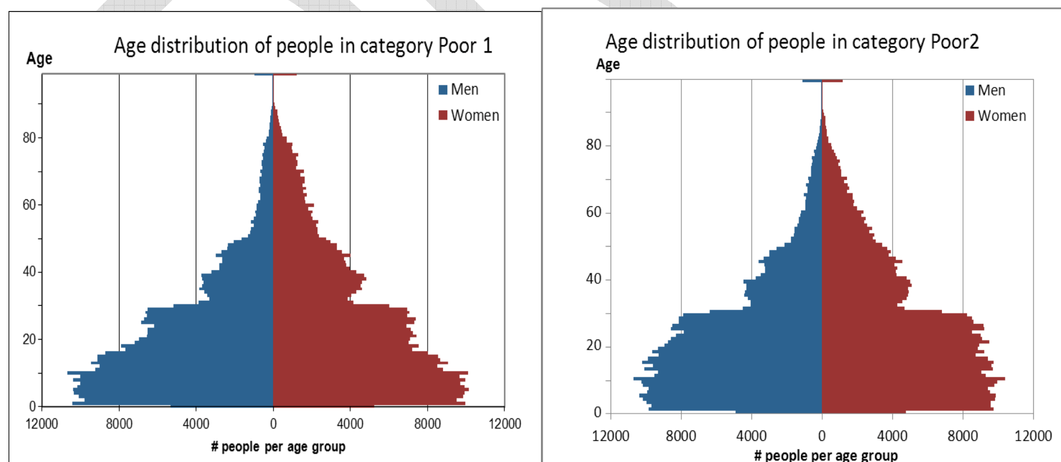
Figure 5.1 Total poor population, ID-Poor data, 2009/10



Source: Author's calculations from ID-Poor raw data.

Separating the age distribution for the two categories of poor shows a high proportion of young children (ages 0–10) living under the food poverty line amongst the ID-Poor 1 population, whereas, in relative terms, there are fewer in the age group 20–30 amongst those extremely poor.[33] Overall, however, there seems to be little difference in the age/sex distribution of ID-Poor 1 and ID-Poor 2 populations (see figures 5.2 and 5.3). Also, it is noted that the census data used here was "processed", whereas the ID-Poor data set used comprised only "raw" data. This is most apparent for the age group of persons older than 99 years of age.

Figure 5.2 Population pyramid, ID-Poor 1 **Figure 5.3 Population pyramid, ID-Poor 2**

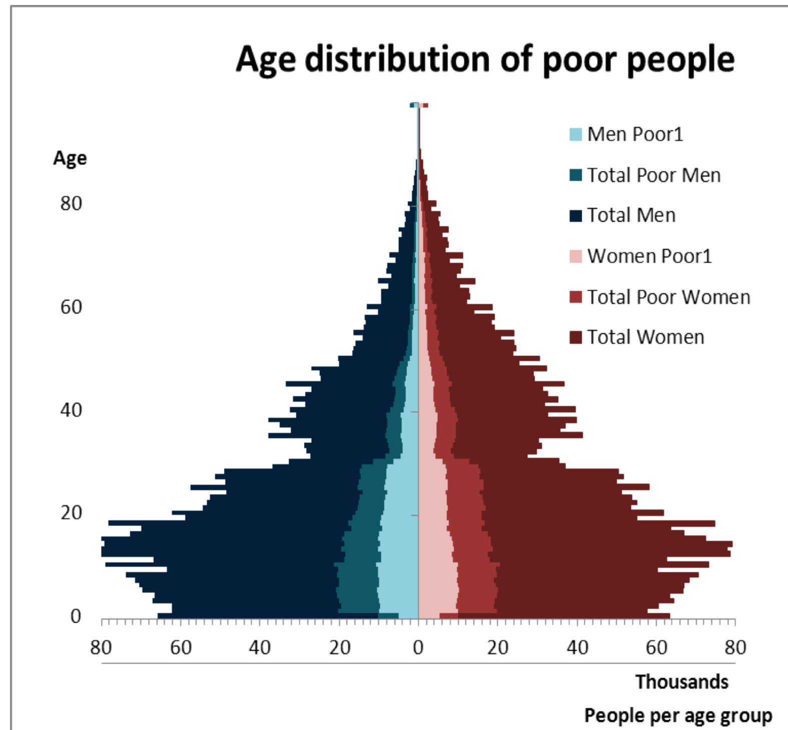


Source: ILO, from ID-Poor raw data provided.

[33] Since poverty is assessed on the basis of aggregate household consumption, the data suggests that for those living in extreme poverty the average number of young children per household may be comparatively high.

Figure 5.4 shows the ID-Poor population in comparison to the total population for all villages where ID-Poor data has been collected. It is noted that some of the villages covered by ID-Poor were not covered by the 2008 population census; these were excluded for the comparison of the two data sets.

Figure 5.4 Population pyramid, total population versus ID-Poor, 2009/10



Source: ILO, from ID-Poor raw data provided.

The main findings are summarized in table 5.3. It can be observed that the total headcount poverty rate based on ID-Poor criteria is estimated at 26.9 per cent, whereas the extreme poverty (ID-Poor 1 only) headcount rate is estimated at 12.8 per cent. Women and children are more likely to be poor than men. Since poverty is assessed on a household basis, it can be concluded that poverty among female-headed households is relatively high.

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Table 5.3 Poverty distribution by gender and age group, ID-Poor data, 2009/10

	Total[1]	Men	Women	Children (< 15)	Working age (15–64)	Elderly (>65)
Headcount (persons)						
ID-Poor 1	738 292	344 689	388 211	286 825	410 360	36 148
ID-Poor 2	822 274	390 500	426 168	287 866	495 358	33 773
Population[2]	**5 791 798**	**2 832 755**	**2 959 043**	**2 078 518**	**3 476 572**	**236 708**
Headcount rate (%)						
ID-Poor 1	12.8	12.1	13.1	13.8	11.8	15.3
ID-Poor 2	14.3	13.8	14.4	13.9	14.3	14.3
ID-Poor 1 & ID-Poor 2	**26.9**	**25.9**	**27.4**	**27.7**	**26.1**	**29.5**

Notes: [1]Including those with "unknown sex" in the ID-Poor data. [2] Population according to the 2008 census in the villages covered by ID-Poor.

Source: ILO estimates, from ID-Poor raw data provided.

The ID-Poor data set presented relates to a total population of about 5.8 million persons. A simple up-scaling of the estimated headcount poverty rates yields a total poor population of about 3.6 million, among which an estimated 1.7 million would live in extreme poverty (see table 5.4). It can be observed that the estimates suggest that the number of poor women exceeds the number of poor men by about 200,000 in absolute terms.

Table 5.4 Estimated total poor population of Cambodia, 2009/10

	Total[1]	Men	Women	Children (<15)	Working age (15–64)	Elderly (>65)
Total 2008 census population	13 395 682	6 516 054	6 879 628	4 513 792	8 310 590	571 300
ID-Poor 1[2] population	1 687 293	782 933	893 563	622 296	982 915	82 082
ID-Poor 2[2] population	1 888 520	891 386	985 689	624 701	1 188 059	75 760
ID-Poor 1 & ID-Poor 2	3 575 813	1 674 319	1 879 252	1 246 998	2 170 974	157 842

Notes: [1]Including those with "unknown sex" in the ID-Poor data. [2] Estimated total ID-Poor population.

Source: ILO estimates, from ID-Poor sample data provided

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6 Health

6.1 Overview

6.1.1 Health status

The health status of Cambodia's population has an impact on the country's future socio-economic development and potential for economic growth. After a period of extensive labour productivity growth together with an expansion of the labour force, future economic growth will have to rely increasingly on intensive labour productivity growth if is to be sustained over the longer term. Although there is much potential for capital productivity to unfold, long-term economic expansion at the current pace will only be possible and sustainable if labour productivity develops in order to support the growth of the secondary and tertiary sectors. This however is only possible through improved education, for which a good health status is a prerequisite. Also, increased labour productivity means higher wages, disposable household incomes, and ultimately enhanced capacity to contribute to the national social protection system to be developed in the future.

Cambodia's health status is nevertheless still among the poorest in South East Asia. A heavy burden of communicable diseases and high child and maternal mortality rates still affect many Cambodians caught in a vicious cycle of ill health, debt and poverty; this is delaying the country's development. Although progress has been achieved in strengthening the national health system and improving access to health care for the poor, continued effort is needed to further improve the access to quality health-care services and the protection of households against catastrophic health expenditures. An international comparison of key health indicators provides a mixed picture of the health status of Cambodia's population (see table 6.1).

Table 6.1 Cambodia and its neighbours, regional comparison of health-related indicators, various years

Country	**GDP per capita (2008)** (US$)	**Life expectancy at birth 2008** (years)	**Adult mortality rate 2008**[1]	**IMR 2008**[2]	**U5MR 2008**[3]	**DPT3 rate 2008**[4]	**Measles prev. rate 2008**[5]	**MMR 2005**[6]	**% births assisted by skilled birth attendant** (year)
Cambodia	711	62.4	403	69	89	91	89	540	71 (2010)
Indonesia	1 304	67	206	31	41	77	83	420	73 (2007)
Viet Nam	1 051	73	150	12	14	93	92	150	88 (2006)
Thailand	4 043	70	209	13	14	99	98	110	97 (2006)
Myanmar	n.a.	54	336	76	122	85	82	380	57 (2001)
Laos	893	62	302	48	61	61	52	660	20 (2006)
Bangladesh	497	65	238	43	54	95	89	570	n.a.
India	740	64	213	52	69	66	70	450	47 (2006)

Notes: [1] Number of deaths per cohort of 1,000 persons 15 –60 years of age (45 years life span). [2] Infant mortality rate: number of infant deaths per 1,000 live births (still births excluded). [3] Under-5 mortality rate: number of deaths per 1,000 persons between birth and 5 years of age (5 years life span). [4] DPT: diphtheria, pertussis and tetanus; per cent of children vaccinated. [5] Number of confirmed cases per 100,000 persons in population. [6] Maternal mortality rate: Deaths per 100,000 live births.

n.a. = not available.

Sources: Population Census 2008, NIS (2009a); WHO data.

It can be observed that for several indicators, Cambodia scores among the worst in the region, particularly for infant, child, and adult mortality rates. Despite this bleak picture, key child health indicators have been improving recently and Cambodia has been successful in containing and

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reversing the spreading of HIV/AIDS and, to a certain extent, tuberculosis. Overall life expectancy, for instance, improved markedly from 50.3 to 60.5 years for men, and for women from 58.6 to 64.3 years over the period 1998–2008 (see table 6.2). It can be reasonably expected that these positive trends will sooner or later translate into increased well-being and productivity of adults, and an improvement in the educational status of children and youth.

Table 6.2 Life expectancy at birth, 1950–2008

Period	Life expectancy at birth (years)		
	Male	Female	Average
1950–1955	38.1	40.8	39.4
1955–1960	40.0	42.8	41.4
1960–1965	42.0	44.9	43.4
1965–1970	44.0	46.9	45.4
1970–1975	39.0	41.7	40.3
1975–1980	30.0	32.5	31.2
1980–1985	48.9	52.3	50.7
1985–1990	52.1	55.5	53.9
1998[1]	50.3	58.6	54.4
2008[2]	60.5	64.3	62.4

Sources: Population Census 2008, NIS (2009a) ; [1] UNDESA (2010). [2] MOP (1998).

The increase in life expectancy at birth is mainly a result of improvements in child and infant mortality rates, since adult mortality does not really show a decreasing trend (see table 6.3).

Table 6.3 Adult mortality rates, 1990–2010[1]

	1990	2000	2008	2010
Male	306	382	294	410
Female	248	255	216	250
Average	272	315	253	330

Note: [1] Estimated number of deaths before reaching age 60 for a cohort of 1,000 persons aged 15.

Sources: WHO (2010) for 1990–2008; Cambodia Demographic and Health Survey (CDHS) 2010.

The health status of the poor has markedly improved as a result of poverty reduction efforts and increased spending on health, but is still considered a critical factor. According to CSES data on self-reported health status (see table 6.4), the poorest wealth quintile scores higher than the second-poorest quintile, with almost 21 per cent of the poorest quintile reporting a good health status for their respective ages.

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Table 6.4 Rate of change in self-reported health status of the poor, 2004 and 2007 (percentages)

	2004	2007	Change (%)
Poorest wealth quintile			
Has one or more disabilities	10.5	4.6	–56
Health status relatively good for age	13.7	20.7	+51
Health status relatively poor for age	18.6	15.2	–18
Second-poorest wealth quintile			
Has one or more disabilities	10.1	7.5	–26
Health status relatively good for age	15.4	19.1	+24
Health status relatively poor for age	18.9	15	–21

Source: Cambodia Socio-Economic Survey (CSES) 2004, 2007.

Progress towards achieving the Cambodia Millennium Development Goals (CMDG) is mixed, although remarkable progress seems to have been achieved on several fronts, particularly on child and maternal mortality (see table 6.5). Furthermore, Cambodia is on track to achieving its infant and child health immunization goals, with immunization rates against measles already above the MDG target for the year 2015. Improvements have also been observed in HIV/AIDS prevalence, but the country is still far from achieving its goals with respect to reducing maternal mortality and TB prevalence rates.

Table 6.5 Key health Cambodia Millennium Development Goals (CMDGs)

Goal	Measure	2015 target	2010 target	Recent data (year)
Reduce child mortality	Children under-5 mortality rate (per 1,000 live births)	65	85	83 (2005) 54 (2010)
	Children under 1 immunized against measles (%)	90	85	91 (2008)
Improve maternal health	Maternal mortality rate (per 100,000 live births)	250 *(revised NSDP)*	350 *(revised NSDP)*	461 (2008) 206 (2010)
Combat HIV/AIDs, malaria and other diseases	TB prevalence rate (per 1,000 persons)	135	214	617 (2008) 590 (2009)
	People 15–49 years old living with HIV (%)	1.8	2.0	0.7 (2008)
	Malaria severe case fatality rate (%)	0.1	0.25	0.35 (2009)

Sources: CDHS 2008 and 2010; Population Census 2008, NIS (2009a).

With Cambodia on track towards reaching its Millennium Development Goals for infant and child mortality rates this is likely to show positive effects on primary and secondary education: healthy children learn better than sick ones. It is observed, however, that inequalities continue to exist in health outcomes between population groups. According to the Cambodia Demographic and Health Survey (CDHS 2010), the under-five mortality rate remains three times higher for Cambodians from the lowest wealth quintile compared to those from the highest quintile.

Improvements in the maternal mortality rate are also expected to materialize with improvements in utilization and coverage of maternal health services. According to the 2008 population census, the maternal mortality ratio declined from 472 deaths per 100,000 live births in 2005 to 461 in 2008, still far from the revised NSDP targets of 350 in 2010 and 300 in 2013. According to the most recent data from CDHS 2010, the maternal mortality rate is estimated at only 206, a remarkable decrease although a statistical bias cannot be excluded given such a drastic change.

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Lack of contraceptive use contributes to a high rate of abortion- and miscarriage-related complications, due also to lack of access to safe abortion services.

Communicable diseases remain the main source of ill health in Cambodia and this is obviously an area for potential improvement. The prevalence of HIV peaked in 1998 at 2 per cent among the adult population (15–49 years old), but has since been declining steadily, reaching 0.7 per cent in 2008.[34] The TB prevalence rate has also been gradually declining, reaching 617 per 100,000 in 2008 from 764 per 100,000 in 1998, though it remains much higher than in the neighbouring countries. Progress has also been limited regarding the containment of malaria-related deaths, with the fatality rate rising to 0.35 per cent of cases in 2009, well above the rates that would allow for reaching CMDG targets.

6.1.2 Access

Access to and use of public health facilities has increased, including among the poor, with high coverage rates reported for key preventive interventions, and improved coverage of facility-based deliveries. The use of outpatient services in health centres has also increased but remains at a relatively low level compared to the rate for private providers. However, a significant increase in access to and use of public-sector care has been observed for preventive interventions. Childbirth is also better provided for, with trained attendance at delivery rising from 22 per cent in 2003 to 63 per cent in 2009 and deliveries at public health facilities up from 11 per cent to 44 per cent in 2009, and 54 per cent in 2010.

However, Cambodians still tend to avoid seeking outpatient care with public providers, showing preference for the private sector and self-treatment. According to the CDHS 2010 only 31 per cent of those ill who sought care in the past months visited a public health facility, compared to 62 per cent preferring a private provider such as a private clinic, hospital, pharmacy or health worker. This tendency is likely to persist as long as there is no marked improvement in quality of care in the public health sector.

Overall improvements should not distract from addressing the remaining inequalities in access to care among the poor and non-poor and among different regions within Cambodia. The 2007 CSES also reported that for inpatient care, persons of the poorest wealth quintile were hospitalized on average for 4.65 days versus 8.09 days for persons in the richest. The 2005 CDHS suggested that 20 per cent of rural women visited a public provider when ill as opposed to only 8 per cent for Phnom Penh-dwelling women.

6.1.3 Utilization

Utilization of health services varies according to age, gender, geographic location and socio-economic status. The elderly are less likely to receive treatment than the young, even though they carry a greater burden of disease. Women seek treatment comparatively more often than men, although this relates to the fact that they have greater health-care needs, particularly in the reproductive ages.

The CDHS 2010 also illustrated generally lower health-care utilization by the rural population compared with urban populations. It was found that rural women are more than three times as likely to give birth at home than urban women. With regard to acute respiratory infections, the

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[34] This result, however, suggests a possibly high mortality rate among the target group.

leading cause of morbidity and mortality in Cambodia, the CDHS found a lower rate of treatment by trained providers in urban areas. This may be a result of the easy access to pharmacies in urban areas, facilitating self-medication.

Socio-economic status also plays a strong role in determining utilization (see table 6.6). The richest generally utilize health-care services more frequently than the poor. In part this may be because they perceive themselves to have more health problems, although international experience suggests that such perception relates partly to having more contact with health-care providers (supplier-induced demand). However, this is certainly also an indication that inequalities of access to care remain.

Table 6.6 Health problems and health-care utilization across population quintiles, 2007

	Wealth quintiles				
	Poorest	**2nd**	**3rd**	**4th**	**Richest**
Illness or other health problem in past 4 weeks (%)	11.3	14.7	16.5	16.4	18.3
Received medical care for reported health problem (%)	71.8	79.3	83.5	86.2	90.8
Hospitalized in connection with reported health problem (%)	3.5	2.1	3.5	4.2	5.1
Average number of inpatient days	4.65	5.62	5.29	3.67	8.09

Source: CSES 2007.

Wealthier women in Cambodia are twice as likely as poorer women to deliver at a health facility. The 2010 CDHS found wealth to be the main determinant in explaining delivery at a health facility compared to other variables. Overwhelmingly, poorer Cambodian mothers still deliver at home, which partly explains the country’s high maternal mortality rate. According to the CDHS 2010, 79 per cent of women from the poorest quintiles mentioned affordability as a problem in accessing care, compared to only 48 per cent of the richest quintile.

Generally, care-seeking behaviour is highly skewed for deliveries but less so for other public health issues. In 2005, 90 per cent of mothers from the highest income quintile had their births attended by a doctor, nurse or midwife, compared to only 21 per cent for mothers from the lowest quintile. The data from the 2010 CDHS indicates that important progress has been made in this area, with the respective rates reported at 97 per cent for the richest quintile and 49 per cent for the poorest quintile. Many other major public health programmes, such as immunization, are reaching out across all population quintiles. HIV testing is an exception to this and may reflect a higher HIV prevalence rate among richer quintiles.

Indicators of preventive maternal and child health (MCH) measures show only moderate differences between wealth quintiles (table 6.7). In some cases they are highest for the poorest quintile, which could be due to outreach activities in poor population areas.

Table 6.7 Selected maternal and child health (MCH) service indicators, 2007 (percentages)

MCH indicator	Wealth quintiles				
	Poorest	**2nd**	**3rd**	**4th**	**Richest**
Child under 5 years given vitamin A	90.2	94.0	95.0	91.3	93.5
Child under 2 first given breast milk	80.5	79.5	76.5	76.5	76.0

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Child under 2 has vaccination card	81.2	79.3	86.5	90.6	89.3
Child under 2 received three DPT doses	72.5	65.7	71.7	74.1	64.2
Child under 2 never vaccinated	11.9	11.8	3.6	2.6	1.7

Source: CSES 2007.

The trend observed over recent years shows a progressive improvement in uptake rates, with indicators rising faster for the poorest quintile than for the richest (table 6.8).

Table 6.8 Changes in selected MCH service indicators, 2004–2007 (percentages)

MCH indicator	Wealth quintiles				
	Poorest	2nd	3rd	4th	Richest
Child under 5 years given vitamin A	12.40	12.30	12.20	6.50	6.50
Child under 2 first given breast milk	51.80	49.50	44.50	43.70	39.50
Child under 2 has vaccination card	3.90	2.70	4.20	5.30	2.80
Child under 2 received three DPT doses	15.70	4.30	10.30	12.60	3.60
Child under 2 never vaccinated	4.20	0.90	9.40	5.50	7.80

Source: CSES 2004, 2007.

6.2 Public health system

Since the end of the civil war, the Ministry of Health has made continuous efforts to improve the public health infrastructure and the scope and quality of health services provided. In particular since 1995, Cambodia's health reform focused on improving the provision of health services through a process of staff training, infrastructural development and the supply of drugs to public health facilities. Health service strengthening began with the Health Coverage Plan, under which reconstruction of district-level referral hospitals and health centres was undertaken. Service coverage was reorganized through the establishment of Operational Health Districts (ODs), comprising referral hospitals, health centres and health posts. There are currently 77 ODs, 75 referral hospitals, 967 health centres and 108 health posts in operation, and their number is gradually increasing to respond to the demands of a growing population.

Consecutive health sector strategic plans have been developed and implemented by the MOH since 1996. Along with these, strategic plans were adopted for different diseases or intervention areas such as HIV/AIDS, malaria, and reproductive health, this with considerable support from bilateral and multilateral partners. The adoption of the Health Financing Charter in 1996 paved the way for public health facilities to levy user fees, with exemptions being provided on a pilot basis to the poor. A long period of planning and systems development followed, leading to the preparation of the draft Health Strategic Plan 2008–2015 and the Strategic Framework for Health Financing 2008–2015 (see section 6.3).

During the last decade a number of contracting models were piloted in Cambodia, aiming at improving the administrative efficiency of health services delivery by introducing market economy principles. A first phase of contracting was piloted from 1999 using two types of contracting, "contracting-in" and "contracting-out". *Contracting-in* consists in outsourcing the management of government health services to a local or international NGO while everything else remains in the government system, including facilities, staffing and drug supplies. *Contracting-out* refers to a system where a third party is given the responsibility of managing the whole

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operational district health system, including staffing, procurement and distribution of supplies, using the infrastructure of the government such as buildings and facilities. The pilot phase indicated success of the model in improving health coverage rates and reducing private out-of-pocket (OOP) expenditure for health. Starting in 2004, a different model of internal contracting was piloted successfully at OD level using performance-based incentives and monitoring along with proactive forms of management of ODs. An assessment showed improved worker motivation, higher utilization of health services, better maternal and child health outcomes and higher efficiency and transparency of management (see Kheovathanak and Annear, 2011).

A further step was taken recently to expand the model of internal contracting for MOH district level services, based on the view at MOH that service delivery at public facilities should remain the responsibility of the Ministry. The objective of this approach was to transform and institutionalize internal contracting within operational health districts under the concept of the "special operating agency" (SOA). The concept of the SOA was formalized in 2008 through Royal Decree 346, which approved the application of the procedure across all government services. It involves a new set of instruments, derived from government policy on public services delivery and designed to improve the quality of public service delivery. Under the Decree, local government administrations and ministries are given a degree of autonomy in making the best use of their human, physical and financial resources to deliver the highest possible quality of services in the most effective way and to enhance performance and accountability through streamlining administration to be more transparent and more responsive to people's needs.

Despite significant improvements in the management of health services at public facilities, the demand for services has not increased in parallel because financial and other barriers continue to limit access, particularly for the poor. According to CDHS 2010 data only 32 per cent of reported treatment episodes are provided in public-sector facilities, where the quality of service delivery remains low. The constraints on the delivery of quality public health services still include inadequate management capacity, low salary levels that create incentives for different forms of private practice, and inadequate skill levels at most health centres and some hospitals. The private health-care sector, which is quite diverse and largely unregulated, provides treatment of unknown quality and accounts for 62 per cent of treatment episodes (CDHS 2010). A variety of other providers such as drug vendors, traditional and religious healers and birth attendants attract 6 per cent of patients, although this rate decreased markedly compared to earlier survey results.

Nonetheless, the MOH remains the main provider of national health-care infrastructure and human resources in Cambodia. Furthermore, while small in absolute terms, the health budget constitutes a large and increasing proportion of national budget expenditures. For the year 2010, MOH spending amounted to an estimated 12.8 per cent of total recurrent fiscal spending (see section 6.3 below), an increase from an estimated 11.2 per cent in 2007. Notwithstanding, despite a sizable allocation of fiscal resources for health, per capita spending remains lower in nominal terms than in other countries of the region with the exception of the Lao PDR (see table 6.9). This is due to the fact that total government spending accounts for only about 20 per cent of GDP, and GDP per capita is below the level of most countries, with the exception of Lao PDR.

Table 6.9 Total health expenditures for Cambodia and other countries in the region, 2007

	Cambodia	Lao PDR	Viet Nam	China	Mongolia	Philippines
Per capita expenditures on health in US$ (including private out-of-pocket spending)	35.5	24.1	57.5	112.4	91.4	63.3
Total health expenditure as a % of GDP	5.9	3.7	7.1	4.5	6.2	3.9
Government expenditure on health as a % of total recurrent government expenditure	11.2	2.7	8.7	10.3	12.2	6.8

Source: WHO Western Pacific Region (WPRO) website, data from 2007.

6.3 Health financing

The allocation of adequate financing for an effective national health-care system is a major challenge in most developing countries. With fiscal resources tight and a limited ability to pay by users, often together with the absence of sizable demand-side financing schemes, resources available are generally too little to allow for a reasonably functional system granting access to affordable services of appropriate quality. Given the sheer amount of recurrent health financing required in addition to an adequate infrastructure, skilled medical staff and administrative capacity, development actors focus much of their attention and resources on supporting the health sector in developing countries, including in Cambodia.

In 2007 the MOH developed, along with the National Health Strategic Plan (2008–2015), a comprehensive health financing strategy for Cambodia: the *Strategic Framework for Health Financing, 2008–2015*. The document spells out a vision for health financing in Cambodia towards the achievement of universal coverage, and identifies focus areas for health financing activities. The Strategic Framework provides the basis for improved inter-sectoral collaboration between national ministries, donor partners and other stakeholders. The proposed strategy envisions the mainstreaming of various disparate forms of health financing into a single 'mixed model' that provides coverage for different segments of the population through different mechanisms, with resources originating from a combination of government funding, donor funding, assistance from NGOs, out-of-pocket expenditure, private insurance, social and community-based health insurance and equity funds. The Strategic Framework recommends a realistic and step-by-step approach, comprising initially the development of existing schemes towards national coverage; and in a second step, a move towards universal health insurance coverage under a national health insurance authority in the longer term.

Financing for health in Cambodia is currently still derived from a variety of sources, including mainly the government budget, multilateral and bilateral donor funding, NGO and other charitable donations, the private insurance sector, and household out-of-pocket spending.

6.3.1 Government expenditure on health

According to the MOH, the adjusted total budget for health in the year 2010 amounted to about KHR 645 billion, with total disbursements estimated at 611.4 billion (US$153 million), an amount equivalent to 12.8 per cent of recurrent government expenditure (see Chapter 3, section 3.3). Since the MOH is piloting programme-based budgeting, the budget is divided between regular budget and programme budget. Detailed expenditure broken down by central and provincial levels is shown in table 6.10. It can be observed that in the year 2010 total expenditure for the procurement of drugs and consumables amounted to KHR 328.4 billion, or 54 per cent of the total, which seems high by international comparison. A further 19 per cent was spent on equipment whereas only 17.5 per cent was spent on salaries, which is low by international comparison.

Table 6.10 National budget health expenditure by centre/province and budget line, 2010

Budget line	**Government budget expenditure** (KHR millions)			Share (% of total)
	Central level	Provincial level	Total	
Equipment (60)	84 200	33 100	117 301	19.2
Maintenance (61)	6 772	23 948	30 720	5.0

Communication (62)	13 053	14 591	27 645	4.5
Salaries (63)	24 171	82 927	107 098	17.5
Drugs & procurement (64)	317 071	11 304	328 375	53.7
Taxes (65)	161	57	218	0.04
Total	**445 430**	**165 928**	**611 358**	**100**

Source: MOH (2010b).

6.3.2 ODA and NGO-funded expenditure

Total ODA monies disbursed in Cambodia in 2010 are estimated at over US$1 billion according to the Council for the Development of Cambodia (CDC). Since the health sector is one of the priority sectors for most donor countries, ODA funding for the sector is substantial and cannot be ignored. According to CDC, total funding for health and HIV/AIDS programmes and projects amounted to approximately US$238 million in 2010, including 28 million under the Health Sector Support Project (HSSP-2) and 19 million under the Global Fund, both of which are administered by the MOH. Assuming overheads for ODA at 20 per cent, the estimated total net spending on health under all ODA-funded programmes and projects excluding HSSP-2 and the Global Fund amounted to US$146.6 million. For NGO-funded health projects, total expenditure in 2010 is reported at US$47 million by CDC, not including NGO-implemented projects funded by ODA monies, i.e. core funding only. With overheads estimated at 30 per cent for NGOs, this yields an estimated net amount of total disbursements for health at US$33 million in 2010.

6.3.3 Out-of-pocket expenditure (OOP)

According to all surveys undertaken in recent years, OOP expenditure represents a high share of aggregate total health spending in Cambodia. According to CSES 2009 data, the average OOP expenditure per capita is estimated at US$29.5 per annum. Compared to the data from CSES 2004 (US$15.9), this yields a rate of increase of 13.1 per cent per annum. Based on these estimates, OOP per capita spending in 2010 is estimated at US$33.3, or US$463 million in aggregate.[35] However, although OOP expenditure is high, only an estimated 33 per cent thereof is spent in the public sector, whereas 54 per cent is spent in the private sector and 11 per cent for treatments abroad (CDHS 2010). Estimated provider share and cost per encounter are shown in table 6.11, not including cost for transportation to the health facility. According to CSES 2009, average transport cost to medical providers is estimated at US$3.65 per month, yielding a total of US$57 million (in 2010 dollars).

Table 6.11 Out-of-pocket expenditure by provider type, 2010

Type of provider	Provider share (%)	Cost per case (US$)	Cost-weighted provider share (%)	Total OOP share (%)
Public provider	31.4	31.3	9.81	32.9
Private provider	61.7	26.0	16.01	53.7
Non-medical sector	5.9	12.1	0.71	2.4
Provider abroad	1.1	304.3	3.30	11.1
Total	**100**		**29.83**	**100**

Source: Own calculations based on CDHS 2010 data

[35] The total population for the year 2010 is projected at 13.89 million.

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6.3.4 Health equity funds and CBHI

Total expenditure of health equity funds (HEFs) is reported at US$4.8 million in 2010, with funding provided through different donors. Total disbursements for medical services made under HEFs to public providers is reported at US$2.8 million in 2010. Community-based health insurance is also expanding, and so far the only contributory mechanism apart from private health insurance. Nevertheless, provider payments from CBHI to providers are still marginal at only US$0.4 million in 2010, not including allowances for food and reimbursements for transport costs.

6.3.5 Private health insurance

The private health insurance market is only beginning to develop in Cambodia; therefore health expenditure from private insurance companies is currently marginal. In the year 2009, total gross premiums paid for health insurance is reported at only US$2.75 million; the total amount spent for medical services is therefore estimated at less than US$2 million.[36] It is noteworthy that total gross premium amount increased by 22 per cent from the year 2008 and is likely to grow further in future years, given the lack of social health insurance coverage for most Cambodians.

Aggregate national health expenditure from all funding sources has been estimated for the year 2010 at about US$857 million, of which about 18 per cent is from the national budget (US$153 million) and approximately 27 per cent from development assistance and NGO core funds, which accounted together for approximately US$232 million including HSSP-2 and Global Fund contributions (see table 6.12). Out-of-pocket health expenditure still accounted for more than half (55 per cent) of total health spending at an estimated US$463 million (see above). Aggregate national expenditure for health in 2010 was equivalent to 7.1 per cent of GDP, which is relatively high in comparison to other countries of the region. Total health expenditure per capita in the year 2010 is estimated at KHR 244,000 (US$61.0). Given the high share of donor funding for health (28 per cent), it is questionable whether all resources spent directly benefited Cambodians, and whether they were spent in the most cost-effective manner.

Table 6.12 Health expenditure by source and total, 2010 (estimates)

Funding source	KHR billion	US$ million	Share of total (%)	Source
National budget	611.2	152.8	18.0	MOH[1]
HSSP-2	89.6	22.4	2.6	MOH[1]
Global Fund	61.4	15.4	1.8	MOH[1]
ODA (other)	586.4	146.6	17.3	CDC[2]
NGOs	189.6	47.4	5.6	CDC[3]
Out-of-pocket (OOP)	1 852.0	463.0	54.6	CSES 2009[4]
Total	**3 390.2**	**847.6**	**100.0**	
% of GDP	7.1			
Expenditure per capita	**KHR/cap** 244 078	**US$/cap** 61.0		

Notes: [1] See MOH (2010b); for HSSP-2 and Global Fund overheads (e.g. consultancies) are assumed at 20%. [2] Estimated ODA expenditure figure for health and HIV/AIDS (see CDC, 2011)), excluding HSSP-2 and Global Fund, and assuming overheads at 20%. [3] Estimated NGO core funding for health and HIV/AIDS (CDC, 2011), assuming overheads at 30%. [4]According to CSES 2009, average out-of-pocket spending is estimated at US$29.60 per capita for the year 2009. With an average annual rate of increase of 13.2% (2004–2009), this yields US$33.50 per capita for the year 2010. Total population for the year 2010 is projected at 13,890,000.

[36] See MOEF (2009b). The main providers of private health insurance are the companies Infinity and Forte.

The share of total health expenditure considered as "social", that is, comprising all resources channelled through public transfer mechanisms or risk-pooling schemes, is estimated at 45 per cent of total health expenditure, or about US$385 million.[37]

The main part of health financing for public providers is channelled through the supply side. Although aggregate demand-side financing, including HEFs, CBHIs and OOP spending, amounts to an estimated 28.6 per cent (US$156 million) of total spending in the public health system, only about 3.3 million (2 per cent thereof) is channelled through risk pooling and/or transfer mechanisms (HEFs and CBHIs). Despite the success of equity funds in granting access to care for the poor, little has been achieved in terms of reducing catastrophic risk for the other four income quintiles, particularly the three middle quintiles, all of which are believed to be economically vulnerable and therefore face exposure to catastrophic risk (see section 7.6).

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[37] Includes all expenditures displayed in table 6.12 with the exception of out-of-pocket spending.

7 Current state of social protection

7.1 Introduction

After three decades of war and instability, social stability was completely re-established towards the end of the 1990s and Cambodia has since embarked on a path of economic growth and poverty reduction. However, despite the progress achieved in poverty reduction, particularly during the last decade, a high share of the population continues to face numerous and serious vulnerabilities such as food and/or income insecurity, natural disasters, economic shocks, injury, illness, catastrophic health expenditures, unemployment, and the like (see Chapter 4).

Traditional coping mechanisms in Cambodia relied on informal arrangements within the family or community, as in most countries in the region. However, these have their limitations in terms of risk pooling and level of protection provided. They are not well suited for instance to cope with risks facing whole families or communities (e.g. poverty or natural disasters). Furthermore, in light of the increased mobility of Cambodians, the loosening of communities, and the gradual decrease of the average household size due to the decreasing fertility rate, these practices are eroding. In any case they cannot substitute for a well-designed and sustainable social protection system dealing with the major vulnerabilities in a sound and systematic manner.

Whereas priority efforts during the past two decades have been directed mostly towards reconstruction, rehabilitation and food security by different means, a new vision and approach has emerged recently aiming to deal with social protection policy planning in a more consistent, systematic and coordinated manner. The new approach led to the development of a long-term and coordinated social protection strategy, under the leadership of the Council for Agricultural and Rural Development (CARD), with the support of various development partners.[38] The National Social Protection Strategy for the Poor and Vulnerable (NSPS) was officially launched in November 2011.

The purpose of this chapter is to provide a comprehensive review of the currently existing social protection provisions in Cambodia, including social security entitlements under statutory schemes, national social protection programmes, and the main donor-funded programmes and projects that are of national importance. Given the large number of donor-funded initiatives, projects and activities, some of which are limited in scope, geographical focus or duration, only major ones have been included in the following assessment, based on their scope, relevance or strategic importance in relation to the NSPS. The objective pursued here is to review in detail the existing system from both a qualitative and quantitative perspective, where the focus lies with institutionalized schemes such as provisions enacted into law, as opposed to ad-hoc measures that deal with rare events (e.g. disasters) or that are of short-term nature and/or unsustainable interventions.

Notwithstanding, since the statutory social protection system is still incomplete in Cambodia due to both fiscal constraints and limited capacity of the national institutions and government agencies, it is relevant to include donor-funded initiatives that are of national importance. This relates in particular to programmes that have been embraced by the NSPS, and hence embody priority interventions in the national policy agenda. These include mainly donor-funded cash

[38] Including the World Bank, ADB, AusAid, GIZ, ILO, UNICEF and WFP.

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transfer programmes, food rations and allowances for schoolchildren ('school feeding'), public works programmes, and subsidized social health protection schemes.

It is noted that, in order to be consistent with the NSPS, the scope of interventions included in the following analysis is broader than the standard definition of social protection as per the conventional ILO and EU classifications.[39] This relates in particular to public works programmes and vocational training, both of which are generally classified as active labour market policies (ALMP), and which further the social protection of households only indirectly through their impact on employment and employability of beneficiaries. In this context, reference should also be made to the contingencies defined by ILO Social Security (Minimum Standards) Convention, 1952 (No. 102) and the corresponding minimum benefits. These are generally understood as the main social risks to be addressed by social protection provisions, together with basic income security and health care for the poor, the destitute and those unable to work, as advocated by the SPF Initiative.

The next sections of this chapter review the following social protection schemes, programmes, projects and benefit provisions:

- **statutory provisions relating to social protection**, including those mandated by the Labour Law and other relevant laws;

- **the National Social Security Fund for Civil Servants (NSSFC),** which provides social security benefits to civil servants;

- **the National Fund for Veterans (NFV)**, providing pensions and other benefits to members of the armed forces and the national police;

- **the National Social Security Fund for private-sector employees (NSSF)**, which currently provides employment injury insurance to private-sector workers;

- **social health protection programmes,** including those that are of national scope or relevance, including health equity funds (HEF), community-based health insurance schemes (CBHI), and the Health Insurance Programme for Garment Workers (HIP);

- **social assistance programmes (government budget),** including social welfare services provided through MOSVY and other line ministries or public agencies;

- **donor-funded social safety net programmes,** as relevant, including the school-feeding programme that benefits children enrolled in public schools, and public works programmes targeting the rural poor and vulnerable. They are largely funded through donor support, including from the World Bank, the Asian Development Bank, the World Food Programme, AUSAID, UNICEF, and others; and

- **vocational training,** as provided under the technical and vocational education and training programme (TEVT) of MOLVT.

[39] According to EUROSTAT: "Social protection encompasses all interventions from public or private bodies intended to relieve households and individuals of the burden of a defined set of risks or needs, provided that there is neither a simultaneous reciprocal nor an individual arrangement involved. The list of risks or needs that may give rise to social protection is, by convention, as follows: 1. Sickness/Health care, 2. Disability, 3. Old age, 4. Survivors, 5. Family/children, 6. Unemployment, 7. Housing, 8. Social exclusion not elsewhere classified" (EC, 2008, p. 9).

7.2 Statutory provisions on social protection

The legal framework of Cambodia contains a range of provisions relating to social security entitlements for different occupational sectors and to the social protection of vulnerable groups.

7.2.1 The Constitution (1993)[40]

The Constitution of Cambodia recognizes the role of the State in protecting citizens and providing social protection to those in need. The Constitution stipulates in particular that:

- Every Khmer citizen shall have the right to obtain social security and other social benefits as determined by law (Article 36).
- The health of the people is to be guaranteed. The State gives full consideration to disease prevention and medical treatment. (…) Poor citizens receive free medical consultations in public hospitals, infirmaries, and maternities; and The State establishes infirmaries in rural areas (Article 72).
- The State gives full consideration to children and mothers. The State establishes nurseries and helps support women and children who have inadequate support (Article 73).
- The State assists the disabled and the families of combatants who sacrificed their lives for the nation (Article 74).
- The State establishes a social security system for workers and employees (Article 75).

7.2.2 The Labour Law

The Labour Law, adopted in October 1997, provides the legal framework for the protection of workers and employees. It applies to all wage employees in the private sector, with the exception of civil servants, members of the army and the police, the judiciary, employees serving in air or maritime transportation, and domestic workers. It is noteworthy that the minimum working conditions and labour standards adopted by the Labour Law go far beyond the core labour Conventions of ILO that Cambodia has ratified.[41] The Law notably stipulates a minimum working age (15 years of age), working hours, overtime pay, paid holidays, and the protection of workers employed in hazardous occupations. In addition, it stipulates a minimum of social security benefits to be granted to all employees by their employer; and a minimum wage for different economic sectors to be set by MOLVT via a *Prakas* (ministerial regulation) based on recommendation from the tripartite Labour Advisory Committee (LAC).[42] In principle, all enterprises with more than seven employees have to register with MOLVT and are subject to inspections by MOLVT. Furthermore, registered enterprises have to adopt internal company regulations that are subject to approval by MOLVT (cf. Article 22); these regulations must include the benefit provisions to which employees are entitled, for instance in case of sickness, maternity or dismissal.

[40] Amended in 1999.
[41] Cambodia has ratified all eight ILO core Conventions, including the Forced Labour Convention , 1930 (No. 29).
[42] So far MOLVT has issued a notification fixing the minimum wage for the garment sector but not yet for other economic sectors.

The social security benefits mandated by the Labour Law include the following:

- *Employment injury benefits.* Employers are liable for the medical cost and financial compensation of workers injured during workplace accidents. Factories with more than 50 workers must have an on-site infirmary staffed with a doctor or nurse, in order to ensure basic medical care and first aid in case of accident (cf. Article 242). Financial compensation of workers is required in case a worker sustains a permanent loss of working capacity as a result of a workplace accident. Benefits include a monthly pension in case a worker sustains a severe disability.
- *Maternity leave.* Female employees are entitled to paid maternity leave at 50 per cent of their salary for 90 days per confinement, provided they have been employed for at least 12 months before delivery.
- *Sick leave.* The Labour Law stipulates the entitlement of workers to paid sick leave but does not specify a minimum benefit level. MOLVT recommends full salary during the first month of sickness and 50 per cent of salary for the second consecutive month per sickness spell. Enforcement is ensured through internal company regulations that are subject to endorsement by MOLVT for employers with eight or more employees.
- *Severance pay.* Employees dismissed by their employer are entitled to a cash allowance (Indemnity of dismissal), the amount of which is equal to 15 days of salary per year of seniority (cf. Article 89). In addition, the employee can claim damages at the same amount of the dismissal allowance in case of breach of contract (cf. Article 91). Furthermore, a minimum notification period is prescribed in case of employment termination; where the length of the minimum notification period depends on seniority, reaching up to three months from ten years of seniority onwards.

7.2.3 The Social Security Law, 2002

The *Law on Social Security Schemes for Persons Defined by the Labour Law* was passed in 2002 and stipulates the establishment of a social security scheme for private-sector employees. Benefits to be provided under the scheme include pensions, employment injury benefits, and other benefits as relevant (see section 7.5 below).

7.2.4 Other relevant laws

A range of laws relate to social security benefits for permanent government employees and war veterans:

- *The Law on the Common Statute of Civil Servants, 1994* and several related Ministerial Decisions stipulate benefit entitlements of civil servants (see section 7.3).
- *The Law on [old-age] Pensions and Invalidity Pensions for Soldiers of the Armed Forces* and related Decrees define benefit entitlements for members of the RCAF and the National Police (see section 7.4).
- *The Law on War Veterans* stipulates benefit entitlements of war veterans.
- *The National Disability Law, 2009* and subordinate legislation stipulate the protection of the rights of people with disabilities and promote the employment of the disabled through a quota system.

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- *The Law on Suppression of Kidnapping, Trafficking, and Exploitation of Human Persons, 1994* (amended in 2007) prohibits activities related to human trafficking, exploitation for prostitution, and immoral acts on minors.
- *The Insurance Law*, adopted in June 2000, provides a legal framework for the regulation of the insurance sector. To develop the insurance sector, the Government is planning to expand the product range of the state-owned Cambodian National Insurance Company (CAMINCO) to include life insurance, pensions, credit, and natural disaster insurance.

7.3 National Social Security Fund for Civil Servants (NSSFC)

The National Social Security Fund for Civil Servants (NSSFC) was established by Royal *Kret* (Decree) on 18 January 2008. The new administrative body started operations in May 2009 under the governance of a board of directors, comprising amongst others the Minister of Economics and Finance and the Minister of Social Affairs, Veterans and Youth. At the time of writing, the NSSFC employs 34 persons at the central level and about 500 at provincial and municipality levels.

The NSSFC was established with the twofold objectives to:

(i) centralize the administration and disbursement of social security benefits for civil servants in order to increase efficiency, improve service standards, and strengthen the overall governance of the system; and

(ii) establish a contributory and financially sustainable social insurance scheme for civil servants.

A reform of benefit provisions for civil servants is planned but so far the details of the reform have not been worked out in detail. All benefits currently disbursed to civil servants and their family dependants are still assessed based on prior entitlements, mainly those defined in the Common Statute of Civil Servants.

During the year 2011, NSSFC carried out a registration of retired civil servants and organized, in cooperation with a local bank, the opening of bank accounts for all retirees. The disbursement of retirement pensions will be made via bank transfer in future.[43]

Currently all other benefits are still disbursed through the respective line ministries; but the transfer to NSSFC is planned for the near future.

7.3.1 Legal framework

The Law on Common Statute of Civil Servants of the Kingdom of Cambodia, 1994, defines the rights, obligations and conditions of service of civil servants, including entitlements to social security benefits such as retirement, invalidity and survivor pensions. A number of other enactments remain relevant today with regard to benefit entitlements of civil servants, including Decision No. 245 SSR, 1988; Decision No. 150 SSR, 1985; Decision No. 184 SSR, 1990; and Sub-Decree No. 59 ANKR.BK, 1997.

Decision No. 245 (1988) stipulates entitlements of civil servants to maternity leave, sick leave,

[43] This in order to speed up disbursements and to avoid administrative charges being levied at different levels.

sickness cash benefits, employment injury benefits and free access to health services at public hospitals.

The Royal *Kret* (Decree) No. 108/039 NS/RKT adopted on 18 January 2008, stipulates the establishment of NSSFC and the list of benefits to be provided, including retirement, invalidity, maternity, work injury, death and survivor benefits.

Anu-Kret (Sub-Decree) No. 14 ANKR.BK, 2008, on the establishment of NSSFC, spells out the governing structures of NSSFC. The sub-decree stipulates that NSSFC is a legally and financially autonomous body governed by a board of directors comprising 11 members including the executive director, a representative of retired civil servants, a representative of the Council of Ministers (COM), and representatives of different ministries, including MOSVY and MOEF.

7.3.2 Coverage

The scheme currently covers around 175,000 civil servants, including about 60,000 women. Family dependants of civil servants and civil service pensioners also benefit in case of death of the breadwinner, which applies for surviving spouses and children below the age of 16. The estimated number of persons covered under the NSSFC is shown in table 7.1. It can be observed that the number of civil-service pensioners, excluding survivors' pensions totalled 36,000 in 2010, comprising about 30,700 retirees and about 5,300 invalidity pensioners. The total number of persons covered under the scheme including family dependants of civil servants and pensioners is estimated at approximately 702,800.

Table 7.1 Civil servants, civil service pensioners and family dependants, 2010

	Male	Female	Total
Civil servants	**114 709**	**60 316**	**175 025**
Dependants of civil servants	197 024	240 538	437 563
Spouses	48 253	91 767	140 020
Children	148 771	148 771	297 543
Subtotal 1	311 733	300 854	612 588
Civil service pensioners	**28 863**	**7 216**	**36,079**
Old-age pensioners	24 589	6 147	30 737
Invalidity pensioners	4 274	1 069	5 343
Dependants of pensioners	21 648	32 471	54 119
Spouses	3 608	14 432	18 040
Children	18 040	18 040	36 079
Subtotal 2	50 511	39 687	90 198
Grand total	**362 244**	**340 542**	**702 786**

Note: Preliminary estimates.

Source: GIZ/ILO (2012).

The figures displayed in table 7.1 do not include members of the Cambodian Royal Armed Forces and the National Police who are covered under the National Fund for Veterans. Also not included are parliamentarians and members of the judiciary, who are covered by special provisions, and some other state employees who do not have the status of civil servant.

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7.3.3 Benefits

Civil servants are currently entitled to the following social security benefits:

- *Sickness cash benefit* – full salary including allowances for up to three consecutive months of illness, and 90 per cent of salary thereafter for up to 12 months duration depending on the number of past service years.
- *Work-injury benefits* – includes medical care, cash benefit at full salary during treatment and convalescence, and permanent invalidity benefits for permanent disability.
- *Maternity benefits* – including maternity leave for 90 days at full salary and a cash allowance of KHR 600,000 (US$150) per child or miscarriage.
- *Retirement benefits*, comprising:
  - (a) Lifetime pension payable after 20 years of service (minimum) at the normal retirement age of 55. The minimum benefit amount is 60 per cent of the final basic salary plus allowances (excluding position allowance). The maximum benefit is 80 per cent of final salary for 30 years of service. The pension amount is subject to a minimum amount depending on the salary grade.
  - (b) Retirement allowance (lump sum benefit) equal to eight months of total final salary.
- *Invalidity benefits*, comprising:
  - (a) Lifetime pension payable after 20 years of service (minimum). The minimum benefit amount is 50 per cent of final salary plus allowances (not including position allowance). The maximum benefit is 65 per cent of final salary payable for 30 years of service. The pension amount is subject to a minimum based on the respective salary grade. If there is less than 20 years of service a lump sum benefit is payable equal to 4–10 months of final salary.
  - (b) Invalidity allowance equal to six months of total final salary.
- *Death benefits* for death of *civil servants*, comprising all the following:
  - (a) Cash allowance of six months of final salary of the deceased.
  - (b) Funeral allowance.
  - (c) Survivor pension payable to widows and widowers at KHR 6,000 per month and KHR 4,000 per month for each child younger than 16 years of age.
- *Death benefits* for the death of a pensioner, comprising:
  - (a) Funeral allowance of 12 months of pension of the deceased.
  - (b) Survivor pension payable to widow at KHR 6,000 per month and KHR 4,000 per month for each child younger than 16 years of age.

In addition to the benefits listed above, civil servants also benefit from family allowances, including a “spouse allowance” of KHR 6,000 per month if they are legally married, and a “child allowance” of KHR 4,000 per month for each one of their children younger than 16. These family allowances are not disbursed through the NSSFC but by the MOEF as monthly salary supplements.

In 2009 the number of all pension beneficiaries, including survivors, totalled 67,500, comprising about 23,000 widow/ers and 11,300 surviving children (see table 7.2).

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Table 7.2 Civil service pensioners, benefits disbursed, 2007–2009

Benefits	2007	2008	2009
Pensions[1]	**61 840**	**63 723**	**67 506**
Retirement	22 521	25 456	27 972
Invalidity	5 228	5 108	5 224
Widow/er	19 222	21 151	23 031
Orphan	14 869	12 008	11 279
Cash benefits	**3 318**	**3 906**	**4 526**
Death grant	n.a.	n.a.	n.a.
Maternity allowance	557	656	812
Invalidity lump sum	138	163	121
Retirement allowance	2 440	2 871	3 235
Retirement lump sum	137	162	141
Severance pay	46	54	217

Notes: [1] Number of pensions in payment, paid monthly. n.a.= not available.

The demographic ratio for different pension benefits is shown in table 7.3. It can be observed that for retirement pensions, there are about 17 pensioners per 100 civil servants. It can be expected that this ratio will increase sharply during the next decade, since the generation of civil servants recruited after the war (1980) is due for retirement in the coming years.

Table 7.3 NSSFC pensioners, demographic ratios, 2009

Type of pension	Number of beneficiaries	Demographic ratio (%) [1]
Retirement	27 972	16.8
Widow/er	23 031	13.9
Orphan	11 279	6.8
Invalidity	5 224	3.1

Note: [1] Number of beneficiaries divided by the number of active civil servants.
Source: Author's calculations from data provided by NSSFC.

The average benefit amount and replacement rate of pension benefits is shown in table 7.4. It can be observed that the average benefit amount for both widow and orphans' pensions is very low at only about two per cent of the average salary of civil servants, whereas the replacement rate for age pensions and invalidity pensions is estimated at 63 and 57 per cent respectively.[44] The average monthly retirement pension in 2009 amounted to about 192,000 KHR (approximately 48 US$ or about 1.60 US$ per day).

Table 7.4 Civil service pensions, average amounts and replacement rates, May 2009

Type of pension	Average benefit (KHR/mth)	Replacement rate (%)[1] (estimate)
Retirement	192 219	62.9
Widow/er	6 000	2.0
Orphan	5 000	1.7
Invalidity	173 384	56.7

Note: [1]Average benefit divided by average total salary including allowances.
Source: Author's estimates from data provided by NSSFC.

[44] According to ILO Convention No. 102, the total amount of survivors' pensions (including family allowances) payable to a qualifying widow/er with two children should be no less than 40 per cent of the salary of the deceased.

Both retirement and invalidity pensions are regularly adjusted for inflation based on a specific index. Although there is no automatic indexation mechanism, ad-hoc adjustments are undertaken more or less regularly. This is not the case for survivor pensions, which are fixed in nominal terms and adjusted rarely.

7.3.4 Financing

So far, all benefits for civil servants are financed from the treasury, via the budget of MOSVY. However, a *Prakas* (ministerial regulation) has already been prepared and submitted to MOEF, stipulating that the fund will be financed from contributions at 24 per cent of civil servants' salaries, to be shared between the Government as the employer (18 per cent) and the civil servants as employees (6 per cent). It is yet unclear as of when contributions will be collected and whether the income from contributions will be sufficient to cover benefit expenditure. It is also unclear whether contributions will be levied on salary allowances or on basic salary only. The benefit expenditure for the years 2007–2009 is displayed in table 7.5.

Table 7.5 NSSFC benefits, expenditure 2007–2009 (KHR millions)[1]

Benefit	2007	2008	2009
Retirement pensions	55 675.9	63 759.1	70 943.9
Invalidity pensions	10 107.4	9 954.8	10 078.6
Survivor pensions	2 276.1	2 243.4	2 335.0
Death grants	3 769.8	4 626.6	6 259.5
Maternity grants	334.2	393.6	487.2
Work injury pensions	521.0	613.0	722.0
Total	**72 684.5**	**81 590.5**	**90 826.2**

Note: [1] Number of pensions in payment, monthly average.

It can be observed that total benefit expenditure disbursed in 2009 amounted to KHR 91 billion KHR (~ US$22.7 million), thus representing about 2.1 per cent of recurrent government budget expenditure for the fiscal year 2009.

7.3.5 Social health insurance

The introduction of social health insurance (SHI) for civil servants and civil service pensioners was under discussion in 2010 and a relevant Sub-Decree prepared. A preliminary costing was also undertaken by GIZ/ILO in 2010/2011. However, due to other priorities and limited capacity at NSSFC the introduction of SHI has been postponed. The estimated total coverage, including pensioners and family dependants (spouse and children) is estimated at 675,000 persons, or about five per cent of the total population. In light of the low level of salaries in the public sector, the introduction of SHI would help to protect civil servants against the risk of catastrophic health expenditures. This is particularly relevant for public-sector pensioners, many of whom are likely to face financial hardship when they encounter serious health problems.

7.3.6 Institutional capacity

NSSFC has been administering to date only the disbursement of civil servants' pensions. For other benefits, the disbursement still occurs through the respective line ministries, although their transfer into NSSFC is planned for the near future. In order to ensure the effective management of the scheme as an autonomous body, there is a need to further strengthen the institutional capacity of the new agency. In particular, the introduction of SHI for civil servants and civil service pensioners that is under consideration will require substantive administrative preparations in order to establish an operational administration throughout all provinces. This will require a considerable further development of specialized staff capacity, administrative procedures, contracting arrangements and appropriate IT systems. It is hardly imaginable that with its current set-up, notably staffing and administrative resources, the new agency will be able to handle the challenges ahead successfully.

7.4 The National Fund for Veterans (NFV)

The National Fund for Veterans (NFV) was created by Royal *Kret* (Decree) in 2010 to manage the administration of social security benefits for veterans. The new administrative body started operations in 2010 and is governed by a board of directors, comprising amongst others the Minister of Economics and Finance and the Minister of Social Affairs, Veterans and Youth. So far, the NFV is not yet fully independent and still operates under MOSVY at the central level (Phnom Penh) only; but there are plans to open offices in Kandal and Konpong Speu provinces in 2012.

The NFV was established with the twofold objectives to:

(i) centralize the administration and disbursement of social security benefits for veterans in order to increase efficiency, improve service standards, and strengthen the overall governance of the system; and

(ii) establish a contributory and financially sustainable social security scheme for veterans.

A reform of benefit provisions is planned but is still being discussed. All benefits currently disbursed are assessed based on prior entitlements (see section 7.4.3.).

7.4.1 Legal framework

The Law on Pensions and Invalidity Pensions for the soldiers of the Cambodian Armed Forces stipulates pension entitlements for personnel of the armed forces. The law was amended by the Royal Decree NS/RKT 0406/008 on 7 April 2006 and includes revisions regarding the level of benefit entitlements.

The Royal *Kret* (Decree) NS/RKT 0710/595 on social security for veterans, dated 15 July 2010, stipulates the establishment of the NFV and the list of benefits to be provided, including retirement, invalidity, survivor, maternity, work injury, death and medical benefits.

Anu-Kret (Sub-Decree) No. 79 ANKR.BK on the establishment of the NFV dated 23 July 2010 spells out its governing structures. The sub-decree stipulates that the NFV is a legally and financially autonomous body governed by a board of directors comprising 11 members including the executive director, a representative of war veterans, a representative of the Council of Ministers (COM), and representatives of different ministries including MOSVY, MOI, MOD and MOEF.

7.4.2 Coverage

The NFV covers the following categories of active members:
a) Members of the Royal Cambodian Armed Forces
b) Members of the National Police Force (Ministry of Interior)

In addition, the NFV also provides benefits to persons certified as war veterans, including former civil servants and laymen who enrolled as soldiers during the war.

7.4.3 Benefits

Persons covered by the scheme are entitled to the following benefits:

- *Sickness cash benefit* – full salary including allowances for up to three consecutive months of illness, and 90 per cent of salary thereafter for up to 12 months duration depending on the number of past service years.
- *Maternity benefits* – including maternity leave for 90 days at full salary and a cash allowance of KHR 600,000 (US$150) per child or miscarriage.
- *Marriage allowance* – a cash allowance payable on the first marriage.
- *Work-injury benefits* – includes medical care, cash benefit at full salary during treatment and convalescence, and permanent invalidity benefits for permanent disability.
- *Retirement benefits*, comprising:
  (a) Lifetime pension payable after 20 years of service (minimum) at the normal retirement age of 55. The minimum benefit amount is 60 per cent of the final basic salary plus allowances (excluding position allowance). The maximum benefit is 80 per cent of final salary for 30 years of service. The pension amount is subject to a minimum amount depending on the salary grade.
  (b) Retirement allowance equal to eight months of total final salary.
- *Invalidity benefits*, comprising:
  (a) Lifetime pension payable after 20 years of service (minimum). The minimum benefit amount is 50 per cent of final salary plus allowances (not including position allowance). The maximum benefit is 65 per cent of final salary payable for 30 years of service. The pension amount is subject to a minimum based on the respective salary grade. If less than 20 years of service a lump sum benefit is payable equal to 4–10 months of final salary.
  (b) Invalidity allowance equal to six months of total final salary.
- *Death benefits* in case of death "on mission" (i.e. work-related), comprising:
  (a) Cash allowance of six months final salary of the deceased.
  (b) Funeral allowance.
  (c) Survivor pension payable to widow at KHR 6,000 per month (US$1.50) and KHR 5,000 per month (US$1.25) for each child younger than 16 years of age.
- *Death benefits* in case of civilian death, comprising:
  (a) Funeral allowance of 12 months of pension of the deceased.
  (b) Survivor pension payable to widow at KHR 6,000 per month (US$1.50) and KHR 5,000 per month (US$1.25) for each child younger than 16 years of age.

7.4.4 Financing

So far, all benefits for veterans have been financed through the budget of MOSVY. However, plans are to establish the NFV as an autonomous fund to be financed from contributions at 24 per

cent of salaries (of active members), shared between the Government as the employer (18 per cent) and active members (6 per cent). An implementation date has not yet been set, and it is unclear whether the income from contributions will be sufficient to cover benefit expenditure, particularly for existing pension liabilities.

In December 2010, total expenditure for pensions under the NFV (see table 7.6) was reported at about KHR 6.5 billion (~ US$1.6 million). On an annualized basis, this yields an estimated US$19.2 million, including about US$12 million for war veterans.

Table 7.6 NFV pension benefits, expenditure 2009 and 2010 (KHR millions)

Type of pension	2009	2010
Monthly[1]	**5 462**	**6 446**
War veterans	3 604	4 003
Retirement	751	1 266
Invalidity	150	240
Survivors	956	936
Annual[2]	**65 540**	**77 354**
War veterans	43 250	48 042
Retirement	9 013	15 190
Invalidity	1 804	2 886
Survivors	11 473	11 236

Notes: [1)]Expenditure as of the month of December. [2] Estimated from monthly data.
Source: National Fund for Veterans, MOSVY.

The total number of pensioners was about 199,000 in December 2010, of whom about 28,600 were veterans and 162,000 survivors (see table 7.7). The large number of survivors can be explained by the fact that dependants qualifying for a survivor pension include all of the following: spouse, children, parents, and “guardian” of the deceased.[45]

Table 7.7 Number of NFV pension benefits disbursed, 2009 and 2010

Type of pension	2009	2010
Total[1]	**199 484**	**198 761**
War veterans	28 393	28 626
Retirement	5 238	6 829
Invalidity	1 101	1 476
Survivors	164 752	161 830
Parents	*58 040*	*57 192*
Widow/er	*36 923*	*38 735*
Orphan	*69 714*	*65 719*
Guardian	*75*	*184*

Note: [1] Number of pensions disbursed in December 2009 and 2010.
Source: National Fund for Veterans, MOSVY.

The average pension amount disbursed to veterans in December 2010 is estimated at about US$35 per month, whereas retired police and army personnel received on average about US$46.30 per month. Survivors received on average 1.40 US$ per month, which is clearly inadequate. Survivor pensions are fixed in nominal amounts, and the low amount of benefits can be explained by a delay of adjustments to account for price inflation.

[45] “Guardian” refers to a personal assistant or guard who has been employed the deceased.

Table 7.8 Veterans and army pensions, average benefit amount, 2010

Type of pension	Average benefit amount [1]	
	KHR	US$
War veterans	139 854	35.0
Retirement	185 359	46.3
Invalidity	162 934	40.7
Survivors	5 786	1.4

Note: [1] Estimated from pension benefits disbursed in December 2010.

Source: Own estimates from data provided by NFV.

7.4.5 Institutional capacity

The NFV is currently operating as a MOSVY department but plans to become an autonomous body according to the relevant decree passed in 2010. This will require a considerable development of institutional capacity and the allocation of financial resources required over the next years.

7.5 National Social Security Fund for private-sector employees (NSSF)

With emerging industrialization and economic development, the introduction of mandatory employment-based social insurance benefits follows a common path of socio-economic development. Most countries in the region have followed this path, including most recently Thailand (1990) and the Lao PDR (2001). In Cambodia the provision of social security to workers and employees is mandated by the Constitution and mentioned in the main strategic development frameworks including the Rectangular Strategy, the National Strategic Development Plan, and most recently the Financial Sector Strategy. Recent legal and institutional developments are therefore positive signs; they demonstrate political commitment to fill the gap, and shared aspirations towards enhanced social protection of workers and employees.

7.5.1 Legal framework

The Law on Social Security Scheme for workers covered under the Labour Law was enacted in 2002, stipulating the introduction of social security benefits and the establishment of a new administrative institution, the National Social Security Fund (NSSF). According to the law, the NSSF is governed by a tripartite board of directors, comprising representatives of workers and employers (two each), and of the Government (one seat each for MOLVT, MOEF and MOH).

The law stipulates the introduction of the following social security benefit branches:

- a compensation fund for victims of employment injuries and occupational diseases;
- a pension insurance fund; and
- other benefit branches as relevant.

According to the law, the scheme covers all persons defined by the provisions of the Labour Law. However, due to the limited administrative capacity, scheme coverage has been restricted initially to cover only enterprises with eight employees or more. The extension of coverage to smaller enterprises will follow in a second stage.

Anu-Kret (Sub-Decree) No. 16 E.S. on the establishment of the NSSF was passed in March 2007, providing the legal basis for administrative arrangements and the implementation of the scheme.

Following its establishment, a *Prakas* (ministerial regulation) on benefit entitlements was adopted by the MOLVT in February 2008 and the scheme started operations in November of that year.

7.5.2 Employment Injury Fund

The employment injury branch was launched in November 2008 as the first benefit branch implemented under the social security law, 2002.

Coverage

In December 2010 the NSSF had registered more than 1,500 enterprises and reported 522,685 insured workers, or about 7.5 per cent of all persons employed in Cambodia. The average number of insured workers over the twelve months of the year 2010 totalled 480,446, among whom an estimated 386,678 women accounted for 80.5 per cent of all insured. The number of insured workers by economic sector is presented in table 7.9 for the years 2009 and 2010:

Table 7.9 Enterprises by sector and number of employees, 2009 and 2010

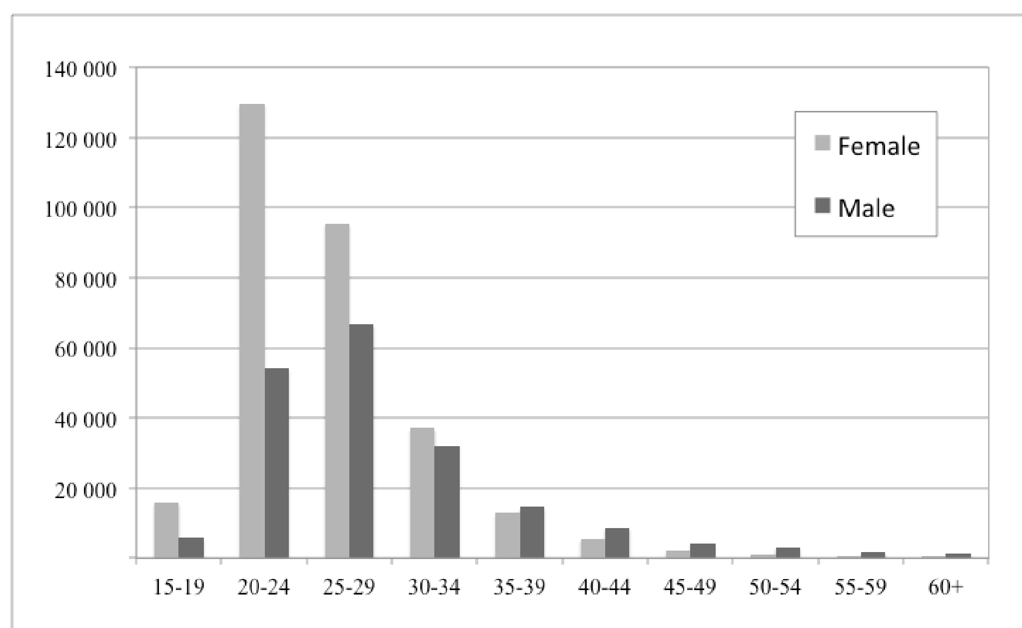
Economic sector	No. of workers insured[1]	
	2009	2010
Garment and footwear industries	274 911	373 445
Manufacturing (other)	5 808	13 031
Mining and construction	1 171	2 188
Transport and telecommunications	5 501	9 344
Wholesale and retail trade	3 369	7 108
Services	31 148	75 330
Total (all sectors)	**321 908**	**480 446**

Note: [1]Annual average.

Source: National Social Security Fund of Cambodia, IT Division.

It can be observed that the total number of employees insured in 2010 was about 480,000, among whom were about 373,000 workers (78 per cent) in the garment and footwear industry. The profile of insured members by age and sex is pictured in figure 7.1, which shows that the majority of insured are young female workers of the age group 20–29.

Figure 7.1 Number of NSSF insured workers, by age group and sex, July 2010



Source: Estimated from data provided by the IT Division, NSSF.

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The estimated total number of workers potentially to be covered is estimated conservatively at around 760 thousand;[46] this yields a coverage rate of approximately 69 per cent in December 2010. With the extension to all remaining provinces planned in 2012, the coverage rate is expected to increase swiftly and the number of insured may reach about 700,000 workers by the end of the year 2012.

Benefits

Employment injury (EI) benefits, as stated in Article 15 of the 2002 social security law, cover workplace accidents and work-related diseases, including road accidents during commutes between home and work. More specifically, the EI branch provides the following benefits:

(a) Medical care (in-kind)
(b) Nursing cash allowance
(c) Temporary disability allowance (income replacement benefit)
(d) Funeral (death) benefit
(e) Permanent disability benefit (pension) and caretaker benefit
(f) Survivor benefit (pension)
(g) Rehabilitation benefit (in-kind)

The number of benefits disbursed during 2009 and 2010 is shown in table 7.10 by type of benefit.

Table 7.10 Number of NSSF beneficiaries of cash benefits, 2009 and 2010

Benefit	2009	2010
Nursing allowance	3	413
Temporary disability benefit	794	2 445

[46] The Establishment Survey 2009 (NIS, 2009b) counted 757,685 persons working in enterprises with eight or more employees.

Funeral benefit (death grant)	15	37
Permanent disability allowance[1]	12	16
Permanent disability pension[2]	6	3
Survivor benefit (pension) [2]	8	22
Rehabilitation benefit	-	-

[1]An allowance is paid if the degree of loss of working capacity is less than 20%.
[2] New pensioners.

Source: National Social Security Fund of Cambodia, IT Division.

Financing

Employers are generally made liable to cover the cost of work-related accidents and diseases, including the compensation of survivors in fatal cases. This is also the case in Cambodia, where the principle of employer liability is enshrined in the 1997 Labour Law. It is therefore natural that the financing of the NSSF employment injury branch falls onto employers. The fund is financed through wage-based contributions at the rate of 0.8 per cent of reported wages up to a ceiling of KHR one million per month. The average contributory wage in the year 2010 was KHR 446,000 per month (US$111.50). The distribution of insured wages reveals that around 65 per cent of all insured women earn monthly wages between KHR 250,000 and 450,000 (i.e. around US$60–110), whereas only about one-third of insured men are within the same wage bracket. It was furthermore observed that almost 25 per cent of insured men are in the highest wage bracket of KHR one million (US$250) per month or above (see GIZ/ILO, 2012).

During 2008–2010 the NSSF collected contributions as follows:

- in 2008 (Nov./Dec. only): around KHR 2 billion (~ US$0.5 million);
- in 2009: around KHR 11 billion (~ US$2.75 million); and
- in 2010: almost KHR 20 billion (~ US$5 million).

It should be noted that about one-third of the contributions collected consisted of government subsidies introduced in 2009 to mitigate the effect of the financial crisis on the garment and footwear manufacturing sector.

Expenditure

Total benefit expenditure for the years 2009 and 2010 is presented in table 7.11 for the different benefits provided. It can be observed that in 2010 expenditure for medical care amounted to about KHR 1.94 billion, accounting for about 80 per cent of total benefit expenditure. Total expenditure in that year, including administration costs and capital investments, totalled KHR 5.0 billion (US$1.3 million).

Table 7.11 NSSF benefit expenditure by type of benefit, 2009 and 2010 (KHR millions)[1]

Type of benefit	2009	2010
Medical benefits	915.4	1 937.7
Nursing allowance	0.4	18.1
Temporary disability benefits	132.5	356.2
Funeral benefits (death grant)	15.0	37.0
Permanent disability benefits[2]	10.1	45.6
Survivor benefits	2.7	29.0

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Rehabilitation benefits	-	-
Total (all benefits)	**1 076.1**	**2 423.6**

Note: [1]Total amounts incurred in the respective calendar year (cash basis). [2] Including lump sum benefits and permanent disability pensions.

Source: National Social Security Fund of Cambodia, IT Division

By international comparison, the incidence rate of occupational accidents experienced so far is very low. This could be due to underreporting of accidents by employers. Larger factories operate on-site infirmaries staffed with a nurse or doctor, and it is suspected that minor injuries are treated on site and therefore not reported to the NSSF.[47] However, since the introduction of the scheme is recent, it is expected that reporting of accidents will improve over the next few years. Due to the low number of benefits disbursed so far, a sizable surplus was achieved in 2009 and 2010 and reserves have been accumulated. Total reserves as at the end of 2010 amounted to about KHR 17.5 billion (~ US$4.4 million).

7.5.3 Social health insurance (SHI)

The social health insurance branch is the second branch of the NSSF planned for implementation, possibly towards the end of the year 2012. The design of provisions is ongoing at the time of writing, and a final agreement on scheme provisions has yet to be reached with workers and employers. A preliminary costing was undertaken in 2010/2011 by GIZ in cooperation with the ILO (GIZ/ILO, 2012).

The benefits considered are medical care (inpatient and outpatient care), sickness cash benefit (income replacement), and maternity cash benefit (income replacement during maternity leave). The coverage of family dependants (spouse and children) is under consideration and was strongly recommended by the GIZ/ ILO review. Since most insured members are young and in their reproductive ages, their main concerns and health expenditures relate mostly to the cost of maternity and medical care for their children. It is therefore considered sensible to include dependants under the coverage of the scheme as common for employment-based social health insurance schemes.

The contribution rate required for the financing of the planned provisions of the scheme was estimated as follows:

- Medical benefits: 1.6–2.3 per cent of insurable wages depending on provisions
- Maternity benefits: 1.2 per cent of insurable wages
- Sickness (cash) benefits: 0.4 per cent of insurable wages

With an estimated dependency ratio of 0.98 (dependants per insured) on average (see GIZ/ILO, 2012), the potential future coverage under the SHI branch could reach up to 1.5 million members, or about 11 per cent of the total population when including dependants. Total future payments to health-care providers are estimated at US$15–20 million per year.[48] Since the new funding would be channelled through the demand side to the public health-care system, it could be instrumental in inducing positive changes, particularly on staff motivation and quality of care. This would, however, require that NSSF would leverage its position as a powerful purchaser to induce the said

[47] According the Labour Law, all factories employing 100 workers or more must operate an on-site infirmary staffed by a doctor or nurse.
[48] This compares to about US$4 million spent by all HEFs in 2010, including about US$2.8 million in payments to providers for medical services (OPD & IPD).

changes by using appropriate contracting arrangements built on incentivized payment provisions, and by monitoring quality of care.

7.5.4 Pensions

The introduction of social security pensions, as specified in the Social Security Law (2002), is planned by NSSF for the year 2015 (RGC/ADB, 2011). According to the law, the pension branch will comprise retirement, invalidity and survivor pensions for surviving widow/ers and children. Benefit provisions have not yet been developed, but it is expected that the scheme will follow the standard guidelines for defined benefit pension schemes. A crucial question for the design will be the degree of funding and the provisions for the phasing-in of benefits. Given the youth of the pool of contributors, it will take two to three decades before the first generation of contributors retire, so that few retirement pensions are likely to be disbursed before the year 2035. Since reserves will be accumulating during the waiting period, during which entitlements of members accrue, a sound investment of reserves will be an important aspect of the design, in particular the adoption of adequate risk management provisions.[49]

The introduction of social insurance pensions is deemed relevant and sensible, provided the formal economy continues to expand such that the current generation of young contributors will have the opportunity to remain insured until retirement and accumulate sufficient entitlements for a decent pension (see box 7.1).

[49] The main risks are deemed to be investment risk, fiduciary risk and risk of political misappropriation.

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Box 7.1 Demographics and labour mobility: Implications for social insurance schemes

The age and gender profile of the population insured under a social security scheme is an important feature that has implications on the cost and financial viability of the scheme.

In case of a predominantly young pool of members, the overall cost of health insurance coverage is relatively low in general due to a favourable morbidity risk profile (as a general rule, morbidity increases gradually with age after childhood). Young workers and employees typically have a low morbidity and therefore visit medical providers less often than older ones do. However, the cost of maternity benefits, both in kind (medical care) and in cash (maternity allowance), can be substantial, particularly if the share of female workers in the reproductive age groups is high, as in the case of the NSSF.

A young age profile is also favourable for the introduction of social insurance pensions (i.e. a *defined benefit pension* scheme), since young workers have most of their working years ahead to accumulate entitlements and secure the right to a decent pension. (The replacement rate of social insurance pensions is typically a function of both the number of working years during which contributions have been paid and the contributory wage during working years.). This, however, only applies if insured members remain insured until they reach retirement age (typically age 60 or 65). Hence, if insured members stop working or are dismissed prematurely, they fail to reach the minimum years of contributions required to secure the right to a decent pension.

This can be a problem in countries where only selected industries or sectors are covered by pension insurance, particularly if workers tend to change jobs frequently or to leave industries covered by insurance (e.g. manufacturing or construction, where work is hazardous or strenuous) at a certain age or after a few years. It is also sometimes the case that employers, for whatever reason, have a preference for younger workers. Female insured members often drop out of insured employment after the birth of their first child, particularly in countries where no extended maternity leave is provided for.

One solution is to allow for voluntary membership with the pension insurance fund after termination of employment. But since this requires workers to pay, after leaving employment, the full cost of contributions including the employer's share (typically 50 per cent), which they may not be inclined to do due to other spending priorities or lack of disposable income, they often discontinue contributions and fail to secure the right to a decent pension or to any pension at all. (A minimum number of contribution years, usually between 10 and 20, is generally required to qualify for a monthly pension benefit). On the other hand, the prospect of acquiring pension rights (along with other benefits such as health insurance for family members) can also be a strong incentive for employees to maintain employment with an affiliated employer and thereby reduce the staff "dropout" rate for registered employers.

In sum, labour mobility between economic sectors and the early dropout of women at childbirth can undermine the purpose of a social insurance pension scheme, in particular if the scheme does not cover all economic sectors or if the size of the informal economy overall is large.

Source: ILO.

7.6 Social health protection

Universal access to affordable health care is an important objective pursued in Cambodia, as elsewhere in the world. Given the high level of household out-of-pocket expenditures in Cambodia, users are the main source of national health financing. The establishment of social health protection mechanisms is therefore of particular relevance and a critical issue for the social protection of the poor. Catastrophic health expenditures have dire consequences for the poor and near poor. Recent surveys show that they are still a major cause of impoverishment, indebtedness and forced sale of livelihood assets. This section reviews existing health protection mechanisms in Cambodia and discusses issues related to their future development.

7.6.1 User fee exemptions

According to the Constitution, “The health of the people is to be guaranteed. The State gives full consideration to disease prevention and medical treatment.” Furthermore, “Poor citizens receive free medical consultations in public hospitals, infirmaries, and maternities” and “[t]he State establishes infirmaries in rural areas.”

The Health Financing Charter, 1996, while paving the way for the introduction of user fees, maintained user fee exemptions for the poor to be granted at the facility level. However, the official exemptions system was unfunded and the additional cost was supposed to be absorbed from the limited budget allocated together with income from paying users. In practice, exemptions were a drain on facility revenues and staff incentives and the proportion of patients receiving exemptions remained low. Exemptions for the poor averaged around 18 per cent of patient admissions nationally, compared to the national poverty rate of more than 35 per cent at the time (World Bank, 1999). The ineffectiveness of fee exemptions in ensuring access to care for the poor created the circumstances that gave rise to the development of health equity funds (see next section).

In 2007 a subsidy scheme was introduced by MOH through a *Prakas* (ministerial regulation), providing for the reimbursement of public providers for the treatment cost incurred for fee exemptions. The subsidy scheme has already been implemented in all six national hospitals and in ten operational districts, covering altogether ten referral hospitals and 89 health centres. The total number of fee exemptions granted at health centres and referral hospitals is shown in table 7.12 for the year 2010.[50] It can be observed that fee exemptions were granted for a total of 1,769,249 cases, including 49,731 admissions. The cost of the subsidy scheme is funded as part of the MOH regular budget allocation.

Table 7.12 User fee exemptions for the poor, 2010 (number of cases)

	OPD	IPD	Paramedic clinic	Delivery	Other	Total
Health centres	1 535 243	27 701	26 106	31 808	9 664	1 630 522
Referral hospitals	73 527	22 030	36 135	5 265	1 770	138 727
Total	**1 608 770**	**49 731**	**62 241**	**37 073**	**11 434**	**1 769 249**

Notes: OPD = outpatient department; IPD = inpatient department.

Source: MOH (2010b).

7.6.2 Health vouchers

In January 2011 MOH launched a new programme, Health Vouchers for Reproductive Health Services. Under the new scheme vouchers will be provided to pregnant women who are poor, to ensure that they have the opportunity to efficiently and equitably access reproductive health-care services. The voucher system, initially launched in nine districts of three provinces, is expected to strengthen the coverage of antenatal care, institutional deliveries (including complications and caesarean sections), postnatal care, safe abortion and family planning services for women, with the aim of reducing the country’s maternal mortality ratio (MMR). Targeting of poor women will be based on to the ID-Poor classification.

The scheme is co-funded by the German Development Bank KfW and implemented in

[50] Data on user fee subsidies for national hospitals could not be made available.

cooperation with GIZ and other partners. Detailed information on actual beneficiaries and expenditure is not yet available at the time of writing.

7.6.3 Health equity funds

Health equity funds (HEF) are currently the most widespread and the most effective form of social health protection provided in Cambodia, together with the fee exemption scheme. The documented evidence indicates that HEFs are an effective means for providing financial access to health services for the poor, have extensive donor support, are well regarded by beneficiaries, and furthermore are associated with surprisingly little social stigma (Annear, 2008). Over 50 HEF schemes are currently operating in Cambodia's 77 districts, covering more than half of Cambodia's poor population. In the districts where they operate, HEFs effectively provide free access to health care for a large majority of the poor (who comprise one-third to one-half of the district population in most cases). HEFs operate by covering the cost of user fees for those identified as poor (see box 7.2); they also reimburse the cost of transportation and the food consumed by the patient during hospitalization.

The concept of HEFs was developed in 2003 and thereafter embraced by the Health Sector Support Project (HSSP-1, 2004–2008). Extensive support to HEFs has continued under the second phase project (HSSP-2, 2009–2013). After a piloting trial, HEFs were introduced in the form of four models, involving different implementers and operators, benefit packages and financing mechanisms. HEFs are operated mostly by local and international NGOs, and have been supported financially by a number of development partners (DPs) through various projects. MOH plans to consolidate and harmonize HEFs under common principles and guidelines spelled out in the national HEF Implementation and Monitoring Framework, the HEF Monitoring Manual, and the HEF Implementation guidelines. The responsibility for oversight and monitoring of HEFs rests with the Bureau for Health Economics and Finance in the Department of Planning and Health Information, MOH.

Box 7.2 Targeting the poor under health equity funds (HEF)

HEF beneficiaries are identified universally through pre-identification, post-identification or a combination of the two methods.

Pre-identification occurs before patients need services: at a given point in time, the poorest of all the communities' households are identified, increasingly via the ID-Poor programme. The pre-identified households receive a numbered Pre-Id card, called an Equity Access Card. The Ministry of Planning (MOP) is responsible for building the local government capacity to organize annual pre-identification in order to gradually cover all Cambodian districts, provinces and municipalities.

Post-identification occurs after the illness has occurred, at the health facility (hospital, health centre) when the patient presents for service. To establish whether the patient should benefit from exemption from user fees covered under HEF or subsidy schemes, the MOH recommends the use of a simplified MOH post-identification form. This form distinguishes three categories: "very poor" and "poor" (both eligible for fee weaver), and "non poor" (not eligible). If a patient has been post-identified in the past and returns to the health facility, s/he does not become a pre-identified case but will be re-assessed via the post-identification procedure.

Several studies have assessed the relative merits of pre- and post-identification. The most recent evidence shows pre-identification as both the most effective in targeting and coverage of the poor and the most cost-effective in delivering benefits to the poor (Annear, 2010). While the identification of the poor may not be sufficient to ensure that poor people use public health services, the available evidence suggests that pre-identification by existing HEFs has increased service utilization by the poor (ibid.).

In the year 2010 all HEFs covered a total of approximately 3.2 million poor in 58 operational districts throughout Cambodia.[51] The overall coverage has increased by almost one million since 2008 (MOH, 2010a). In 2010 more than 700,000 HEF patients were reported to have received subsidized medical services and many among them also cash allowances to cover the cost of transport and food.[52] This compares to 407,000 encounters reported in 2009, and 227,000 in 2008. The reported number of medical services provided to the poor by HEFs in the year 2010 is summarized in table 7.13. The total number of ambulatory visits was reported at about 581,000 in 2010, whereas there were 106,000 reported admissions, and about 19,000 deliveries.

Table 7.13 Health equity funds, reported number of encounters, 2010

	OPD	IPD	Deliveries	Total
Health centres	522 751	-	9 370	532 121
Referral hospitals	58 523	106 018	9 821	174 362
Total	**581 274**	**106 018**	**19 191**	**706 483**

Notes: OPD = outpatient department; IPD = inpatient department.

Source: MOH (2010b).

Total expenditure for all equity funds totalled US$4.7 million in the year 2010. The main share (88.6 per cent) thereof was spent on direct costs, i.e. the benefit package, which includes outpatient (OPD) and inpatient (IPD) care, deliveries, food during inpatient stay, reimbursements for transport costs, and other benefits (see table 7.14); whereas about 11.9 per cent or about US$553,300 of the total was spent for indirect costs including administration (63 per cent), equipment (21 per cent), pre-identification (13 per cent), and programme development (3 per cent).

Table 7.14 Health equity funds, direct costs by line item and provider type, 2010 (in US$)

	Health centres	Referral hospitals	Total	Share (%)
OPD	455 116	282 312	737 427	18.0
IPD	8 351	2 102 274	2 110 625	51.5
Deliveries	3 612	603 464	607 076	14.8
Transport	2 064	595 994	598 058	14.6
Food	-	11 477	11 477	0.3
Other	-	34 432	34 432	0.8
Total	**469 143**	**3 629 953**	**4 099 096**	**100.0**

Notes: OPD = outpatient department; IPD = inpatient department.

Source: MOH (2010b).

7.6.4 Community-based health insurance (CBHI)

Community-based health insurance (CBHI) refers to voluntary health insurance schemes organized at the level of the community. Aimed at the "near poor", mainly workers engaged in the informal economy and their families who can afford modest contribution payments, CBHI

[51] Includes the coverage under the MOH user fee subsidy scheme. The figure reported was estimated from data tables provided to the author by the MOH.
[52] Not all HEFs are reporting their encounters; hence these figures are incomplete.

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complements other social health protection schemes within the country such as health equity funds that target only the poor.

The first CBHI scheme was established in 1998; there are currently schemes operating in over 15 Operational Districts (ODs) across the country, run by a variety of local and international NGOs. Benefit packages vary, but all CBHIs cover user fees for access to primary health care through contracted public health centres, and health-care costs for members at one or more contracted public hospitals. In addition, most schemes cover the costs of transportation to hospital in emergency cases and a funeral grant in case of death. While premium payments are often sufficient to cover the costs of direct medical and non-medical benefits, most CBHIs also receive external funding from a variety of sources to help cover administrative and other costs.

In 2006, the MOH developed guidelines for CBHI aiming at streamlining operational procedures and establishing standards on provider payment methods and benefit package. The objectives pursued through the harmonization of schemes were: to provide guidance to local operators, and to prepare the ground for a future merger of schemes, aiming at increasing the risk pool and improving their overall viability.

In the meantime, the number of CBHI schemes has increased to 18 in total, operating in 17 ODs in ten provinces and in Phnom Penh Municipality. Total membership in the year 2010 is reported at about 170,000 including about 96,000 newly recruited members. All but one of the schemes (SKY) are managed by local NGOs. Membership is family-based in order to limit the impact of adverse selection. In the year 2010, the dropout rate was reported at 23 per cent of members. The aggregated income and expenditure of all CBHI schemes in Cambodia is presented in table 7.15 for the year 2010.

Table 7.15 Community-based health insurance schemes (CBHIs), aggregated income and expenditure, 2010

	US$	Share in total (%)
Income	734 104	100.00
Premiums	440 020	59.9
Other	294 084	40.1
Expenditure	1 213 428	100.00
Benefits	433 085	35.7
Indirect cost	64 695	5.3
Administration	452 128	37.3
Promotion	146 874	12.1
Other	116 646	9.6
Balance	**– 479 324**	

Source: MOH (2010b).

It can be observed that CBHIs incurred an overall negative balance in 2010. Furthermore, it is striking that administration and promotion costs absorbed 49.4 per cent of total expenditure, while total benefits accounted for only 36 per cent. It was also noted that utilization rates among the covered members was much higher than for HEFs, an indication that, despite family coverage, adverse selection is at work. However, experiences seem to vary depending on catchment area and CBHI operator; some of the schemes seem to be more successful than others in recruiting new members and retaining them.

Currently, several pilot projects are being implemented that aim at establishing a link between

CBHIs and HEFs operating in the same district. The objective is to progressively harmonize the schemes with a view to merge operations in the future. This approach is believed to result in economies of scale by way of merging duplicate administrative structures at district level.

7.6.5 Social health insurance for the formal economy

The first Master Plan for the Development of Social Health Insurance was prepared by MOH in 2003. An Inter-Ministerial Committee for Social Health Insurance was set up to oversee implementation, comprising besides the MOH, the Council of Ministers, and other line ministries including MOLVT, MOSVY, MOEF and MOP. The adoption of the SHI Master Plan was based on the need to develop alternative health financing schemes in order to support the vision spelled out in the Health Strategic Plan 2003–2007. The SHI Master Plan suggests a pluralistic approach towards universal health insurance coverage, comprising:

(a) compulsory social health insurance coverage for formal-sector salaried workers and their dependants, including:

- SHI coverage for private-sector workers employed under labour law provisions; the scheme to be administered by the National Social Security Fund (NSSF) according to the Social Security Law, 2002;
- SHI coverage for civil servants to be administered by MOSVY, based on the benefit provisions stipulated in Decision Letter No. 245, 1988 (see section 7.3);

(b) voluntary health insurance through the development of CBHI schemes targeting the informal sector, notably families who can afford to contribute small premium payments on a regular basis;

(c) social assistance through the use of district-based HEFs and, later, through government funds to purchase health insurance for non-economically active and indigent populations;[53] and

(d) private insurance and user payments for those who can afford them.

The SHI Master Plan is obviously a long-term conceptual vision intended to pave the way for the development of more concrete and realistic goals to be aspired to in the short and medium term. In the meantime, the slow development of CBHIs and the rapid expansion of HEFs seem to have changed the conceptual balance between the various social protection schemes. Given the known weaknesses of voluntary microinsurance schemes and the lack of solid international evidence demonstrating that a successful scaling up is a realistic possibility, the future coverage of the non-poor informal sector remains a conundrum, not only in Cambodia but elsewhere in the developing world.[54]

The introduction of social health insurance for wage employees of the formal economy and civil servants, as spelled out in the SHI Master Plan, has not yet occurred. Despite some progress made with preparatory planning, the apparent lack of political commitment to set a clear timetable is rather puzzling. Although the formal economy remains small in relative terms, with total employment estimated at only 1.24 million including public-sector workers – a total share of about 17 per cent of total employment – it is on an expanding trend. If family dependants are included under SHI coverage, the formal sector represents slightly more than 20 per cent of the

[53] The legal provisions for the MOH subsidy scheme were adopted only in 2007.

[54] Known weaknesses of voluntary microinsurance are adverse selection, lack of capacity of local operators, actuarial risk, high administration costs, fiduciary risk and overall weak financial sustainability.

total population. The introduction of SHI by both the NSSF (private sector) and the NSSFC (civil servants) is therefore considered an important objective that should be pursued.

In the private sector a pilot SHI scheme is currently operating in a few garment factories under the management of the French NGO Groupe de Recherche et d'Echanges Technologiques (GRET). The Health Insurance Project for Garment Workers (HIP) currently covers about 5,000 workers and operates in about 12 factories. The scheme was introduced in 2009 with the aim of piloting employment-based social health insurance in Cambodia, this in order to gather information and experience data for assessing the feasibility of introducing SHI on a wider scale in the private (formal) sector. The HIP scheme covers mainly female workers and does not provide benefits to dependants. For some factories, coverage includes all workers and the employer pays the full premium (US$1.6 per month per insured), whereas for other companies the employer pays 50 per cent of the premium and enrolment is voluntary.

Based on the experience of HIP, the NSSF is currently preparing for the introduction of social health insurance, possibly by the end of the year 2012. A preliminary costing was undertaken in 2011 although the design is yet to be finalized. The NSSFC also started preparations during 2009 for the introduction of SHI for civil servants and public-sector pensioners. However, due to limited administrative capacity and fiscal constraints, implementation has been postponed.

The introduction of SHI for the formal sector is likely to result in a boost of the health system overall, with total population coverage estimated at over two million, and resources of the two schemes estimated at US$20–25 million in additional demand-side financing. Furthermore, the two future purchasers (NSSF and NSSFC) could be instrumental in inducing quality improvements at service level, provided they are able (and willing) to use their leverage on providers in an appropriate manner. This in turn will help to attract a higher share of private visitors and "crowd in" a higher share of OOP monies that are currently lost to the private health sector. However, with administrative capacity still limited at both NSSF and NSSFC, and little donor support, it is questionable whether the potential systemic improvements that the two schemes could induce will materialize in the near future.

In light of the recent improvements on the supply side of the health system, mainly through increased funding from the Government and donors, and the rising salary level of formal-sector employees, a window of opportunity seems to present itself that calls for the swift introduction of social health insurance for private and public-sector wage employees. Taking into account the low penetration rate of private insurance coverage at present, there should be few obstacles so long as the required political commitment is given. However, the longer the introduction of SHI is deferred and private insurance companies take a foothold, the more vested interests will develop that could potentially exert political pressure and undermine the introduction of social health insurance in the future.

7.7 Social assistance programmes (government budget)

Social assistance or welfare programmes are non-contributory and aim to provide assistance to those in need, including people who are poor and vulnerable, homeless, disabled, and/or victims of natural disasters or human trafficking. The Government runs a number of such programmes under different line ministries, with funding provided mainly through the national budget. Although the assistance provided under these programmes is mostly in kind, budget allocations often insignificant, effectiveness limited and benefit distribution generally ad hoc (i.e. there is entitlement or periodicity), they are worth mentioning because they are institutionalized

government programmes. While for donor-funded initiatives, ownership by the Government and long-term sustainability are generally issues of concern and sometimes questionable, this is rarely the case for programmes funded and implemented by line ministries, despite any shortcomings. This section provides a brief description of the main social assistance programmes under the different ministries.

The Council for Agricultural and Rural Development (CARD), under the direction of the Council of Ministers, is the national agency in charge of coordinating the progammes implemented by different line ministries. The National Social Protection Strategy for the Poor and Vulnerable (NSPS) was prepared by CARD during 2010–2011, and launched officially by the Prime Minister in December 2010. The NSPS provides a long-term framework for a comprehensive and sustainable social protection system aiming at poverty reduction and social development.

7.7.1 Ministry of Social Affairs, Veterans and Youth Rehabilitation (MOSVY)

MOSVY is the lead agency among line ministries for the administration of social welfare programmes, in addition to veterans' affairs and youth rehabilitation. MOSVY was reorganized in 2011, and its mission and functional set-up redefined.[55] According to the MOSVY work plan 2008–2013, the following domains of responsibility, referred to as sub-sectors, come under this Ministry:

- social welfare services for the vulnerable poor
- social welfare services for the elderly
- social security and welfare for veterans
- child welfare and youth rehabilitation
- social welfare and rehabilitation for people with disabilities
- capacity development, partnerships and fund-raising

At subnational level, MOSVY operates through provincial branch offices (DOSVYs), and district social affairs offices (OSVYs). District-level offices communicate with sangkat (commune) councils that provide information on social welfare needs in their commune. Sangkat councils collect all kinds of data on the needy, including orphans, the disabled, people living with HIV, and victims of disasters. MOSVY is one of the ministries selected as a priority for the decentralization and deconcentration (D&D) reform process, so that the functional responsibilities of district offices and commune councils may be extended in the future.

No detailed figures could be made available on the number of benefits provided through MOSVY, or the number of beneficiaries. The MOSVY work plan 2008–2013 spells out, among others, the following outputs as strategic goals:

- 11,000 orphaned children to receive shelter, care and education in state- and NGO-managed orphanages;
- 15,185 children and teenagers who are delinquents or drug addicts to receive shelter, care, detoxification treatment, moral education and vocational training;
- 676 children with disabilities to receive shelter, education and vocational training in state- and NGO-managed centres;
- 7,620 homeless people to receive temporary shelter, moral education, vocational training and reintegration into their communities;

[55] See Sub-decree No. 54

- 1,500 HIV/AIDS-affected women, children and their families to receive social services and care;
- 8,500 female and child victims of human trafficking to receive education, health care, vocational training and reintegration into their community;
- 250,000 victims of natural disasters, and poor people facing food shortages, to receive emergency relief assistance.

Total expenditure by MOSVY in 2010 is reported at US$63.9 million, including the budget allocated to the provinces (US$55.7 million, 87 per cent of the total). Seventy-six per cent of the totalwas spent on salaries, while an estimated 18 per cent (US$11.5 million went on benefits (MOSVY/UNICEF/EU, 2011). It is unclear whether the budget for salaries includes salary outlays for the administration of NSSFC and NFV. No budget breakdown by programme or function apparently exists. Most of the non-central budget is allocated across provinces (DOSVYs), which may then budget for the district/commune level, and this constitutes a key constraint for costing the functions associated with MOSVY operations (ibid., section 4, p. 7).

Although social welfare benefit expenditure under MOSVY is relatively insignificant at present, MOSVY could be instrumental in the future for administering other social benefits (e.g. cash transfers) given its set-up and network reaching down to the district level and below, and its relationship with sangkat councils.

7.7.2 Ministry of Labour and Vocational Training (MOLVT)

MOLVT is in charge of all labour-related matters, in particular labour protection through the enforcement of the Labour Law. This includes regular inspections of enterprises, approval of company HR regulations, and prevention of child labour. MOLVT is also supervising the implementation of the Social Security Law (through NSSF) and chairing the Labour Advisory Committee, a tripartite committee advising on social issues such as the minimum wage. MOLVT also runs a vocational training programme throughout the country, which aims to improve technical skills and enhance employability of participants (see section 7.9).

7.7.3 Ministry of Economics and Finance (MOEF)

MOEF is involved in the implementation of emergency relief operations. In 2008 it launched the Emergency Food Assistance Project with the objective of assisting poor households in coping with the rapid increase in food prices. The total budget of the project is US$40 million, supported mainly by the Asian Development Bank which has provided a grant of US$12.5 million and a concessional loan of US$17.5 million. From the total budget, US$19 million is earmarked for social protection measures, including rice distribution, school feeding and public works, whereas the remainder is earmarked for activities aimed at increasing agricultural productivity and capacity building on food security operations (CARD, 2010).

7.7.4 Ministry of Education, Youth and Sport (MOEYS)

Since 2003/04, MOEYS has been operating a scholarship programme for poor students at the lower secondary education level. Targeting is achieved through a poverty assessment mechanism to identify poor students. Based on a survey, school management committees collect information on students' living standards and use a poverty index to establish a poverty ranking for all children. Scholarships are awarded to the 50 per cent of students with the highest poverty index. The poorest 25 per cent are qualified as "very poor" while the remaining 25 per cent are qualified

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as “medium poor”. The scholarship amounts awarded per year are US$60 for the very poor and US$45 for the medium poor. Since the scholarships are provided in cash to the parents on the basis of school attendance, the programme is basically a conditional cash transfer (CCT) programme.

In 2009 the programme disbursed scholarships to 18,684 children across all provinces except Phnom Penh and according to an evaluation, the programme raised enrolment of students by 20 per cent (Filmer and Schady, 2008). A second component with scholarships for the upper secondary level was implemented in 2006/07. Given the success of the programme, a pilot is planned for extending it to primary schools. The scholarship programme is financed through an allocation from the national budget but also benefits from the financial support of various donors. According to the financing plan (MOEYS, 2005), the total budget of the scholarship programme for the year 2010 totalled KHR 13.8 billion (US$3.5 million).

7.7.5 National Committee for Disaster Management (NCDM)

NCDM has the mandate to supply emergency aid in case of natural or man-made disasters. Cambodia is regularly affected by weather-related disasters such as flooding and droughts, most recently in 2011 when an estimated 1.2 million people were affected by flooding (IFRC, 2011). The main role of NCDM is to coordinate the different line ministries and donors involved in disaster relief operations and assistance projects. In such cases MOSVY provides food and other relief services, while the Ministry of Defence often provides logistic support when required. The Ministry of Water Resources and Meteorology is in charge of forecasting and reporting water levels in case of flooding, while funding for relief operations is generally identified by MOEF from different sources including from development partners. NCDM also works closely with the Cambodian Red Cross (CRC), which runs relief operations funded through the Disaster Relief Emergency Fund (DREF) of the International Federation of Red Cross and Red Crescent Societies (IFRC).

A disaster management team comprising members from different line ministries was recently established to provide backup as needed. During the year 2011, a new law on disaster management was passed so as to establish a framework for institutional responsibilities.

A detailed account of expenditures under various relief operations could not be made available for the year 2010. According to the Council for the Development of Cambodia (CDC), total ODA disbursements for emergency programmes, including food procurement, totalled US$14.8 million (CDC , 2011, table 6).

7.7.6 Other ministries

Various other ministries are operating minor social assistance programmes, including the Ministry for Rural Development, the Ministry for Agriculture and the Ministry of Women’s Affairs. These are mostly ODA-funded and implemented in collaboration with development partners or NGOs (see section 7.8).

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7.8 Social safety net programmes (donor-funded)

With poverty rates still high and a large part of the country's population facing serious vulnerabilities, social safety nets are naturally a priority area of intervention for development partners. The main programmes and projects currently implemented in Cambodia are summarized in this section. However, given the large number of donor-funded initiatives, projects and activities, some of which are limited in scope, geographical focus or duration, only major ones have been included in the following assessment, based on their scope of relevance in relation to the NSPS. It is noted that most of the programmes are implemented in cooperation with a line ministry or integrated in the relevant ministry's activities. However, as noted earlier, the Council for Agricultural and Rural Development (CARD) has the mandate to coordinate donors, provide inputs on programme formulation, and ensure overall consistency of social safety net programmes.

7.8.1 The School Meal Programme (SMP)

The School Meal Programme was initiated in 2001 with assistance from the World Food Programme as part of the WFP-funded Protracted Relief and Recovery Programme. The programme targets children aged 3 to 12 attending pre-primary and primary school, and provides them with a daily meal served at the school premises. The number of beneficiaries rose from 291,593 in 2002 to 482,961 in 2009, peaking at 610,000 in 2006. The decrease after 2006 was due to a reduction in funding available for food procurement. The programme reached a significant 20 percentage of primary pupils in the 2009/10 school year, operating in 1,624 of the 6,665 schools in the country (WFP, 2011).

Apart from the daily food rations delivered to schools, the programme has a second component providing monthly take-home rations to students from poor families, targeting in particular girls in grades 4, 5, and 6 so as to provide an incentive for parents to send their daughters to school. Over 20,000 poor students in grades 4 to 6 benefited from the Food Scholarship Take-Home Ration (THR) scheme during the school year 2009/10. The amount of food distributed in that year totalled 10,670 metric tons and benefited about 463,400 children and their families. Total expenditure for the two schemes amounted to about US$8.95 million in the school year 2009/2010 (see table 7.16).

Table 7.16 World Food Programme, school meals and take-home rations, school year 2009/10

	Food distributed (netric tons)	Expenditure (US$)[1]	No. of beneficiaries	
			Total	Girls
School meal component (SMP)	7 472	6 264 226	444 225	214 137
Take-home rations (THR)	3 198	2 681 075	19 208	14 063
Total (SMP &TRH)	**10 670**	**8 945 301**	**463 433**	**228 200**

Note: [1] Total expenditure, including administration cost

Source: WFP (2011).

A recent evaluation of the programme concluded that the SMP has had a significant effect on school enrolment, in the sense that it has provided strong incentives for parents to send their children to school. Unsurprisingly, however, the positive effect was only sustained while schools benefited from the programme. The evaluation also found that take-home rations had a significant

positive effect on attendance. Overall, therefore, the programme was found to have had a positive impact. School feeding also reduced dropout rates, especially in grades 2, 3 and 4, but standard performance tests showed minimal benefits in terms of improved learning, a fact attributed to contextual factors (ibid.).

According to the WFP, the NSPS is the most appropriate framework to integrate future school feeding initiatives, with take-home rations being the approach preferred by WFP because they benefit the whole household. Take-home rations have a higher nominal value for beneficiaries than school meals, and may therefore be more effective as an instrument of social protection policy (ibid.)

7.8.2 Cash transfer programmes

Cash transfers (CT) to the poor are known to be an effective way of providing social protection and reducing poverty swiftly. In recent years CT programmes have enjoyed increasing popularity, partly due to their successful introduction in Latin America and the documented evidence on their effectiveness as an instrument of poverty alleviation and social protection. In some instances they are made conditional, in an attempt to induce behavioural changes that result in long-term social and economic benefits for the country. In one typical conditional cash transfer (CCT) model, schoolchildren are provided cash grants if they attend school and/or comply with health-related requirements (e.g. vaccinations or medical check-ups).

CT and CCT programmes targeting the poor also bring about indirect benefits to whole communities, as they stimulate the economy at the local level through expansion of the demand side, given that beneficiaries generally spend the benefits received within their local community or village. This particularly applies to remote areas, where access to the global market is often severely constrained due to distance, terrain or non-existing roads.

Despite these positive aspects, the cost of large-scale CT programmes can become sizable and sometimes a constraint, particularly in developing countries with high poverty rates and tight fiscal conditions. The cost of large-scale CT programmes, however, depends on their design and the pace of their implementation over time. For low-income countries, the introduction of large-scale CT programmes therefore often depends on donors committed to allocating the resources required. Furthermore, CT programmes for the poor require appropriate targeting through means-testing, a process that requires administrative capacity and additional resources, particularly if no targeting mechanism (such as the ID-Poor in Cambodia) is in place.

In Cambodia, there is currently no CT programme of broad scope in operation. It is noted, however, that CT programmes are designated in the NSPS as a priority intervention for the future. UNICEF is planning to launch a pilot programme during 2012 aimed at addressing child and maternal malnutrition. According to the NSPS, the programme could benefit up to 64,000 children and mothers in the year 2012, with total resource requirements estimated at US$4 million. The programme is still in the design stage, hence no details are available yet on benefit provisions and financial commitments by donors.

7.8.3 Public works programmes

A commonly accepted definition of a public works programme (PWP) suggests that:

> The main feature of a PWP is the provision of employment for the creation of public goods at a prescribed wage for those unable to find alternative employment, in order to provide some

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form of social safety net. PWP may be defined as all activities which entail the payment of a wage (in cash or in kind) by the state, or by an agent acting on behalf of the state, in return for the provision of labour, in order to i) enhance employment and ii) produce an asset (either physical or social), with the overall objective of promoting social protection. (McCord, 2008)

PWPs are considered part of active labour market policies (ALMP) and thus qualify as social protection programmes in a broader sense (see section 7.1). However, since PWP programmes provide benefits (wages in cash or kind) in exchange for labour – in the same way as takes place naturally in the labour market – they do not represent pure transfers to households. Nevertheless, since PWPs create gainful employment opportunities they help to generate household income for the poor and vulnerable, particularly in areas where employment opportunities are scarce or affected by seasonal variations. It is therefore generally agreed that PWP programmes, if well designed, can improve the livelihood of poor households and increase the welfare of beneficiaries. They have been included in the present analysis because they are an integral part of the NSPS; a summary description of the main PWP programmes in Cambodia is provided below.

The Rural Investment and Local Governance Project (RILGP)

RILGP was originally financed through a credit of US$22 million from the International Development Association (IDA), with the objectives of (1) assisting rural development and poverty reduction efforts by supporting the provision of priority public goods and infrastructure at the commune level; and (2) promoting good local governance via the support of decentralized and participatory local governance systems at the commune and provincial levels.

The implementation of the initial project phase covered the period 2003–2006 and included 14 provinces. Due to the success of the first phase, the project was extended via an "additional financing grant" of about US$36.3 million provided by IDA. The coverage of the project was expanded to all provinces and the timeline extended to December 2010.

RILGP support plays an important role in strengthening capabilities at commune and provincial level to design, manage and contract small infrastructure projects, and in developing systems to ensure that environmental and social risks are taken into account. Total expenditure for PWPs under RILGP during the years 2009 and 2010 is displayed in table 7.17 for the different sectors that benefited.

Table 7.17 Rural Investment and Local Governance Project (RILGP), public works by sector, 2009–2010

Sector of activity	Total expenditure (US$)			Share (%)
	2009	2010	Totals	
Agriculture	38 342	322 080	360 422	1.07
Education	219 930	151 086	371 016	1.11
Environmental management	6 029	242 697	248 726	0.74
Irrigation, rural drainage & flood protection	1 571 938	1 027 525	2 599 463	7.74
Rural domestic water supplies	184 532	77 045	261 577	0.78
Rural and urban transport	14 168 747	15 559 761	29 728 508	88.56
Total	16 189 519	17 380 194	33 569 713	100.00

Source: ADB (2010).

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As shown in the table, during 2009–2010 the project spent in total about US$33.6 million on public works programmes, most of it on rural and urban transport infrastructure.

The Emergency Food Assistance Project (EFAP)

The Emergency Food Assistance Project was initiated by the Asian Development Bank in May 2008 with the aim of providing assistance to Cambodia to mitigate the effects of soaring food prices. The project comprises three components, including: (1) compensatory consumption support; (2) productivity enhancement support; and (3) capacity development for emergency response to food crisis, and project management (see http://pid.adb.org). The first component includes a food-for-work programme (FFW) implemented by the World Food Programme in collaboration with the Ministry for Rural Development (MRD), and deals with the rehabilitation of tertiary roads and canals. The FFW programme was implemented during November 2008 to July 2010 in the provinces of Siem Reap, Pursat, Kampong Thom and Kampong Chhnang. The project budget was US$35 million including a preferential loan of about half the total budget.

According to the EFAP's monitoring report of June 2010, the FFW programme had implemented a total of 42 subprojects that had rehabilitated 55.6 kilometres of rural roads and created 146,259 workdays of employment. A total of 4,900 households participated in the programme and received in exchange a total of 819.05 tons of rice (ibid.).

The EFAP project also funded a cash-for-work (CFW) programme implemented by the MOEF in collaboration with MRD and the Ministry of Water Resources and Meteorology. Under this programme a total of 396,636 work days of employment were created, resulting in the rehabilitation of 115.4 kilometres of road. The workers employed were paid daily wages of KHR 10,000 (about US$2.5). The total amount budgeted for the programme was SDR 2.13 million, an amount equivalent to US$3.3 million.

7.8.4 Other programmes

Apart from the main social assistance programmes outlined above, there is a wide range of other programmes, projects and interventions targeting the poor and vulnerable, most of them funded and/or implemented by development partnerss. A summary of the main programmes, grouped by supervising line ministry, is shown in table 7.18. Some of the programmes listed are minor ones that are not of national scope or sizable in terms of expenditure or social transfers.

Table 7.18 Social safety net programmes and projects, and responsible lIne ministry

Name of programme/project	Line ministry in charge
• Emergency Food Assistance Project (EFAP): free distribution of rice • Smallholder agriculture and social protection development policy operation	MOEF
• Child survival: components on improving maternal health and newborn care, promotion of key health and nutrition practices • Maternal and Child Health and Nutrition Programme	MOH
• Emergency assistance: cash and in-kind assistance to communes to support achievement of MDGs	MOI
• Support to the National Plan of Action on the Elimination of the Worst Forms of Child Labour 2008–2012 • Technical and vocational education and training (TVET) pilot; skills bridging programme, including - TVET post-harvest processing - TVET voucher skills training programme (non-formal)	MOLVT

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• HIV/AIDS workplace programme for garment factory workers	
• Fast Track Initiative Project (grades 4–6) • Education Sector Support Project (grades 7–9) • Japan Fund for Poverty Reduction Project (grades 7–9) • Basic Education and Teacher Training Project (grades 7–9) • Enhancing Education Quality Project (grades 10–12) • Dormitory Project (grades 10–11)	MOEYS
• Elderly persons' association support and services • Physical rehabilitation centres/community-based rehabilitation services for people with disabilities • Orphans: allowance, alternative care, residential care; child victims of trafficking, sexual exploitation and abuse; children in conflict with the law and drug-addicted children • Child protection: helping to develop laws, policies and standards, and raise awareness to protect children at particular risk • Social services and care to children and families of victims and people affected by HIV/AIDS; children in conflict with the law and drug-addicted children	MOSVY
• Food assistance to people living with HIV/AIDS • Food assistance to TB patients	MOH & MOSVY
• Disaster response and preparedness; general food distribution	NCDM

Source: CARD.

The Council for the Development of Cambodia (CDC) compiles data on expenditure by development partnerss. According to CDC (2011, tables 6 and 10, sector "Community and Social Welfare"), total disbursements for social assistance programmes in 2010 totalled US$52.4 million for programmes supported through ODA funding, including bilateral and multilateral programmes, whereas total disbursements for projects supported through NGO core funding totalled US$36.8 million.

7.9 Vocational training

Vocational training (VT) is part of a broader range of active labour market policies (ALMP) designed to enhance skills and address supply-side gaps or weaknesses in the labour market. VT aims to improve employability of beneficiaries and facilitate their entry or re-entry into the labour market. With their skills enhanced through VT, beneficiaries have access to better-paid jobs and therefore an improved livelihood. In that sense, VT qualifies as social protection in the broader sense, particularly if it is provided to beneficiaries free of charge.

VT can be organized through the private sector, through a governmental programme, or through a combination of both. The cost of VT programmes is often subsidized by the State and sometimes by employers, either directly (e.g. via donations or sponsoring) or through collective arrangements such as unemployment insurance schemes. The success of VT programmes is dependent on their ability to (i) successfully enhance the skills of participants; and (ii) transfer skills that are in demand on the labour market.

In Cambodia the main VT programme operates under the Ministry of Labour and Vocational Training (MOLVT). The Technical and Vocational Education and Training Programme (TVET) comprises 38 government-funded training sites at provincial and district levels and the National Technical Training Institute (NTTI). Apart from short VT courses, it is TVET that provides higher technical and academic education in Cambodia.

At the provincial and district levels TVET offers training consisting mainly of one-year hands-on courses in the following subjects:

- agriculture (irrigation techniques, etc.)
- mechanical engineering
- business management
- information technology

The curriculum at the NTTI is of a higher educational level, as is usual for a technical university offering bachelor, diploma, and master's courses in technical subjects. NTTI also provides education to VT teachers who are employed at the provincial and district level vocational training centres. NTTI has curricula in the following subjects:

- civil engineering
- electrical engineering
- electronics
- architecture
- information technology

Overall, TVET provides vocational training to an estimated 10,000 students per year.[56] It is funded under the MOLVT budget; in 2010 the training budget amounted to KHR 8.4 billion, or about US$2.1 million, not including salaries of MOLVT staff and infrastructure costs.

In 2009 a special fund was established by the Prime Minister to further vocational education. An ad-hoc allotment to the fund of KHR 31.2 billion (~ US$7.8 million) was made, to be disbursed during the biennium 2009–2010, as shown in table 7.19. A further ad-hoc allotment to the special fund was planned for 2011 to target vocational training needs in Special Economic Zones (SEZ).

Table 7.19 Technical and Vocational Education and Training Programme (TVET), national budget expenditure, 2008–2010 (KHR millions)

	2008	2009	2010
Regular budget expenditure (MOLVT)[1]	6 962.40	7 643.50	8 444.70
Special Fund for Vocational Training[(2)]		31 200.00	

Notes: [1]Training budget, excluding salaries of civil servants and infrastructure cost. [2]Total budget provision in the 2009 budget law for disbursement in 2009 and 2010..

Source: TVET, MOLVT.

In 2010 the Asian Development Bank provided a grant of US$24.5 million for a national project: "Strengthening Technical and Vocational Education and Training (2010–2015)"; the Government allocated an additional US$3 million US$ to this project. The main project objective is to expand TVET by providing more integrated training aligned with basic and mid-level skills requirements of enterprises in the sectors of mechanics, construction, business services and information technology.

[56] Information provided by Laov Him, Director General, TVET Department, MOLVT.

7.10 Summary and conclusions

- This chapter has attempted to provide an overview of existing social protection schemes and programmes in Cambodia and to assess their coverage, expenditure, and prospective future development. Due to the large number of donor-funded social protection programmes and the lack of detailed and comprehensive expenditure data, it was not possible to establish a complete social budget for Cambodia as initially intended. A compilation of all expenditure under all provisions and schemes is given in table 7.20. It can be observed that in the year 2010 total social protection expenditure under all social protection schemes is estimated at US$634 million, an amount equivalent to 5.5 per cent of GDP, including about US$385 million (3.3 per cent of GDP) in social spending for health.[57]

Table 7.20 Social protection programmes in Cambodia, benefits provided, coverage and estimated expenditure, 2010: A summary

Social protection programme/scheme or statutory provisions	Benefits provided	Coverage / beneficiaries	Funding source	Expenditure (US$ millions)	% of GDP
National Fund for Veterans (NFV)	Sickness, maternity, work injury and death benefits; retirement, invalidity and survivors' pensions	Armed forces, police force and war veterans	National budget	19.4[1]	0.17
National Social Security Fund for Civil Servants (NSSFC)	Sickness, maternity, work injury, and death benefits; retirement, invalidity and survivors' pensions	Civil servants (175,000), retired civil servants and family dependants	National budget	25.4[1]	0.22
National Social Security Fund (NSSF)	Employment injury benefits including medical benefits, sickness cash benefits, death benefits, and disability and survivors' pensions	Private-sector workers (mandatory coverage for enterprises with 8 or more employees)	Employers (wage-based contributions)	1.3	0.01
Employer liabilities	Paid sick and maternity leave, severance pay and employment-injury benefits	Private-sector workers employed under labour law provisions	Employers	( )[2]	
Hospital subsidies	Cost of infrastructure, salaries, drugs and some operation cost	Whole population	National budget (MOH)	152.8[3]	1.31
ODA and NGO support to health sector	Cost of infrastructure, salaries, drugs and some operation cost	Whole population	ODA and NGO grants and projects	226.0[4]	1.99
Hospital user fee exemption scheme (MOH)	User fee subsidies for the poor	The poor (mostly ID-Poor)	National budget (MOH)	4.6	0.04
Health equity funds (HEFs)	User fee subsidies for the poor and allowances for food, transport and funeral cost	The poor (mostly ID-Poor)	ODA (HSSP-2 and other donors)		
Community-based health insurance schemes (CBHI)	Medical benefits (social health insurance) and allowances for food, transport and funeral cost	Contributors (mostly the near poor)	Members' contributions and ODA funding	1.2	0.01
Social assistance benefits and welfare services for the poor and vulnerable (MOSVY)	Social welfare services and in-kind benefits (food) for the poor and selected vulnerable groups	Various vulnerable groups (disabled, elderly, orphans, etc.)	National budget (MOSVY)	63.9[5]	0.55
Disaster relief operations (NCDM and CRC)	Emergency assistance and food aid	Persons affected by disasters	MOEF, ODA, NGOs	14.8[6]	0.13
MOEYS Scholarship Programme	Cash transfers for poor students if attending school	Poor students	MOEYS	3.5[7]	0.03

[57] Including all administration costs of the respective schemes.

School feeding and take-home rations for schoolchildren	Free school meals and take-home rations for children	Primary schoolchildren	WFP (AusAid, USAID, Canada, etc,)	8.9	0.08
ODA-funded social assistance projects	Various, mostly in-kind benefits	The poor and vulnerable	ODA (various donors)	41.9[8]	0.36
NGO-funded social assistance projects	Various, mostly in-kind benefits	The poor and vulnerable	NGOs (various)	25.8[9]	0.22
Subtotal				**589.5**	**5.12**
Public works programmes	Food and/or cash for work	Mainly rural poor	ODA grants and loans (IDA, World Bank, ADB)	20.7[10]	0.18
Vocational training	Skills training	Unskilled adult population	National budget (MOLVT)	24.0[11]	0.21
GRAND TOTAL				**634.2**	**5.50**

Notes: [1] Excluding administration cost. [2] No data available. [3] Including MOH administration cost. [4] As reported by CDC (health & HIV/AIDS) with deduction of external overheads (e.g. experts' fees) assumed at 20% for ODA and 30% for NGOs, excluding allocations for HEFs and CBHIs.[5] Including MOSVY administration cost. [6] As reported by CDC (emergency & food), not including allocations of the national budget. [7] Amount budgeted in Financing Plan 2006–2010. [8] As reported by CDC (community & welfare) with deduction of overheads assumed at 20%. [9] As reported by CDC (community & welfare) with deduction of overheads assumed at 30%. [10] Comprising RILGP (US$17.4 milllion) and EFAB (US$3.3 million). [11] TVET training budget (excluding salaries) and Special Fund at 50% of budget for the biennium 2009–2010.

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- The fundamental right to social protection, including the protection of the poor and vulnerable, is firmly established in the Constitution of Cambodia. A number of laws have been adopted that give substance to these rights and define their application in the respective contexts. The Labour Law provides for extensive provisions on labour protection, including basic social security entitlements to workers and employees in the private sector. Civil servants and other public employees are granted extensive social security benefits, including retirement pensions. Furthermore, a number of laws exist that promote the rights of the vulnerable and seek to ensure their social protection.
- Two social security agencies have been established recently, NSSFC and NFV, aiming to improve the administration of social security benefits for public-sector workers and achieving long-term financial sustainability. There is a need to further strengthen their institutional capacity to ensure that they can assume their role as autonomous social insurance funds. Entitlements for survivors are currently inadequate and should be adjusted to ensure that survivors are adequately protected through minimum benefit levels in accordance with international standards. Furthermore, public-sector workers are not covered by any social health protection and currently face the risk of catastrophic health expenditures.
- The National Social Security Fund (NSSF) was established in 2008 to provide social security benefits for private employees in the formal economy. To date the scheme provides only employment injury benefits, mainly to workers in the garment and footwear industry. The introduction of social health insurance and pension benefits is under consideration and should be pursued swiftly to extend the scope of protection provided to wage workers.
- Social health protection is a critical issue in Cambodia, in particular for the protection of the poor. Fee exemptions and health equity funds are important mechanisms for ensuring equitable access of the poor to basic health-care services. A number of community-based health insurance schemes (CBHI) have been established that target informal-sector workers who can afford to contribute by purchasing social health protection coverage. However, the overall coverage under these schemes remains low and the potential for their future scaling-up is questionable. Non-poor workers in the informal economy and their families thus remain largely unprotected against the risk of catastrophic health expenditures.
- Social assistance or welfare services are currently provided through a number of line ministries and national agencies. The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MOSVY) operates welfare services to provide assistance to the poor, the disabled, the elderly, and to vulnerable youth. The Ministry of Education, Youth and Sport (MOEYS) operates a programme of scholarships for poor children. Emergency food assistance to victims of natural disaster is provided through several agencies, including mainly MOEF, MOSVY and NCDM. Most of the government programmes, however, have insufficient resources to provide assistance to all those in need.
- Donor-funded social safety nets supplement the assistance provided under the line ministries. The Council for Agricultural and Rural Development (CARD) is coordinating the inputs of all stakeholders and the overall national strategy and priorities. The National Social Protection Strategy for the Poor and Vulnerable (NSPS) was launched in December 2011 and spells out priority interventions, including cash transfers, emergency assistance, social health protection for the poor, public works programmes and vocational training. The World Food Programme (WFP) operates a national programme comprising school feeding and take-home food rations for schoolchildren. UNICEF is planning to pilot a cash transfer programme for young children

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and mothers. The Asian Development Bank (ADB) is implementing public works programmes (PWPs) to upgrade rural infrastructure, and other PWPs are being planned for the future.

- Vocational training (VT) is part of the national priority seeking to improve technical skills and employability of the poor and vulnerable. MOLVT runs a national programme providing short VT courses in several areas, including irrigation, mechanics, business management and IT. The programme is supported through an ADB project with the objective to improve alignment with labour market requirements and extended coverage of the programme.

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8 Report summary and conclusions

During the past decade, rapid economic growth along with political stability and ODA-funded assistance has made possible positive changes and the achievement of lasting development progress in Cambodia. Nevertheless, more than three million Cambodians, a significant share of the total population of 13.4 million (2008), remains poor and many others highly vulnerable. Despite the rapid economic growth, GDP per capita remains low, at less than KHR 9,500 (US$2.40) per day in 2010.

Even at low income levels, income redistribution policies are possible and should be part of a social protection strategy. Due to fiscal constraints, however, in the short term they will be focused on extreme poverty alleviation rather than poverty eradication, and a step-wise introduction will be required. Therefore, to achieve a visible impact on poverty alleviation and the extension of social protection for the poor, the vulnerable and the non-poor, a strong commitment is needed on the part of both government and donors to ensure the allocation of the resources required (Pal, 2005). In light of resource limitations for providing a basic livelihood to the poor and extending social protection to the non-poor, policy choices are required. Since a gradual approach is the only viable option, it is relevant to first consider such policies and programmes as relieve the plight of the neediest, in particular the poor and the most vulnerable. The introduction of basic social protection provisions for all, as promoted under the global Social Protection Floor Initiative (SPF) launched by the UN family under the lead of the ILO and WHO, therefore deserves due consideration for the design of new social protection policies and programmes in Cambodia, this within the overall strategic framework outlined in the NSPS (see Cichon et al., 2011).

At present, Cambodia's social protection expenditure consists mainly of outlays for subsidized health services and social security benefits for civil servants, war veterans and their families. Other social protection measures, including social welfare and cash transfers to the poor and vulnerable, are of minor scope and funded mainly by donor countries. Given the tight fiscal space, further ODA assistance will be required in the near to medium-term future to achieve progress and the development objectives as defined by the CMDG framework. However, since donor-funded social programmes are rarely institutionalized and/or backed by long-term financial commitments, their long-term sustainability is often questionable. Furthermore, through the rapid economic development in Cambodia new fiscal space is opening up continuously, creating new opportunities for the allocation of budgetary resources to priority projects selected by the Government. In light of these considerations, it is indispensable that over the short to medium term new fiscal resources are allocated towards the extension of social protection, in order to supplement and eventually replace the resources made available by donor countries.

Social protection generally pursues a twofold objective: (i) the institution of social transfer mechanisms to benefit the poor and needy; and (ii) the management of social risks through appropriate risk-pooling arrangements. In light of the scale of unmet needs of the poor and vulnerable in Cambodia, the policy priorities of both the Government and the development partners are still focused predominantly on the first objective. Given the pace of economic development, the decrease in poverty rates, and the continuous increase in household incomes, a paradigm shift will be required in the near future towards the second objective, in order to further the development of appropriate risk-pooling mechanisms and institutionalized arrangements. Since the development of such instruments takes years if not decades, in particular for the

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development of the human and institutional capacity required, it should not be delayed for too long. Further technical assistance will be required from development partners to support the Government in developing the required institutions and their institutional capacity for an effective delivery of the social protection benefits required in the future.

In the health sector much progress has been achieved in recent years. Nevertheless, out-of-pocket health spending of households remains high, and a high percentage thereof is spent outside the public health system. There is a need to improve quality of care in order to incorporate household spending into the public health system. But the vast majority of Cambodians remain without coverage under any social health protection scheme and therefore continue to face risks of catastrophic health expenditures. Health equity funds have been instrumental in improving access to care for the poor; the non-poor, however, still largely remain unprotected, including the most vulnerable among them. There is a need to move ahead with the implementation of social health insurance for formal-sector workers, both in the public and private sectors. This could be a critical step forward that would allow additional funding to be channelled into the public health system from the demand side. Furthermore, the new health purchasers could be instrumental in improving quality standards in public hospitals through the consistent use of performance-based contracting arrangements. This will require, however, not only a strong commitment by the new purchasers (i.e. NSSF and NSSFC), but also the prior development of adequate human and institutional capacity within these institutions.

Regarding pensions, the national coverage rate is low apart from public-sector workers, who are entitled to retirement, invalidity and survivor pensions. The planned introduction of social security pensions for the private sector should be pursued as stipulated by the Social Security Law, 2002. For workers engaged in the informal economy, the labour market participation rate of the elderly is high, due in part to the lack of old-age pension provisions. Social protection provisions are needed that provide income security to both the elderly and the disabled. Given the low age dependency ratio in Cambodia, the introduction of social pensions for the elderly and disabled, as promoted under the SPF Initiative, would not be very costly in relative terms. Furthermore, international experience has shown that pensions for the elderly are often shared within the household and often benefit other household members, notably schoolchildren.[58]

With social transfers deemed indispensable to protect those unable to earn a decent living, cash transfer programmes are part of the key policy measures identified by the NSPS and promoted under the SPF Initiative. In Cambodia the WFP-initiated school feeding programme is currently the only large-scale social transfer programme to benefit the poor. The planned up-scaling of the programme to cover all schools in Cambodia is a positive development. Cash transfer programmes for pregnant women and mothers with young children have also proven successful around the world, notably through their positive impact on maternal and child mortality rates. The introduction of such a programme in Cambodia, as currently planned by UNICEF in collaboration with CARD, would be a further positive step towards the extension of social protection.

The governance of the social protection system is still fragmented in Cambodia, with responsibilities for policy formulation and implementation shared between several line ministries and key programmes of development partners. The recent adoption of the NSPS is a commendable step forward towards a more coherent and coordinated policy approach under the leadership of CARD. The planned costing of priority interventions outlined in the NSPS should help to assess resource needs for different interventions, and thereby establish a sound basis for

[58] This, for instance, was the experience in Namibia, where universal pensions were introduced in the year 2000.

informed policy-making. Resource-based and long-term policy planning by the Government is an important step forward to support the transition of the Cambodian social protection system; moving from a collection of fixed-term donor-funded projects towards a more coherent, institutionalized and financially sustainable system under full government ownership.

The ongoing reform process of decentralization and deconcentration, aiming at strengthening local governance and public service delivery, is opening new perspectives for the delivery of social protection benefits at the community level. The new administrations to emerge at subnational level could be instrumental for the delivery of a comprehensive social protection benefit package to the rural population. However, any novel approaches will need to be carefully designed and piloted first before they can be mainstreamed on a national scale. Overall, an efficient and effective public administration system is a key requirement for the functioning of a comprehensive social protection system. Further efforts to upgrade administrative capacities and to strengthen national social protection agencies will no doubt be required; they are a precondition for lasting progress on the path towards universal coverage.

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Annex tables

Table A.1 Labour market balance, 2008–2010 (thousands and percentages)

	2008	2009^{p}	2010^{p}
Total population	13 396	13 617	13 847
Male	6 516	6 631	6 750
Female	6 880	6 986	7 097
Working-age population (15+)	8 882	9 159	9 440
Male	4 201	4 343	4 492
Female	4 681	4 816	4 947
Non-active working-age population	1 926	1 986	2 046
Male	805	832	861
Female	1 121	1 154	1 185
Non-active working-age population, % of working-age population	21.7	21.7	21.7
Male	19.2	19.2	19.2
Female	24	24	24
Labour force within working-age population	6 956	7 173	7 394
Male	3 396	3 511	3 632
Female	3 559	3 662	3 762
Memorandum item: Labour force aged <15 (%)	98	88	78
Labour market participation rate	78.3	78.3	78.3
Male	80.8	80.8	80.8
Female	76	76.2	76.4
Employed population aged 15+	6 841	7 056	7 272
Male	3 346	3 459	3 578
Female	3 495	3 597	3694
Paid employed population	3 904	4 029	4 157
Male	2 526	2 611	2 701
Female	1 377	1 417	1 456
Employers (%)	17	18	18
Male	10	10	11
Female	7	7	7
Paid employees	1 192	1 274	1 361
Male	698	745	796
Female	495	528	565
Public administration and defence	305	310	316
Male	233	237	242
Female	72	73	74
% of population	2.3	2.3	2.3
Civil servants	166	166	166
Male	111	111	111
Female	55	55	55
Own-account workers	2 714	2 743	2 775
Male	1 830	1 848	1 871
Female	885	894	905
Unpaid family workers	2 938	3 027	3 115
Male	820	909	997
Female	2 118	2 118	2 118
Unemployed population aged 15+	114	118	122
Male	51	52	54
Female	64	66	67
Unemployment rate	1.6	1.6	1.6
Male	1.5	1.5	1.5
Female	1.8	1.8	1.8

Note: Actual for 2008; author's projections for 2009 and 2010.

Source: Census 2008 and author's projections.

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Table A.2 Economic and fiscal indicators, 2002–2010

	2002	2003	2004	2005	2006	2007	2008	2009	2010
GDP at constant 2000 prices (KHR billions)	16 232	17 613	19 434	22 009	24 380	26 870	28 668	28 107	29 799
Change in % p.a.	6.6	8.5	10.3	13.3	10.8	10.2	6.7	–2.0	6.0
GDP at current prices (KHR billions)	16 781	18 535	21 438	25 754	29 849	35 042	45 583	44 841	47 805
Change in % p.a.	7.3	10.5	15.7	20.1	15.9	17.4	30.1	–1.6	6.6
GDP Deflator	103.4	105.2	110.3	117.0	122.4	130.4	159.0	159.5	160.4
Change in % p.a.	0.7	1.8	4.8	6.1	4.6	6.5	21.9	0.3	0.6
GDP growth by industrial sector (% p.a.)									
Agriculture, Fishery & Forestry		10.5	–0.9	15.7	5.5	5.0	5.7		
Crops		21.9	–2.3	27.6	5.3	8.2	6.6		
Livestock & Poultry		5.7	3.8	5.6	8.2	3.7	3.8		
Fisheries		1.7	–1.7	5.6	3.8	0.8	6.5		
Forestry & Logging		–3.0	0.9	5.1	7.1	1.0	1.0		
Industry		12.1	16.6	12.7	18.3	8.4	4.0		
Mining		17.0	25.5	26.1	16.1	7.9	15.6		
Manufacturing		12.3	17.7	9.7	17.4	8.9	3.1		
Food, Beverages & Tobacco		4.7	–5.3	9.0	3.5	3.0	6.0		
Textile,Wearing Apparel & Footwear		16.8	24.9	9.2	20.4	10.0	2.2		
Wood, Paper & Publishing		–14.9	5.0	9.5	8.7	5.0	4.8		
Rubber Manufacturing		–10.1	–8.1	–8.8	3.8	9.3	8.5		
Other Manufacturing		7.7	8.2	17.3	15.2	6.8	6.3		
Electricity, Gas & Water		9.3	12.2	12.0	32.0	11.0	8.6		
Construction		11.1	13.2	22.0	20.0	6.8	5.8		
Services		5.9	13.2	13.1	10.1	10.1	9.0		
Trade		3.7	5.9	8.5	7.1	9.5	9.4		
Hotel & Restaurants		–16.7	23.3	22.3	13.7	10.2	9.8		
Transport & Communications		3.2	9.6	14.4	2.1	7.2	7.1		
Finance		6.7	20.0	19.5	24.3	22.1	19.2		
Public Administration		–4.5	–6.7	6.0	–1.2	0.3	4.5		
Real Estate & Business		23.4	20.3	7.7	10.9	10.7	5.0		
Other services		13.6	18.0	18.3	17.2	12.0	12.0		
Fiscal indicators									
Total revenue	10.6	9.8	10.3	10.5	11.4	12.1	11.6	11.0	12.3
Tax revenue	7.5	6.8	7.7	7.7	8.0	10.2	9.7	9.3	9.8
Domestic	5.0	4.7	5.3	5.5	5.9	7.1	6.9	7.4	9.8
Tax on foreign trade	2.5	2.1	2.4	2.2	2.2	2.6	2.4	2.4	7.4
Current non-tax revenue	3.0	2.8	2.5	2.2	2.1	1.8	1.7	1.6	2.2
Capital revenue	0.1	0.2	0.1	0.6	1.3	0.1	0.2	0.1	0.3
Total expenditure	18.0	16.1	14.2	13.2	14.1	14.7	14.1	17.0	19.9
Current expenditure	9.7	9.7	8.5	8.0	8.3	8.6	8.3	8.5	10.6
Civil administration	6.8	7.1	5.9	5.7	6.0	6.5	6.5	6.4	8.1
Wages and salaries	3.5	3.3	3.0	2.8	3.2	3.3	3.2	3.3	2.5
Social spending	3.5	3.3	3.1	2.8	2.6	2.8	2.6	2.8	2.7
Other civil spending	–0.2	0.5	–0.2	0.1	0.8	0.8	0.8	0.3	2.9
Military and security	2.4	2.2	2.0	1.8	1.7	1.0	1.0	1.3	1.8
Interest payments	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Other current expenditure	0.3	0.2	0.4	0.3	0.4	0.6	0.6	0.6	0.5
Capital expenditure	8.3	6.4	5.7	5.2	5.8	6.1	5.8	8.5	9.3
Balance	–7.4	–6.3	–3.8	–2.6	–2.7	–2.6	–2.5	–6.0	–7.6
Domestic financing[*)]	0.0	1.4	–0.5	–1.8	–2.2	–2.6	–3.0	–0.3	0.6
External financing	7.4	4.9	4.3	4.4	4.9	5.2	5.3	6.3	7.0

Sources: IMF; NIS.

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