Social Protection in Action: Building social protection floors for all

Country Brief: Cambodia

December 2021

Extending Social Health Protection in Cambodia: Accelerating progress towards Universal Health Coverage

1. Introduction

Cambodia has experienced more than two decades of solid economic growth, at an average rate of 7.7 per cent from 1995–2017 (World Bank 2021). With a GDP per capita of US$1,643.12 in 2019 and a GDP growth rate sustained above 5 per cent over the past 10 years, Cambodia was reclassified from a low-income to a lower middle-income country in 2016 (World Bank n.d.). However, in 2014, around 13.5 per cent of Cambodia's population were living below the poverty line, and the country faces significant wealth inequality. To address this, efforts to improve social protection have been forthcoming. Specifically, in 2017, the government launched the National Social Protection Policy Framework (NSPPF) for the period 2016–2025 to prevent and reduce poverty, vulnerability and inequality by strengthening and expanding social security and social assistance.

In tandem with these developments, Cambodia has significantly improved several key health outcomes and achieved high coverage of maternal and child health services (Mathauer, Dale, and Meessen 2017). However, with a growing private for-profit health provider sector, out-of-pocket (OOP) expenditures represented 60 per cent of health expenditure in 2017, indicating that a significant proportion of the poor and vulnerable population in Cambodia lack social health protection. Improving Cambodia's health system along a pro-poor path continues to be a critical challenge, particularly with regard to quality of care and coverage. An increased prevalence of non-communicable diseases (NCDs), together with an aging population and increasing urbanization pose challenges to the structure and delivery model of the existing health system in Cambodia (Cambodia Ministry of Health 2016). As such, the extension of social health protection towards Universal Health Coverage (UHC) is among the government's key strategies to achieve sustainable economic growth and reduce poverty and vulnerability. Specifically, Cambodia's health strategy aims to increase coverage to 50 per cent of the population by 2020 and the National Strategic Development Plan 2019–2023 targets "65 per cent of the population [to be] covered by social health protection systems by 2023" (Cambodia Ministry of Health 2016).

2. Context

The progress of the social health protection framework in Cambodia is part of the broader development of comprehensive social protection policies, which began with the enactment of the Labour Code in 1997, granting maternity and sickness cash benefits. A major milestone in the development of the social health protection system in Cambodia was the first pilot of the Health Equity Fund (HEF) in the early 2000s. The Ministry of Health officially launched the HEF scheme in 2006 to cover the poor, and rolled it out in several provinces, progressively reaching nationwide coverage in 2015. In parallel, between 2005 and 2016, various models of community-based health insurance were piloted.

In 2008, the National Social Security Fund (NSSF) was created, and almost a decade later, in 2017, the government launched social health insurance schemes for private sector workers through the NSSF (NSSF-F) and for active and retired civil servants (NSSF-C), alongside the implementation of Prakas (proclamation) 404. Issued by the Ministry of Economy and Finance (MOEF), the Ministry of Health (MOH) and the Ministry of Labour and Vocational Training (MOLVT), this joint legal directive extended coverage to some informal workers defined as part-time, seasonal and casual workers through the HEF. In the same year (2017), the government adopted the National Social Protection Policy Framework (2016–2025), which provides a medium-term roadmap focusing on two main pillars: social assistance and social Security, including health. This was followed by the enactment of a new Social Security Law in 2019.

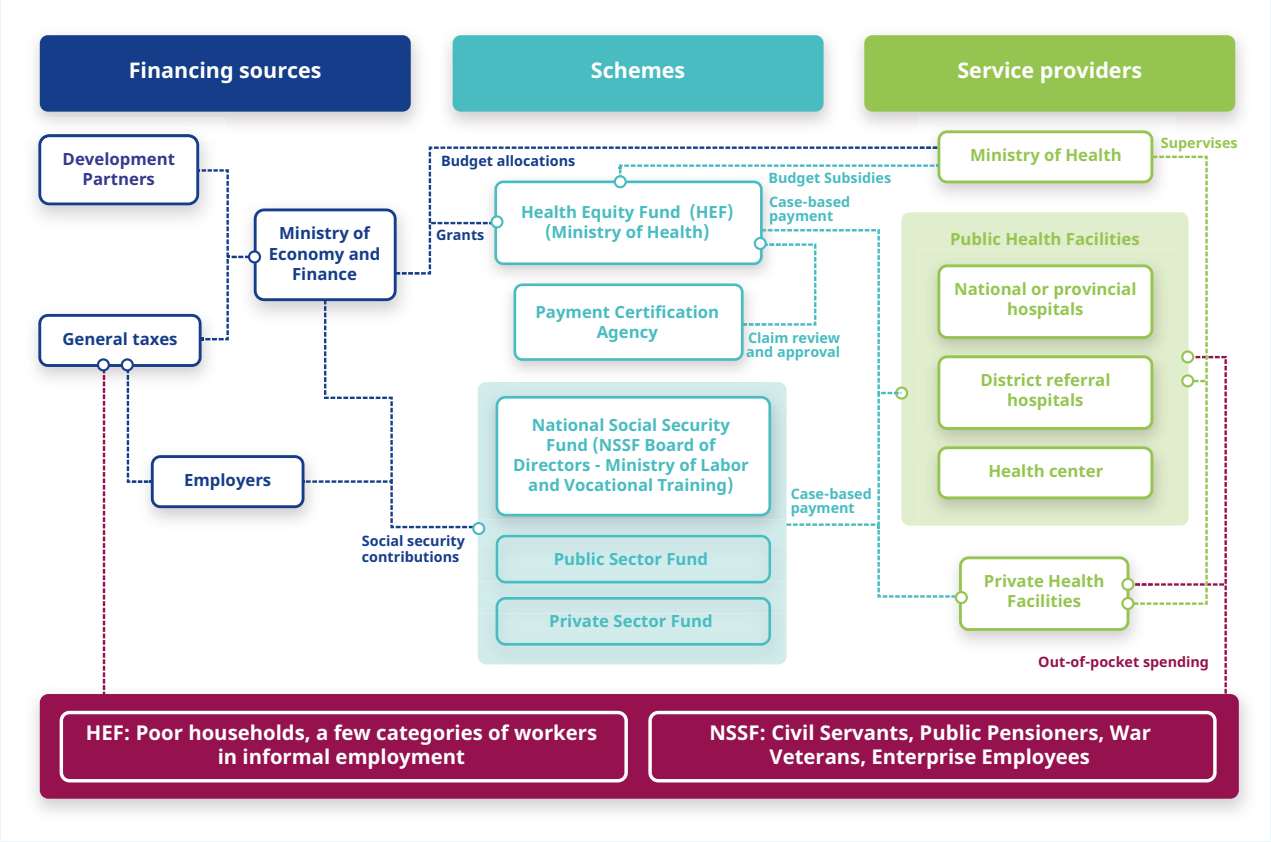
3. Design of the social health protection system

- Financing

The revenues of the scheme for private sector workers (NSSF-F) are collected directly from employers, and the contribution rate for formal private sector workers is set at 2.6 per cent of the employee's salary, paid entirely by the employer. The monthly contribution calculation is capped at 1.2 million Cambodian Riel (KHR), or approximately US$300. The contribution rate for the civil servants' scheme (NSSF-C) is set at one per cent of the member's salary, which is paid by the MOEF to the NSSF-C.

Unlike the NSSF schemes, the HEF scheme is non-contributory. Financing comes from development partners' grants and from general taxes, which are allocated through the MOEF. The Health Equity and Quality Improvement Project (H-EQIP) finances up to US$6 million per year in user-fee reimbursements for health services provided to poor beneficiaries, and the balance is paid from the national budget. In 2019, total user-fee reimbursement exceeded US$18.4 million.

▶ **Figure 1. Overview of main financial flows of the social health protection system in Cambodia**



Source: Authors

- Governance

The social health insurance schemes for civil servants (NSSF-C) and for private sector employees (NSSF-F) are managed by NSSF, with technical oversight from the MOLVT. Since the new Social Security Law was enacted in 2019, the NSSF governance board has been comprised of the Minister of the MLVT (Chair) and representatives from the MOEF, the MOH, the Ministry of Civil Service, the Ministry of Social Affairs, and the Council of Ministers. Veteran and Youth groups are also represented, along with two representatives from employers' federations, two representatives from trade unions and the NSSF Director General.

The MOH manages the HEF for poor households and its extension via the informal workers' scheme, through the Department of Planning and Health Information (DPHI), and the Department of Budget and Finance. The governance of the HEF is overseen by Health Financing Steering Committees (HFSC) at provincial and district levels, chaired by the vice-governors of respective localities. The HFSC for Phnom Penh is the final referral point for any decisions or problems that cannot be resolved at a lower level. The Payment Certification Agency (PCA) monitors and assesses HEF utilization and Service Delivery Grants implementation, identifies issues and recommends solutions. In addition to monitoring and assessing the quality of health services used by HEF beneficiaries, the Payment Certification Agency (PCA) was established to review and verify payment and audit claims received from all public facilities.

The National Social Protection Council (NSPC) and its Executive Committee have a critical decision-making, stewardship, oversight and coordination role to expand coverage and improve existing social protection schemes. The council works

to accelerate progress on priority areas while ensuring optimal performance and efficiency of all social health protection schemes. The Minister of Economy and Finance chairs the Council, which is constituted by ten other Ministers including the Minister of Health and the Minister of Labour and Vocational Training. The same ministries also have high-level representation on the Executive Committee of the Council.

- Legal Coverage and eligibility

Eligibility for the NSSF-F scheme is restricted to workers who are registered with the NSSF as formal private sector employees. Initially, companies with fewer than eight workers were not eligible to register with the NSSF, but this has now been extended to all enterprises regardless of their size. Membership for the NSSF-C scheme is limited to individual civil servants and retirees. NSSF members are covered on an individual basis without consideration of dependents. Enrolment is mandatory for both NSSF-F and NSSF-C schemes.

HEF is targeted to poor households, as well as people living with HIV/AIDS. In addition, some groups of informal workers whose registration is undertaken by NSSF are eligible for HEF in line with Prakas 404. These workers are defined as individuals with an employment contract for work not exceeding eight hours a week, including part-time, casual or seasonal work.

To identify beneficiaries of the HEF determined as poor, a nationwide ID Poor system is applied, and the government issues an equity card to identified households. The identification system combines proxy means testing using observable household characteristics and assets, and community-based targeting. This system is complemented with a post-identification system, enabling enrolment at the point of service delivery. The identification of eligible HEF beneficiaries is evolving with different identification strategies (ex-ante, ex-post, and more recently, on-demand). Initially, the identification criteria varied among various NGOs and development partners, but in 2005, the Ministry of Planning developed a uniform assessment to capture the poorest households. The identification of poor households in Cambodia is implemented in yearly rounds, covering one-third of the country every year. To facilitate enrolment among the new poor between rounds and improve efficiency of the process, in 2020 the Ministry of Planning rolled out its On-Demand Identification (OD-ID) system. This system is operationalized by commune councils using mobile tablets.

- Benefits

The benefits packages for the NSSF-C and NSSF-F schemes are very similar. Both include outpatient and inpatient care; maternity-related care; child general medicine; family planning; medium surgical intervention; and transport (referral and corpse). Rehabilitation, a daily allowance and a room with air conditioning are also included, and the NSSF provides cash benefits to replace income in cases of illness and maternity. There is a negative list of exclusions in addition to this positive list. [1] Reimbursement of drug costs [2] is limited to pharmaceuticals included on the essential drug list published by the MOH. The NSSF benefit package specifically excludes reimbursement for public health services offered free of charge to the patient in line with Article 4 of Prakas No. 109. This includes treatment for HIV, tuberculosis, malaria and vaccination services.

The HEF includes 36 “medical service packages” which are reimbursed by the HEF. Benefits cover inpatient admission, outpatient consultations, emergency care, preventive services, physiotherapy and rehabilitation. The service packages include consultations, diagnostic tests and medicines on the essential drug list, which are provided based on availability. Additionally, a transportation allowance is offered for referred cases, delivery/attempted delivery and post-abortion care. A funeral grant is also provided for referred cases. Services excluded from the HEF benefit packages include oncology, organ transplants, cosmetic surgery and infertility treatments.

[1] Excluded services include: dental care; sex change operations and care; organ transplants; artificial insemination; self-treatment; plastic surgery; artificial vision devices and laser vision surgery; treatments for drug abuse; infertility treatment; eye implant surgery; coronary and heart surgery; hemodialysis; and general health check-ups.

[2] The NSSF reimbursements are case fees—fixed fees payable for predefined “cases” of care reflecting the type of medical treatment and cost category; different rates apply for different types of service providers. In addition to case fees, a selected list of treatments and diagnostic procedures considered to be high cost will be reimbursed separately on a fee-for-service service basis but subject to a cap or maximum amount per case.

- Provision of benefits and services

Public facilities are the backbone of the network for all schemes. In addition to all public providers, the NSSF also contracts selected private health facilities to facilitate access to reproductive and maternity services, given that 68 per cent of its members are women. Presently, the NSSF contracts around 90 private providers to improve access, particularly nearby manufacturing areas where public services may be limited. Most facilities contracted by the NSSF are concentrated in Phnom Penh. To access NSSF services, there are no user-fees at the point of service provision, and no waiting periods, co-payments, ceilings or deductibles. There is no referral system or incentive to seek care at primary level first.

Similarly, for the HEF, eligible beneficiaries do not pay at the point of service provision and there are no waiting periods or other criteria before eligible households can avail of medical benefits. There is no waiting period to access benefits and the scheme reimburses public health facilities for user fees normally paid by the patient (Mathauer, Dale, and Meessen 2017). Although there is no strictly enforced referral system to access different levels of care, there is an incentive for beneficiaries to access care at primary level first if they wish to be eligible for transportation allowance.

The HEF and NSSF insurance schemes use somewhat different case-based classifications with different payment rates. The overall payment by the HEF for medical services to each individual facility is subject to change based on the quality-of-care score; the score is determined quarterly for each hospital and semi-annually for each health centre, based on (1) the quarterly quality enhancement score and (2) patient dossier and health register reviews (Jain and Srey 2020). Currently, the purchaser-provider split is not complete, as the PCA co-locates with and operates under the technical supervision of the MOH. Additionally, the PCA does not actually make payments to facilities, but it approves them before payments are made by the MOH. The NSSF also reimburses public facilities on a case-based basis but the rates are not reviewed on a regular basis. Furthermore, as noted above, the NSSF has started purchasing care from the private sector with a view to extend the network of providers available to protected persons.

The fragmentation of (and within) the current schemes creates inefficiencies, leads to unnecessary duplication of efforts and limits purchasing power. For example, parallel systems used by NSSF and HEF reimburse (mostly) the same health facilities; moreover, these systems are not digitally connected. There are several interconnected issues which need to be addressed, including: the current reliance on manual claims submission processes through the H-SPIS; reliance on a paper-based system at many facilities for the HEF; a lack of interoperability between the two claims systems, causing duplication of work at the health facility level; and the operational capacity and constraints of institutions managing claims and payments for each scheme. Health system efficiency can be improved by leveraging, aligning and linking the strengths from various existing system elements. Specifically, the claims processing for the NSSF and HEF schemes are managed separately through the H-SPIS and the Patient Management and Registration System (PMRS), respectively. If unaddressed, fragmentation within the social health protection sector will only become further entrenched with time.

▶ 4. Results

- Coverage

Despite sustained efforts to expand coverage, the majority of the Cambodian population remains uncovered. Prior to COVID-19, enrolment in the NSSF-F and NSSF-C schemes was intensifying (Kolesar et al. 2020). Since the launch of the two schemes for workers, as of 2020, the NSSF registered 11,326 enterprises/establishments with 2,141,030 workers (1,418,165 females) (NSSF 2020). This accounts for 13.0 per cent of the total population and 23.4 per cent of the labour force. Around 11,000 enterprises are currently registered, with approximately 1.25 million employees enrolled in the NSSF-F scheme. Current membership of the NSSF-C scheme is about 430,000. Inclusion of dependents (for example, dependent spouses, children under 18 years of age, parents, and older adults residing in the household) could potentially increase coverage by 4.77 million people: 4.25 million under the NSSF-F scheme, and 523,000 under the NSSF-C (Kolesar et al. 2020). At present, because contributions are paid solely by the employer, the administrative and logistical obligation of contribution collection

is minimal. However, extending benefits or coverage to dependents of the contributory schemes would require increasing contributions and/or introducing a contribution from the workers, which may be an obstacle to necessary reforms.

As for the HEF scheme, at the end of November 2020, a total of 701,290 households were enrolled, raising the total number of individual beneficiaries to 2,785,847 or approximately 16.7 per cent of the total population. More recently, service statistics suggest that the HEF extension scheme for informal workers and selected populations covered 131,755 members as of 2020 (NSFF 2020). Using Cambodia Socio-Economic Surveys data and administrative statistics, the total population that can be legally covered under the HEF extensions is estimated to be about 817,000. Low enrolment in the scheme can be attributed to a passive enrolment with no promotion of the scheme among the public. Coverage of households with an ID Poor card in the bottom decile is much higher than among those in the top decile, suggesting some favourable results from the targeting process (Shrestha 2020). However, evidence also suggests there are exclusion and inclusion errors related to the ID Poor targeting system, which restricts health care access among poor Cambodians, with only 56 per cent of those in the poorest decile included and 7 per cent of the richest also included (Shrestha 2020). As noted above, the ID Poor registered HEF beneficiaries presently comprise about 16.7 per cent of the population. This is less than the proportion in the first quintile (20 per cent), but higher than the (2019) official national poverty rate of 12.5 per cent. [3]

A considerable percentage of the vulnerable and near poor population (second and third wealth quintile households) are not covered by social health protection schemes. Despite efforts to expand social health protection coverage in recent years, over 54 per cent of the population currently has no legal social health protection coverage, and about 16 per cent of the population who are legally covered are not yet effectively enrolled. According to estimates from the MOH, the combination of all social health protection schemes effectively covers about five million Cambodians, which is less than a third of the population (27.6 per cent in 2018). Relatively narrow eligibility criteria (for example, the exclusion of dependents under NSSF schemes and poverty targeting under the HEF), and difficulties in enrolment are explanatory factors. In addition, recent coverage expansion to some informal workers leaves significant gaps, since the HEF extension scheme for informal workers and selected populations is limited to specific categories of work (Kolesar et al. 2020).

The expansion of existing schemes (NSSF and HEF) provides an adequate pathway to cover the "missing middle". It would require expansion of legal coverage to dependents of workers already covered under NSSF schemes and to the near poor (including second and third wealth quintiles) in the informal economy, on a mandatory basis to substantially reduce the coverage gap. Including dependents of formally employed workers could rapidly increase coverage by about 3.38 million for the NSSF-F scheme and 523,000 for the NSSF-C scheme (Kolesar et al. 2020). Extending HEF coverage to the near-poor would allow for the provision of financial health protection to around 5.7 million financially vulnerable persons who rely predominantly on the informal economy for their livelihoods but are not classified as poor, and therefore not covered by the HEF.

- Adequacy of benefits/financial protection

Cambodia ranks among the world's top 10 countries in terms of OOP health spending, with OOP payments for health services at 60 per cent of total health expenditure in 2017 (World Bank 2017). This has a disproportionate impact on the poor and vulnerable, with evidence indicating that lower-income households are at the greatest risk of impoverishment due to health spending (Fernandes Antunes et al. 2018). Empirical evidence suggests that a one-size-fits-all approach to individual monthly health care contributions among the lower three quintiles has limited potential for revenue generation, especially considering collection costs (Kolesar et al. 2020). This indicates the need for more public resources to be made available to protect poor and vulnerable population groups.

While the HEF aims to provide free access to health care among the poor, there is a lack of evidence demonstrating higher utilization of public services among the poor (Kolesar et al. 2019), with a very high proportion (54–86 per cent) of HEF beneficiaries seeking care in the private sector. Similarly, 75 per cent of rural patients

[3] The previous rate (from 2013) was 13.5 per cent.

have been found to use the private sector as their first provider choice. This trend is driven by a perception of inferior service quality in the public sector. As HEF does not reimburse services provided in the private sector, financial protection is limited in such cases. Notably, research suggests that 24.5 per cent of HEF beneficiaries borrow money with interest to pay for medical expenses, compared to 12.5 per cent of non-HEF members (Ir et al. 2019).

- Responsiveness to population needs

    o Availability and accessibility

Low-utilization of cost-effective health services and a shortage of providers, especially in rural areas, point to limited accessibility and availability of health care in Cambodia, with available services failing to meet the emerging needs of the population. Adequate access to services is limited by a lack of clinical expertise and pharmaceutical availability. Services are also constrained by the availability of medicines within public facilities. Presently, only 15 predetermined items from the National Essential Drug List are monitored for stock-out.

    o Acceptability and quality

There are many challenges affecting the quality and acceptability of health services in Cambodia, including the lack of an accreditation system and no systematic assessment of the quality of health care, especially in the private sector. This is compounded by a lack of harmonization and coordination between private and public health services. As previously noted, the perception of inferior service quality in the public sector is commonly cited as the reason for high private sector utilization in Cambodia. [4] Although recent information on patient satisfaction is limited, a 2012 national health care services client satisfaction survey of the public sector found dissatisfaction in several areas, including "attentiveness of health-facility staff, cleanliness of facilities and communication on diagnosis and prevention" (Peou and Depasse 2012). Patients typically view public facilities as being too far, requiring long waiting times and lacking in efficiency and hospitality (Basu et al. 2012; World Bank 2014). Despite these challenges, a study also found that health care users reported trusting public providers' skills and abilities as well as the referral system (Ozawa and Walker 2011). To gain a clearer picture of health care quality, in 2019, Cambodia scaled-up its health care quality monitoring system to the national level for the public sector, considering three dimensions of assessment, namely structure, process and outcome. [5]

▶ 5. Way forward

Since 2000, Cambodia has significantly improved several key health outcomes, including achieving a major reduction in maternal and child mortality (UNICEF 2019). However, looking forward, Cambodia is entering into a period of demographic and epidemiological transition. The aging population and increasing prevalence of non-communicable diseases puts increasing pressure on the national health system and will undoubtedly impact on the country's health indicators. Enhancing social health protection will contribute to reduced vulnerability, increased household productivity and benefit the long-term economic prospects of Cambodia.

To this end, efforts to expand the NSSF are underway, focusing on enrolment of formally employed workers in new business units, and primarily concerning higher income households, since the effort so far has mostly focused on low-paid garment factory workers. The government is also interested in exploring the option of extending SHP to dependents and piloting new procedures to facilitate the affiliation of tuk-tuk drivers and domestic workers in the capital city (GRET 2019). However, without a single risk pool or at least a solidarity mechanism between the different risk pools, these efforts are unlikely to foster equity. Efforts are also needed to consolidate the current pension schemes, and launch a pension for the elderly poor to guarantee much needed income security for older persons, who tend to experience greater morbidity. The

[4] More than three out four rural patients (75.7 per cent) use the private sector as their first point of contact for either curative or preventive health services (Kolesar et al. 2019).

[5] "Structure" assesses management, financing, staff, infrastructure, interpersonal communication and equipment using direct observation, record review and checklists; "Process" assesses technical competency and interaction between patients and providers using vignettes; and "Outcome" assesses patient perception of quality through patient interviews using a standardized tool (Fritsche and Peabody 2018).

focus of expansion efforts should be placed on rural areas, where access to health care is more limited.

In addition to enhancing protection among vulnerable groups, the reduction of OOP spending, and the improvement of health care quality are among the primary challenges for Cambodia. As noted above, in 2019, Cambodia scaled-up its health care quality monitoring system to the national level. However, there are still significant challenges relating to quality of care, and the issue has been identified as the most pressing imperative for health-system strengthening in Cambodia (Annear et al. 2016; Pheakdey et al. 2020). To address the issue of quality of services, a Law on Administration of Health Services has been drafted "to ensure and promote quality of health care services provided by health facilities to ensure health and safety of clients". The law is expected to apply to both public and private health facilities at all levels. When promulgated, the law will establish a national accreditation system (Pheakdey et al. 2020). Although voluntary, the idea is that accreditation will be required in order for facilities to be contracted by the NSSF and HEF schemes.

▶ 6. Main lessons learned

- Strategies to cover the "missing middle" must be taken up early on when developing social health protection systems so that population gaps are addressed progressively. Despite the existing NSSF and HEF schemes, the vast majority of the population remain uncovered. Expanding population coverage through existing schemes systems can provide an adequate pathway to cover the "missing middle". The expansion of legal coverage to dependents of workers already covered under NSSF schemes, and the extension of HEF coverage to the near poor in the informal economy on a mandatory basis would substantially reduce coverage gaps. In addition, some adjustments will be needed to ensure coverage of informal self-employed workers, as current registration procedures require employers to register their workers.
- While Cambodia has made significant progress in reducing impoverishment and catastrophic health care expenses, a continued focus on financial risk protection is needed. There is evidence that the HEF is not currently eliminating OOP costs among the poorest (Kolesar et al. 2019). As low utilization of public health care providers contributes to this issue, increased utilization of public facilities would likely improve technical efficiency while reducing OOP spending.
- The fragmentation of (and within) the current schemes leads to unnecessary duplications of efforts, inefficiencies, and limited purchasing power. To address these issues and ensure equity, the focus is slowly shifting towards progressively aligning and harmonizing the design and implementation of the NSSF and HEF schemes.
- Strategic purchasing to incentivize quality service provision and enhance value for money can start with a simple approach. A first step is to establish quarterly performance assessments of quality with selected facilities, and once the design of system is fully operational and accepted by both parties, the linkage of health facility quality scores to actual reimbursement payments to providers can be implemented and rolled out. This approach could then be optimized by increasing reimbursement rates upon the score achieved.

References

Annear, Peter Leslie, Keovathanak Khim, Por Ir, Ellen Moscoe, Tapley Jordanwood, and Thomas Bossert. 2016. *National Coverage and Health Service Utilization by Health Equity Fund Members, 2004-2015*. ADRA Research Report.

Basu, S., J. Andrews, S. Kishore, R. Panjabi, and D. Stuckler. 2012. "Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review." *PLoS Medicine* 9 (6).

Cambodia Ministry of Health. 2016. *Health Strategic Plan 2016-2020*. Department of Planning and Health Information, May 2016.

Fernandes Antunes, A., B. Jacobs, R. de Groot, K. Thin, P. Hanvoravongchai, and F. Steffen. 2018. "Equality in Financial Access to Healthcare in Cambodia from 2004 to 2014." *Health Policy Plan* 33: 906–19.

Fritsche, G., and J. Peabody. 2018. "Methods to Improve Quality Performance at Scale in Lower- and Middle-Income Countries." *Journal of Global Health* 8 (2).

GRET. 2019. "In Cambodia, Health Coverage Is Being Extended to Some Stakeholders in the Informal Sector", available at: https://www.gret.org/2019/03/in-cambodia-health-coverage-is-being-extended-to-some-stakeholders-in-the-informal-sector/?lang=en.

Ir, Por, Bart Jacobs, Augustine D Asante, Marco Liverani, Stephen Jan, Srean Chhim, and Virginia Wiseman. 2019. "Exploring the Determinants of Distress Health Financing in Cambodia." *Health Policy and Planning* 34 (Supplement 1): i26–37.

Jain, B., and M. Srey. 2020. *Expanding Health Equity Fund Coverage for People Living with HIV in Cambodia: Costing and Policy Options*. Washington, DC: Palladium, Health Policy Plus.

Kolesar, R. J, S. Pheakdey, B. Jacobs, N. Chan, S. Yok, and M. Audibert. 2020. "Expanding Social Health Protection in Cambodia: An Assessment of the Current Coverage Potential, Gaps, and Social Equity Considerations." *International Social Security Review* 73 (1).

Kolesar, R., Sambo Pheakdey, Bart Jacobs, and Rebecca Ross. 2019. "Healthcare Access among Cambodia's Poor: An Econometric Examination of Rural Care-Seeking and out-of-Pocket Expenditure." *International Journal of Health Economics and Policy* 4: 122–31.

Mathauer, Inke, Elina Dale, and Bruno Meessen. 2017. *Strategic Purchasing for Universal Health Coverage: Key Policy Issues and Questions*. WHO.

NSFF. 2020. *Report on Annual Achievements 2020 and Action Plans of the National Social Security Fund (NSFF).*

Ozawa, S., and D. Walker. 2011. "Comparison of Trust in Public vs. Private Health Care Providers in Rural Cambodia." *Health Policy and Planning* 26 (1): i20–29.

Peou, E., and J. Depasse. 2012. *National Client Satisfaction Survey: Healthcare Services at Public Health Facilities in Cambodia—Baseline Report. Cambodia Ministry of Health.*

Pheakdey, Sambo, Narith Chan, Robert John Kolesar, and Chantha Chak. 2020. "Improving Health Service Quality in the Kingdom of Cambodia: A Policy Perspective." *Asia Pacific Journal of Public Health* 32 (8): 426–29.

Shrestha, Maheshwor. 2020. *An Assessment of Cambodia's Cash Transfer Program for the Poor and Vulnerable Households During COVID-19*. World Bank.

UNICEF (United Nations Children's Fund). 2019. *Health and Nutrition UNICEF Country Programme 2019-2023.*

World Bank. 2014. *Cambodia's Rural Health Markets and the Quality of Care*. Knowledge Brief No. 93386.

——. 2017. *Cambodia - Sustaining Strong Growth for the Benefit of All.*

——. 2021. "The World Bank in Cambodia: Overview", available at: https://www.worldbank.org/en/country/cambodia/overview.

——. n.d. "Cambodia, Annual GDP Growth", The World Bank Data. Available at: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=KH. Accessed 2 May 2021.

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