DATA COLLECTION SURVEY
ON
THE SOCIAL HEALTH PROTECTION SYSTEM
IN
THE KINGDOM OF CAMBODIA

MAY 2016

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

GLOBAL LINK MANAGEMENT, INC.

HM
JR
16-026

Exchange Rate

US$ 1 = ¥ 111.10

1 Cambodian Riels = ¥ 0.03

（JICA Rate in May 2016）

US$ 1 = 4,000 Cambodian Riels

LIST OF ACRONYMS/ABBREVIATIONS

Acronyms/ Abbreviations	Standard Nomenclature
ABT	Action Based Thoughts Consulting Firm
AD	Administrative District
AFD	Agence Française de Développement/ French Development Agency
AFH	Action For Health
ANC	Antenatal Care
ASEAN	Association of Southeast Asian Nations
BFH	Buddhism For Health
CARD	Council for Agriculture and Rural Development
CBHI	Community Based Health Insurance
CBO	Community Based Organization
CGD	Comptroller General's Department
CHC	Cambodian Health Committee
CHPF	Community Health Protection Fund
CMHEF	Community Managed Health Equity Fund
CMU	Couverture Maladie Universelle (= universal health care benefit plans)
CPA	Complementary Package of Activities
CPMI	Cambodian People Micro Insurance
CRVS	Civil Registration and Vital Statistics
CSMBS	Civil Servant Medical Benefit Scheme
CT	Computed Tomography
DFAT	Department of Foreign Affairs and Trade
DPHI	Department of Planning and Health Information
DPL	Development Policy Loan
DRG	Diagnosis Related Group
EPI	Expanded Program on Immunization
EPOS	EPOS Health Management
EY	Ernst & Young
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit /German Corporation for International Cooperation
GMAC	Garment Manufacturers Association in Cambodia
GNI	Gross National Income
GRET	Group de Recherche et Déchanges Technologiques/ Group For Research and Technology Exchanges
HCMC	Health Center Management Committee
HEF	Health Equity Fund
HEFI	Health Equity Fund Implementer
HEFO	Health Equity Fund Operator
H-EQIP	Health Equity and Quality Improvement Project
HFG	Health Finance and Governance
HiP	Health Insurance Project
HIRA	Health Insurance Review Agency
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HSSP	Health Sector Support Program
ID	Identification
ILO	International Labour Organization

IMCI	Integrated Management of Childhood Illness
IPD	Inpatient Department
IPIS	Integrated Population Identification System
IT	Information Technology
IUD	Intra-Uterine Device
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau Bankengruppe/German Development Bank
KHANA	Khmer HIV/AIDS NGO Alliance
Kid-C	Khmer Identity Code
KOICA	Korea International Cooperation Agency
MEF	Ministry of Economy and Finance
MLVT	Ministry of Labor and Vocational Training
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Interior
MOP	Ministry of Planning
MOU	Memorandum of Understanding
MPA	Minimum Package of Activities
MRI	Magnetic Resonanse Imaging
MSAVYR	Ministry of Social Affairs, Veterans and Youth Rehabilitation
NCD	Non-Communicable Disease
NCDD	National Committee for Sub-national Democratic Development
NGO	Non-Governmental Organization
NHI	National Health Insurance
NHSO	National Health Security Office
NIF	National Insurance Fund
NIFO	National Insurance Fund Operator
NSPI	National Strategic Plan on Identification
NSSF	National Social Security Fund
NSSF-C	National Social Security Fund for Civil Servants
NSPS	National Social Protection Strategy for the Poor and Vulnerable
OD	Operational District
ODA	Official Development Assistance
OPD	Outpatient Department
PAC	Priority Access Card
PAE	Public Administration Enterprise
PFM	Public Financial Management
PHD	Provincial Health Department
PKMI	Prevoir Kampuchea Micro Life Insurance Plc.
PMHEF	Pagoda Managed HEF
PMRS	Patient Management and Registration System
PNC	Postnatal Care
P4H	Providing for Health
P4HC+	Providing for Health in Cambodia+
P4P	Pay for Performance
QI	Quality Indicator
SD	Standard Deviation
SDC	Swiss Agency for Development and Cooperation
SDG	Service Delivery Grant

SHI	Social Health Insurance
SKY	Sokapheap Krousat Yeugn/Our Family's Health
SOA	Special Operating Agency
SSDM	Social Service Delivery Mechanism
SSF	Social Security Fund
SSO	Social Security Office
SSS	Social Security Scheme
STSA	Sahakum Theanea Rab Rong Sokhapheap Srok Pratekbat Angkor Chum/Angkor Chum OD Cooperative Health Insurance
SUB	Government Subsidy
TA	Technical Assistance
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNTAC	United Nations Transitional Authority in Cambodia
USA	United States of America
USAID	United States Agency for International Development
URC	University Research Co.
VHI	Voluntary Health Insurance
VMA	Voucher Management Agency
VRG	Village Representative Group
WHO	World Health Organization

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EXECUTIVE SUMMARY

The Data Collection Survey on the the Social Health Protection System in the Kingdom of Cambodia was conducted with two objectives: (1) to analyze the current status, issues and needs of the social health protection system in Cambodia and (2) to make recommendations to Japan International Cooperation Agency (JICA) for a new cooperation program in the area of social health protection. The Survey consists of five activities: (1) interviews with Cambodian government officials, health service and health protection providers, and development partners, (2) a household survey on people's behavior and perceptions of health services and health protection, (3) a study tour to Japan, (4) a study tour to a country in the Association of Southeast Asian Nations (ASEAN), and (5) a workshop in Cambodia. The active survey methods of the study tours and the workshop clarified the issues in regard to enhancing a social health protection system in Cambodia and resulted in concrete ideas for JICA's possible assistance.

Although the population of Cambodia is still young today, it is estimated that aging will progress rapidly. Cambodia is forecasted to become an aging society with 7% of aged population (65+ years) in 2030-2035. As the economy grows, industrial and employment composition changes, and consequently the population will be no longer allowed to depend on the traditional family safety net. Therefore, social health protection system should be developed in the country urgently.

While decentralization process was initiated in the health sector, most executive responsibility is still held by the central government in Cambodia.The health referral system functions for the Health Equity Fund (HEF) beneficiaries, and those who pay user fees can access any level of health facility freely. In principle, drugs and medical equipment are provided to health facilities by the Ministry of Health (MOH), however, when they are insufficient, health facilities are expected to fill the gap. Adoption of Special Operating Agency (SOA), a performance-based incentivization system, has improved the quality of health services.

Although a national certificate system for medical practitioners has still not been introduced in Cambodia, the national graduation examination has been practiced since 2013. It is recognized that salaries for the health service providers in the public health institutions are not enough to maintain daily living expenses, therefore many doctors as well as nurses who work at the public health facilities also work at private facilities or their own private practices/clinics. However, this dual practice is considered to be one of the factors to lower quality of care at the public health institutions.

Curently 20% of total health expenditure accounts for the Royal Government of Cambodia, another 20% for development partners and the remaining 60% for out-of-pocket payment. The proportion of out of pocket payment has been icreasing slightly since 2008. For the health facilities, user fees, including payments from HEF and other insurers, are an important source of income. Based on the ordinances of the Ministry of Health (MOH) and the Ministry of

Economy and Finance (MEF), 60% of user fees can be used as staff incentives, 39% for operations, purchase of drugs and equipment and infrastructure development, and 1% transferred to the National Treasury. In Cambodia, medical fees are decided by each health facility, which has created diaparity not only in user fee itself, but quality of care, even among the public health facilities. To achieve Universal Health Coverage (UHC), reducing such disparity in medical fees should be considered.

There are a number of social health protection programs in Cambodia which contributed to improvement of people's health in the past decade. However, few programs have covered the target population sufficiently. There should be an efoort to establish a system to effectively cover the entire nation.

The findings of the household survey suggested that the people in Kampong Cham and Siem Reap provinces generally accept the health care at public health facilities and they are satisfied when they use the services. However, "expenses" were identifed as a major problem particularly for a referral. Less than 20% responded that they have knowledge on social health insurance, however, all who experienced use of the health insurance responded that they were "grateful and necessary for their lives" as their impression of the scheme. After explaination of health insurance, 80.0% of them said that were willing to join the health insurance scheme, and more than half of them responded that they were willing to pay for the health insurance up to 10,000 riels (US$2.50) per person per year and 21.0% were willing to pay more than 10,000 riels. For a health insurance operated by a pagoda, 34.7% responded that they would pay more than 10,000 riels. The survey found different attitudes and perception towarads social health protection in Siem Reap and Kampong Cham provinces, which suggests further investigation and analyses of the factors behind the difference to be utilized in the course of social helath protection system development.

Currently, social health protection policy framework is actively developed by the Technical Working Group (TWG) comprising interminsterial members. It is recommended for JICA to assist the development process, particularly for that of the informal sector[1] which few development partners are currently assisting. As Cambodia wishes to adopt the social health insurance for the informal sector which accounts for 80% of the population, JICA should assist the Cambodian government's efforts in developing the system by applying the own experience of developing the original community-based health insurance system for the informal sector in Japan. The three options: (1) health financial mechanism development, (2) social insurance information and premium collection systems development, and (3) enrolement advocacy and promotion, are particularly recommended for JICA to pursue as their assistance program(s) for the next six to seven years.

[1] "Informal sector" is defined as "all people who are not covered by any emplyees' insurance" in this report.

CHAPTER 1 Overview of the Survey

1-1 Background

Universal Health Coverage (UHC) is defined by the World Health Organization (WHO) as "all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[2] However, in reality, 150 million people in the world are suffering from catastrophic expenditures for medical services every year. In order to avoid impoverishment by medical payment and achieve UHC, it is necessary to improve the social health protection system while enhancing healthcare delivery system in a country.

In Cambodia, out of pocket payment for medical services accounts for more than 60% of total health expenditures and it has become a serious financial burden on the people, falling into indebtness or further impoverishment.[3,4] Improving the social health protection system has become an urgent issue in the country as it has been increasingly difficult for the people, particularly the poor and the near poor, to financially access medical services.

Under the circumstances, MOH in Cambodia is implementing the Health Equity Fund (HEF) for the poor. In fact, there are also a variety of health protection programs implemented by development partners and non-governmental organizations (NGOs) in the country. However, no program has covered sufficient area and population. MOH has drafted the Health Financial Policy and intends to build a holistic social health protection system for the entire informal sector[5]. However, there are a number of organizational, judicial as well as financial issues that the Ministry must resolve, such as the establishment of the administrative body for the health insurance scheme, transition of the insurance from voluntary to compulsory, and improving quality of the service at the public health institutions, while enhancing the social health protection system.

Meanwhile, UHC has been identified as one of the major strategic areas in the Japanese global health policy and it is expected for Japan to spontaneously contribute to promoting UHC in developing countries by applying its own experience of achieving and sustaining UHC for more than 50 years.

MOH has requested that the Japan International Cooperation Agency (JICA) assist the Ministry to improve the social health protection system in the country and, based on that request, JICA has dispatched the Data Collection Survey Team to analyze the current situation and make recommendations to JICA for the assistance program planning.

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[2] WHO. Health financing for universal coverage. http://www.who.int/health_financing/universal_coverage_definition/en/

[3] Ir P. et al. (2012). Toward a typology of health-related informal credit: an exploration of borrowing practices for paying for health care by the poor in Cambodia. BMC Health Serv. Res. Nov. 7; 12: 383.

[4] Van Damme W. et al. (2004). Out-of-pocket health expenditure and debt in poor households: evidence from Cambodia. Trop Med Int Health. Feb. 9(2): 273-80.

[5] "Informal sector" is defined as "all people who are not covered by any emplyees' insurance" in this report.

1-2 Objectives

This survey aims (1) to analyse the current status, issues and needs of the social health protection system in Cambodia, and (2) to make recommendations to JICA for a new cooperation project/program in the area of social health protection.

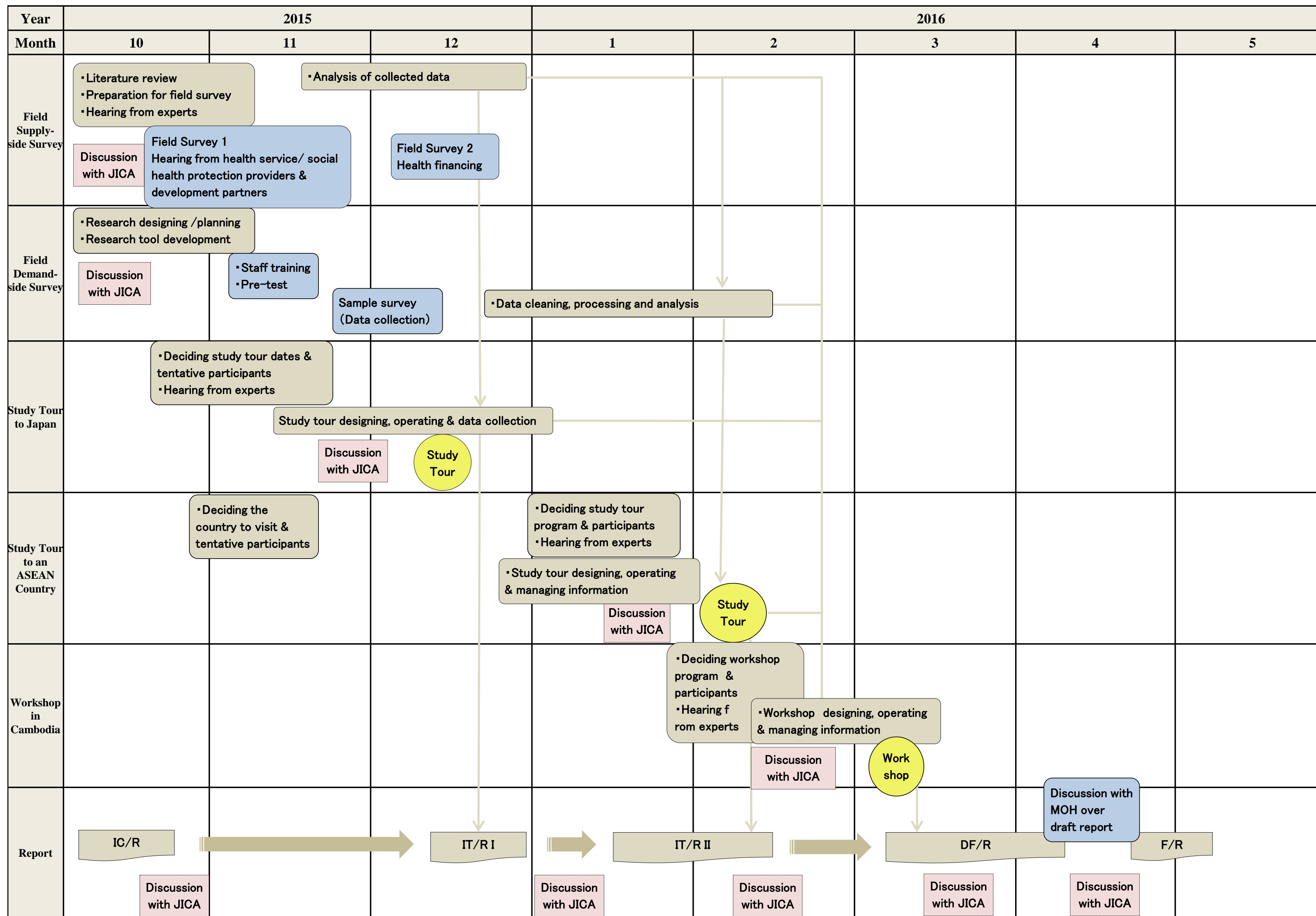
1-3 Contents

The Data Collection Survey consists of five activities: (1) a Field Supply-side Survey, (2) a Field Demand-side Survey, (3) a Study Tour to Japan, (4) a Study Tour to an ASEAN Country, and (5) a Workshop in Cambodia. Through the study tours and workshop, the Survey Team attempted to draw out the Cambodian government's assistance needs in social health protection and JICA's possible future assistance, while learning about and discussing the social health protection systems in other countries. Figure 1-1 shows the schedule of the survey activities. The summary of each survey activity is as follows.

(1) Field Supply-side Survey

The Survey Team conducted interviews with health service providers, people concerned with social health protection, and development partners (hereinafter the Supply-side Survey) for five weeks from October 18 to November 14 (Field Survey 1), and December 7 to 12 (Field Survey 2). The Survey Team visited five geographical areas: Phnom Penh, Kampong Cham, Siem Reap provinces, Takeo and Kampong Thom provinces. The five sites were selected as the target of the Supply-side survey because Phnom Penh is the capital of Cambodia, Kampong Cham is the province where JICA has been providing assistance intensively, and Siem Reap, Takeo and Kampong Thom are the provinces known for good practice of the Community-based Health Insurance (CBHI). During Field Survey 1, the Survey Team captured the current status of health service delivery and social health protection in the country. In Field Survey 2, the Survey Team focused on health financing issues. Figure 1-2 shows the geographical target areas of the Field Surveys and Attachment 1 contains the list of interviewees.

When interviewing government officials and development partners, the Survey Team explained the background and purpose of the survey, asked them about their activities and concerns, and encouraged them to join the study tours and the workshop. For health providers and people concerned with social health protection, the Survey Team observed their work and asked them about their achievements and challenges. In the meantime, the Survey Team also attended the social protection core group meeting and observed the overview of how the government officials and development partners are working together on the issue of social protection in Cambodia.



※IC/R:Inception Report, IT/R:Interim Report, DF/R:Draft Final Report, F/R:Final Report

Figure 1- 1 Workflow of the Survey

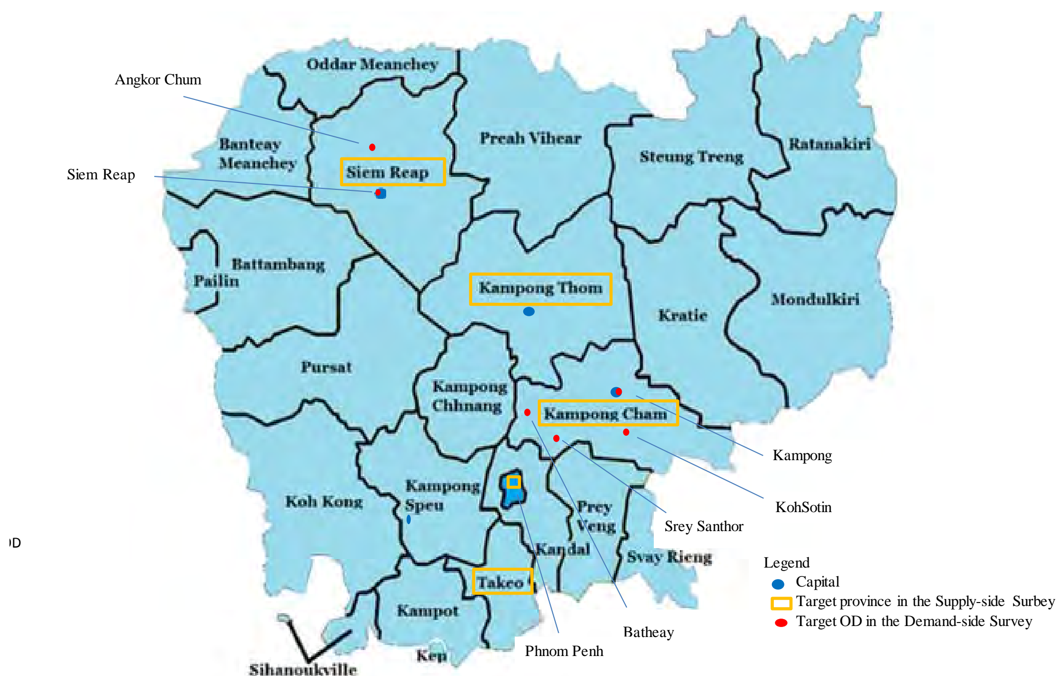


Figure 1- 2 Field Survey Target Provinces and Operational Districts (ODs)[6]

(2) Field Demand-side Survey

Based on the belief that one should understand people's behavior and perception in order to carry out an effective assistance in the particular area, the Survey Team conducted the household survey (hereinafter the Demand-side Survey) on people's behavior and perception towards social health protection.

The Survey Team developed the Demand-side Survey tools based on discussion with local consultants, the Khmer HIV/AIDS NGO Alliance (KHANA) Research Center, for the household survey design, sampling methods and contents of the questionnaire. Training for the data collectors and the pre-test were performed on November 25 and 26, and the data collection was conducted from November 27 to December 6. A total of 306 households were selected, of which six were found to be occupied during data collection. Among these households, 300 completed the questionnaire, yielding a response rate of 98 percent. Data collectors visited the households and conducted face-to-face interviews based on the questionnaire (see Attachment 2). Data collectors were supervised by the Director of the KHANA Research Center. Data were coded and entered into a computerized database by the KHANA data entry staff. Double data entry was performed to minimize entry errors. Finally, the KHANA Research Center submitted the data set as well as the summary of the report to the Survey Team in January 2016.

[6] Operational Health Districts (ODs) are the health administrative divisions described in the 1995 Charter on Health Financing. Each OD covers 100,000 to 200,000 people and will has at least one Referral Hospital and Health Center to cover 10,000 to 20,000 people each.

Table 1- 1 Sampling Frame

Province	OD	Commune	Village	Number of households
Siem Reap	Siem Reap	Krobeiriel	Popil	10
			Boeng	10
		Salakamreuk	Trapaing Treng	10
			Sala Kamreuk	10
		Srorngei	Prey Thom	10
	Angkor Chum	Daunpeng	Roka	10
			Khchas	10
		Kokdaung	Tumloab	10
			Prasat Trav	10
		Norkorpheas	Nokor Pheas2	10
Kampong Cham	Batheay	Batheay	Sras Pring	10
			Batheay	10
		Chbarampov	Chba Ampov	10
			Anlong Chrey	10
		Sambo	Trabek	10
	Kampong Cham/ Kampong Siem	Osvay	Khel Chey	10
			Prey Chakrey	10
		RorAng	Thmor Kol	10
			Tuol Roka	10
		Vealvong	Phoum 5	10
	Koh Sotin	Mohakhghoung	Angkor Chey Leu	10
			Khpob	10
		Pongror	Pong Ror Khang Keut	10
			Kampong Ov Chring	10
		Prektanoung	Phoum 8	10
	Srey Santhor	Pteaskandal	Phteah Kandal Leu	10
			O Leav	10
		Prekrumdeng	Prek Rumdeng (A)	10
			Takoch	10
		KohAndet	Chong Koh	10
			Total	300

Sampling Method

In this survey, a sample size of 300 was calculated by setting response percentage[7] as 50% to collect various types of information, with a confidence level of 95%, and allow a margin of error of ±5.66%.[8] Kampong Cham[9] and Siem Reap provinces were selected as they are part of the target areas of the Supply-side Survey which allow the Survey Team to collect the

[7] This is the percentage of one's sample that picks a particular answer. If 99% of the sample said "Yes," and 1% said "No," the chances of error are remote, irrespective of sample size. However, if the percentages are 51% and 49% the chances of error are much greater.When determining the sample size needed for a given level of accuracy, it is recommended to use the worst case percentage (50%) which ensures that one's sample will be large enough.

[8] Sample size = (z-score of confidence level)² × response rate (1- response rate) / (margin of error)² / 1+ (z-score of confidence level)² × response rate (1- response rate) / population × (z-score of confidence level)²

[9] Kampong Cham was officially divided into two provinces in December 2013: Kampong Cham province and Tbong Khmum province; the current population is 1,090,000 and 800,000, respectively. Howver, the former administrative divisoin was used for sampling in this survey.

complete information of the Supply-side and Demand-side. Another reason to choose the two provinces is their different socio-economic and geographical characteristics which allow better representativeness of the nation. Kampong Cham province is located on the central lowlands of the Mekong River, northeast of Phnom Penh. It is one of the most populated provinces in the nation. Siem Reap is one of the poorest rural northwestern provinces with some tourist spots. According to the 2008 Population Census, the size of the total population in Kampong Cham was twice as large as that in Siem Reap (Kampong Cham: 1,679,819 and Siem Reap: 896,171). Thus, 200 random samples were selected from Kampong Cham province and 100 from Siem Reap province.

Multi-stage sampling was applied. First, by using the provincial OD list in which all ODs are alphabetically listed, out of 12 ODs in Kampong Cham province, the first, the fourth, the seventh, and the tenth ODs were selected. Likewise, the first and the third ODs were selected from the Siem Reap OD list. Secondly, using Commune lists, three Communes from each selected OD were randomly chosen. Third, using village lists, one to two villages were selected randomly from each Commune. Finally, with collaboration from a village chief or health workers in a village, 10 households were randomly selected from each village (see Table 1-1).

Data analysis

Descriptive statistical tests were used to compute means and standard deviations (SDs) for numerical variables as well as frequencies for nominal and ordinal variables to describe the socio-demographic characteristics of the households, utilization of health services and perception of social health protection. $\chi 2$ test or Fisher's exact test[10] was used for categorical variables, and Student's t-test for continuous variables to compare all the above-mentioned variables among households in Kampong Cham and Siem Reap provinces. Two-sided p-values of less than 0.05 were regarded as statistically significant. Furthermore, for statistically significant results of $\chi 2$ test with a degree of freedom≧2, a category with adjusted residual≧1.96 was considered to be a contributor for statistical significance. Stata 13 (StataCorp, Texas, USA) was used for all statistical analyses. Please see Chapter 3 3-5 for the detail of the Demand-side Survey results.

(3) Study Tour to Japan

During five days from December 14 to 18, 2015, the Survey Team received three officials from MOH, another three from the Ministry of Economy and Finance (MEF), two from the Ministry of Planning (MOP: one official was financially supported by the Deutsche Gesellschaft für Internationale [GIZ]), and one each from the Ministry of Interior (MOI), the Ministry of Labor and Vocational Training (MLVT), and the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MSAVYR). Please see the Attachment 3 for participant details.

[10] Following the Cochran's rule, $\chi 2$ test was not performed when more than 20% of all expected frequencies is smaller than 5. Instead, Fisher's Exact Test was perfomed on 2x2 tables, if more than 20% of all expected frequencies is smaller than 5.

Lectures and field visits were provided to support the participants learning about the social health protection system in Japan. Throughout the study tour, the participants discussed among themselves about how they are going to apply the knowledge and experiences they gained during the Study Tour. The Survey Team designed the program by choosing lectures and field visits to meet the current demands of Cambodia based on the results of the Supply-side Survey and advice from experts (see Attachment 4). Even so, the Survey Team conducted a pre-event questionnaire for the participants asking each ministry's roles and responsibilities in social health protection, and their vision and expectations for future social health protection in Cambodia. The results were shared at the opening of discussion session on the last day. Please see Chapter 4, 4-2 for results of the discussion.

The Study Tour to Japan clarified the issues in regard to enhancing a social health protection system in Cambodia, and resulted in concrete ideas for JICA's possible future assistance. As social health protection is a multi-sectoral issue, it is necessary for the related ministries to discuss the issue. However, it was not easy to hold interministorial meetings in Cambodia as all the ministries are fully engaged in their own tasks. Given such circumstances, the Study Tour to Japan became a rare opportunity for the six ministries to spend ample time together and discuss the important issue of Cambodia's pathway to building a social health protection system in the country. In the meantime, this event has also united the participants and encouraged them to work together to achieve their country's most ambitious aim.

(4) Study Tour to an ASEAN Country

The Survey Team with the members of the Study Tour to Japan and an official of the Council for Agriculture and Rural Development (CARD), a leading institution in social protection, visited Thailand from February 1 to 5, 2016. Please see Attachment 5 for the details of the participants. Based on the discussions with Cambodian officials, Thailand was chosen as the country to visit for the following reasons.

1) The cultural and environmental contexts of Thailand are similar to that of Cambodia.

2) The Thai government maintains a centralized sturuture as Cambodia does.

3) Like Cambodia, currently there are three social health protection schemes in Thailand: civil servants', the private sector and the informal sector.

4) Thailand has achieved UHC.

The Study Tour program was designed based on the results of the Supply-side Survey and the Study Tour to Japan, as well as advice from experts (see Attachment 6).

It was an effective intervention for Cambodian officials to learn about the process of achieving UHC in Thailand. The experience has enabled Cambodia to prepare for potential challenges which they may face in the course of social health protection system development. Particularly,

introduction of the Thai tax-based social health protection system for the informal sector, which is different from that in Japan, provided Cambodia with another option for informal sector coverage. On the other hand, it is considered to be beneficial for Cambodia to learn about Thailand's efforts in disease prevention and health promotion to reduce medical costs, and the hardship and challenges they are facing due to the multiple payment system.

Besides JICA officials, a large variety of participants joined the ASEAN Country Study Tour, including observers from the United States Agency for International Development (USAID) and Swiss Development and Cooperation (SDC), and Kenyan government officials.

It is noteworthy that the collective knowledge of social health protection systems in Japan and Thailand were accumulated by the seven related governmental institutions. Please refer to Chapter 4, 4-2 for more details of the Study Tour outcomes.

(5) Workshop in Cambodia

The Workshop was held on March 2 – 3, 2016 in Cambodia to share the results of the Survey with relevant parties, and to pave the way for building the social health protection system in Cambodia. The Survey Team made the Workshop organized by MOH, as this Survey was conducted in response to the request of the Ministry. For the same reason, the workshop theme was decided to be social health protection for the informal sector, which is the target population of MOH. A total of 63 participants, including the Study Tour participants, other ministerial officials, development partners and NGOs, attended the workshop on either one day or for the full program (see Attachment 7).

The first day was a seminar which included: a presentation of the World Bank's study on the efforts of 24 countries towards UHC, "Going Universal," the Japan-World Bank Partnership Program on Universal Health Coverage, "Moving towards universal health coverage: lessons from 11 country studies," a lecture on the social health protection system in Japan, an introduction of JICA's assistance programs in UHC, reports from the Study Tour participants, and presentations of the currect informal sector social health protection in Cambodia. On the second day, after the Survey Team presented the results of the Field Demand-side Survey, small group discussions were held. The participants were grouped into three and worked on three topics each with regard to activities for developing a social health protection system in Cambodia. Each group presented the discussion outcomes and all were summarized by MOH at the end of the Workshop. Please see Attachment 8 for the Workshop program.

Social health protection is a new area for JICA's assistance in Cambodia. Therefeore, the Workshop became an opportunity to present JICA's new initiative to support the area to all the stakeholders. The event has also created a sense of solidarity among the participants and made them determined to work together for developing the informal sector social health protection system in the country.

1-4 Survey Team Members

The Survey Team members are as shown in Table 1-2.

Table 1- 2 Survey Team Members

Name	Expertise and responsibility	Affiliation
Haruyo Nakamura, MHS/MSW	Team Leader / UHC/ Social Health Protection	Global Link Management, Inc.
Kenji Shimazaki, Ph.D	UHC/Social Health Protection	National Graduate Institute for Policy Studies (GRIPS)
Junya Hoshida, MPP	Social Health Protection	National Graduate Institute for Policy Studies (GRIPS)
Yasuo Uchida, Ph.D	Social Health Protection	Doshisha University
Siyan Yi, Ph.D	Health System	Khmer HIV/AIDS NGO Alliance (KHANA)
Yasuo Sumita, MPH	Workshop planning / UHC information collection	Global Link Management, Inc.
Hanae Aida, MPH	Workshop planning / UHC information collection	Global Link Management, Inc.

CHAPTER 2 Socio-Economic Situation in Cambodia

2-1 Ethnicity and Religion

According to the Cambodia Inter-Censal Population Survey 2013 by the National Institute of Statistics,[11] 97.05% of Cambodians' mother tongue is Khmer. Speakers of ethnic minority languages constitute 2.26% and persons with a foreign language as a mother tongue (such as Vietnamese, Thai, Chinese and Lao) are less than 1.0%. About 97.9 % of Cambodian people are Buddhist, the next largest group are Muslims, 1.1%. Highland tribal groups and a few minority religious groups account for 0.6% and Christians are only 0.5% of the population.

2-2 Population Statistics and Future Projections

The estimated population of Cambodia is 15,578,000 in 2015 and it is expected to increase to 15,827,241 by July 2016（population growth rate: 1.5618%, population density: 89 persons per km^2）.[12] It is projected that the total population will continuously increase to 24,485,000 in 2080, with a subsequent decline.

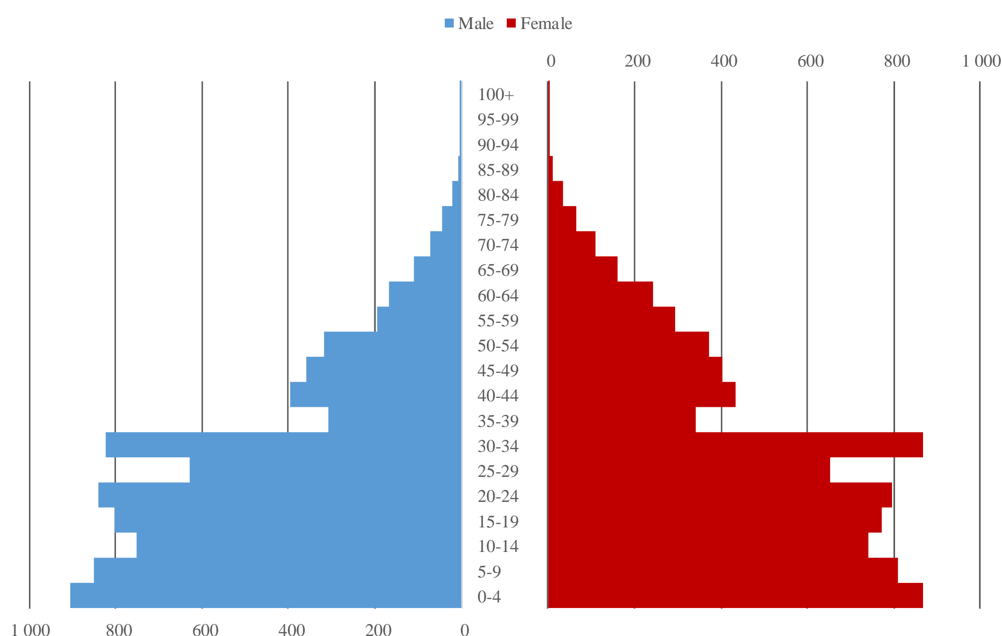


Figure 2- 1 Population pyramids in Cambodia, 2015

Source：Department of Economic and Social Affairs, Population Division, United Nations

The proportion of three age categories (0-14 years, 15-64 years and 65+ years) are 31.6%, 64.3% and 4.1%, respectively, in 2015. The child dependency ratio[13] is 49.2 and the old-age

[11] Ministry of Planning. 2013. National Institute of Statistics. Cambodia Inter-Censal Population Survey 2013 Final Report. http://www.stat.go.jp/info/meetings/cambodia/pdf/ci_fn02.pdf

[12] United Nations, Department of Economic and Social Affairs, Population Division, 2015. http://esa.un.org/unpd/wpp/Publications/Files/WPP2015_Volume-II-Demographic-Profiles.pdf

[13] The child dependency ratio is an age-population ratio of children under the age of 15 and those typically in the labor force (the productive part). It is used to measure the pressure on productive population.

dependency ratio[14] is 6.4, totaling 55.6. The total fertility rate from 2010 to 2015 is 2.7, the under five mortality rate is 35 per 1,000 live births, and average life expectancy is estimated at 67.6 years.

The total fertility rate is similar to Japan in 1955-1960. Life expectancy is also similar to Japan in the 1960s, 67.75 years old. However, the population ratio of people 65+ years is lower than that of Japan in 1950, 4.9%.[15]

The population of Cambodia is still very young; however, it is estimated that aging will progress rapidly.[16] Cambodia is forecasted to become an aging society with 7% of aged people (65+ years) in 2030-2035 and an aged society with 14% of aged people in 2050-2055. The doubling time[17] is projected to be 15 to 25 years which is similar or faster than that of Japan, 24 years. Furthermore, the projections indicate that the proportion of aged people will become more than 21% in 2070- 2075 and Cambodia will be a super aged society, the current situation in Japan.

It is predicted that the labor force ratio (15-64 years) will be 68.0% in 2045 at the highest point and then will decrease, while the dependency ratio will be 47.0% at the lowest in the same year and then will increase. Japan experienced the same transition in the early 1990s. In Cambodia, child dependency is higher than old age dependency (child dependency: 49.2, old-age dependency: 6.4), and it will become the same in 2065 (child dependency: 29.2, old-age dependency: 29.6) and then old-age dependency will become higher. Japan experienced the same transition in the late 1990s. The population aged 0-14 is expected to decrease and it will become 18.4% in 2065 which is the same level as that of Japan in the 1990s.

2-3 Poverty and Economic Disparity

The Gross Domestic Product (GDP) of Cambodia was US$16,777,820,000[18] in 2014, the Gross National Income (GNI) per capita was US$1,020,[19] and the real GDP growth rate stayed around 7% from 2011 to 2014. According to this definition,[20] Cambodia is categorized as a "low-income economy." However, if the GNI per capita in 2015 becomes US$1,046 or higher, Cambodia will be categorized as a "lower-middle-income economy" with the July 2016 revision.[21]

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[14] The old-age dependency ratio is an age-population ratio of those over the age of 64, not in the labor force, and those typically in the labor force (the productive part). It is used to measure the pressure on productive population.
[15] Statistics of Japan 2016, Statistics Bureau, Ministry of Internal Affairs and Communications. http://www.stat.go.jp/data/nihon/02.htm
[16] All the population estimates here are moderate-range estimates.
[17] Number of years required for the proportion of the aged population to move from 7% to 14%. It is an indicator which shows the speed of aging in each country.
[18] At the time of the US$ market price.
[19] Calculated using Atlas method of the World Bank (Converted to the current US$).
[20] The World Bank's country classification by income level takes place in July every year and it uses GNI per capita of the previous years as an indicator. A country with GNI per capita below US$ 1,046 is classified as a "low-income economy" and a country with GNI per capita of US$ 1,046 and above is classified as a "low-middle-income economy."
[21] World Bank Open Data. http://data.worldbank.org/

A survey[22] conducted by the World Bank reported that the national poverty headcount ratio[23] of Cambodia was 17.7% (Urban: 6.4%, Rural 20.8%) in 2012 and the poverty gap ratio[24] was 3.1%. The figure presents the decreasing trend of the national poverty headcount ratio which was 34.0 % (Urban: 15.1%, Rural: 38.5%) in 2008 and 22.1 % (Urban: 8.5%, Rural 25.3%) in 2010. Meanwhile, the Gini Index has changed from 41.1 in 2007 to 30.8 in 2012, which indicates that the income distribution is gradually becoming narrower.

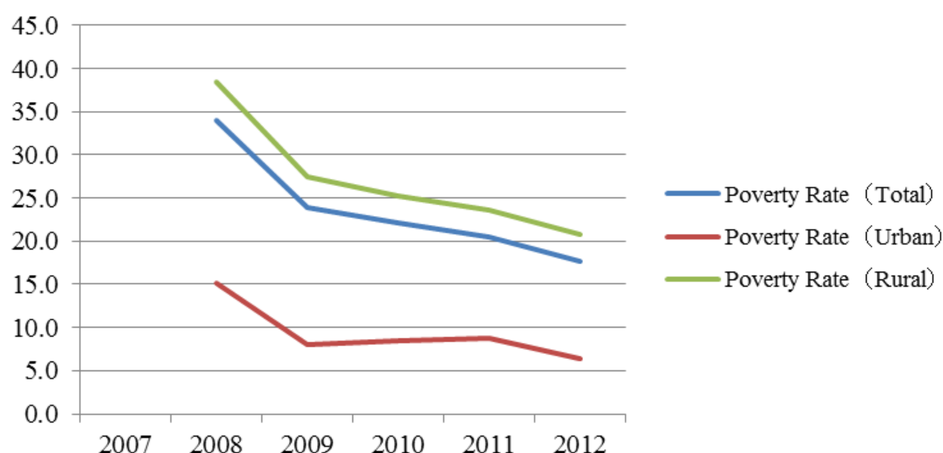

Figure 2- 2 Trends of national poverty headcount ratio, 2007-2012

Source: World Bank. The World Development Indicators

2-4 Industrial Structure and Labour Market

In Cambodia, the composition ratio by industry to GDP in 2013 was as follows: agriculture (28.7%), manufacturing (15.3%), trade (14.4%), construction (8.5%), and finance (8.3%). In 1997, agriculture accounted for 44.4%, while trade was 15.0%, manufacturing was 11.7%, finance was 6.9%, and transport and communication was 5.6%. These changes indicate the shift of industrial composition from agriculture to manufacturing and construction.[25]

The labour force (aged 15-64) of Cambodia in 2014 was 10,001,000 people, and of those, 8,259,000 were considered willing to work. Among those who were willing to work, 8,244,000 were employed and 15,000 were unemployed. The unemployment rate among the labour force is 17.6% and the completely unemployed rate is 0.2%.[26,27]

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[22] World Bank,World Development Indicators. http://data.worldbank.org/country/cambodia
[23] National poverty headcount ratio is the percentage of the population living below the national poverty line which is defined based on both food and non-food consumption in Cambodia. In 2012, these were 5,326 riels in Phnom Penh, 4,273 riels in other urban areas and 3,914 riels in rural areas (Source: World Development Indicators, and Bank staff estimates).
[24] Poverty gap ratio is the mean shortfall of the total population from the poverty line (counting the non-poor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.
[25] Asia Development Bank 2015. Key Indicators for Asia and the Pacific 2015. http://www.adb.org/sites/default/files/publication/175162/cam.pdf
[26] Proportion of people who are both jobless and looking for a job.
[27] Asia Development Bank 2015. Key Indicators for Asia and the Pacific 2015. http://www.adb.org/sites/default/files/publication/175162/cam.pdf

In 2014, 45.3% of Cambodians were engaged in agriculture, a decrease from the 2009 rate that was 57.6%. On the other hand, people working in the service industry increased from 26.5% in 2009 to 30.4% in 2014 and industrial workers increased from 15.9% in 2009 to 24.3% in 2014. The share of paid employees increased from 26.9% in 2009 to 44.4% % in 2014, while the share of unpaid family workers dropped from 23.5% in 2009 to 5.6% in 2014. The most common employment status was self-employment both in 2009 and 2014, and it was 49.2% and 49.6%, respectively. While the statistics data vary,[28,29,30] it is generally estimated that informal sector economy acconts for 80% of the total labor force in Cambodia. One of the issues in Cambodia is child labour and 19.3% of people aged 5-17 were in the labor force and among those, 58.2% were not going to a school.[31]

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[28] Danish Trade Union, Council for International Development Cooperation. (2014). Cambodia Labor Market Profile 2014.
[29] World Bank & Economic Institute of Cambodia. (2008). Cambodia's Labor Market and Employment.
[30] International Labor Organization & Economic Institute of Cambodia (2006). Handbook on Decent Work in the Informal Economy in Cambodia.
[31] Ministry of Planning, National Institute of Statistics. 2015. Cambodia Socio-economic Survey 2014. http://www.nis.gov.kh/nis/CSES/CSES_2014_Report.pdf

CHAPTER 3 Current Status and Challenges of Health Services in Cambodia

3-1 Public Health Service Delivery

(1) Health Services Delivery System in the Public Sector

The current Cambodian public health service delivery system is based on the Health Coverage Plan and ODs that were established in 1995. Each OD is established to cover 100,000 to 200,000 people and to have at least one Referral Hospital and Health Centers to cover 10,000 to 20,000 people each. A Health Post is a public health facility that covers 2,000 to 3,000 people and it is set farther than 15 km away from the next nearest Health Center.

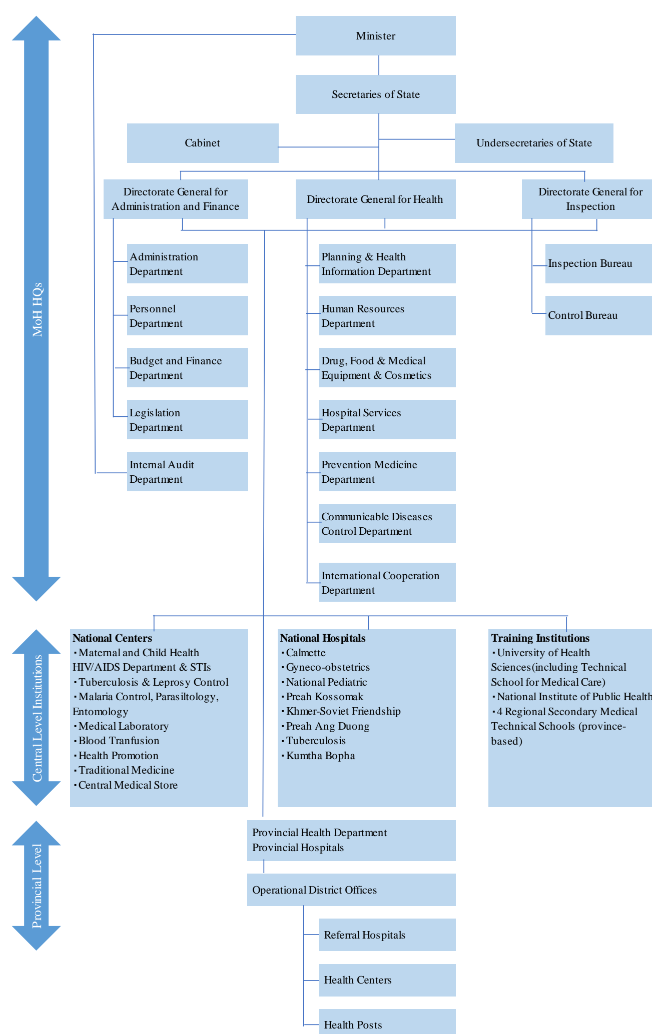


Figure 3- 1 Organogram of the MOH and public health facilities in Cambodia

Source: The Kingdom of Cambodia Health Systems Review & Annual Health Financing Report, 2015

Each health facility provides services based on MOH guidelines (See Table 3-1). A Health Center and a Health Post provide primary care or a Minimum Package of Activities (MPA), and a Referral Hospital and higher-level facilities provide secondary or tertiary care or a

Complementary Package of Activities (CPA). Facilities providing secondary or tertiary care are further divided into CPA 1 to CPA 3 based on their level of service. All eight National Hospitals and 21 Provincial Hospitals are categorized to be CPA 3 facilities. The number of public health facilities is described in Table 3-2.

Table 3- 1 Levels and functions of public health facilities in Cambdodia

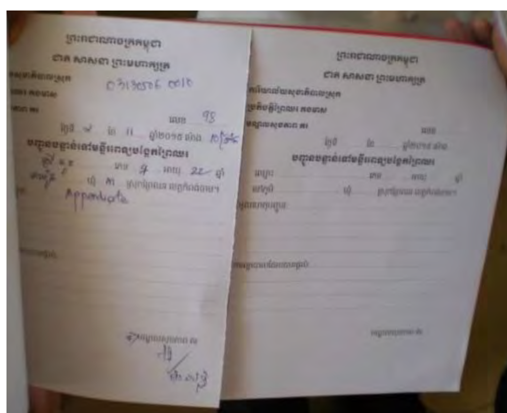
Level of health facilities	Functions required
MPA	Antenatal check-up, delivery, pediatrics, immunization, tuberculosis, malaria, health education and others
CPA 1	Internal medicine, pediatrics, obstetrics/gynecology, outpatient diagnosis, emergency, radiology, sterilization, clinical testing, pharmacy with 40-60 beds
CPA 2	CPA 1 services, surgery, operation with 60-100 beds
CPA 3	CPA 2 services, ophthalmology, otolaryngology, and blood bank with 100-250 beds

Source: The Kingdom of Cambodia Health Systems Review, 2015

Table 3- 2 Number of public health facilities in Cambodia, 2014

Number of Operational Health Districts (ODs)	88
Total number of hospitals	106
Number of National Hospitals including MCH	8
Number of Referral Hospitals	98
Number of Referral Hospitals (CPA1)	51
Number of Referral Hospitals (CPA2)	29
Number of Referral Hospitals (CPA3)	18
Number of Health Centers	1,105
Number of Health Posts	106
Number of Beds	12,249

Source: Annual Health Financing Report 2015



(Two copies are made and one is to be kept in the referring health facility)

Figure 3- 2 Standardized Referral Formats

In Kampong Cham, Siem Reap and Kampong Thom provinces where the Field Supply-side Survey was conducted, a referral system and standardized referral formats were observed (see Figure 3-2). However, in reality, the referral system only functions for HEF beneficiaries[32] and those who pay user fees can access any level of health facility freely (Free-Access). Specifically, the people prefer going directly to a Referral Hospital because there are many specialists in the hospital and the waiting time is not as long as a Health Center (see Figure 3-3). Under "Free-Access," people go to a health facility that has a good reputation, and consequently a popular hospital receives patients that exceed its physical capacity. The hospital put beds in the corridors to accommodate the excess patients (see Figure 3-4). This is not the case for emergency, as a notice of an emergency patient is sent to a hub hospital in the region (i.e. Calmette Hospital in Phnom Penh), and the hub hospital appoints a suitable hospital to receive the patient.

(People waiting to see a doctor)

Figure 3- 3   A Health Center in Siem Reap province

(Overflow patients acommodated in the corridor)

Figure 3- 4   A Referral Hospital in Angkor Chum OD

[32] It is required for a HEF patient to initially go to the nearest Health Center or Health Post and he/she goes to a higher-level health facility only if the MPA facility decides that it cannot treat the patient.

Although health facilities are typically crowded in the morning, many health facilities including Health Centers operate for the whole day, and some open 24 hours a day and/or provide outreach services for remote villages to meet the needs of the people. In Cambodia, as Traditional Birth Attendant (TBA) was abolished in 2009[33], about 83% of children are delivered at health facilities today,[34] of which half are taking place at Health Centers.[35]

In principle, drugs and medical equipment are provided to health facilities by MOH; however, sometimes they are inadequate. In such cases, health facilities use their revenue from user fees to fill the gap. When a health facility cannot afford to buy large medical equipment (i.e. CT or MRI machines), they lease equipment in some cases. Some provincial health practitioners express their concerns that some patients still have to go to Phnom Penh for examination or consultation as the provincial facilities are not sufficiently equipped. Furthermore, medical doctors who have acquired the latest skills are usually reluctant to stay at a provincial hospital as they are not able to apply their skills there.[36]

Establishment of a new public health facility is considered based on a request from a village. A village which wishes to have a new health facility submits a request to a Commune Council. When the Commune Council accepts the request, the request goes to an OD, a Provincial Health Department (PHD),[37] and a final decision is made at MOH. For establishment of a private health facility, one should apply to the PHD[38] if one's facility only has out-patient department (OPD), and to MOH if the facility has both OPD and in-patient department (IPD).

In regards to health service delivery in a particular community, a PHD, an OD and a Health Center set up a committee and discuss the activities and concerns at the health facilities, and have regular consultation meetings with Provincial and District government officials and other sectoral organizations as well as development partners. PHD assesses Health Centers and Health Posts, and improves the health service delivery system in each province with MOH. PHD also visits and monitors private health facilities within the province, and provides health services with private health facilities in a coordinated manner when necessary.[39]

MOH adopted SOA to improve the quality of health services (see BOX 3-1). SOA was enacted in 2006 to improve the quality of public services. The requirement for a SOA is set by each ministry and MOH has defined it as service delivery institutions under the direct control of MOH which includes Provincial Hospitals as well as ODs. As of 2014, 26 ODs and 10 Provincial Hospitals are designated as SOA.[40]

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[33] A TBA receives 1.25 USD when she brings a pregnant woman to a health facility, which has promoted institutional delivery. (Source: Interview with STSA, November 9, 2015)
[34] Cambodia Demographic Health Survey (2014).
[35] Interview with the Director of the Kampong Cham Health Centers (November 2, 2015).
[36] Interview with the Director of the Kampong Cham Provincial Hospital (October 30, 2015).
[37] Administrative subdivision under district.
[38] The function will be transferred to the Provincial Government.
[39] Interview with the staff at Health Center in Kampong Cham Province (October 30, 2015).
[40] The Kingdom of Cambodia Health System Review (2015).

BOX 3- 1 Special Operating Agency (SOA) and Service Delivery Grant (SDG)

MOH encourages health institutions to become a Special Operating Agency (SOA) for the following four objectives:

1. Improve the quality and delivery of government health services in response to health needs;

2. Change the behaviour of health sector staff gradually towards the principles of motivation, loyalty, service and professionalism;

3. Promote prudent, effective and transparent performance based management;

4. Develop sustainable service delivery capacity within the available resources.

MOH signs a performance contract with the Directorate of the Provincial Health Department (PHD), which in turn signs a service delivery agreement with the respective SOA (the OD office) and the Provincial Hospital. Referral Hospitals and Heatlh Centers are eligible to sign a contract with the supervising OD, if the OD becomes a SOA.

In some cases, health facilities sign performance agreements with the health staff.

PHDs, ODs and Provincial Hospitals must exceed the standard of readiness criteria based on MOH Assessment Tools. The contracting process is as follows:

- MOH signs a Performance Agreement with each PHD based on the Three Year Rolling Plan. Performance Agreement should include management standards of health facilities, medium term objectives for health facility improvement in the province, and specific targets for the coming year based on the Annual Operational Plan.

- A PHD signs a Service Delivery Management Contract with a prospective SOA (i.e. ODs and Provincial Hospital). The Contract should include roles of a PHD and a SOA, a contract period, types of service provided, objectives, financial plan, quality standards of services, performance management and payment methods.

- A SOA signs a sub contract with a Referral Hospital, a Health Center and a Health Post if appropriate.

A SOA enjoys a greater degree of flexibility in budget allocation, supported by Program-based budgeting, and receives additional discretionary funds, called a "Service Delivery Grant (SDG)." The funding source of SDG is a pooled fund of Health Sector Support Program (HSSP2) which is financed by development partners and MOH.

- The amount of SDG for each SOA is determined by a fixed allocation estimated by budget unit per person multiplied by the population of the area, with variable allocation with consideration of other subsidies, geographical and environmental conditions, number and level of health facilities. Eighty percent of SDG is paid in advance, with 65% for staff incentives and the remainder for operating costs; and the remaining 20% is designated as an SOA performance-based payment and is paid upon verification of services delivered.

SDG directly passes to ODs and Provincial Hospitals based on the Annual Operational Plan and Service Delivery Management Contract.

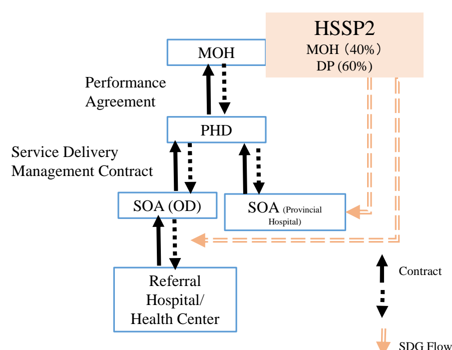


Figure 3- 5 Contracting arrangements of SOA and financial flows of SDG

Source: The Kingdom of Cambodia Health System Review (2015).
Service Delivery Grants-Operational Manual, 2008

In Cambodia, although a decentralization process was initiated in 2001, most executive responsibility is still held by the central government. Today, MOH is encouraged to start a pilot project in 2016 by the National Committee for Sub-national Democratic Development (NCDD), an interministorial committee in which the Ministry of Interior (MOI) is playing a central role. NCDD is requesting MOH to reconsider the health administration system, including such issues as "the role of an OD" as it is only MOH that uses an OD and all other ministries use an Administrative District (AD) as an administrative subdivision.

(2) Health Workforce

Although a national certificate system for medical practitioners has not yet been introduced in Cambodia, the national graduation examination system for dentists, pharmacists, and nurses with bachelor's degrees started in 2013 and that for medical doctors did in 2014. It is also expected that the examination system for midwives with bachelor's degrees will begin in 2016.[41] Graduates are required to be registered with their respective health professional council, e.g. medical doctors with the Medical Council, and nurses with the Nurse Council. Although the number of training institutions is increasing in Cambodia today, they are still facing a number of challenges, such as a lack of standardized teaching materials and teachers' limited knowledge, clinical experiences and teaching skills to train good quality health personnel. Newly recruitees who passed recruitment examination will be on the payroll. Retirees who are still on the payroll in case they are appointed as divisors or assistants. Table 3-3 shows the number of health workers in the public health sector.

Medical doctors are stationed at Referral Hospitals and higher level health facilities, and nurses and midwives are the main workforce at Health Centers and Health Posts. It is recognized that salaries for the health service providers in the public health institutions are not enough to maintain daily living expenses, therefore many doctors as well as nurses who work at the public health facilities also work at private facilities or their own private practices/clinics. Furthermore, it is reported that some medical doctors who work in both public institutions and their own private clinics guide patients of the former to the latter and provide them with better treatment. In Cambodia's Quality of Care Study, conducted by the World Bank in 2013, reported that a private health service provider dedicates more time communicating with each patient than a public health service provider.[42] This dual practice is one of the causes that lower quality of care at the public health institutions. Thus, some people concerned insist that the government should pay the public health service providers sufficient salaries in order to abolish the dual practice.[43]

[41] Information provded by JICA Project for Strengthening Human Resources Development System of Co-medicals.
[42] World Bank. 2013. Cambodia's Quality of Care Survey.
[43] Interview with Director of the Kampong Cham Provincial Hospital (October 30, 2015).

Table 3- 3 Number, geographical distribution and salary of health workers by professional category

Professional category/cadre (Public sector only)	2010		2011		Central level (%)2	Average monthly salary (US$)3
	Number	HW1/ 1000 population 1	Number	HW/ 1000 population		
Genaral medical practitioners	2,292	0.166	2,144	0.152	40.3	135
Special medical practitioners	91	0.007	351	0.025	74.4	153
Physician assistants/ Health officers	911	0.066	796	0.057	23.6	122
Graduate/registered/professional nurses	5,182	0.374	5,389	0.383	21.7	79
Vocational/ enrolled practical nurses	3,311	0.239	3,260	0.232	2.6	55
Midwives	1,924	0.139	2,053	0.146	12.3	79
Primary midwives	1,834	0.133	1,997	0.142	0.5	55
Dentisits	190	0.014	230	0.016	40.9	134
Dental assistants and therapists	52	0.004	62	0.004	12.9	122
Pharmacists	446	0.032	489	0.035	43.6	134
Pharmaceutical assistants	102	0.007	92	0.007	48.9	122
Physiotherapists	125	0.009	137	0.01	32.8	79
Radiological technology and therapeutic equipment operators	14	0.001	17	0.001	5.9	79
Laboratory technicians	520	0.038	509	0.036	42.6	79
Skilled administratitive staff	33	0.002	71	0.005	36.6	106
Accountants	103	0.007	144	0.001	36.8	106
Information and communications technology proffessionals	34	0.002	49	0.003	73.5	106
Building caretakers	87	0.006	94	0.007	14.9	41
Drivers	52	0.004	65	0.005	30.8	45
Other health support staff	830	0.06	647	0.046	31.8	—

1 HW: Health Workers

2 Central level includes: Ministry of Health Headquarters, the University of Health Sciences, national centres, national institutions and six national hospitals in Phnom Penh.

3 Based on 2011 data

Source: WHO Human Resource for Health Country Profiles Cambodia, 2014

Many facilities visited during the Survey reported that the staff became well motivated and quality of health services improved due to SDG incentive system. In Kampong Thom province, Pay for Performance (P4P),[44] a performance-based payment system, is applied, and as a result, has also improved performance of the staff.[45]

[44] Under the P4P, bonuses are not provided if one's performance evaluation score does not reach 50% of the total. However, it does not discourage medical providers as the evaluation is conducted every quarter; even if one fails in one quarter, one can try to receive a bonus in the next.

[45] Interview at the Kampong Thom HEFO (November 3, 2015).

(3) Health Financing

Table 3-4 shows the current circumstances surrounding health financing in Cambodia. Curently, 20% of total health expenditure accounts are from the Royal Government of Cambodia, another 20% from development partners and the remaining 60% are from out of pocket payments. The proportion of out of pocket payment has been increasing slightly since 2008. Even though the total health expenditure doubled in the last eight years, it should be noted that the national budget and the health budget both doubled in the same period, and the proportion of government contribution to the total health expenditure still decreased. On the other hand, contributions of social health insurance accounted for only 0.2% of the total health expenditure in 2012.[46]

Table 3- 4 Health Financing in Cambodia (2008–2014)

	2008		2014	
1 Macroeconomic indicator				
GDP(million US$)	10,337		18,040	
Population (million)	13.4		15.2	
GDP per capita (US$)	772		1,188	
2 Total government budget				
Total government budget (million US$)	1,638		3,187	
Total government budget as % of GDP	15.8%		17.7%	
3 Government budget for health				
Govt budget for health (million US$)	111		241	
Govt health budget as % of GDP	1.1%		1.3%	
% of total government budget	6.8%		7.6%	
4 Government expenditure on health				
Total health expenditure (THE) (million US$)	550		1,042	
THE as % of GDP	5.3%		5.8%	
5 Distribution of THE (million US$)		**Share**		**Share**
Government	105	19.0%	193	18.5%
External donors	111	20.1%	191	18.3%
Out-of-pocket expenditure	335	60.9%	658	63.2%
6 Expenditure per capita by source (US$)				
Government	7.81		12.71	
External donors	8.27		12.59	
Out-of-pocket expenditure	25.00		43.37	
THE	41.08		68.67	

Source: Annual Health Financing Report, MOH, 2015

MOH provides funding to national hospitals. PHD and MOH channel funding to the ODs, which in turn transfer funds to referral hospitals and health centres for provision of primary and secondary health care. There are also funding channelled through HEF and other health insurance, such as CBHI, work injury scheme of National Social Security Fund (NSSF) and vouchers.[47] The flow of the health financing is shown in Figure 3-6. The survey revealed that the spread of commercial banks in rural areas has contributed to smooth distribution of funds to

[46] Estimating Health Expenditure in Cambodia: National Health Accounts Report (2014).
[47] Annual Health Financing Report (2015).

local governments and health facilities in rural areas.

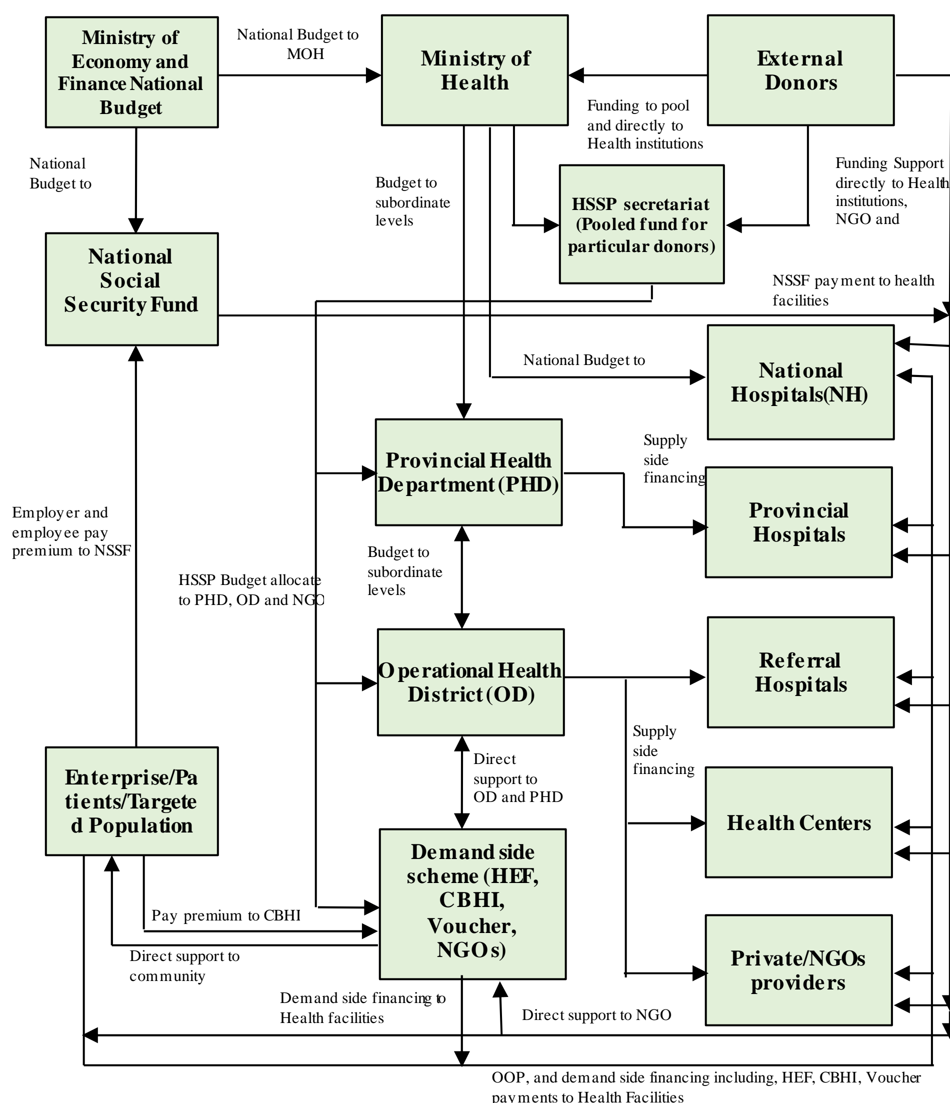


Figure 3- 6 Revenue sources and flows within the public health system

Source: The Kingdom of Cambodia Health System Review, 2015

During the survey, the government draft budget for 2016 was passed in the Parliament. The total national budget for 2016 is US$4,300 million, a 16.1% increase from the previous year. While the budgets for the national development priority sectors - education, labor and agriculture -increased by 28%, 45.8% and 25% respectively, the budget for the health sector merely increased 8.6 % (US$274 million). Informants commented that the slight increase in budget for health may reflect to weak capacity for financial management of health institutions, in addition to the intention to improving efficiency in budget spending. According to the Integrated Fiduciary Assessment and Public Expenditure Review published in 2011 by the World Bank, the procurement cost for drugs is significantly higher than that of the international average and it

increased from 40% of the health budget in 2004 to 46% in 2009. In addition, nearly 60% of the total operational costs accounts for procurement costs and the cost for human resources increased from 13% in 2004 to 20% in 2009.

To increase resources for social health insurance, MOH proposed to MEF the introduction of so-called "sin" taxes for tobacco and alcohol; however, MEF indicated it would not make a decision on this issue until 2018. According to MEF, the rate of the value-added taxes increased in June 2015 and it is difficult to raise the rate again now. Also, as the rapid increase of taxes may affect the growth of the Cambodian economy, MEF is cautious about the introduction of "sin" taxes. On the other hand, it is reportedly decided that a new budget will be allocated to the health related institutions as a pilot in 2016, as the health sector is one of the national priority sectors. The fund is allowed to be used flexibly to cover operational costs, but not personnel expenses. It was explained that a Referral Hospital, for example, will receive 1 million riels (approximately US$250) per month. MEF also commented that they are discussing the introduction of individual income taxes.[48]

For the health facilities, user fees, including payments from social health protection schemes, are an important source of income. Based on MOH and MEF Interministerial *Prakas* (ordinances), 60% of user fees can be used as staff incentives, 39% for operations, including the purchase of drugs and equipment and infrastructure maintenance development, and 1% transferred to the national Treasury. In Cambodia, the price of health services is established by each health facility in consultation with local authorities, representatives of communities and relevant sector at local level and based on capacity to pay of the population. Therefore fee schedules are not consistent across health facilities. A survey of user fees, conducted by the United Nations Population Fund (UNFPA) and other development partners, revealed that there is a disparity in user fees even among the public health facilities. For example, the price of a caesarian section ranges from US$100 to US$250. Among health centers, there is a disparity in user fees and the highest user fees are almost three times as high as the lowest. It is also reported that, in some private facilities, unnecessary cesarean sections or echo diagnoses are performed to increase profits.[49]

In any situation, wealthy people use expensive services, so facilities which set high user fees can generate adequate income to fulfill staffing and infrastructure. On the other hand, facilities with low user fees cannot generate enough income to improve staffing, infrastructure and quality of services after all. Disparate price setting makes it more difficult for health facilities to provide quality health services. To achieve UHC, reducing user fee disparity should also be considered.

[48] Interview with the General Department of Economic and Public Finance, MEF (November 6, 2015).
[49] Interview with UNICEF (November 5, 2015).

Table 3- 5 Social Health Protection Schemes in Cambodia

	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Scheme	**Health Equity Fund (HEF)**	**Government Subsidy (SUB)**	**Community-based Health Insurance (CBHI)**	**Voucher Scheme**	**Integrated Program**	**Community-managed Health Equity Fund (CMHEF)**	**Private Insurance:**	**National Social Security Fund (NSSF)**	**National Social Security Fund for Civil Servants (NSSF-C)**	**Others**
Year of the establishment	2000	2006	1998	2008	—	2004	—	2007	2009	—
Operational management	Health Equity Fund Secretariat, Health Equity Fund Operator (HEFO) and Health Equity Fund Implementer (HEFI)	Health Facilities	NGO, CBO	Voucher Management Agency (VMA)	HEFO in Kampong Thom OD	Health Center Management Committee (HCMC) and BFH	Each company	NSSF	NSSF-C	Development Partners (DPs), NGOs, etc.
Features	Social assistance for "ID Poor" households	Exemption of medical payment by the poor to reduce the financial burden on them and to promote their utilization of public health services	A non-profit voluntary health insurance based in a community that is managed and organized by NGOs and CBOs	A health protection system in which a patient receives a specific health care for free with a voucher. The health facility receives payment from the VMA in exchange for the collected voucher.	A pilot program which combines HEF, CBHI and Voucher Scheme into oneto make it possible to reduce the number of staff and remove the duplicated work, and capture a wider range of the insured population	A scheme that covers transportation costs and food allowances of the vulnerable population by providing them with vouchers	Benefit packages are decided by the insured, but mainly IPD services. There are small-scale insurance, called "micro insurance."	A social insurance program for private employees in which only work injury insurance is currently operated, but it is planned to undertake health insurance and pensions within a few years	- A social health protection scheme for civil servants and their dependents in which only pension is currently operated - There is a plan to integrate NSSF-C with NSSF.	There are a number of health services provided for free with support from DPs, in the area of maternal and child health, malaria, tuberculosis, HIV/AIDS and EPI.
Challenges	・The ID Poor identification is complicated and costly. ・Low utilization is a challenge, but the increased utilization will subsequently increase the burden on the government. ・A rapid growth of patients with non-communicable diseases (NCD) is increasing OPD expenditure.	Hospitals are reluctant to receive use this system as a hospital receives only US$20 as a maximum rate for one consultation and exceeding costs have to be covered by the hospital receiving the patient.	・A small scale operation that does not allow the insurer to collect much premiums. ・The voluntary insurance scheme causes adverse selection. ・The primary financial source for CBHI is premiums and there is no government subsidy.	- Low Utilization of growth monitoring and cervical cancer screening - Some service coverage duplicates with HEF	- Voucher Scheme has not been fully integrated. - Integration of financial resources of HEF and CBHI is not accomplished yet.	—	—	- Retainment of medical staff in NSSF is difficult . - The working space at HQ is inadequate. - NSSF wishes to introduce ID cards with fingerprint authentification to manage the insured, but MOI has not agreed with the plan.	There are 3,000-4,000 retired civil servants every year which burdens on the government.	—
Target population	Pre-ID Poor households identified by Ministry of Planning and post-ID Poor households identified by a HEFO at a health facility	Poor households certified through an interview conducted at a health facility	Informal sector population that is identified as ID Poor	Depends on the program, such as ID poor pregnant women, children under two years, ID poor women in reproductive age, women between 30 and 50 years, people over 50 years, and the disabled	Target population of HEF, CBHI and Voucher Scheme	The vulnerable that ae not covered by HEF, including the elderly, the disabled and pregnant women	All citizens	Employees of private companies with more than eight employees	Civil servants and their dependents	Depends on the health service
Number of beneficiaries	About 3.2 million（2015）	—	About 1.18 million （2015）	About 4 million (2016)	—	—	—	About 1.11 million （2016）	About 0.8 million (2016)	—
Funding source	Government 40% Development Partners 60% (2015)	Government and health facilities	Premiums collected from the insured and development partners' aid	KfW	Funding source of HEF, CBHI and Voucher Scheme	Donation from community people	Premiums collected from the insured and private companies' capital	Premiums collected form private companies	Government	Development Partners
Registered health facilities	Public health facilities : - 1,069 health centers - 138 hospital in provinces - Khmer Soviet Friendship Hospital, as of August 2015	Public health facilities : - National hospitals - 12 Referral hospitals - 152 health centers	Public health facilities	Public health facilities : - 6 National hospitals - 21 Referral hospitals - 280 health centers	Public health facilities	Public health facilities	Public and private health facilities	96 public health facilities in the nation（1~3 facilities per province）, and a few affiliated private clinics	—	Depends on the health service
Benefit package	- Inpatients/outpatient services - Transportation fees - Food allowance for the care-takers - Funeral costs	All the necessary health services	Depends on the operator, but usually limited OPD services	- Pregnancy/delivery, family planning, abortion care - Children's health promotion and nutrition - Cervical cancer prevention and treatment - Cataract check-ups and operation - Rehabilitation	Same as HEF, CBHI and Voucher scheme	Transportation fee to go to a health facility and food allowance for care-takers	There are various benefit packages and the insured choose when they are enrolled.	All the necessary health services	—	—
Premium rate	—	—	Set by the operator (US$ 2.5-8 per person per year)	—	Same as HEF, CBHI and Voucher scheme	—	Depends on the benefit package	—	—	—

3-2 Social Health Protection Schemes in Cambodia

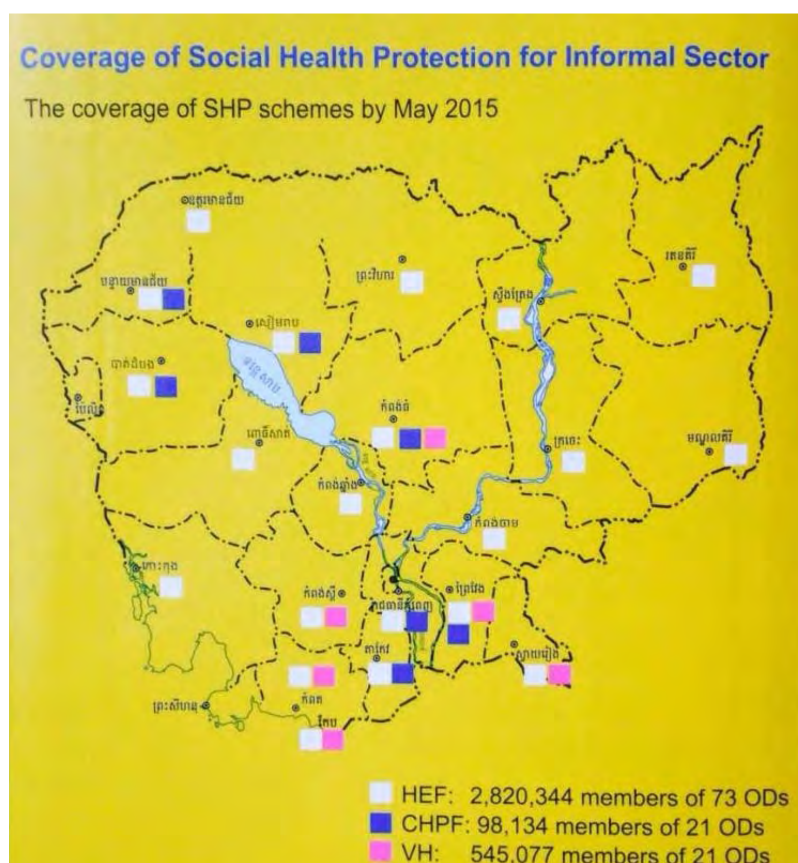
(1) Constitutional Statement

In September 1993, soon after the Paris Peace Accords were signed in 1991, and while the country was still ruled by the United Nations Transitional Authority in Cambodia (UNTAC), the Constitution of the Kingdom of Cambodia was enacted. The Article 72, Chapter 6 of the Constitution stipulates as follows:

CHAPTER VI

EDUCATION, CULTURE, AND SOCIAL AFFAIRS

Article 72: The health of the people shall be guaranteed. The State shall pay attention to disease prevention and medical treatment. Poor people shall receive free medical consultations in public hospitals, infirmaries and maternity clinics. The State shall establish infirmaries and maternity clinics in rural areas.



HEF: Health Equity Fund; CHPF: Community Health Protection Fund; VH: Vucher for Health (= Voucher Scheme)

Figure 3- 7 Coverage of Informal Sector Social Healh Protection Schemes in Cambodia, May 2015

Source : Social Health Protection Association

(2) Social Health Protection Schemes in Cambodia

The currently operated social health protection schems in Cambodia are as shown in Table 3-5. Social health protection is provided for private employees by the National Social Security Fund (NSSF) under the Ministry of Labor and Vocational Training (MLVT), MEF, for civil servants and their families by the National Social Security Fund for Civil Servants (NSSF-C), under the Ministry of Social Affairs Veteran and Youth Rehabilitation (MSAVYR) and MEF, and for the poor by MOH. The following section explains the details of each health protection scheme.

① Health Equity Funds (HEF)

HEF is social assistance for “ID Poor” households. Around 1999, Cambodia started pilot programs[50] in some areas of the country to remove financial barrier in accessing health care by the poor, and HEF was introduced in 2000.[51] A household which is identified as ”ID Poor” receives benefits, including free health care and reimbursement of transportation costs to go to a health facility (See Table 3-6). Essential drugs are also free, but patients must pay for drugs that are not on the essential drug list.

Table 3- 6 HEF Benefit package

Item	National/Provincial Hospitals		Referral Hospitals		Health Centers
	IPD	OPD	IPD	OPD	OPD
User Fees	✓	✓	✓	✓	✓
Transport Reimbursement	✓	✓	Delivery, Attempted Delivery, and Post Abortion Care Only	No	Delivery, Attempted Delivery, and Post Abortion Care Only
Caretaker Food Support	✓	No	Delivery and Attempted Delivery Only	No	No
Funeral Support	✓	✓	No	No	No

Source: Health Equity Fund System Technical Brief, 2015

As of August 2015, it is estimated that around 3,200,000 people (about 20% of the total population) are HEF beneficiaries and HEF had paid for total 1,600,000 cases in 2014. There were 1,069 Health Centers, 138 local hospitals and the Khmer Soviet Friendship Hospital registered as HEF health facilities as of August 2015.[52]

To receive HEF benefits, a household needs to be identified as “ID Poor” by procedures explained below.

1) Pre-ID Poor

[50] Health Equity Funds System Technical Brief (2015).
[51] Asia Pacific Observatory on Health Systems Policies (2015). The Kingdom of Cambodia Health System in Transition Vol.5 No.2.
[52] Health Equity Fund System Technical Brief. (2015).

MOP conducts the ID-Poor (see Chapter 3 3-3 for the detailed procedure) once every three years in each province. Eligible poor household receives an “Equity Card” which is valid for three years (see Figure 3-8).

2) Post-ID Poor

The Post-ID Poor is conducted by a Health Equity Fund Operator (HEFO), stationed at the hospital, for patients who do not have the “Equity Card” and cliam they are poor. The Post-ID poor is conducted through an interview based on the questionnaire (see Attachment 9). The eligible Post-ID poor patients will receive a Priority Access Card (PAC) (see Figure 3-9) which is valid for one year. The information regarding the Post-ID Poor households is to be sent to the MOP’s database and the Post-ID Poor households will be incorporate into the Pre-ID Poor process in the next round.

Figure 3- 8 Equity Card

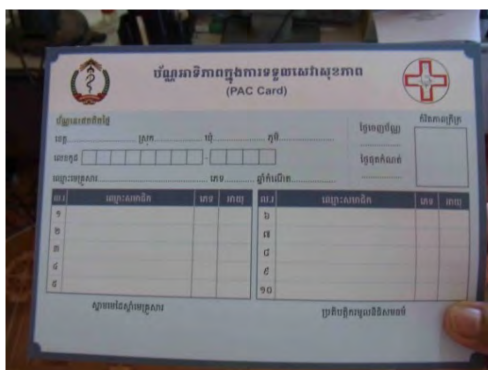


Figure 3- 9 Priority Access Card (PAC)

Forty percent of HEF financial resources come from the Cambodian Government and 60% from pooled funds under the Health Sector Support Program 2 (HSSP2), which is supported by development partners. Based on the rules and regulations of the World Bank, the HSSP2 secretariat signs up a contract, draws up a budget and manages the funds (See the Figure 3-10). The HSSP2 secretariat signs a contract with the HEFO and HEFO signs a contract with each

health facility based on MOH guidelines. A PHD at the provincial level and the OD at the district level organize a committee quarterly to provide technical advice for HEF operation.[53]

The Health Equity Fund Implementer (HEFI) monitors HEFO's activities including verification of claims to the HSSP2 secretariat and conducting home visits and interviews of HEF beneficiaries. University Research Co. (URC), financially supported by USAID, has played the role of HEFI for the past seven years.

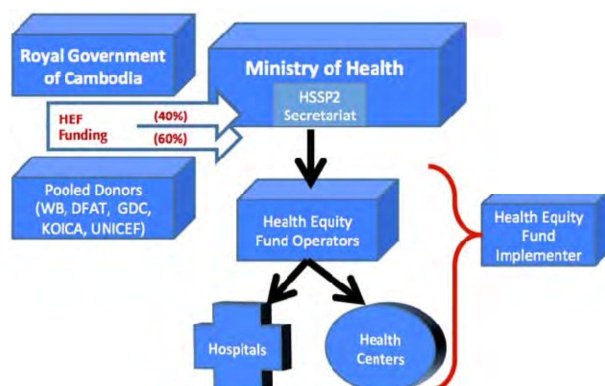


Figure 3- 10 Overview of HEF

Source: Health Equity Fund System Technical Brief, 2015

Table 3- 7 User fees covered under HEF

Direct Benefit Case Categories and Payment Rate	CPA1	CPA2	CPA3*	National Hospitals
Average OPD Cost - Hospitals (including minor surgery)	US$1.5	US$2.0	US$2.5	US$4.5
Average IPD Medical cost (including delivery, attempted delivery with referral, and post-abortion	US$15.0	US$25.0	US$30.0	US$75.0
Average cost of Surgery (excluding minor surgery)	-	US$80.0	US$100.0	US$280.0
Long-Acting Reversible Contraception (IUD/Implants)	US$5.0	US$5.0	US$5.0	US$5.0
Permanent Contraceptive Methods (Vasectomy and Tubal Ligation)	-	US$25.0	US$25.0	US$25.0

*Excluding National Hospital

Source: Health Equity Fund System Technical Brief, 2015

Documentation on HEF beneficiaries is filled at a health institution (see Figure 3-11) and the data are managed by using MOH Patient Management and Registration System (PMRS). The HEF total expenditure in 2014 was US$11,557,675 and breaks down as follows: 77% for the benefit package (user fees, transportation and food allowance for caretaker), 17.1% for HEFO operation costs and 5.4% for HEFI operation costs.[54]

[53] Interview at the Kampong Cham Provincial Health Department (October 30, 2015).
[54] Independent Verification of the Health Equity Fund System Discussion Paper, 2015.

Curently, about half of the contract with HEF Operators is output-based. The payment to the health facilities under the output-based contract is determined by using the Standard HEF Operator Output Units for Management Costs (See Table 3-8). A HEFO assesses the performance of the contracted health facilities based on the 12 "Output Units." In case of health center, It is repoted that the output-based contract resulted in an immediate reduction in HEF Operator costs and greatly simplified their financial management. Key to this simplification was the switch from an accounting-based process of reviewing monthly HEF Operator management invoices to a field-based verification of the number of output units in a given month.

Figure 3- 11 HEF Document at a Health Center in Kampong Cham province

Table 3- 8 Standard HEF Operator Output Units for Management Costs

1	Coverage of a Referral Hospital with Meet and Greet Services	Non-Variable
2	Number of HEF Beneficiaries Processed at RH Level for IPD Services	Variable
3	Number of HEF Beneficiaries Processed at RH Level for OPD Services	Variable
4	Coverage of Health Centers with HEF Services Available	Non-Variable
5	Number of HEF Beneficiaries Processed at HC Level	Variable
6	Timely Payment of Direct Benefit User Fees to Health Facilities	Non-Variable
7	Number of Facility Based Births at RH and HC Level	Variable
8	Number of Household Spot Checks	Variable
9	Number of Villages with a Representative at a Community Network Meeting	Variable
10	Completed Quarterly P/DHFSC and District Monitoring Group	Non-Variable
11	Timely, Accurate, and Complete Quarterly Progress and MOH/DPHI Reports	Non-Variable
12	Completed Annual Village Survey	Non-Variable

Source: Health Policy Brief, 2015

Many hospitals have an office for a patient with an Equity Card to apply for the HEF benefit package. After arrival at the hospital, a patient goes to the HEFO office, shows his/her Equity Card and receives medical services free of charge. For a person who does not have an Equity Card, a Post-ID Poor certification will be conducted as explained earlier. While assisting the ID

Poor families, HEFO also conducts health education for the families in the office. Attachments 10-11 are examples of the promotional brochures.

It is reported that, after the introduction of HEF, the amount of loans for health expenditure decreased by 25% in poor households[55]. Furthermore, HEF beneficiaries have increased their utilization of public health facilities[56].

Meanwhile, it is pointed out that some HEF beneficiaries are not using an Equity Card,[57] though public health service is free of charge. Health Equity Fund Utilization Survey revealed that only one in three, and one in two, HEF beneficiaries seeking OPD and IPD health care, respectively, ever used HEF in the past 12 months.[58] However, if the utilization increases, the Cambodian government will face a dilemma that it will increase the financial burden on it.[59] In recent years, the increase of patients with non-communicable diseases (NCDs), such as diabetes, hypertension and mental diseases, is even increasing the financial burden on the government. There is an urgent need for the national NCD guidelines to avoid unnecessary consultations and treatments.[60]

② Government Subsidy (SUB) for the poor

Government Subsidy (SUB) is the system to exempt medical payment by the poor. SUB was enacted in 2006 under Prakas 809 to reduce the financial burden on the poor and to promote the utilization of public health services. According to the Annual Health Financing Report 2015, the scheme was introduced in six National Hospitals, 12 Referral Hospitals and 152 Health Centers in 12 ODs in eight provinces. When a health facility identifies a patient as poor under the SUB scheme, the health facility receives official flat rate per consultation that is US$20 at the National Hospital, and the cost exceeding the rate has to be covered by the health facility.[61]

③ Community-based Health Insurance (CBHI)

CBHI is a non-profit voluntary health insurance based in a community that is managed and organized by NGOs or Community-based Organizations (CBOs). The basic funding source is premiums from the insured and the benefit package covers health services at public health facilities. CBHI was first introduced in 1998[62] and is now also called "Voluntary Health Insurance (VHI)" or "Voluntary Enrollment Scheme." Today, CBHI approximately covers 118,000 people in 21 ODs, and seven provinces.[63] Non-poor informal sector population is estimated to be about 10 million and therefore only 1.2% of the target population is currently

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[55] Independent Verification of the Health Equity Fund System Discussion Paper (2015).
[56] Health Equity Fund System Technical Brief (2015).
[57] Health Equity Fund Utilization Survey report provided by GIZ.
[58] Health Equity Fund Utilization Survey report provided by GIZ.
[59] Interview with VMA (October 29, 2015).
[60] Health Equity Fund System Technical Brief, 2015.
[61] Interview at the Khmer Soviet Friendship Hospital (Octobe 27, 2015).
[62] Assessment of the Community Based Health Insurance in Pursat Province in Camobodia by RACHA Team, funded by USAID.
[63] Lo, Veasnakiry. (2016). SOCIAL HEALTH PROTECTION IN CAMBODIA: WAYS MOVING FORWARD. Presented to the meeting of TWG for Developing National Social Protection Policy Framework in 18 February, 2016.

covered by CBHI. MOH developed CBHI guidelines and oversees the schemes but does not support it financially.

Figure 3- 12 SKY Handbook

The first CBHI program introduced in Cambodia is called “SKY” (see Figure 3-12) run by a French NGO, Group de Recherche et Dechanges Technologiques (GRET). “SKY” is named after the Khmer language, “Sokapheap Krousat Yeugn,” which means “Family Health.” After the Pol Pot Regime, the economy in villages grew gradually, however villagers still suffered from unexpected health expenditures. To improve the situation, the SKY project was introduced. Through the project, changes in people’s health seeking behavior were observed and health service delivery was also improved. In response to the results, other NGOs applied the methods and started similar projects.

In the late 2000s, as part of the development of the Social Security Law, MEF proposed licensing CBHI and taxation. However, most of the organizations managing CBHI were non-profit organizations working with the poor, therefore they opposed the idea together with development partners. In the end, CBHI was placed under MOH and all CBHI implementing organizations signed Memorandums of Understanding (MOU) with MOH. Some organizations that run schemes for profit were registered under MEF.

CBHI management varies depending on organizations, however, most organizations have an office at health facilities with staff who handle patients, while visiting house to house for premium collections. The insured can recieve health services at a public health facility free of charge by showing the insurance card.

In CBHI, premiums and benefit packages are set by each organization. The premiums vary from one CBHI to another: US$2.5 to 18 per person per year.[64] Lower premium rate can prevent dropouts and increase the coverage of the scheme. However, this is available only for an organization that has external financial support. Most organizations do not have choice, but set a higher premium to increase the pooling.[65] Some CBHIs limit their benefit packages to reduce the financial burden. CBHIs were very active around the time between 2008 and 2011. However,

[64] Interviews with CBHI operators (October - November, 2015).
[65] Interview with SHPA (October 26, 2015).

in recent years, support from development partners has been decreasing and it is making it difficult for CBHI organizations to manage the scheme sustainably. The following are three basic factors comprising CBHI's failing in Cambodia to date:

1) The community-based health insurance scheme is operated on a small scale that does not allow the insurer to collect large amount of premiums.

2) The voluntary insurance scheme has caused adverse selection,[66] in which only those who are prone to sickness join the scheme, and therefore it is common that health expenditures exceed the revenues.

3) Although some CBHI operators are financially assisted by development partners, the primary financial source for CBHI is premiums collected from the beneficiaries and there is no government subsidy.

Another way to state the situation is that there is no risk distribution mechanism in CBHI.

While many CBHIs are failing, some NGOs manage CBHI successfully through their own methods. Below are examples of NGOs who run CBHI with unique approaches.

STSA[67]

Sahakum Theanea Rab Rong Sokhapheap Srok Pratekbat Angkor Chum (STSA), meaning "Angkor Chum OD Cooperative Health Insurance," was registered by the MOI and MOH in 2010 and it covers three ADs (Angkor Chum, Puok, Varin) with 26 communes and 250 villages. There are two Referral Hospitals and 21 Health Centers. The population of the area is 224,904 and among them 48,311 (21.5%) are registered as ID Poor and covered under HEF. Thirty six thousand people (360 villages: 16.0% of the area population) are the membership of CBHI. For the CBHI run by STSA, affiliation is done through the village and all members of family need to join the scheme. There are only 120 villages not STSA members in the target area.

Between 2010 and 2013, the CBHI was supported by USAID/URC as a village-based CBHI pilot project. The project developed a system to reduce adverse selection and a mechanism to reduce the premium payment depending on the coverage rate of the membership in a village. As a result, an enrollment rate for CBHI became higher in Angkor Chum OD (14%) compared to the national average (11%). However, the pilot project ended in 2013 as achievement was less than expected. Since then, STSA has been managing the scheme by itself.

STSA requires a minimum of 30% of participation in a village and if the participation rate increases, the amount of the premium decreases (See the Table 3-9). To avoid adverse selection, STSA developed a system in which villagers invite others in the village to join the scheme. There is no age or pre-existing condition limitation on participation. STSA together with health

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[66] Adverse Selection is a concept that traders with better private information about the quality of a product will selectively participate in trades which benefit them at the expense of the other trader. In the context of health insurance, sick people tend to participate in a health insurance as they know that they will require much health expenses, while healthy people do not.

[67] Interview with STSA (November 9, 2015).

facilities also cracked down on illegal private health facilities. As a result, there is only one private health facility remaining in the area and it led to an increase of the utilization of public health facilities and enrollment rate of the CBHI. As of 2014, the scheme covers 17% of the population.

Table 3- 9 STSA Premium Collection System

Participation rate of villagers	Premium per capita per annum
30-39%	24,000 Riel (US$6.0)
40-49%	20,000 Riel (US$5.0)
50-59%	16,000 Riel (US$4.0)
60-69%	14,000 Riel (US$3.5)
70-79%	12,000 Riel (US$3.0)
80% and above	10,000 Riel (US$2.5)

Source: Information provided by STSA

Table 3- 10 STSA Budget Allocation

Allocation of budget	Breakdown
5%	Operational Cost
10%	Incentives to Commune Council
55%	Health Center
15%	Referral Hospital
15%	Provincial Hospital

Source: Information provided by STSA

All the financial sources of STSA are premiums. Budget allocation is done based on the utilization of health facilities in the past few years. The current budget allocation rates are as shown in Table 3-10. The unit cost for the user fees is set after the negotiation with health facilities. The current user fees are shown in Table 3-11.

Table 3- 11 Unit Cost of Medical Services Set by STSA

Allocation of budget	National Hospital	Provincial Hospital	Referral Hospital	Health Center
Surgery	US$300	US$70 (Lump-sum payment)		
IPD	US$75		US$15	
Delivery			US$5	US$5
OPD (Specific NCD)			US$2.50	
OPD	US$6.50		US$1.50	US$0.75

Source: Information provided by STSA

In order to maintain quality of healh care, STSA pays an additional 20% of user fees if a health facility achieves more than 80% in the assessment with Quality Indicator (QI),[68] developed by MOH. If the achievement is below 60%, STSA does not renew the contract with the heath facilty.

[68] A Quality Assessment Team, comprising the staff of Hospital Department, Ministry of Health (MOH) and Provincial Health Departments, assesses quality of health facilities with the assessment tools of Level 1: providing a snapshot of available basic health service, including infrastructure, equipment, and manpower, and Level 2: measuring the appropriateness of the patient-provider interaction by focusing on the fundamentals of clinical care and clinical standards.

The contracting health facilities claim payments to STSA every month. STSA compares the claimed amount and the upper limit which the organization sets based on the calculation shown in Box 3-2, and pays the smaller one to the facilities.

BOX 3- 2 Calculation of STSA's upper monthly limit

Case of a Health Center with 5,000 insured people and 50,000,000 riels as total premium collection:

- Total budget for a Health Center: 55% of the total premium collection (50,000,000 x 0.55) → 27,500,000 riels
- Number of deliveries: Assume 3% of the population deliver once a year (5,000 x 0.03) → 150 cases
- Annual number of deliveries at a Health Center: Assume 65% of the total deliveries (150 x 0.65) → 78 cases
- **Upper monthly limit number of deliveries at a Health Center: (78 / 12) → 6.5 = 6 cases**
- Budget for deliveries : Unit cost of delivery at Health Center (20,000 riels) x Annual number of deliveries (78 cases) → 1,560,000 Riels
- Budget for OPD: Total budget for a Health Center (27,500,000 Riels) - Budget for deliveries (1,560,000 riels) → 25,940,000 riels
- Annual number of OPD consultation: Budget for OPD(25,940,000 Riels) / Unit cost of OPD consultation (3,000 riels) → 8,646 cases
- **Upper monthly limit numbers of OPD consultation: Annual number of OPD consultation (8,646 cases) / 12 month → 720 cases**

STSA manages the CBHI scheme together with the Health Center Management Committee (HCMC), the OD, Commune Councils and villages. Particarly, the Commune Council promotes the participation of the schemes and payment of premiums.

Figure 3- 13 STSA Beneficiaries at a Health Center

AFH[69]

In Kampong Thom HEFO, Action for Health (AFH) changed the name of the CBHI scheme to "Voluntary Enrollment Scheme" to renew the image of the scheme as once CBHI was not functioning well. As shown in the Table 3-12, the premium is set based on the size of family.

Table 3- 12 Premium collection at Kampong Thom HEFO

No. of family members	Premium per household (per capita) per annum
1	US$7.5 (7.5)
2-4	US$14 (3.5-7)
5-6	US$22.5 (3.75-4.5)
7-8	US$27.5 (3.5-4)
9 and above	US$35 (Less than 3.9)

Source: Information provided by Kampong Thom HEFO

The Voluntary Enrollment Scheme covers about 26,000 people in Kampong Thom province (5% of the area population).[70] Currently, they are supported by and receive funds from GIZ. After the support ends, they are planning to increase the premium. NCDs (hypertension, diabetes, heart diseases, cancer, etc.) and ICU care are outside the benefit package.

CHC[71]

Cambodia Health Committee (CHC) manages CBHI in Siam Reap OD in Siam Reap province. CHC covers 3,200 out of 66,265 households (4.8% of the total households) with 5,509 out of 370,032 people (1.5% of the population) in the OD. The premium covers medical fees, transportation costs and food allowances.

CHC receives funds (operation cost only) from a private insurance company called "Achmea" to manage the scheme. The strategy of Achmea is to encourage the participation in the scheme through promotion by the NGO staff. CHC appoints a focal person per village and if the focal person can bring in 16 newly insured persons,[72] he/she receives US$30.

BFH[73]

In Takeo province, GRET introduced CBHI in Kirivong District in 2007. Buddhism for Health (BFH) has taken over the scheme and there are 7,000 members at this moment. They were financially supported by Agence Française de Developpement（AFD）who support GRET, however since 2012, BFH has been running the scheme using premiums and the HEF budget.

There are three types of benefit packages as shown in Table 3-13 (Package 3 is an option to the Package 1 or 2). The enrollment is done by the family as a unit for the period of a year. The premium can be paid twice a year.

[69] Interview with AFH (November 3, 2015).
[70] According to the Inter-sensal Population Survey 2013, population of Kampong Thom is 523,202. http://www.stat.go.jp/info/meetings/cambodia/pdf/ci_fn02.pdf
[71] Interview with CHC (November 9, 2015).
[72] Membership is renewed annually and a renewed person is counted as newly insured.
[73] Interview with BFH (October 29, 2015).

Table 3- 13 Benefit package of BFH CBHI scheme

Type	Premium	Benefit Package
Package 1	US$ 4.5～5.5	User fee at Health Centers/Referral Hospitals /Provincial Hospitals, Funeral cost, Transport
Package 2	US$ 7.5～8.0	Package1+User fee at National Hospital
	US$5.0	Miscellaneous when hospitalized (Option)

Source: Information provided by BFH

To increase enrollments, BFH proposes to organize a campaign in the harvest season and give a 50% discount of premiums or better benefit package for a village in which more than 50% of the villagers join in the scheme. BFH also proposes utilization of donations collected at pagodas for the insurance management.

④ **Voucher Scheme**[74]

The Voucher Scheme is the health protection system that a patient receives a specific health care for free with a voucher and the health institution receives payment in exchange for the collected vouchers. The scheme started in 2008 to provide reproductive health services including Antenatal Care (ANC) and delivery free of charge. When the scheme started, the Voucher Scheme promoted the use of the services at Health Centers and it was linked to staff incentives, while HEF was operated mainly at Referral Hospitals.[75] The scheme currently covers 21 ODs, 21 Referral Hospitals and 280 Health Centers in six provinces (Kampot, Kep, Kampong Thom, Kampong Speu, Prey Veng and Svay Rieng), and approximately 4 million people (25% of the total population in Cambodia).[76] The scheme is supported by Kreditanstalt für Wiederaufbau Bankengruppe/German Development Bank (KfW) and managed by the Voucher Management Agency (VMA).

The first phase of the scheme started in 2008 and it targeted the ID Poor, distributing vouchers for targeted services, such as maternal and delivery services, family planning (IUD and implant etc.) and abortion care. The second phase started in 2013. In addition to the services of the first phase, child nutrition, growth monitoring for children less than 24 months of an ID poor family, cervical cancer screening and treatment for women aged 30-49, cataract surgery targeting over 50 year olds, and rehabilitations for the disabled were introduced. Services are selected which have a high impact on public health and preventive value. For the services that the scheme wants to promote, the higher price is set for services. VMA reported that the utilization rates of ANC and Postnatal Care (PNC) services are high, but that of growth monitoring and cervical cancer screening remains low.[77] The second phase benefit package is shown in Box 3-3.

[74] Interview with VMA (October 29,2015).
[75] HEF is in operation at Health Centers since April 2015.
[76] Information provided by VMA (April 21, 2016).
[77] Project achievements: Results vs. targets Phase 2 until Aug 2015: Coupon Use.

All types of vouchers are collected in a booklet and delivered, along with a health promotional

BOX 3- 3 Voucher Scheme Services and Target groups in Phase 2

Safe Motherhood (ID Poor)

- Payment of user fees (handed over to HEF since July 2015)
- Social support (transport, food, conditional cash transfer), if not covered by HEF

Family Planning (Long acting & permanent methods) (ID Poor)

- User fee (if not covered by HEF)
- Transport

Child Health & Nutrition (ID-Poor)

- User fees which are not covered by HEF or Integrated Management of Childhood Illness (IMCI)
- Social support (transport & food)

Safe Abortion (All women of reproductive age)

- User fees
- Transport

Cervical Cancer screening & treatment (Women 30-49 years old)

- User fees
- Transport
- Lump-sum (US$500) social support for cancer cases

Cataract screening and Surgery – (people over 50 years old)

- User fees
- Transport & food

People with reduced mobility (handicapped and elderly)

- Rehabilitation
- Transport

brochure (see Attachment 15) to each household by a Voucher Promotor, a villager appointed as staff. One Voucher Promotor is responsible for two to three Health Centers. A Voucher Promotor stays at a Health Center for several hours per day and he/she also visits households. Periodically, a Voucher Promotor organizes meetings in villages and conducts health promotion activities with voucher booklets. There are 130 Voucher Promotors registered at this moment. When the distributed vouchers are utilized, a voucher promotor receives incentives. The frequency of booklet distribution is managed by the voucher promoter and if there is low performance, he/she is replaced by another person.

In July 2015, the services that were covered under HEF, such as maternal and delivery care and part of the family planning services, were removed from the benefit package of the Voucher Scheme. Also, there is discussion to merge the current activities of the scheme into HEF by 2017. Currently the technical transfer to MOH and NGO are in process. High utilization of ANC and PNC are considered due to the achievement of the Voucher Scheme.

⑤ **Integrated Program**[78]

Kampong Thom HEFO, managed by Action for Health (AFH), operates a pilot program which combines the HEF, CBHI and Voucher Scheme into one. In Kampong Thom province, HEF was introduced to the Provincial Hospital and a Referral Hospital in 2005, and CBHI (currently called "Voluntary Enrollment Scheme") started in 2010. CBHI is supported by GIZ and the Voucher Scheme is entrusted by EPOS Health Management (EPOS) which is further entrusted by KfW (See the Figure 3-14).

As mentioned earlier, Voucher Scheme, HEF and CBHI signed a MOU to make them into an integrated program. Through the integration, it made it possible to reduce the number of staff and remove the duplication of the work load. It also enabled them to cover a wider range of the beneficiaries. For example, generally the voucher for ANC is distributed to the ID Poor women, however, in the Integrated Program, the women insured under CBHI also receive an ANC voucher to promote the overall ANC utilization.

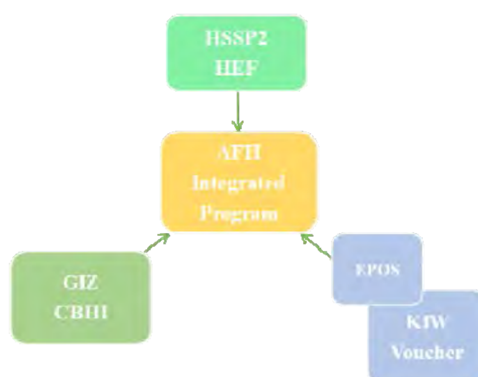

Figure 3- 14 Conceptual diagram of the Integrated Program

Source: Made by a survey team based on information from Kampong Thom HEFO

The integration of HEF and CBHI is taking place on the ground, however, the integration of the Voucher Schemes is still in process. Integration of financial resources of the HEF and CBHI is also not accomplished yet.

[78] Interview with AFH (November 3, 2015).

⑥ Community Managed HEF (CMHEF)[79]

Community Managed HEF (CMHEF) is the scheme that covers transportation costs and food allowances of the vulnerable population, such as the elderly, the disabled and pregnant women, by providing them with vouchers (see Figure 3-15). CMHEF was invented by community members of Kirivong district in Takeo province in 2003 as a social health protection scheme for the poor, before the introduction of HEF. BFH implemented the scheme and initially named it "Pagoda Managed HEF (PMHEF)". However, the name was later changed to allow other religious members to join. In 2012-2013, HEF was introduced in Takeo province, and they changed the strategy of the scheme to complement HEF. CMHEF is currently managed by HCMC, and BFH provides the Committee with technical support.

Figure 3- 15 CMHEF Transportation Voucher

CMHEF funds are raised at various events organized in the area (schools, pagodas, mosques, churches, etc.). The amount collected annually is around US$10,000-20,000.

In 2016, CMHEF plans to up-scale its operation to other areas (Kampot, Kep, Preah Sihanouk, Battambang, Banteay Meanchey, Kampong Speu, Kampong Cham, Pailin, Tboung Khmum and Kandal).

⑦ Private Insurance[80]

In Cambodia, private insurance coverage is still limited; however, it is expanding gradually. There are 11 private insurance companies (including non-health insurance) registered by MEF. The total amount of premiums collected was US$3,339,082 in 2010 and US$6,887,306 in 2014, more than doubling in five years.[81] Previously, the affiliation was mainly through companies, however in recent years, the number of individuals buying private insurance is increasing, especially among the wealthy. Each insurance company has a direct alliance with health facilities.

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[79] Interview with BFH (October 29, 2015).
[80] Interview at PKMI (December 11, 2015).
[81] Interview at MEF (November 6, 2015).

There are four companies which operate small scale insurance called "Micro Insurance"[82] and Prevoir Kampuchea Micro Life Insurance Plc. (PKMI) was the first company to offer it. PKMI is a French company registered in 2011 by MEF. In addition to health insurance, they provide individual accident insurance, life insurance and credit life insurance.[83]

Table 3- 14 Basic package of medical insurance by PKMI Micro Insurance

Health insurance		Classic	Silver	Gold	Platinum
Hospitalization					
Pre-hospitalization	Max per event -Max period 10 days before hospitalization	20	40	70	100
Post-hospitalization	Max per event -Max period 90 days	20	30	50	80
Hospital General Fees	Max per event	150	350	500	800
Surgical Fees	Max per occurrence	500	1,000	1,500	2,000
In-hospital Doctor Visits	Max per event -Max period 90 days	10	15	20	40
Daily Cash Allowance (Public Hospitals only)	Max per event -Max period 90 days	5	5	10	10
Ambulance	Max per event	20	30	50	80
Ordinary Room	Max per event -Max period 90 days	10	20	30	50
Intensive Care Room	Max per event -Max period 21 days	50	75	100	150
In case of Acciddental minor injury					
Outpatient Care	Max per event	30	70	150	300
In case of birth (By the insured or his legal spouse)					
Birth benefit	Max per event	150	250	350	450

*The figures show upper limit with US$

Source: Information provided by PKMI

Currently, there are 80,000 people (about 0.5% of the national population) covered under PKMI's insurance. It is recommended by PKMI that all family members join, however, it is not compulsory. Ages 5-65 years can join Micro Insurance.

They have branch offices in all 25 provinces that provide customer service as well as promotion of the insurance. One hundred seventy public and private hospitals have alliances with PKMI. A major component of the benefit package is hospitalization coverage, therefore the partners are health facilities with inpatient departments. The basic benefit packages are in Table 3-14.

The maximum amount reflected in the table above is applied to private hospitals and National Hospitals, and all costs are covered for treatment at Provincial Hospitals and Referral Hospitals. OPD care can be added to the benefit package as an option. The premium is calculated based on the contents of the benefit package.

When an insured person wants to visit a health facility, he/she calls a "Hotline" and identifies which facilities can be used. At the affiliated health facility, an insured person receives services free of charge by showing an insurance card. An insured person can also visit a non-affiliated

[82] Milvik (Cambodia) Micro Insurance Plc.、Cambodian People Micro Insurance (CPMI)、Prevoir Kampuchea Micro Life Insurance Plc. (PKMI), MEADA.

[83] Credit life insurance provides families with loan protection and guarantees to settle the loan to the creditor in case of death.

hospital and be reimbursed later. Health facilities that are not registered under the government are not covered by PKMI insurance.[84]

⑧ **National Social Security Fund (NSSF)[85]**

NSSF is a social insurance program for private employees. NSSF plans to undertake insurance for work injuries, health insurance and pensions, however, it currently operates only work injury scheme.

Insurance for work injuries started in December 2012 with technical and financial support from the International Labour Organization (ILO) since 2006. The targets are private companies with more than eight employees. It collects 0.8% of the employee's salary as a premium from only the employers. Work injury insurance was introduced in the provinces with high potential for economic growth: Phnom Penh, Kandal and Kampong Speu provinces, in the first year. It was expanded for Sihanoukville, Siem Reap, Kampong Cham, Banteay Meanchey and Svay Rieng provinces in the second year, and the rest in the third year. NSSF has offices in all 25 provinces, and there are about 300 staff in Phnom Penh and 400-500 staff nationwide.[86] Currently, NSSF covers 6,470 companies and 1,105,890 workers (about 7% of the national population) for the work injury insurance.[87]

For health insurance, GRET, a French NGO and the French government provided technical assistance since 2009 and piloted a project, the Health Insurance Project, called "HiP" targeting workers at garment factories together with the Garment Manufacturers Association in Cambodia (GMAC). The project targeted 7,200 workers in 11 factories and ended in 2013. After that, the project was taken over by NSSF and has been managed successfully. In 2016, it is planned to be introduced as a national scheme. As the first step, they are targeting Phnom Penh, Kandal and Kampong Speu, as they did for the work injury insurance scheme.

The work injury program of NSSF has alliances with 96 public health facilities (1-3 facilities per province), CT Clinic in Sihanoukville and Molmit Clinic in Steng Meanchey, Phnom Penh. In principle, NSSF should be affiliated with public health facilities, however, the two private facilities were exceptionally included because there is no facility with a CT in Sihanoukville and there are many factories around Molmit Clinic. For the selection of facilities, nominations are done by each NSSF branch office in a province, but verification and final approval are made by the director of the relevant Division in NSSF headquarters.

NSSF covers all medical costs without any upper limit restriction. There are NSSF offices at affiliated health facilities. An insured person shows his/her insurance card and receives services

[84] Interview with PKMI (December 11, 2015).
[85] Interview with NSSF (November 5, 2015).
[86] The current situation of establishing the social protection program in Cambodia (2015).
[87] Lo, Veasnakiry. (2016). SOCIAL HEALTH PROTECTION IN CAMBODIA: WAYS MOVING FORWARD. Presented at the Meeting of TWG for Developing National Social Protection Policy Framework on 18 February, 2016.

free of charge. Payment to health facilities is made based on MOH and MLVT interministerial *Prakas* (ordinance).

Following MEF guidance, an Investment Committee has been established to manage the funds.

NSSF has a plan to introduce ID cards with fingerprint authentification to manage membership for the work injury and health insurance. As of November 2015, NSSF has fingerprint authentification for 70,000 workers.[88]

⑨ **National Social Security Fund for Civil Servants (NSSF-C[89])**

NSSF-C is a social health protection scheme for civil servants and their families. Currently NSSF-C provides pensions to civil servants and their dependents, but has not initiated health insurance as of yet.

As for pensions, the government provides NSSF-C with 24% of the staff salary as their premiums. However, there is a discussion that 6% out of 24% premium should be deducted from the staff salary. Today, there are 3,000-4,000 retired workers every year which burdens on the government, and therefore it is necessary to secure new financial resources. NSSF-C commented that each citizen needs to understand that premium payment is people's responsibility.[90]

⑩ **Others**

The World Bank, the United Nations Children's Fund (UNICEF), Save the Children, USAID and others implement Conditional Cash Transfer programs, mainly in maternal and child health.[91] Also services for malaria, tuberculosis, HIV/AIDS and Expanded Program on Immunization (EPI) are provided free of charge with support from various development partners.

3-3 ID Poor Program[92]

The ID Poor Program was introduced in Cambodia in 2007 and has operated in all 24 provinces (currently 25 provinces) since 2010. The verification is conducted in eight provinces every year. Therefore, it takes three years to complete in all provinces. The Equity Card is issued per ID Poor family and is valid for three years. Once every three years, the financial status of each family is re-examined throuh a household survey at the village level. On the ID Poor Program website, the verification process is explained and one can check the information on Equity Cards. A challenge for the ID Poor Program is difficulty to capture the status of the homeless as

[88] Interview with NSSF (November 5, 2015).
[89] Interview with NSSF-C (November 12, 2015).
[90] Interview with NSSF-C (November 12, 2015).
[91] It is a program to encourage a targeted population to utilize a certain health service. Under the program, a patient receives cash when he/she receives the health service.
[92] Interview with Ministry of Planning (November 6, 2015).

the survey for poor households is conducted in a "village." The benefits for ID Poor households include health care, scholarships, food assistance and more. It is managed by the MOP.

The process of ID Poor verification and issuing a card is as follows:

① The MOP targets areas to survey. Until 2015, surveys were conducted in rural areas but will shift to urban areas starting in 2016.

② Select a Village Representative Group (VRG) consisting of five to seven members from the targeted village. The number of the VRG is determined depending on the number of households in a village: five VRG members for a village with less than 150 households, six members for 151-200 households, seven members for 201-260 households. After participating in training, the VRG surveys the household of the ID Poor candidate, including observation of the house and interviews.

③ Based on the survey, each household is scored and categorized as follows: a household scoring 59-68 is grouped under Poor 1 (very poor) and a household scoring 45-58 is grouped under Poor 2 (poor). There are slight differences in the benefit package between the two. For example, Poor 1 receives transportation costs to a health facility, while Poor 2 does not. Factors taken into account include household income, family structure, and the health condition of family members.

④ A list of ID Poor households with scores is submitted to the village chief for validation. If the list is considered invalid, discussions continues until an arrival at a consensus. Then, the approved list is submitted to the Commune Council and publicly posted for a period of time. If there are no objections to the list, it is officially approved as the village's ID Poor households list.

⑤ The approved ID Poor households list is submitted to a district office of the MOP, then a provincial office and a central office. After data entry of the survey results (i.e. family structure and score), an ID code is issued to each household and the MOP takes a photo of the household. After the photo is taken, an Equity Card is created. The process takes three to four months from the approval of the list to issuing the card.

⑥ Previously, the Commune Council wrote family member names on the Equity Card. However, currently only the name of household head is on the ID card, as there was misuse when people falsely identified themselves as ID Poor family members. The names and status of the ID Poor family members are registered in computer-based information, which is available through their registration code at a health facility. Therefore, even without the Equity Card, the ID Poor family member can receive the HEF benefit.

3-4 Civil Registration and Vital Statistics (CRVS) and its Usage for Social Health Protection

As of today, there are no linkages among civil registration, the social protection system and the ID Poor information system. However, according to MOI, they are planning to collaborate with NSSF in the near future, and willing to make it possible for the informal sector social health insurance system to utilize the civil registration data.

Until 1975, a civil registration system existed in Cambodia. However, during the Pol Pot regime, all the documents were lost. It was 2002 when the national Sub-Decree on civil registration was enacted. After the Sub-Decree was passed, a person who was born before the Sub-Decree was able to obtain a birth certificate by self report. However, less than 5% of the population was registered by 2004. Due to low registration, MOI started a mobile campaign for civil registration (birth registration) from 2004 to 2006, and consequently birth certificates came to be issued for more than 90% of the total population (11,828,208 people).[93] In Cambodia, civil registration is made individually, unlike Japan or Korea where it is made by the family as a unit.

Currently, the registration is conducted by manually using two notebooks that are called the "Twin Book." Registration is made at the commune/Sangkat level and information on births, marriages and deaths are collected (see Figure 3-16). One book is kept at the district office and is used to issue certificates (birth, marriage and death), and the other book is sent to a provincial office and after compilation, it is sent to MOI.

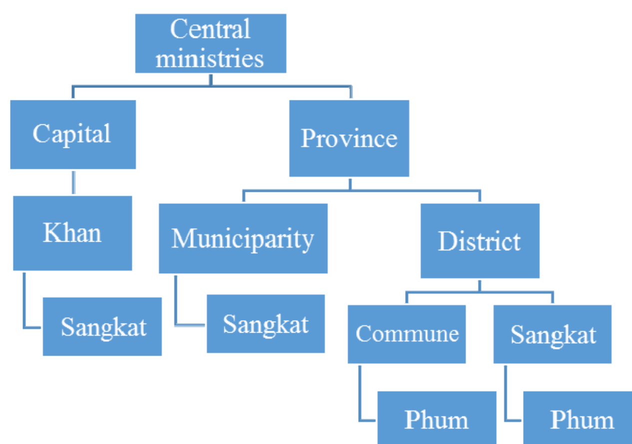

Figure 3- 16 Administrative Structure in Cambodia

When a baby is born at a public health facility, the facility issues a "Notification," and parents go to the sangkat/commune office for birth registration with the "Notification." Whereas, there is no such rule for private health facilities, and therefore it has been a challenge for civil registration. Furthermore, if a baby is born at home, a "Notification" issued by the village chief

[93] The population in 2006 was 12,860,124: THE CIVIL REGISTRATION OF KINGDOM OF CAMBODIA. http://www.nchads.org/Events/000179/hippp/day1/afternoon/05-Civil%20Registration%20of%20Kingdom%20of%20Cambodia.pdf

is required for birth registration. It is compulsory that parents register their baby within 30 days after birth. If there are delays there is a 10,000 riels fine. When a mother delivers in a place where she does not reside, her baby still has to be registered at her residential place. When a person transfers to another area, he/she has to report to a police post of the old and the new residence. People's transfer is recorded on the Residential Book[94].

MOI started a pilot project for a web-based civil registration system (birth, marriage and death) from 2013/2014 supported by URC/USAID.[95] The project is implemented in one district in Tboung Khmum province and four Sangkats in Kampong Cham province, and it was expanded to ten Sangkats in Battambang province in 2015. Data entered at the Commune/ Sangkat level is shared at the district, province and central level instantly. Necessary items for the web-based civil registration system are a computer, modem, fingerprint authentification machine and web camera.

MOI believes that, by scaling up this system, the information could be utilized in various sectors such as health, education and others. For the health sector, it could be used to collect demographic statistics, such as child growth, mother's age and cause of death. MOI is planning to strengthen the linkages with health facilities.

In 2015, MOI developed the National Strategic Plan on Identification 2015-2024 (NSPI), and the three year rolling plan based on the NSPI. In the NSPI, a Khmer Identity Code (Kid-C) is to be distributed to every citizen, which could be utilized for a social health insurance system through the Integrated Population Identification System (IPIS).

Challenges for civil registration are: 1) slow progress in slums (500 spots), border and deprived areas; 2) due to the history of the Pol Pot regime, some people resist providing information; and 3) most of the information is paper-based, which enables one individual to simultaneously hold two IDs. MOI is planning to promote IT by 2024.

3-5 The People's Behavior and Perception towards Health Services and Health Protection: Results of the Demand-side (Household) Survey

(1) Socio-demographic Characteristics of the Survey Respondents

Table 3-15 describes socio-demographic characteristics of the Field Demand-side Survey respondents (200 households in Kampong Cham province and 100 households in Siem Reap province). Seventy seven percent of household heads[96] were male with a mean age of 49.0 years, 76.9% were literate, 21.0% had no educational background, 45.0% had an educational level up to primary school, 23.7% up to junior high school and 9.7% up to high school and above. Seventy percent of household heads' main occupation was agriculture and fishery and all are Buddhist. The average family size was five and 77.4% of households had three to six family

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94 Information provided by Ministry of Interior (April 7, 2016).

95 http://www.crvscambodia.org/en (Accessed on March 16, 2016).

96 In Cambodia, a "household head" means the oldest person in a family rather than the main breadwinner of the family.

members. Nine point three percent of the respondents participated in community organizations for development and agriculture.

Table 3- 15 Socio-demographic characteristics of people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Sex of household head (N=300)				0.77
Male	231 (77.0)	153 (76.5)	78 (78.0)	
Female	69 (23.0)	47 (23.5)	22 (22.0)	
Average age of household head (N=300)				$<$0.01
	49.0±13.9	51.1±14.0	44.9±12.7	
Literacy of household head (N=300)				0.01
Literate	228 (76.0)	161 (80.5)	67 (67.0)	
Illiterate	72 (24.0)	39 (19.5)	33 (33.0)	
Educational level of household head (N=300)				$<$0.01
No education	63 (21.0)	32 (16.0)*	31 (31.0)*	
Up to primary	135 (45.0)	92 (46.0)	43 (43.0)	
Up to junior high	71 (23.7)	57 (28.5)*	14 (14.0)*	
Junior high grad+ [a]	29 (9.7)	17 (8.5)*	12 (12.0)*	
Don't know	2 (0.7)	2 (1.0)	0 (0.0)	
Main occupation of household head (N=300)				0.59
Professional/technical	14 (4.7)	10 (5.0)	4 (4.0)	
Sales/service/clerical	22 (7.3)	16 (8.0)	6 (6.0)	
Manual work	20 (6.7)	13 (6.5)	7 (7.0)	
Agriculture/fishery	210 (70.0)	141 (70.5)	69 (69.0)	
Taxi driver[b]	10 (3.3)	4 (2.0)	6 (6.0)	
Housewife/retired/unemployed	24 (8.0)	16 (8.0)	8 (8.0)	
Religion				N/A
Buddhism	300 (100.0)	200 (100.0)	100 (100.0)	
Number of family members (N=300)				0.13
1~2	14 (4.7)	11 (5.5)	3 (3.0)	
3	43 (14.3)	25 (12.5)	18 (18.0)	
4	77 (25.7)	45 (22.5)	32 (32.0)	
5	62 (20.7)	45 (22.5)	17 (17.0)	
6	50 (16.7)	34 (17.0)	16 (16.0)	
7	27 (9.0)	17 (8.5)	10 (10.0)	
8+	31 (10.3)	23 (11.5)	4 (4.0)	
Participation to community organization (N=300)				$<$0.01
Yes	28 (9.3)	8 (4.0)	20 (20.0)	
No	271 (90.3)	192 (96.0)	79 (79.0)	
No answer	1 (0.3)	0 (0.0)	1 (1.0)	

Frequency (%) for categorical variables and mean and SD for average age of household head are described.
* Adjusted residual > ±1.96
[a] All the respondents graduated high school in Siem Reap and two respondents had university and higher education in Kampong Cham
[b] Others included both four wheels' and two wheel's drivers.

Comparing the results from Kampong Cham and Siem Reap, the mean age of household head and literacy level were higher in Kampong Cham than in Siem Reap ([mean age] Kampong Cham: 51.1years old, Siem Reap: 44.9 years old, [literacy] Kampong Cham: 80.5%, Siem Reap: 67.0%). On the other hand, the proportion of people with educational level up to junior high school was higher in Kampong Cham (Kampong Cham: 28.5%, Siem Reap: 14.0%), however the proportion of people with no-education and educational level above junior high school was higher in Siem Reap ([No-education]: Kampong Cham: 16.0%, Siem Reap: 31.0%, [junior high school and above] Kampong Cham: 8.5%, Siem Reap: 12.0%). The results indicate that participation in community organizations was higher in Siem Reap than in Kampong Cham, 20.0% and 4.0%, respectively.

Table 3-16 describes the current situation of the income management at targeted households. The respondents' average income per month was US$120.80. Ninety three percent of the households responded that they have never saved money, and 41.0% of the households had held loans or sold valuable items. Among those who had held loans or sold items, 64.3% had done that for economic activities such as agriculture and business, 19.0% to maintain daily life and 15.9% for the purchase of real estate or the purchase/repair of vehicles. It was only nine out of 126 households who had taken out loans or sold valuable items to receive health care services.

More people in Siem Reap saved money than those in Kampong Cham, 12.0% and 4.5%, respectively. While more people in Kampong Cham took out a loan or sold valuable goods for their daily life such as the purchase of food and health services (Kampong Cham: 24.7%, Siem Reap:7.3%), more people in Siem Reap used these methods for real estate and vehicles. (Kampong Cham: 11.8%, Siem Reap: 24.4%).

Table 3- 16 Management of household income among people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Household's average income per month (USD) (N=300)	120.8±98.6	119.6±100.5	123.1±95.1	0.78
Experience of saving (N=300)				0.02
Yes	21 (7.0)	9 (4.5)	12 (12.0)	
No	279 (93.0)	191 (95.5)	88 (88.0)	
Experience of loan or selling valuable goods (N=300)				0.80
Yes	126 (41.0)	85 (42.5)	41 (41.0)	
No	174 (58.0)	115 (57.5)	59 (59.0)	
Reason for loan or selling valuable goods (N=126)				0.03
Daily life[a]	24 (19.0)	21 (24.7)*	3 (7.3)*	
Real estate・vehicle[b]	20 (15.9)	10 (11.8)*	10 (24.4)*	
Economic activity[c]	81 (64.3)	53 (62.4)	28 (68.3)	
Unknown	1 (0.8)	1 (1.2)	0 (0.0)	

Frequency for the categorical variables and mean and SD for continuous variables are described.
* Adjusted residual > ±1.96
[a] Others included food, rent, water, electricity, children's education, health expense, marriage
[b] Others included purchase of real estate and purchase and repair of vehicle and motor cycle
[c] Others included purchase of materials, transportation cost, starting and expansion of business

(2) Health services delivery and utilization

Table 3-17 describes access to health services among people living in Kampong Cham and Siem Reap. In regard to the distance to the nearest health facilities, 30.7% responded that the distance was less than 1 km, 20.3% 1-2 km, 36.0% 2-5 km and 12.7% more than 5 km. For the type of the nearest health facility, 74.3% answered Health Center/Health Post and 25.7% said Provincial/District (Referral) Hospital. For the general impression of the health care at public health facilities, 19.7% responded that it was of "high quality and trustworthy," 35.3% as "satisfactory," 30.7% as "acceptable," and 10.0% as "low quality." For the question about problems accessing health services, 42.3% responded "expenses" as a major problem, 11.3% "distance or time," 6.0% "poor quality of care," while 40.3% responded "no problem."

The survey results revealed that there was a difference between the distance and type of the nearest health facility between the studied areas. There were more people living in the area between 1km and 5 km to the health facility in Siem Reap (Kampong Cham: 48.0%, Siem Reap: 73.0%), while there were more people in Kampong Cham who live less than 1 km (Kampong Cham: 36.0%, Siem Reap:20.0 %) or more than 5 km away (Kampong Cham: 16.0%, Siem Reap: 6.0%) from the health facility. More people answered. "Provincial/District (Referral) Hospital" as the nearest health facility in Kampong Cham (Kampong Cham: 32.0%, Siem Reap: 13.0%).

Table 3- 17 Access to health services among people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Distance to the nearest health facilities (N=300)				<0.01
Less than 1 km	92 (30.7)	72 (36.0)*	20 (20.0)*	
1-2 km	61 (20.3)	34 (17.0)*	27 (27.0)*	
2-5 km	108 (36.0)	62 (31.0)*	46 (46.0)*	
More than 5km	38 (12.7)	32 (16.0)*	6 (6.0)*	
Not sure	1 (0.3)	0 (0.0)	1 (1.0)	
Type of the nearest health facility (N=300)				<0.01
Provincial / District (Referral) Hospital	77 (25.7)	64 (32.0)	13 (13.0)	
Health Center / Health Post	223 (74.3)	136 (68.0)	87 (87.0)	
General impression to the health services at a public health facility (N=300)				0.76
High quality and trustworthy	59 (19.7)	38 (19.0)	21 (21.0)	
Satisfactory	106 (35.3)	67 (33.5)	39 (39.0)	
Acceptable	92 (30.7)	64 (32.0)	28 (28.0)	
Low quality	30 (10.0)	21 (10.5)	9 (9.0)	
Not sure	13 (4.3)	10 (5.0)	3 (3.0)	
Main problems in relation to the access to health services (N=300)				0.56
Expenses	127 (42.3)	82 (41.0)	45 (45.0)	
Distance, time	34 (11.3)	26 (13.0)	8 (8.0)	
Poor quality of care	18 (6.0)	13 (6.5)	5 (5.0)	
No problems	121 (40.3)	79 (39.5)	42 (42.0)	

Frequency (%) for categorical variables and mean and SD for continuous variables are described.
* Adjusted residual > ±1.96

Table 3- 18 Utilization of health services for the most recent illness episode among people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Use of health services by family member's most recent illness episode (N=300)				0.02
Yes	288 (96.0)	196 (98.0)	92 (92.0)	
No	12 (4.0)	4 (2.0)	8 (8.0)	
Timing (days ago) of the family member's most recent illness episode for those who used health services (N=288)				0.60
	208±446	217±423	188±493	
Reasons family member not seek care from a health facility/personnel (N=12)				N/A
No time	3 (25.0)	0 (0.0)	3 (37.5)	
Not felt the need	5 (41.7)	2 (50.0)	3 (37.5)	
Others[a]	4 (33.3)	2 (50.0)	2 (25.0)	
Health facility where the family member visited during the most recent illness episode (N=288)				<0.01
National Hospital[b]/Provincial Hospital	54 (18.8)	32 (16.3)*	22 (23.9)*	
District/Referral Hospital	45 (15.6)	43 (21.9)*	2 (2.2)*	
Health Center/ Health Post	97 (33.7)	47 (24.0)*	50 (54.3)*	
Private health facility (incl. pharmacy)	84 (29.2)	71 (36.2)*	13 (14.1)*	
Health facility operated by NGOs	8 (2.8)	3 (1.5)*	5 (5.4)*	
Impression of using the public health services during family's most recent episode (N=196)				0.33
Highly satisfied	38 (19.4)	21 (17.2)	17 (23.0)	
Partially satisfied	147 (75.0)	93 (76.2)	54 (73.0)	
Unsatisfied／highly unsatisfied	10 (5.1)	8 (6.6)	2 (2.7)	
Don't know	1 (0.5)	0 (0.0)	1 (1.4)	
Reasons family member not use public health services during the most recent episode (N=92)				N/A
No nearby facility	17 (18.5)	14 (18.9)	3 (16.7)	
Service time not convenient／waiting time too long	38 (41.3)	33 (44.6)	5 (27.8)	
Poor quality service[c]	24 (26.1)	18 (24.3)	6 (33.3)	
Not serious	5 (5.4)	4 (5.4)	1 (5.6)	
Don't know	1 (1.1)	1 (1.4)	0 (0.0)	
No answer	7 (7.6)	4 (5.4)	3 (16.7)	
Whether the family member referred to a higher-level health facility during the most recent episode (N=288)				＜0.01
Referred	99 (34.4)	80 (40.8)	19 (20.7)	
Not referred	189 (65.6)	116 (59.2)	73 (79.3)	
Whetehr the family member transferred to a higher-level health facility during the most recent episode (N=99)				0.10
Transferred	51 (51.5)	38 (47.5)	13 (68.4)	
Not transferred	48 (48.5)	42 (52.5)	6 (31.6)	
How the family member was transferred to a higher-level health facility during the most recent episode (N=51)				0.08
By him/herself／Family members, relatives, friends	40 (78.4)	30 (78.9)	10 (76.9)	
By health facility (incl. ambulance)	11 (21.6)	8 (21.1)	3 (23.1)	
Reasons family member not transferred to a higher-level health facility (N=48)				0.67
Related to finance	29 (60.4)	26 (61.9)	3 (50.0)	
Not related to finance[d]	19 (39.6)	16 (38.1)	3 (50.0)	

Frequency (%) for categorical variables and mean and SD for continuous variables are described.
* Adjusted residual > ±1.96
[a] Others included "illness was not severe" and "not experienced illness"
[b] Only ten households in Kampong Cham used National Hospital
[c] Others included "staff behaved not well," "poor quality of drugs" and "nursing care for elderly."
[d] Others included "too far," "no time," "not allowed by family," and "fear to visit a hospital."

Table 3-18 describes the health service utilization for the most recent illness episode among people living in Kampong Cham and Siem Reap. Ninety six percent responded that they sought care from a health facility/personnel for the most recent illness episode (208 days ago on average). Among the households who received care from health services providers, 33.7% were from Health Center/Health Post, 29.2 % from private health facilities (include pharmacies), 18.8% from Provincial Hospital or National Hospital in Phnom Penh, 15.6% from Referral/District Hospital and 2.8% from health facility operated by NGOs. Reasons given by those who did not visit health facility or receive care from health service providers (4.0% of the total respondents) were "not felt the need" or "no time." Among those who used public health services, 19.4% answered that they were "highly satisfied" with the services, 75.0% were "partially satisfied," and 5.1% were "unsatisfied/ highly unsatisfied." For the reasons for not using public health services, 41.3% responded that "service time was not convenient/ waiting time was too long," 26.1% for "poor quality service," and 18.5% for "no nearby facility." Among those who received health services, 34.4% were referred to a higher-level health facility and of those, 51.5 % were transferred. Of those transferred, 78.4% were by themselves, family members, relatives or friends, and 21.6% were by the health facility including ambulance. For those who were not transferred to a higher level of health facility, 60.4% responded that it was due to financial reasons.

The survey result revealed that people in Kampong Cham used health services more than in Siem Reap (Kampong Cham: 98.0%, Siem Reap: 92.0%). Also more people in Kampong Cham used District/Referral Hospital (Kampong Cham: 21.9%, Siem Reap: 2.2%) and private health facilities, including pharmacies (Kampong Cham: 36.2%, Siem Reap: 14.1%), while more people in Siem Reap used National/Provincial Hospital (Kampong Cham: 16.3%, Siem Reap: 23.9%), Health Center/Health Post (Kampong Cham: 24.0%, Siem Reap: 54.3%), and health facilities operated by NGOs (Kampong Cham: 1.5%, Siem Reap: 5.4%). On the other hand, more people were referred to a higher level of health facility in Kampong Cham than in Siem Reap (Kampong Cham: 40.6%, Siem Reap: 20.7%).

Table 3- 19 Exposure to social health insurance among people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Anyone in the household covered by a social health protection scheme (N=300)				0.62
Yes	40 (13.3)	28 (14.0)	12 (12.0)	
No	259 (86.3)	171 (85.5)	88 (88.0)	
Don't know	1 (0.3)	1 (0.5)	0 (0.0)	
Type of social health insurance scheme for those who have family members covered by a social health protection scheme (N=40)				N/A
NSSF	11 (27.5)	9 (32.1)	2 (16.7)	
HEF	8 (20.0)	8 (28.6)	0 (0.0)	
CBHI	12 (30.0)	6 (21.4)	6 (50.0)	
Others [a]	7 (17.5)	3 (10.7)	4 (33.3)	
Don't know	2 (5.0)	2 (7.1)	0 (0.0)	
Possession of Equity card for those who have family members covered by a social health protection scheme (N=40)				$<$0.01
Yes	32 (80.0)	26 (92.9)	6 (50.0)	
No	8 (20.0)	2 (7.1)	6 (50.0)	
Know which eligible hospitals to use the scheme for those who have family members covered by a social health protection scheme (N=40)				0.82
Yes	36 (90.0)	25 (89.3)	11 (91.7)	
No	4 (10.0)	3 (10.7)	1 (8.3)	
Experiences of using the scheme for those who have family members covered by a social health protection scheme (N=40)				1.00
Yes	32 (80.0)	22 (78.6)	10 (83.3)	
No	8 (20.0)	6 (21.4)	2 (16.7)	
Type of the most recent illness for which a social health protection scheme was used (N=32)				N/A
Infectious disease	8 (25.0)	6 (27.3)	2 (20.0)	
Injury	5 (15.6)	4 (18.2)	1 (10.0)	
Non-communicable disease	12 (37.5)	6 (27.3)	6 (60.0)	
Pregnancy/child-birth related	6 (18.8)	5 (22.7)	1 (10.0)	
Don't know	1 (3.1)	1 (4.5)	0 (0.0)	
Timing of the most recent illness episode in which a social health protection scheme was used (N=32)				0.14
	387±739	519±860	97±133	
General impression using social health protection scheme (N=32)				N/A
Grateful and necessary for our lives	32 (100)	22 (100)	10 (100)	
Experience not able to use the scheme for those who have family members covered by a social health protection scheme (N=32)				N/A
Yes	1 (3.1)	0 (0.0)	1 (10.0)	
No	31 (96.9)	22 (100.0)	9 (90.0)	

Frequency (%) for categorical variables and mean and SD for continuous variables are described.

[a] Others included NGO, voucher for poor and private insurance

(3) Social Health Protection Utilization

Table 3-19 describes the exposure to social health protection among people living in Kampong Cham and Siem Reap. For the question on whether family members were covered by any social health protection scheme, 40 households (13.3%) responded that their family members were covered by a social health protection scheme. Among those who were covered by a scheme, twelve households were covered under CBHI, eleven households were under NSSF, eight households were under HEF and only one household responded that they were covered under private insurance. Among respondents whose family members were covered by a scheme, 80% (32 households) answered that they had an "Equity Card" and 90.0% (36 households) responded that they knew where eligible health facilities were. In addition, 80.0% (32 households) had experience in using the scheme. The average timing of the most recent illness episode during which social health insurance was used was 387 days ago. All the households who experienced use of the social health protection scheme responded that they were "grateful and necessary for their lives" as their impression of the scheme. Only one household responded that they had experienced that the scheme was not able to be used at a health facility. Among those who were covered under a social health protection scheme, more people in Kampong Cham responded that they had an Equity Card than in Siem Reap (Kampong Cham: 92.9%, Siem Reap: 50.0%).

Table 3-20 describes knowledge and awareness of social health insurance among people living in Kampong Cham and Siem Reap. 19.7% responded that they have knowledge on social health insurance, which means more than 80.0% of them do not have the knowledge. After a data collector explained about health insurance to each respondent, 80.0% of them said that they were willing to join social health insurance and among those 45.4% were willing to join "community health insurance," 41.7% for "government health insurance," and 4.2% for "private health insurance." Reasons given were, 67.7% responded that "able to receive better health services," 20.0% for "no premium collection," and 4.1% for "good reputation." On the other hand, reasons they did not wish to join the insurance were "no trust," answered by 16 households, and "not using health services" by two households. In addition, the Survey Team asked a question if people want to see any other association operating a health insurance scheme. 40.0% responded "women's association," 6.9% "agricultural association," as options. Also it asked a willingness to be registered for the purpose of health insurance and 84.7% agreed.

The survey results revealed that people in Siem Reap had more knowledge of health insurance (Kampong Cham: 10.5%, Siem Reap: 38.0%). More people in Kampong Cham responded "able to receive better health services," as a reason to join health insurance (Kampong Cham: 76.3%, Siem Reap: 53.1%), while more people in Siem Reap responded that "good reputation" (Kampong Cham: 2.2%, Siem Reap: 7.4%), and "no premium collection" (Kampong Cham: 16.5%, Siem Reap: 25.9%) as reasons to join.

Table 3- 20 Knowledge and awareness of social health insurance among people living in Kampong Cham and Siem Reap

	Total	Kampong Cham	Siem Reap	*p* -value
Knowledge of social health insurance (N=300)				<0.01
Yes	59 (19.7)	21 (10.5)	38 (38.0)	
No	237 (79.0)	179 (89.5)	58 (58.0)	
No answer	4 (1.3)	0 (0.0)	4 (4.0)	
Willingness to join social health insurance (N=300)				0.08
Want to join	240 (80.0)	155 (77.5)	85 (85.0)	
Don't want to join	32 (10.7)	26 (13.0)	6 (6.0)	
Not sure	24 (8.0)	19 (9.5)	5 (5.0)	
No answer	4 (1.3)	0 (0.0)	4 (4.0)	
Types of social health insurance want to join for those who are willing to join insurance (N=240)				0.37
Government health insurance	100 (41.7)	63 (40.6)	37 (43.5)	
Community health insurance	109 (45.4)	70 (45.2)	39 (45.9)	
Private health insurance	10 (4.2)	9 (5.8)	1 (1.2)	
Not sure	20 (8.3)	12 (7.7)	8 (9.4)	
No answer	1 (0.4)	1 (0.6)	0 (0.0)	
Reasons of willingness to join social health insurance for those who specified type of insurance to join (N=219)				0.01
Good reputation	9 (4.1)	3 (2.1)*	6 (7.8)*	
No premium	43 (19.6)	22 (15.5)*	21 (27.3)*	
Able to receive better health service	149 (68.0)	106 (74.7)*	43 (55.8)*	
Others[a]	14 (6.4)	7 (4.9)*	7 (9.1)*	
No answer	4 (1.8)	0 (0.0)	0 (0.0)	
Reasons of not willing to join social health insurance (N=32)				N/A
Don't trust	16 (50.0)	14 (53.8)	2 (33.3)	
Don't use health service	2 (6.3)	0 (0.0)	2 (33.3)	
Others[b]	14 (43.8)	12 (46.2)	2 (33.3)	
Other association wish to see operating social health insurance scheme (N=300)				N/A
Women's association	98 (32.7)	62 (31.0)	36 (36.0)	
Agriculture association	17 (5.7)	16 (8.0)	1 (1.0)	
Business association	3 (1.0)	2 (1.0)	1 (1.0)	
Friends' circle	1 (0.3)	0 (0.0)	1 (1.0)	
Others[c]	22 (7.3)	7 (3.5)	15 (15.0)	
Don't know	104 (34.7)	73 (36.5)	31 (31.0)	
No answer	55 (18.3)	40 (20.0)	15 (15.0)	
Willingness to be registered, if the government requires civil registration for the purpose of social health insurance (N=300)				0.32
Yes	254 (84.7)	166 (83.0)	88 (88.0)	
No	43 (14.3)	31 (15.5)	12 (12.0)	
Not sure	3 (1.0)	3 (1.5)	0 (0.0)	

Values are number (%) for continuous variables
* Adjusted residual > ±1.96
[a] Others included "mutual aids," "for safety," "responsibility as an elder in the family," "able to save medical expenditure," "health insurance office is located near the house," etc.
[b] Others included vouchers for the poor from the government (3) and support from NGO (5)
[c] Others included NGOs, organization for handicapped and child care association

The Survey Team added questions of what if a pagoda operated a health insurance scheme because Cambodians are devout Buddhists and it was expected that they would better believe in an insurance operated by a pagoda. Table 3-21 shows the people's willingness to join the pagoda-operated health insurance and willingness to pay premiums in comparison to the case of government-operated insurance. 80.3% were willing to join pagoda operated health insurance, with 51% willing to pay up to 10,000 Riels per person per year, 34.7% more than 10,000 Riels and 14.3% responded not willing to pay premium. For the government-operated insurance, 52.7% responded that they were willing to pay for the health insurance up to 10,000 Riels (US$2.50) per person per year, 26.3% were not willing to pay premiums, and 21.0% were willing to pay more than 10,000 Riels per person per year.

There were more people who did not wish to pay premiums in Kampong Cham (Kampong Cham: 31.5%, Siem Reap: 16.0%), and there were more people in Siem Reap who are willing to pay more than 10,000 Riels per person per year for premiums (Kampong Cham: 18.0%, Siem Reap: 27.0%).

Table 3- 21 Willingness to join pagoda health insurance and premium payment

	Total	Kampong Cham	Siem Reap	*p* -value
Willingness to join pagoda operated social health insurance (N=300)				0.61
Yes	241 (80.3)	159 (79.5)	82 (82.0)	
No	59 (19.7)	41 (20.5)	18 (18.0)	
Willingness to pay for the social health insurance operated by pagoda per person per year (N=300)				0.15
Not willing to pay	43 (14.3)	34 (17.0)	9 (9.0)	
Up to 10,000 Riel (US$ 2.5)	153 (51.0)	101 (50.5)	52 (52.0)	
More than 10,000 Riel (US$ 2.5)	104 (34.7)	65 (32.5)	17 (17.0)	
Willingness to pay for the social health insurance per person per year (N=300)				0.01
Not willing to pay	79 (26.3)	63 (31.5)*	16 (16.0)*	
Up to 10,000 Riel (US$ 2.5)	158 (52.7)	101 (50.5)	57 (57.0)	
More than 10,000 Riel (US$ 2.5)	63 (21.0)	36 (18.0)*	27 (27.0)*	

Values are number (%) for continuous variables
* Adjusted residual > ±1.96

(4) Limitations and significance of the study

The survey is a cross-sectional study and therefore a causal relationship could not be found from the survey results. Due to time and budget constraints, the sample size was limited in only two provinces. Therefore, one should carefully interpret the results of this study as the results in two particular provinces, not the entire nation. However, various measures were taken to minimize bias and increase quality of the data and reliability of the study. Therefore, it is believed that the survey results provide a wide range of information related to people's behavior and perception of health services and health protection, which is useful in the course of developing a policy and a strategy for social health protection system building in Cambodia.

CHAPTER 4 Future Directions for the Social Health Protection System in Cambodia

4-1 Social health protection policy formulation

In 1990s, after the 20-year internal conflicts in Cambodia, social protection for the poor and the vulnerable were urgently needed and massive foreign aid was provided by various organizations from all over the world. Since 2004, the Council for Agriculture and Rural Development (CARD), comprised of 14 governmental agencies, has been organizing core group meetings with development partners in the area of social protection, discussing intersectoral issues, such as health, food security and education. JICA is a member of the core group. The Chairman of CARD was Prime Minister Hun Sen until 2008 when H.E. Yim Chhay Ly, Vice Prime Minister was appointed as a successor. On the other hand, "social security" is a new demand in Cambodia whose economy is rapidly growing. Today, these two movements have been merged and "social protection" is being treated as "social assistance" in the context of "social security." CARD is currently working on a Social Assistance Policy Paper.

Meanwhile, MEF is playing a key role in formulating the strategy for development of social protection system, including pension and health insurance, and in 2015, the Technical Working Group (TWG) for Developing National Social Protection Policy Framework was established. The TWG is holding meetings irregularly, normally once or twice a month, and when necessary, the group invites development partners to the meetings. The Chair is H.E. Nguon Sokha, Secetary of State of MEF, and the Vice Chairs are H.E. Kan Moan, Secretary of State of MLVT and H.E. Samheng Boros, Under Secretary of State of MSAVYR. The TWG has 14 members, and eight of them represent departments of MEF: Departments of Economic Policy, Financial Industry, Insurance and Pension, Taxation, and Budget. Particularly, there are two representatives from the Department of Financial Industry. Other TWG members are as shown in Figure 4-1. It is obvious that social health protection is the priority issue in Cambodia as most of the TWG members are Secretaries of State and Under Secretaries of State in each Ministry.

Figure 4- 1 Member Institutions of TWG for Developing National Social Protection Policy Framework

Source: Ministry of Economy and Finance

The Ministry of Economy and Finance entrusted the development of the social security policy framework paper, “White Paper,” to the consulting company Ernst & Young (EY), and the research began in early October 2015. By the end of December, 2015, the draft was circulated, and stakeholders, including the development partners, made comments on the draft. Currently, EY is finalizing the report. It is expected that the report will have a current situation analysis and recommendations in the policy framework of comprehensive social security, including employment, education and maternity leave. The report is also going to have a roadmap with regard to pension and health protection, and the possibility of scheme integration. Detailed action plans on the basis of the “White Paper” should be developed in the TWG meetings. It is evident that many of the development partners are willing to be involved in efforts to build the social security system, while considering future aid policy on the basis of the “White Paper.”

4-2 Lessons that the Cambodian Officials learned through the Study Tours

It was meaningful that Cambodian government officials, involved in social health protection system development, visited Japan and Thailand and learned about their experiences at the time that the country just started planning on the development. The following are some lessons they learned from the Study Tours and would like to utilize in Cambdodia.

(1) Lessons learned from experience of the two countries

Both Japan and Thailand have their government’s strong commitment and the country’s economic growth fueling the achievement of UHC. Cambodia’s economic growth rate is on average 7% today and, as described above, the government’s commitment has been increasing. Therefore, there is no doubt that it is the correct time for Cambbodia to start building a social health protection system. In the meantime, Cambodian officials learned from the two Study Tours that they had better start making efforts immediately as medical expenses are increasing due to the modernization of health care and population aging which requires long-term care.

The two countries have different social health protection systems for the informal sector. This is an especially important issue for Cambodia as the informal sector accounts for about 80% of the total population. In Thailand, whose population structure is similar to Cambodia, the informal sector is covered by a tax-based health protection system. On the other hand, the Japanese system for the equivalent population is basically covered by the social insurance system, although it is partly compensated by tax. These schemes have the advantages and disadvantages as shown in Table 4-1. Regardless the system of social health protection, it is necessary for a country to determine where to seek sustainable financial resources.

There are more than one insurer in both Thailand and Japan. When there are several insurers and review agencies, the administrative expenses increase. Each of the three social health protection systems in Thailand: the Civil Servant Medical Benefit Scheme (CSMBS), the Social Health Insurance (SHI) under the Social Security Scheme (SSS) and Universal Coverage System (UCS); has its own benefit package, fee schedule, payment system and fund management

system. There is an especially large disparity in benefits between CSMBS, the social health protection system for civil servants working for the central government and their families, and that of other insurance systems. However, once the multiple insurance system is established, scheme integration is extremely difficult because the insurer with more resources and their insured usually oppose it.

Table 4- 1 Advantages and Disadvantages of the medical insurance system that can be introduced in Cambodia

	Advantages	Disadvantages
Social Insurance System	・Financial burden of the government can be reduced.	・It is difficult to identify the population and their income and financial capacity. ・Initial investment in capacity building of the insurance operating agency is required.
Tax-based System	・Initial investment in organizational capacity building can be reduced.	・The government has a large permanent financial burden (More than 80% financial costs are covered by tax in Thailand)

In Japan, UHC is achieved through Employees' Health Insurance and community-based health insurance, "National Health Insurance (NHI)." In addition, the Employees' health insurance includes (a) health insurance societies covering employees at large corporations and their dependents, (b) the Japan Employees' Health Insurance Association covering employees working at small and medium-sized enterprises and their dependents; and (c) a mutual aid association covering public employees and others. The insurers of the NHI are local governments. Hence, these insurers differ considerably in the composition of medical expenditures, as the proportion of the elderly differs in each scheme as well as the income levels of the insured. To mitigate the disparity of the insurers' burden, the Law of Health and Medical Services for the Elderly was enacted in 1982 (enforced in 1983) and a financial adjustment was made to subsidize vulnerable insurers, such as the NHI and mutual aid associations. In the1980s, after going through a couple of oil crises, "financial restructure without increased taxation" became an absolute must in Japan and further adjustment took place, under the same law, the Law of Health and Medical Services for the Elderly. However, it was recognized that the proportion of elderly differs from one insurer to another. Under the adjustment, all the insurers came to pay a contribution of Health and Medical Services for the Elderly, at the national average. Since then, the financial adjustment was revised multiple times, and in 2008, the Advanced Elderly Medical Service System was established for people over 75 years of age, and a financial adjustment, similar to the previous health system for the aged, was introduced for people aged from 65 to 74.

Based on these two countries' experiences, Cambodian officials stated that they would carefully design their own social health protection system, including the institutional arrangement. The Thai government advised Cambdodian officials that unification of payment mechanisms should

be considered from the beginning if the government wishes to have a single payer system in the future, as the single payer system requires a unified payment mechanism at medical institutions.

(2) Japanese elements that attracted Cambodian officials

The following are the elements of the Japanese system in which the Cambodian officials were most interested.

Effective laws and regulations

In Cambodia, disparity in medical care is increasing as private medical institutions as well as private insurance companies increase. Cambodian officials showed interest in using the Japanese system of laws as a reference, as the country is maintaining equity of health care by using effective laws and regulations, including the National Health Insurance Law, the Medical Service Law, the Elderly Welfare Law, the high-cost medical treatment system and the deduction for medical expenses.

Price control and reasonable benefit package

Cambodian officials showed strong interest in the Japanese fee schedule and benefit package. However, they said that the system should be simplified in Cambodia.

National Health Insurance

Cambodian officials especially showed interest in the NHI,[97] as the social insurance system covers the self-employed and retirees, which is equivalent to the informal sector population in Cambodia.

The following are the aspects that they believe are particularly relevant for Cambodia.

• **Insurance premiums set in accordance with the financial capacity of the insured —** One must have a way to capture the informal sector population's economic capacity.

• **Co-payment of the government and the insurer —** At least, MOH wishes to share responsibility of covering medical expenses equally with the government and the insurer.

• **Co-payment by patients at time of health facility visit —** A strategy to reduce the burden of the insurer: thorough negotiation among the relevant parties is necessary to share responsibility. In addition, it is important for Cambodia to grasp the proper timing to introduce the system because it has been unsuccessful in Thailand once it abolished the "30 baht universal healthcare scheme."

• **Insurance operation by the local government —** Public administration should be decentralized and the capacity of local government officials should be improved.

[97] The insurance systems in Korea and Taiwan are similar to that of Japan as their systems were formed based on the Japanese model.

• **One-stop service including promotion, income survey and premium determination at a public office —** This system also requires the improved capacity of local government officials.

(3) Thai elements that attracted Cambodian officials

The following are the elements of the Thai system in which the Cambodian officials were most interested.

Health promotion and disease prevention to reduce medical expenses

Cambodian officials showed interest in the Thai government's health promotion and disease prevention at primary care institutions as a strategy to reduce medical costs.

Management cost control by utilizing Diagnosis Related Group (DRG)

They say that they would like to introduce this system to Cambodia once the information system management becomes enhanced.

Sustainable fund management by the independent institution

Proper asset management is essential to sustain the insurance fund, and therefore Cambodian officials showed interest in learning the fund management style of the Thai government.

(4) The two countries' common elements that attaracted Cambodian officials

The following are the common elements of the two countries in which the Cambodian officials were most interested.

Effective utilization of IT systems

As the consolidation of information is important for efficient insurance management, they say that they would like to enhance the IT systems in Cambodia.

Payment examination by a third party

In Japan, when medical institutions claim medical fees to insurers, cliam is checked by an Examination and Payment Organization before it is sent to the insurers. There is one Examination and Payment Organization for Employees' Insurance system and one each for a prefectual community-based health insurance. Examination and Payment Organization examines whether treatments and prescribed medicines are under the rules of the fee schedule and make payments to medical institutions, if no specific problem was found.[98]

In Thailand, the three separate schemes: CSMBS, SSS and UCS; have different payment systems. For CSMBS, Comptroller General's Department (CGD), under Ministry of Finance, receives claims from medical institutions, examines and pays partly to medical institutions and partly reimburses to patients. The payment of SSS is managed by Social Security Fund (SSF) with its administrative body, the Social Security Office (SSO). For UCS, National Health

[98] Hoshida, J. (2015). National Health Insurance, and Other Insurers.

Security Office (NHSO) makes capitation payment for outpatients and comprehensive payment with DRG-Related Weight for inpatients after examination of claims from medical institutions.[99,100]

Currently, NSSF, the only insurance operator in Cambodia, is doing the payment examination within the organization. However, they admit that it is essential to establish a third-party organization in order to carry out transparent payment management.

Integrated information systems of civil registration and social insurance

When a social insurance system is introduced in a country, it is essential for an insurer to have a comprehensive information system of the insured. The two countries' experiences help Cambodia to think about building an integrated information system with civil registration and vital statistics (CRVS) including birth registration, ID Poor registration and social insurance.

4-3 Social health protection system building

TWG for Developing Social Protection System in Cambodia held a meeting on February 18, 2016, and the basic policies and a roadmap for social health protection building for 2016 to 2025 among others (see Figure 4-2) were proposed as follows.

Basic policy 1. The ultimate goal is Universal Health Coverage.[101]

Basic policy 2. The social protection operating agency should be single payer.

Basic policy 3. The benefit package should be unified.

For future strategy presented at the TWG meeting, NSSF was to become a single payer, renamed as the National Insurance Fund (NIF), covering the entire population. In addition, it was pointed out as necessary to develop a draft law that define the roles and responsibilities of NIF, a new governance structure, policy, and the appointment of a regulator and administrator.

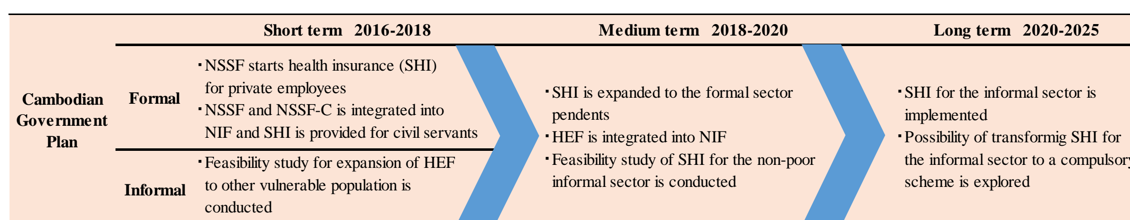

Figure 4- 2 Proposed Roadmap for Social Health Protection Building 2016 to 2025

Through dialogue among the relevant ministries and agencies, a common understanding has emerged that the poor shoud be fully covered through taxes, but a social insurance system

99 Data collection survey on social security sector in Asia final report: country report. (2012). Japan International Cooperation Agency: Mitsunishi UFJ Research and Consulting Co., Ltd.

100 International Labour Oraganization Subregional Office for East Asis. (2006). Thailand: Universal Health Care Coverage Through Pluralistic Approaches.

101 ."UHC." means increase of the population coverage, reduction of out-of-pocket payment and expansion of service packages: explained by MEF (April 7, 2016)

should be adopted for the non-poor informal sector by collecting premiums from the population, as the tax revenue is limited and the country is facing many other priority development issues. However, MOH claims that it is still necessary for the government to subsidize the insurance fund for the informal sector, while MEF suggests that measures that reduce the heavy burden on the government should be considered.

4-4 Development Partners' support

(1) Development Partners's current support in the Social Health Insurance sector

The following describes the major supports provided by development partners in the Social Health Insurance sector.

① France (AFD)[102]

AFD, through the French NGO GRET, provided technical support to NSSF to establish a social health insurance scheme for private employees by the implementation of a pilot project called HiP targeting workers in 10 factories. It included development of a compulsory participation scheme and capacity development of NSSF staff.

In Takeo province, AFD through GRET supported HEF and CBHI comprehensively and brought field evidence to the policy dialogue. It also supported SKY, a pioneer of CBHI schemes.

AFD provided technical support to MOH to develop the National Health Financing Policy, as well as supported the Department of Planning and Health Information (DPHI) for the installment of an IT software system to standardize information on HEF, CBHI and use fees.

In 2010, there was a change in the Official Development Assistance (ODA) direction of the French government from grant aid to loan. Therefore, AFD limits their support to HSSP2 and they will not participate in the next financial support program. "Health Equity and Quality Improvement Project (H-EQIP)".

On the other hand, they have a plan to conduct a survey on the pension sector of NSSF together with ILO. However, NSSF's priority is health insurance. Therefore, AFD monitors the progress of health insurance of NSSF for the time being and will start supporting the pension later.

② Australia (Department of Foreign Affairs and Trade: DFAT)[103]

DFAT chaired HSSP2 and was recently replaced by KfW and Korea International Cooperation Agency (KOICA). They provide technical support to the MOP together with GIZ to strengthen the ID Poor Program. The current phase ends in February 2016, but they will continue the support, especially focusing on the ID Poor certification to urban poor.

[102] Interview with AFD (October 23, 2015)
[103] Interview with DFAT (October 28, 2015)

③ Germany (GIZ, KfW, German Embassy)[104]

Germany provides the most comprehensive support to Cambodian's Social Health Insurance sector. KfW provides financial support while GIZ provides technical support. KfW participates in the HSSP2 and GIZ dispatches an expert to the DPHI of MOH and ID Poor program of the MOP. Until 2014, it supported both the formal and the informal sectors, however, it shifted the focus to supporting the informal sector lately, following the German ODA policy.

KfW, through VMA, has supported the Voucher Scheme since 2011 and it supports the Integrated Program that combines the Voucher Scheme, HEF and CBHI in Kampong Thom province. KfW also provides support to the Conditional Cash Transfer in maternal and child health.

④ International Labour Organization (ILO)[105]

ILO provides support to both the formal and informal sector's social health protection. For support to the informal sector, ILO started a pilot project called the "Social Service Delivery Mechanism (SSDM)" at two districts in Siam Reap, which aims to establish one stop station for social services. The project works together with MOH, the Ministry of Education (MOE), MOP and MLVT in accordance with the National Social Protection Strategy for the Poor and Vulnerable (NSPS).

ILO also supports the development of a tracking system for beneficiaries. It is believed that the existing database for the ID Poor is reliable, however the information for ID Poor is not sufficient to collect all necessary information. They plan to expand the system to a National Personal Information System.

ILO conducted the Social Protection Expenditure and Performance Review in 2010. Together with GIZ, they also conducted the Financial Assessment of the National Social Protection Strategy, responding to the request of MOH. It showed the cost to expand services to the specific target groups (children under five and the elderly). Currently, they are discussing whether to conduct a similar study again. They also received a request from MEF to conduct a study on social insurance targeting civil servants, the police and the military. ILO also plans to conduct a study on NSSF pension in partnership with AFD.

⑤ Korea (KOICA)[106]

The Korean government provided budget support and dispatched an actuarial expert to NSSF through ILO when NSSF started developing the work injury scheme in 2003.[107]

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[104] Interview with GIZ and KfW (November 13, 2015).
[105] Interview with ILO (October 27, 2015).
[106] Interview with KOICA (October 28, 2015).
[107] ILO Sub-regional Office for East Asia. (2005). Report to the Employment Injury Insurance in Cambodia: Legislation, Financing and Administration.

KOICA is the co-chair of HSSP2. KOICA will continue providing information on the Health Insurance Review Agency (HIRA)[108] to MOH and other development partners as they express interest in it. KOICA plans to dispatch a health specialist to work on the HSPP2 as well as H-EQIP.

⑥ **Switzerland (SDC)[109]**

SDC provides support to Kantha Bopha Hospital, as the hospital was established in 1974 with donations from the Swiss and Dr. Beat Richner, a pediatrician with the Swiss Red Cross. SDC started a survey on health financing in 2015.

⑦ **United Nations Populations Fund (UNFPA)[110]**

UNFPA provides support to the HSSP2 and chaired the group for 17 months. Under HSSP2, they conducted a survey on health systems and provided technical advice on obstetrics and gynecology.

⑧ **United Nations Children's Fund (UNICEF)[111]**

According to the known fact that the first 1,000 days after birth are the most critical for life long health, UNICEF is in a process of developing a health protection package for zero- to two-year olds. The package includes coverage for 20 diseases children are susceptible to (i.e., diarrhea, pneumonia and malnutrition). They will calculate the cost for service deliveries and health expenditure at the household level and finalize the package content in 2016. After that, they will operate a pilot project in one to two provinces, analyze the results, and expand it to other areas.

UNICEF is also exploring the possibility of combining the health protection package for pregnant women and children under two years and a voucher scheme to supplement with HEF and other schemes. As UNICEF aims to cover all children regardless the family's income level, they are planning to support MOI's birth registration system.

⑨ **United States Agency for International Development (USAID)[112]**

USAID provides support to the payment and information system of social health protection. In addition, they monitor HEF as a third party through URC. They are planning to provide technical support to MEF with a focus on Sustainability, Education and Partnership. They intend to participate in H-EQUIP.

USAID is developing a plan to integrate three social protection schemes (the private sector, civil servants and the informal sector) into one scheme based on the policy dialogue with MEF. As part of the USAID global project, the Health Finance and Governance (HFG), they are

[108] Under strong presidential leadership in the early 2000s, Korea established a social health insurance scheme rapidly and achieved UHC in 2003. They conducted drastic health system reform, integrating 350 insurers into one, introducing IT and establishing a Health Insurance Review Agency (HIRA) which does payment, verification and evaluation.
[109] Interview with SDC (November 4, 2015).
[110] Interview with UNFPA (November 6, 2015).
[111] Interview with UNICEF (November 5, 2015).
[112] Interview with USAID (November 12, 2015).

conducting a survey on the current situation of health financing in Cambodia thorough a private consulting firm, Action-Based Thoughts (ABT). Currently, they are in the process of developing the USAID assistance program for Cambodia during 2018-2020.

⑩ **World Health Organization (WHO)[113]**

WHO chairs the monthly health sector development partners' meeting and coordinate various meetings in health system and financing eanhancement. WHO also provides Cambodia with technical support in the accounting framework system, the National Health Accounts, to allow timely collection of annual health expenditure data. Under the framework of Providing for Health (P4H),[114] they developed a roadmap for health protection development and conducted a survey on cost calculation.

⑪ **World Bank[115]**

The World Bank manages the pooled funds of the HSSP. Recently, they are preparing for H-EQIP which is a subsequent project of HSSP2 that ends in June 2016. In early December 2015, a mission visited Cambodia for a final evaluation of the project. The new project was to be approved at the board meeting of the Bank in March 2016.

They also conducted a survey on the Voucher Scheme and CBHI through a consulting firm, Angkor Consultant. In addition, they conducted a survey on Public Financial Management (PFM) targeting MEF and MOH, on November 2-13, 2015. In 2014, together with GIZ they supported a study tour to Indonesia by MOH, MEF and MOP. They are planning to support a study tour to Korea.

(2) Trends of the Health Sector Support Program 2 (HSSP2)

HSSP, a pooled fund support, started in 2003. Since 2008, the second phase of the program (HSSP2) has been operated. To date contributing partners of the fund are the World Bank, DFAT, UNFPA, UNICEF, KOICA and KfW. When the program started, development partners contributed 90% of the pooled funds and currently it has decreased by 60%. There is a plan to decrease the contribution of development partners by 10% yearly and increase the government contribution gradually.[116]

Development partners participating in HSSP2 jointly developed a plan of operation and are conducting reviews twice a year. The review covers both operational and financial aspects. They collectively signed an Aide Memoir. HSSP2 provides demand-side financial support (HEF) and supply-side financial support (SOA). There are two ways to contribute to the pooled funds: one is to contribute to the common funds and the other is to the purpose-specific funds.

113 Interview with WHO (October 26, 205).
114 P4H is a global health partnership aimed at improving social health protection and strengthening health financing systems to promote universal coverage in low and middle-income countries. To date the P4H network includes Germany, France, Switzerland, Spain, ILO, WHO, the World Bank and the African Development Bank.
115 Interview with World Bank (October 26, 2015).
116 Interview with Dr. Kanha at MOH (October 27, 2015).

H-EQIP, which is the subsequent project of HSSP2, is in the planning stage. It was developed by the World Bank as a focal point. Receiving results from the pre-evaluation, the new program will be discussed at the board meeting of the Bank in March, 2016. After the approval, the program will be implemented from July 2016 to June 2021 for five years. H-EQIP is supposed to be the last financial support program to Cambodia. After H-EQIP, it is expected that the program will be operated through the government budget. Although it is a five year project, only the budget for the first three years is pledged. Therefore, participation from other development partners is encouraged. In addition to the Bank, DFAT, KfW, KOICA and the Japanese government have shown interest in participating in the H-EQIP.

Below are the key results and components proposed by the pre-evaluation mission:

Key Results of H-EQIP

- Increase of public health facilities exceeding the benchmark score on the Quality Assessment of health facilities[117]
- Reduction of the households that are impoverished as a result of health spending
- Reduction of out-of-pocket payment as a percentage of total health expenditure.
- Increase of health service utilization by HEF beneficiaries

Components of H-EQIP

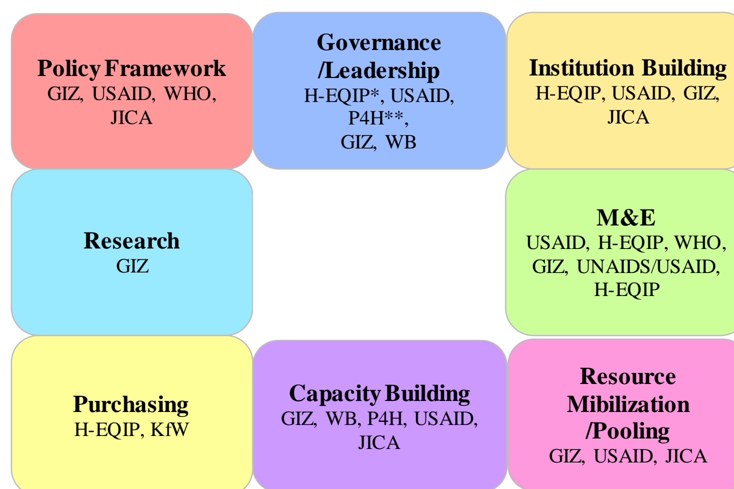
- Strengthen Health Service Delivery
- Improve Financial Protection and Equity
- Ensure Sustainable and Responsive Health Systems
- Contingent Emergency Response

Establishment of an autonomous institution called the “Public Administration Enterprise (PAE)” is a major component under H-EQIP. PAE is a payment agency that pays the Service Delivery Grants (SDG) and HEF directly to the SAOs, and monitors HEF, which is currently performed by URC. PAE is also expected to be a verification agency for the SDG. A detailed organizational arrangement of the PAE has not yet been determined, however, it is envisioned to have it like “HIRA” in Korea. While a Royal Decree is required to establish a PAE, when it is going to be issued is unforeseen. There is also a discussion that the coming H-EQIP should pool not only funds, but also technical assistance (TA).

[117] A Quality Assessment Team, comprising the staff of Hospital Department, Ministry of Health (MOH) and Provincial Health Departments, assesses quality of health facilities with the assessment tools of Level 1: providing a snapshot of available basic health service, including infrastructure, equipment, and manpower, and Level 2: measuring the appropriateness of the patient-provider interaction by focusing on the fundamentals of clinical care and clinical standards.

(3) The Trends of P4HC+

In Cambodia, P4H[118] has been the coordination mechanism of development assistance in the field of social health protection and formerly GIZ, WHO, ILO and AFD were meeting within that framework. There used to be P4H regular biweekly meetings and extra meetings when a special issue arose[119]. However, recently the P4H renamed itself P4HC+, and newly inaugurated as a coordination mechanism that specializes in health financing, and expanded the membership framework. In addition to the original memebers of GIZ, WHO, ILO and AFD, World Bank, UNICEF, USAID, SDC and JICA partipated in the first meeting of P4HC+ which was held on March 4, 2016. P4HC+ is expected to function as an information sharing forum among the development partners to support the health financing field. The advisor to GIZ has compiled this new framework. Currently, P4HC+ has been carrying out a mapping of the development partners' future assistance plans in the field of health financing to confirm whether there is any duplication or shortage of assistance in particular areas (see Figure 4-3).



*World Bank, KfW, DFAT, KOICA and Japan are interested in joining H-EQIP.
**Among the DPs in Cambodia, the official P4H members are WHO, WB, ILO, GIZ, AFD, USAID and SDC.

Figure 4- 3 Overview of P4HC+ DP Activities in Support of Health Financing for UHC (March 2016)

118 Currently, JICA is an observer in P4H.
119 Interview with ILO (October 27, 2015).

CHAPTER 5 Recommendations for JICA's Future Assistance in the Development of the Social Health Protection System in Cambodia

The results of this survey suggested that the people in Kampong Cham and Siem Reap provinces perceive that public health services are generally meeting their needs and they trust in the services to some degree. On the other hand, the survey also confirmed that the people in those areas appealed that finances have been the major barrier in accessing necessary health services, particularly in the case of a referral. These survey results further imply the situation of the entire nation. In Cambodia, out-of-pocket payment in fact accounts for more than 60% of total health expenditure, which often results in "financial catastrophe" for the individual or the household. In other words, Cambodia is in need of achieving Universal Health Coverage (UHC) in which "all people obtain the quality health services, including prevention, treatment and rehabilitation, when they need them, without suffering financial hardship."

Although the Cambodian population is still young today, it was predicted that the country is going to start aging in 15 to 20 years. Meanwhile, the industrial and employment structures are undergoing significant changes. Cambodia has been gradually shifting from an agricultural to a manufacturing and construction economy, which has also shifted from primarily unpaid family employment to paid employment. These social and economic changes in the country further suggest that Cambodia should urgently enhance the social health protection system within the next few decades.

Private employees are covered by NSSF that will expand to civil servants soon. Coverage of the poor is likely to reach close to 100% through the HEF, although there is still an issue of the underutilization.[120] The HEF is receiving assistance from the World Bank, USAID, DFAT, KOICA, KfW, GIZ, UNICEF and UNFPA, as stated earlier. Therefore, a need for additional assistance from Japan is not evident in either the formal sector or for the poor. However, there is very little assistance currently provided to the rest of the population, hereinafter called "non-poor informal sector."

There are two models to achieve UHC: the social insurance-based and the tax-based model. The Cambodian ministries have reached consensus on pursuing UHC by covering the non-poor informal sector population through the social insurance-based model by today.

Shimazaki (2013) [121] suggests that there are the following three advantages in adopting social health insurance:

1) The concept of independence and self-help is embodied by making people prepare for future risks by paying premiums.

[120] Health Equity Funds Utilization Survey: Are Beneficiaries Enjoying their Benefits?
[121] Shimazaki, Kenji. (2013). The Path to Universal Health Coverage - Experiences and Lessons from Japan for Policy Actions -.

2) Social health insurance can maintain fiscal discipline because the contribution level is established in such a way as to balance revenues and expenditures, and expenditures are in principle controlled within the amount of revenue.

3) Compared with the tax-based model, the social insurance model enables the beneficiaries to claim their rights to health care more strongly because the benefits are given in return for paying premiums.

Germany introduced the world's first social insurance system in the 1880s. In Germany, the law for health insurance was established as labor legislation, and therefore enrollment is not compulsory for the self-employed and high-income earners up to the present day. Currently, about 85% of the population is covered by public health insurance, and the rest are uninsured or are enrolled in private insurance.[122] In France, CMU (Couverture Maladie Universelle: universal health care benefit plans) was introduced in January 2000 to cover unemployed workers under the insurance for workers and their dependents, which resulted in 95% population coverage.[123,124] Australia utilizes tax-based health insurance, and public health insurance does not exist in the United States. In Japan, those who are not insured under the Employee's Health Insurance are covered under community-based health insurance (National Health Insurance) operated by local governments. Community-based health insurance was originally created in Japan to cover farmers and other self-employed suffering from poor health and hygiene. Japanese government officials valued the advantages described above of social health insurance and developed the system to cover the informal sector despite the difficulty of collecting premiums from the population.[125]

In Cambodia, where 80% of the population is in the informal sector, it is not realistic to cover the informal sector with employees' social health insurance. It is more suitable for the country to adopt community-based health insurance, while the country should also consider government subsidies to enable the insurer to sustain the fund as practiced in many countries, including Japan. Hence, it is reasonable to conclude that Japan has a comparative advantage over other development partners in developing a community-based social health insurance system for the non-poor informal sector population in Cambodia.

There is the Community-based Health Insurance (CBHI) provided for the non-poor informal sector population in Cambodia, however, most of the Cambodian CBHI schemes are currently in financial crisis due to lack of risk distribution mechanism in the schemes. Therefore, it is crucial to keep this situation in mind as the new CBHI is designed. In addition, the new CBHI should also prepare for increasing medical expenses primarily due to the emergence of non-communicable diseases and the advancement of medical technology.

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[122] Kenji Shimazaki. (2015). Health Care in Japan, Institutions and Policies. P.24

[123] Ministry of Health, Labour and Welfare. (2011). Summary and Trends of Social Health Protection Systems (France). Foreign Situation Report 2009-2010. p.309-319.

[124] The unemployed are enrolled in insurance with a government subsidy and their reimbursement rate is higher than the employed.

[125] Shimazaki, Kenji. (2013). The Path to Universal Health Coverage - Experiences and Lessons from Japan for Policy Actions -.

In Japan, community-based health insurance was successfully adopted and rapidly expanded once the Community-based Health Insurance Law was put into place in 1938. Shimazaki[126] points out the following seven contributing factors for this achievement.

1) Strong political backing supported the policy.

2) The mass media and local governments strongly advocated for the insurance.

3) A sense of social solidarity was strong, particularly in the rural communities.

4) Feasibility studies, including the implementation of pilot projects and interviews with local government officers, were conducted prior to developing the insurance system.

5) A number of grass-roots activities, such as a "campaign for medical services for farmers" was carried out.

6) Accurate information management on the informal sector population and effective contribution collection existed.

7) Existing management mechanisms in the Employees' Health Insurance program were utilized as a basis for designing CBHI.

Whereas in Cambodia, there are political backing and the Employees' Health Insurance program, the National Social Security Fund (NSSF), can be utilized as a basis of the CBHI management mechanisms. However, at this point in time, accurate information management on the insured and effective contribution collection are not likely to exist, and advocacy and grass-roots activities to raise people's awareness and feasibility studies are going to be needed in the course of social health insurance system development in Cambodia. JICA should take these points into consideration when it formulates the future assistance program for Cambodia's social health insurance system development.

Figure 5-1 shows the planned schedules of Cambodia's social health insurance system development proposed by TWG for Developing National Social Protection Policy Framework and JICA's possible assistance for the activities. As seen in the Figure, the Cambodian government has a plan to develop the social health insurance for the non-poor informal sector, however, the procedure of the development is absent. Therefore, it is recommended that JICA uses the initial period of 2016 to 2018 for contributing to drawing a roadmap for Cambodia's informal sector social health insurance scheme development, and thorough planning of JICA's subsequent assistance program. The following are three options recommended for JICA to pursue as the subsequent assistance program after 2018.

[126] Shimazaki, Kenji. (2013). The Path to Universal Health Coverage - Experiences and Lessons from Japan for Policy Actions -.

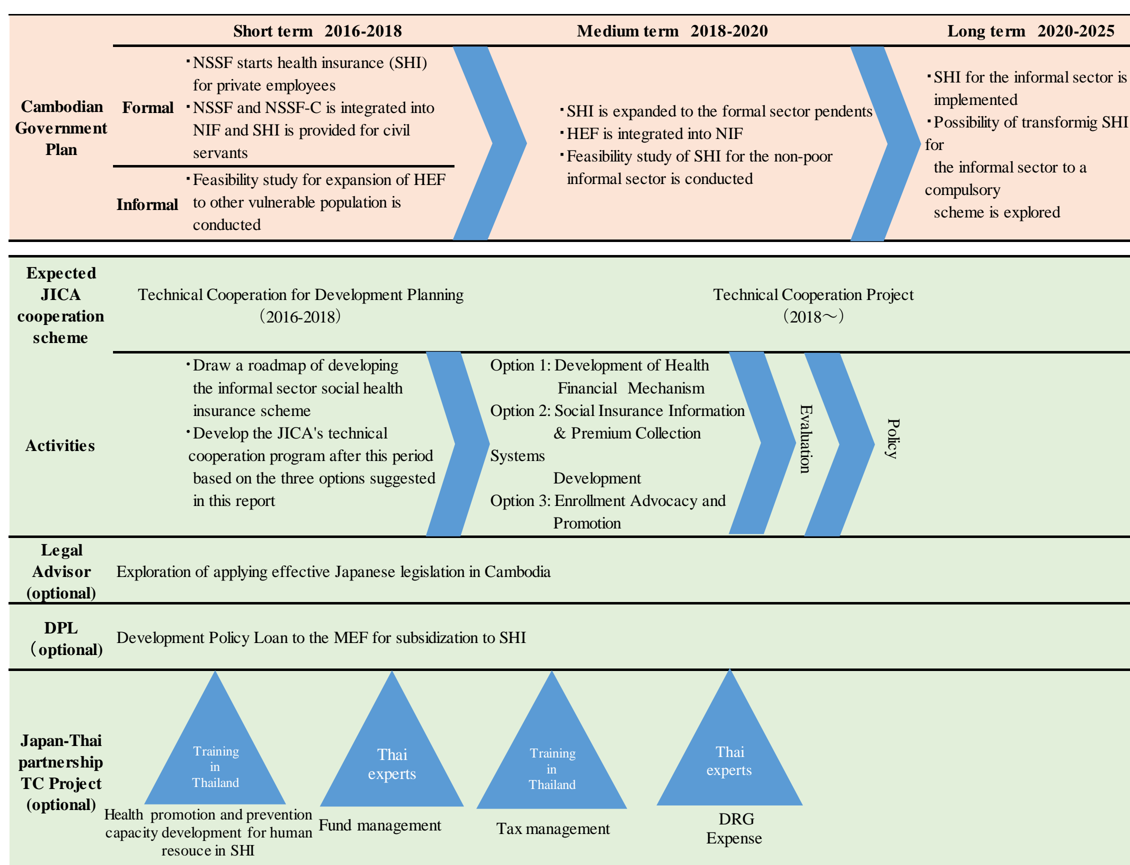


Figure 5- 1 Cambodia's Proposed Roadmap for Social Health Protection Building 2016-2025 and JICA's Recommended Assistance

Option 1: Development of Health Financial Mechanism

In Cambodia, medical fees are set at each health institution, which has created disparity in not only medical fees, but in quality of care, even among public health institutions. Price control was in fact one of the aspects that Cambodian officials were most interested in throughout the Study Tour to Japan. In order to decide the medical fees, the amount of premiums as well as benefit packages should be considered under a specific social health insurance system. Thus, the first recommendation for JICA is to develop a health financial mechanism in Cambodia.

Figure 5-2 shows the scopes of JICA's assistance activities based on the TWG plan. For calculation of medical fees, premiums rates and a benefit package, technical cooperation for development planning is going to be implemented. The technical cooperation team will first consult with NSSF to learn about the current benefit package and the premiums of NSSF as reference. Then the team will modify NSSF benefit package based on the country's disease structure and its impact on the economy, and decide a new benefit package. For the premium and medical fee calculation, the team will consult with the ILO that has conducted actuarial studies for NSSF and possibly collaborate with the organization for implementing the actuarial study. Based on the study findings, medical fees, premium rates and a benefit package for the pilot study will be decided by 2018. Once the tentative health financial mechanism is created,

the subsequent project team is going to pilot the mechanism in a particular area, possibly a JICA project site, to create synergy among the projects. There is a possibility that the health insurance pilot project would encourage the informal sector population to utilize the health services provided with assistance from JICA, while the population may want to be enrolled in a health insurance scheme if the health service is improved by JICA's on-going support.

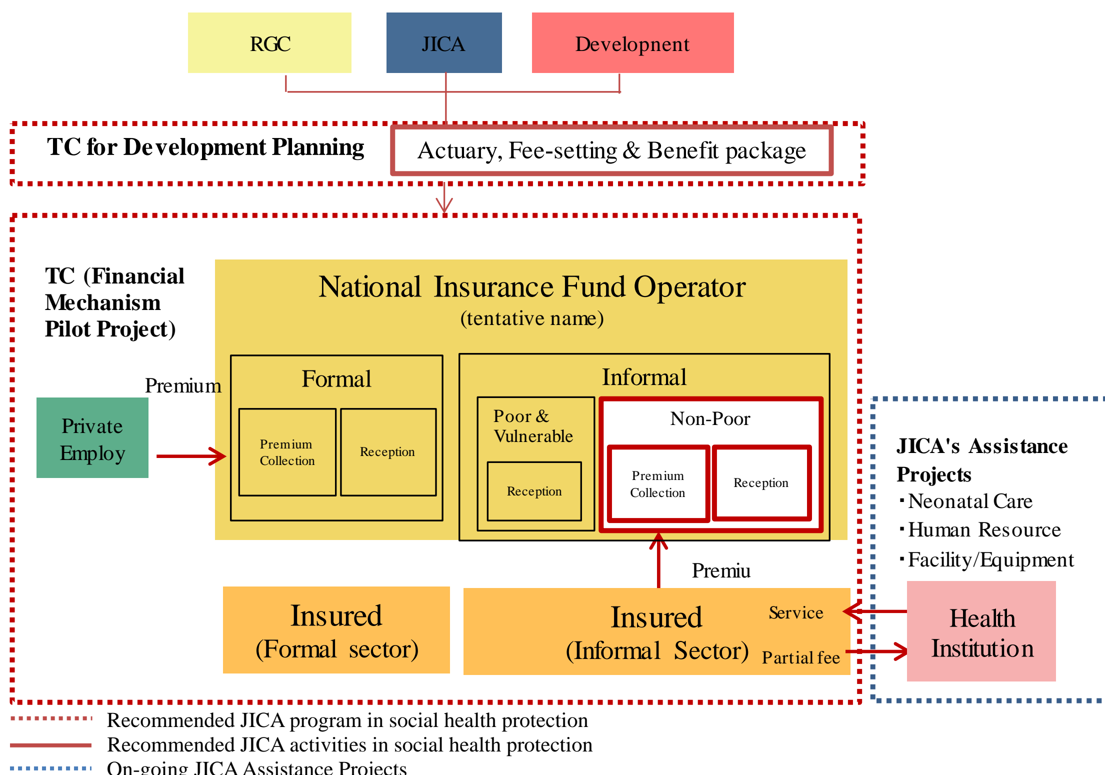


Figure 5- 2 Option 1: Development of Health Financial Mechanism

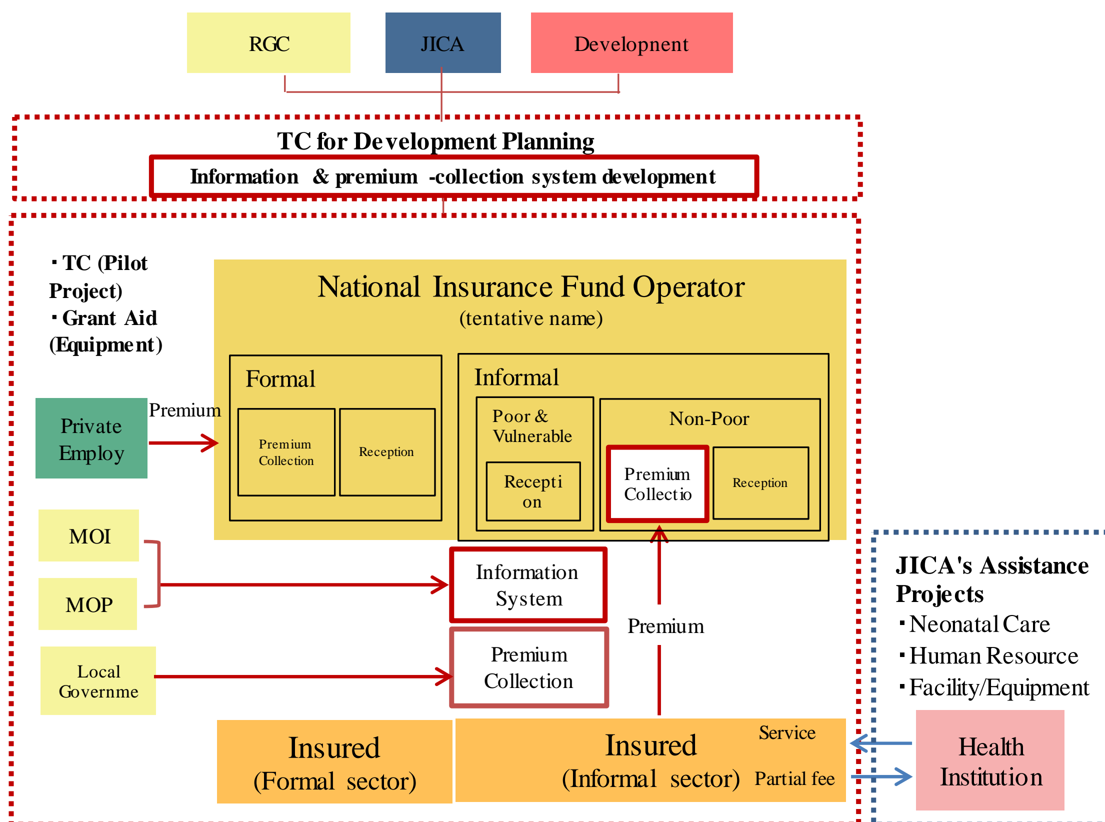
A few years later, the mechanism is going to be evaluated and modified based on the evaluation results. Moreover, the benefit package and the medical fees set by this pilot project are going to be considered to become the national standards for the entire population.

Option 2: Social Insurance Information & Premium Collection Systems Development

Inclusion of the informal sector in a social health insurance-based model is not easy because such factors as reduced premiums for low-income persons are expected in the model. In fact, one of the keys to Japan's success in adopting a community-based health insurance system for the informal sector was the fact that accurate information management on the informal sector and effective premium collection already existed in the country, as stated earlier. Thus, the second recommendation for JICA is to assist Cambodia to develop an accurate information system on addresses and income of the informal sector and a premium collection mechanism, which are considered to be prerequisites for adopting a social health insurance system for the informal sector.

Although NSSF has a mechanism to collect premiums, the non-poor informal sector has to develop its own mechanism to collect premiums directly from the insured. Thus, the social insurance information system should be developed to allow the insurer to identify the insured and collect premiums from them. Figure 5-3 shows scope of the option 2 in the contexts of the TWG Plan. For both information systems and premium collection mechanisms, technical cooperation for development planning is going to be implemented to develop the basic plans and policies by consulting with relevant Cambodian ministries, development partners and JICA from 2016 to 2018. Once the tentative plans and policies are developed, the subsequent project team is going to work on the information system development. The information system-related facility and equipment could be provided as JICA's grant aid. Once the insurance information system is developed, the project team is going to develop the premium collection mechanism. Finally, feasibility of the information system and the premium collection mechanism should be tested in a pilot area. Again, it is ideal to select a province where JICA is currently implementing a technical cooperation project for improving health services to expect a synergy effect. For this option, in particular, JICA's project on neonatal care, which has a birth registration component, is expected to further enhance the social insurance information system.

JICA should closely work with the Ministry of Interior (MOI), which is responsible for civil registration, as the social health insurance information system should be developed based on the civil registration. It is also recommended that JICA work closely with the Ministry of Planning (MOP) which manages the information system on the poor who have potential to become the non-poor, and vice versa. In regard to a premium collection mechanism development, JICA should select proper counterparts, such as ODs, communes and villages, which are most likely to suit premium collection in a community.



RGC: Royal Government of Cambodia; JICA: Japan International Cooperation Agency; TC: Technical Cooperation; MOI: Ministry of Interior;
MOP: Ministry of Planning;
Recommended JICA program in social health protection
Recommended JICA activities in social health protection
On-going JICA Assistance Projects

Figure 5- 3 Option 2: Social Insurance Information & Premium Collection Systems Development

Option 3: Enrollment Advocacy and Promotion

As mentioned earlier, Japan's successful achievement in adopting and rapidly expanding social health insurance was in part due to mass media and local government advocacy. It was also pointed out that there were a number of grass-roots activities, such as a "campaign for medical services for farmers" in the course of expanding insurance in Japan. The survey results suggest that people's knowledge about social health protection is limited in Cambodia, and this may have affected low utilization of public health services. Therefore, advocacy and promotion for enrollment is recommended as JICA's third option in the area of social health protection in Cambodia (see Figure 5-4).

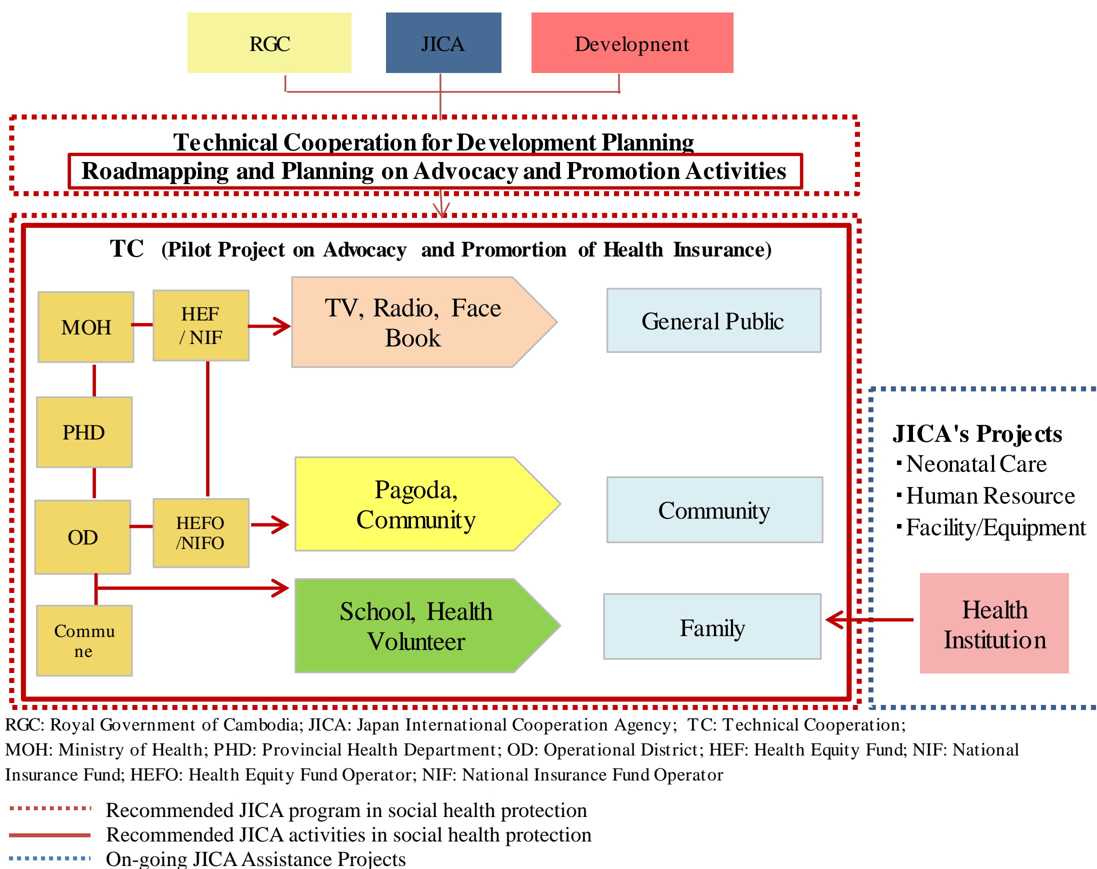


Figure 5- 4 Option 2: New Enrollment Advocacy and Promotion

For developing strategies and planning for advocacy and promotion activities, technical cooperation for development planning is going to be implemented. By consulting with relevant Cambodian ministries, development partners and JICA, the technical cooperation team will determine the media and the partners to work with, depending on the target population. For example, for the general public, TV, radio and social networking services, such as Facebook, are considered to be effective media and the strategy could be further developed with MOH and the insurer. For the community as the target of advocacy and promotion, a religious event held at a pagoda or a community meeting, such as that of the Health Center Management Committee, could be utilized as a platform to disseminate information on advocating and promoting health insurance to community people. At this level, OD and HEFO or National Insurance Fund Operator (NIFO: tentative name) could be the project counterparts. For families or individuals, children could be educated in school, so that they could advocate with their family members at home. Also, health insurance can be advocated with expectant mothers while they receive child rearing education and pre-natal care in a health institution. In this regard, it is possible to synergize the advocacy and promotion activity with JICA's project on neonatal care. This might be an effective approach because childbirth could be a trigger for being enrolled in health insurance for the sake of the new-born baby. Once the strategies and plans for advocacy and

promotion are decided, the subsequent project team is going to implement the activities. The effects of the activities are going to be evaluated by counting the number of the insured.

Additional assistance

With all the options above, a legal advisor could be additionally dispatched to explore the possibility of applying some of the effective Japanese legislation in the Cambodian context, such as the National Health Insurance Law, the Medical Service Law and the Elderly Welfare Law.

Meanwhile, the Japan-Thai Partnership Technical Cooperation Project can be utilized for Cambodia to learn about some aspects of the Thai social health protection system, including (1) the prevention and health promotional activities at the health centers to reduce medical expenditures, (2) human resource development of the social health insurance management, (3) effective fund management, (4) revenue raising by collecting taxes especially for social health protection, and (5) utilization of the DRG for provider payment methods. Within the framework of the project, JICA could conduct training in Thailand, dispatching a Thai expert to Cambodia or combine the two. For example, if there are effective training programs for health institutions or insurance offices in Thailand, training can be organized in Thailand to have a combination of lectures, field visits and on-the-job-training. On the other hand, for such topics as tax-raising for social health insurance and improvement of the information system, it would be more effective to invite a Thai expert to Cambodia, to have him/her observe and understand the situation of the particular issue and conduct a training based on the observed situation.

Finally, regardless the system of social health insurance, it is necessary for the informal sector social health insurance to be subsidized by the government. Therefore, if MEF requests, a Development Policy Loan (DPL)[127] could be considered as JICA's additional assistance, which simultaneously enables Cambodia to prepare the policies for developing social health protection system in the country.

[127] Development policy loan (DPL) sets policy actions and provides loans based on action accomplishments in order to achieve a policy development.

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Field Suppy-side Survey Interviewees (Field Survey 1)

Dates		Time	Activites／Place of visit	Interviewees
Oct. 19	**Mon.**	10:00	Business meeting with KHANA Research Center	Dr. Siyan Yi, Research Director
Oct. 20	**Tue.**	15:00	Courtecy call to JICA Cambodia Office	Mr. Adachi, Chief Representative, Mr. Kojima, Deputy Chief Representaive, Mr. Iguchi and Ms. Mizusawa
Oct. 21	**Wed.**	9:50	Ministry of Health, Department of Planning and Health Information	Dr. Lo Veasnakiry, Director, Department of Planning and Health Information
		15:20	University Reearch Co. (URC)	Dr. Christophe Grudman, Country Director Mr. Tapley Jordanwood, Chief of Party, USAID Social Health Protection Project
Oct. 22	**Thu.**	9:00	Mnistry of Economy and Finance	H.E. Ngoun Sokha, Secretary of State Mr. Pheakdey Sambo, Head of Pension Division, Insurance and Pension Department Ms. Kennariot Than, Deputy Head of Pension Division Mr. Touch Mengleang, Officer of Pension Division
		10:30	Ministry of Health	Professor Eng Huot, Secretary of State for Health
		14:10	WHO	Mr. Eijiro Murakoshi, WHO Consultant for Health Financing
		16:00	Business Meeting with KHANA Research Center	Dr. Siyan Yi, Research Director
Oct. 23	**Fri.**	9:00	Agence Francaise de Developpement (AFD)	Ms. Ninel Ulloa Maureira, Program Officer Ms. Chan Sorya, Project Officer
Oct. 24	**Sat.**		Report writing	
Oct. 25	**Sun.**			
Oct. 26	**Mon.**	15:00	World Bank	Ms. Laura L. Rose, Senior Health Economist
		16:50	Social Helth Protection Association (SHPA)	Mr. Sao Chhorn, Executive Director Mr. Nuon Seila, Program Manager
Oct. 27	**Tue.**	9:00	The Khmer-Soviet Friendship Hospital	Dr. Chan Vicheth, Deputy Director Professor Chak Thida, Deputy Director Dr. Choung Sophal, Chief of the Technical Bureau Dr. Hul Vanthonn, Assistant to Director, Administrative Advisor Ms. Kong Kunthea, Family Health Development Executive Director (HEFO) Mr. Chhon Hok, SHP Program Officer, Family Health Development (HEFO) Ms. Ky Kanary, Health Financing Technical Officer(URC)
		14:00	Ministry of Health, Department of Planning and Health Information	Dr. Sok Kanha, Deputy Director
		16:15	ILO	Ms. Ok Malika, National Programme Officer Ms. Betina Ramirez Lopez, Social Protection Technical Officer

Date	Day	Time	Organization	Persons met
Oct. 28	**Wed.**	9:15	Ministry of Interior	Mr. Yim Sam Oi, Deputy Director, Department of Civil Registration, General Department of Immigration Mr. Oeung Kim Unn, Deputy Director, Department of Civil Registration, General Department of Immigration Mr. Heng Sophat, Deputy Director, Department of Civil Registration, General Department of Immigration Mr. Nic Borgese, Knowledge sharing & Communication, Post-Trauma Community Approaches
Oct. 28	**Wed.**	11:15	GRET	Mr. Phoung Pheakdey, Social Health Protection Technical Advisor Mr. Aing Poro, Project Manager, Nutrikumer Project
		14:00	DFAT(Australian Embassy)	Ms. Benita Sommerville, First Secretary, Development Cooperation Dr. Prempey Suos, Senior Program Manager - Health, Development Cooperation
		16:30	KOICA	Ms. Kim Song Joo, Deputy Country Director Mr. Sangbaek Park, Aid Effectiveness Advisor Mr. Mao Dina, Program Officer, Project Team (Health Sector)
Oct. 29	**Thu.**		To Takeo province	
		10:20	Buddism for Health	Mr.Sam Sam Oeun Managing Director Mr. An Sochet, Program officer Mr. Yann Chamrouen, field coordinator Mr. Ses Soeung, Admin/HR manager
			To Phnom Penh	
		15:30	Voucher Management Agency (VMA)	Ms. Vera Minnik, Project Director
			To Kampong Cham province	
Oct. 30	**Fri.**	9:00	Kampong Cham Provincial Department	Dr. Men Bunnan, Deputy Public Health Director Dr. Ty Chantha, Health Financing Technical Officer, USAID Social Health Protection Project, URC
		10:20	Kampong Cham Provincial Hospital	Prof. Sinath, Director of the hospital Dr. Ty Chantha, Health Financing Technical Officer, USAID, Social Health Protection Project, URC Mr. Arb Sokhum, Action for Health (HEFO)
		14:20	Kampong Cham OD	Dr. Seng DaraKrapum, Deputy Director Dr. Ty Chantha, Health Financing Technical Officer, USAID Social Health Protection Project, URC
		15:30	Kampong Cham Health Center	Ms. Ieng Sokhary, Midwife Ms. Nuth Dang, Midwife Ms. Huy Ranait, Nurse Dr. Ty Chantha, Health Financing Technical Officer, USAID Social Health Protection Project, URC
			To Phnom Penh	

Date	Day	Time	Place	Persons
Oct. 31	Sat.		Team Meeting	
Nov. 1	Sun.		To Kampong Cham	
Nov. 2	Mon.	9:00	Kor Health Center	Mr. Por Kim Phal, Chief of KOR Health Center Dr. Phem Sokkay, HEF-Cluster Manager（HEFO） Mr. Yang Sopheap, Health Financing Coordinator (AFH) Dr. Ty Chantha, Health Financing Technical Officer, USAID, Social Health Protection Project（URC）
		10:30	Chrey Vean Health Center	Mr. Lun Bunly, Chief of Chrey Vean, Health Center Mr. Som Sreng, Department of Drug and iMCi Mr. Phat Sophal, HC Staff Mr. Yem Saro, HC Staff Mr. Sot Sokhorn, HC Staff Dr. Ty Chantha, Health Financing Technical Officer, USAID, Social Health Protection Project, URC Dr. Phem Sokkay, HEF-Cluster Manager（HEFO） Mr. Yang Sopheap, Health Financing Coordinator (AFH)
		11:15	Prey Chhor Referral Hospital	Mr. Chhoeun Vanthan, Chief of Referral Hospital Mr. Loung Savu, Deputy Chief of Referral Hospital Dr. Ty Chantha, Health Financing Technical Officer, USAID Social Health Protection Project, URC
		14:00	Prey Chhor Referral Hospital Health Equity Fund Operator's Office	Dr. Phem Sokkay, HEF-Cluster Manager Dr. Ty Chantha, Health Financing Technical Officer, USAID, Social Health Protection Project, URC Mr. Yang Sopheap, Health Financing Coordinator (AFH)
		15:15	Prey Chhor Kang Meas OD	Mr. Bouth Toum, OD Director Mr. Lung Sarou, Deputy District Governor Dr. Ty Chantha, Health Financing Technical Officer, USAID Social Health Protection Project, URC Dr. Phem Sokkay, HEF-Cluster Manager (HEFO) Mr. Yang Sopheap, Health Financing Coordinator (AFH)
Nov. 3	Tue.		To Kampong Thom province	
		11:00	Kampong Thom AFH:Action for Health (AFH:Action for Health)	Dr. Chhiay Song, Social Health Protection Programme Advisor -Health Financing (GIZ) Mr. Ieng Theang, Health Financing Program Manager (AFH) Mr. Yang Sopheap, Health Financing Coordinator (AFH) Mr. Chhan Dara, HEF-Cluster Manager/SHP Project Manager (AFH)
		13:30	HEFO in Kampong Thom Referral Hospital	HEFO Staff

Nov. 3	**Tue.**		To Phnom Penh	
Nov. 4	**Wed.**	8:30	Interim report to JICA Cambodia Office	Mr. Kojima, Deputy Chief Representative Ms. Mizusawa
		11:00	Meeting at KHANA Research Center	Dr. Siyan Yi, Research Director
		14:00	Swiss Agency for Development and Cooperation (ADC)	Dr. Jacqueline Jakob, Programme Manger Dr. Kouland Thin, Consultant in Health and Development Economics
Nov. 5	**Thu.**	10:00	National Social Security Fund (NSSF)	Mr. Heng Sophannarith, Deputy Director of Health Insurance Division
		14:00	UNICEF	Ms. Maki Kato, Chief of Social Policy Mr. Etienne Poirot, Chief, Health and Nutrition
Nov. 6	**Fri.**	8:30	Ministry of Planning, Identification of Poor Household Department	Mr. Keo Ouly, Director of Identification of Poor Household Department Mr. Maun Chansarak, Director of Social Planning Department and Deputy Director of the ID Poor Program
		10:00	UNFPA	Dr. Derveeuw Marc G.L., Representative
		14:00	Ministry of Economy and Finance, Macroeconomic and Discal Policy Department	Mr. Chamnan Sieng, Deputy Director, Macroeconomic and Fiscal Policy Department Mr. Sim Piseth, National Economist, , Macroeconomic and Fiscal Policy Department Mr. Mak Vichetsackda, National Economist, Macroeconomic and Fiscal Policy Department
		15:00	Ministry of Economy and Finance, Insurance and Pension Department	Mr. Chhay Rattanak, Director, Insurance and Pension Department Mr. Tep Sopheak, Deputy Head of Supervision Division Ms. Kennariot Than, Deputy Head of Pension Division
Nov. 7	**Sat.**		Report writing	
Nov. 8	**Sun.**	10:05	To Siam Reap	
Nov. 9	**Mon.**	8:30	CBHI Program in Angkor Chum OD at STSA URC Office	Mr. Phuong Sam On, Director of STSA (CBHI in Angkor Chum OD) Mr. Kong Chhenglee, Health Financing Technical Officer (URC)
		10:20	CBHI Program in Siem Reap OD at CHC Office	Dr. Chheout Sarun, CGHI-SRP Program Manager Mr. Ly Vanndy, CBHI Programme Manager/Team Leader Ms. Seng Channeang, Admin/Accountant Officer Mr. Kong Chhenglee, Health Financing Technical Officer (URC)
		11:30	HEFO Office at Siem Reap Provincial Hospital	Mr. Nhep Oeurt, Cluster Manger (Poor Family Development) Ms. Than Konthea, HEF Officer (Poor Family Development) Mr. Kong Chhenglee, Health Financing Technical Officer (URC)

Nov. 10	Tue.	8:00	Yeang Health Center in Angkor Chum OD	Mr. Soeun Sokny, Chief of Yeang Health Center in Angkor Chum OD Mr. Phuong Sam On, Head of STSA (CBHI in Angkor Chum OD)
		14:00	Moang Commune (SSDM Office)	Mr. Tin Ty, Commune Chief Ms. Ran Rany, SSDM assistant Mr. Sarom Ros, SSDM Officer
		15:00	Chhrouy Nenag Ngoun commune (SSDM Office)	Mr. Keo Ky, Commune Council Chief Mr. Kan Sokea, SSDM assistant Mr. Sarom Ros, SSDM Officer
		15:45	Srei Snam district office (SSDM Office)	Mr. Kheap Pouleu, SSDM assistant Mr. Sarom Ros, SSDM Officer
		19:15	To Phnom Penh	
Nov. 11	Wed.	9:00	Social Protection Core Group meeting at UNICEF	MEF, CARD, MEF, WFP, ILO, GIZ, AFD, UNICEF, JPIG
Nov. 12	Thu.	13:30	USAID	Ms. Sheri-Nouane Duncan-Jones, Director, Office of Public Health and Education Dr. Chantha Chak, Health Systems Strengthening Team Leader, Office of Public Health and Education
		16:00	National Social Security Fund for Civil Servants (NSSF-C)	Mr. Chhour Sopannha, Deputy Director in Charge of Administration and Staff Mr. Hok Vichet, Deputy Director of National Security Fund For Civil Servants Mr. Sieng Sokkhundy, Accountant of National Security Fund For Civil Servants Mr. Kong Ny deputy head devision of Inspection office Mr. Hak Chanraksmey officer of Allowance office
Nov. 13	Fri.	9:00	GIZ, KfW, German Embassy	Dr. Bart Jacobs, Social Health Protection, Policy Advisor, GIZ Mr. Kob Math, KfW Project Coordinator Ms. Priya Agarwal-Harding, Program Facilitator, Second Health Sector Support Program, Joint Partnership Arrangement Development Partner Interface Group (JPIG)
		10:50	Ministry of Economy and Finance General Department of Financial Industry	H.E. Mr. Mey Vann, Director General Ms. Hor Sovathana, Deputy Director of Insurance and Pension Department Ms. Kennariot Than, Deputy Head of Pension Division
		11:45	Ministry of Health Department of Planning and Health Information Reporting and Data Collection	Dr. Lo Veasnakiry, Director, Department of Planning and Health Information
		14:00	Report to Embassy of Japan	Mr. Yonamine, Second Secretary
		16:45	Report to JICA Cambodia Office	Mr. Adachi, Chief Representative Mr. Kojima, Deputy Chief Representaive Ms. Mizusawa

Field Suppy-side Survey Interviewees (Field Survey 2)

Dates		Time	Activites／Place of visit	Interviewees
Dec. 8	Tue	8:30	Interview with regard to health financing at JICA Cambodia Office	Dr. Bart Jacobs, GIZ
		10:00	Interview with JICA officer with regard to JICA's assistance in Cambodia's health sector at JICA Cambodia Office	Ms. Mizusawa
		14:00	Visit to Royal Phnom Penh Hospital	
		16:30	Courtecy Call & Discussion／Ministry of Health, Department of Planning and Health Information	Dr. Lo Veasnakiry, Director, Department
		19:00	Business meeting	Dr. Siyan Yi, KHANA Research Director
Dec. 9	Wed	8:00	Visit to the Khmer-Soviet Friendship Hos	Dr. Hul Vanthonn, Assistant to Director, Administrative Advisor
		10:00	Follow-up of the Field Demand-side Survey with KHANA Research Center	Dr. Siyan Yi, KHANA Research Director Mr. Ong Seyha Mr. Kuo Chak Mr. Sam Usphea Ms. Chhour Sovann Mollika Mr. Lmot Samkol
		14:00	Discussion over the Study Tour to Thailand	Dr. Kouland Thin, Consultant in Health Economy of Swiss Agency for Development and Cooperation (SDC)
		16:00	Hearing from World Bank	Ms. Nareth LY, Health Operations Officer
		18:30	Business meeting	Mr. Eijiro Murakoshi, WHO Consultant for Health Financing
Dec. 10	Thu	9:00	Hearing from University Reearch Corporation (URC)	Mr. Tapley Jordanwood, Chief of Party, USAID Social Health Protection Project
		11:00	Hearing from Council for Agricultural and Rural Development (CARD)	Dr. Chea Samnang, Director of Cabinet Mr. Sok Silo, Deputy Secretary General, CARD
		17:30	Hearing about NCD programs in Cambod	Mr. Maurits van Pelt, Executive Director of Patient Information Center, Mo Po Tsyo
		17:00	Business meeting	Dr. Momoe Takeuchi, Health System Development Advisor
Dec. 11	Fri	15:00	Report to JICA Cambodia Office	Mr. Kojima, Deputy Chief Representative Ms. Mizusawa
		16:30	Hearing from PKMI(Private Micro Insurance	Mr. David Koy, Corporate manager Ms. Nhim Sorida, Chief of Partnership
Dec. 12	Sat	15:30	Hearing from National Institute of Public Health	Dr. Ir Por, Head of Health System, Development Support Unit

DEMAND-SIDE SURVEY QUESTIONNAIRE

A) Interview Identification

No.	Questions	Coding Categories		Skip To
1	Questionnaire No.			
2	District name			
3	Community name			
4	Date of interview	Day_____, Month_____, 2015 Start time____________ End time____________		
5	Interviewer's full name			
6	Supervisor's full name			
7	Checked by (full name)			
8	Results	Completed	1	
		No household members at home	2	
		Refused	3	
		Dwelling not found	4	
		Other ______________________ (Specify)	5	

Informed Consent

Greetings!

My name is ___________________________. I work at the Center for Population Health Research, Khmer HIV/AIDS NGO Alliance (KHANA) as a data collector. We regularly conduct health surveys in different parts of Cambodia. We are currently covering about 300 households (total) in 6 Operational Health Districts (ODs) in Kampong Cham and Siem Reap districts under an important social health protection survey. We would ask you about health seeking behavior, utilization of health facilities, out of pocket expenditure on health and expectation for health insurance system. It will take approximately 30 minutes.

Your participation in this survey is voluntary. There is no direct benefit or payment to you for taking part in this survey. You do not have to participate, if you do not want to, and even if you agree to participate, you can stop the interview at any time. Everything reported during the interview will remain confidential to the extent allowed by law. Your name or other identification will not be reported to government bodies. Your honest answers may help in improving the public health system in Cambodia. We would also like to inform you that the survey is funded by Japan International Cooperation Agency (JICA). Any anonymous datasets developed using information from this survey will be given to JICA for use by authorized researchers. We would greatly appreciate your help in responding to this survey.

Would you be willing to participate in the survey?

Yes----1	PROCEED WITH THE INTERVIEW
No-----2	THANK AND MOVE TO NEXT HOUSEHOLD

B) Household Profile/ Respondent Identification/ Socio-Economic Status

No.	Question	Coding Categories		Skip To
INSTRUCTION: Q1-Q6 are asking about the respondent. If the respondent is the household head, please skip to Q7.				
1	What is your relationship with the household head?	Parent	1	
		Spouse	2	
		Daughter/ Son	3	
		Sister/ Brother	4	
		Other (Specify)________________	5	
2	What is your sex?	Male	1	
		Female	2	
3	How old are you? (Please state number for the age. The date of birth is also acceptable.)	________________		
4	What is your occupation, that is, what kind of work do you mainly do?	Professional/technical/managerial	1	
		Clerical	2	
		Sales and services	3	
		Skilled manual	4	
		Unskilled manual	5	
		Agriculture	6	
		Other (Specify)________________	7	
5	Can you speak, read and write in Khmer?	Yes	1	
		No	2	
6	What level of education did you achieve? [Note: Education categories refer to the highest level of education attended, whether or not that level was completed.]	None	1	
		Up to primary	2	
		Up to secondary	3	
		Up to higher secondary	4	
		Colleges & Universities	5	
		Don’t know	88	
INSTRUCTION: Q7-Q11 are asking about the household head.				
7	What is the sex of the household?	Male	1	
		Female	2	
8	How old is the household head? [Please state number for the age. The date of birth is also acceptable.]	________________		
9	What is the occupation of the household head, that is, what kind of work does he/she mainly do?	Professional/technical/managerial	1	
		Clerical	2	
		Sales and services	3	
		Skilled manual	4	
		Unskilled manual	5	
		Agriculture	6	
		Other (Specify)________________	7	
10	What is the religion of the household head?	Buddhism	1	
		Islam	2	
		Christianity	3	
		Animism	4	
		None	5	
		Other (Specify)________________	6	

No.	Question	Response	Code	Skip
11	Can the household head speak, read and write in Khmer?	Yes	1	
		No	2	
		Don't know	88	
12	What level of education did the household head achieve? Note: Education categories refer to the highest level of education attended, whether or not that level was completed.	None	1	
		Up to primary	2	
		Up to secondary	3	
		Up to higher secondary	4	
		Colleges & universities	5	
		Don't know	88	
INSTRUCTION: Q12-Q26 are asking about the household.				
13	Please state the sex and age of your family members [Except you and your household head] [Sex: Please state M for male and F for female] [Age: Please state number for the age. The date of birth is also acceptable.]	① Sex:________ Age:________		
		② Sex:________ Age:________		
		③ Sex:________ Age:________		
		④ Sex:________ Age:________		
		⑤ Sex:________ Age:________		
		⑥ Sex:________ Age:________		
		⑦ Sex:________ Age:________		
		⑧ Sex:________ Age:________		
		⑨ Sex:________ Age:________		
		⑩ Sex:________ Age:________		
14	Approximately how much is the household's average income per month? [Please circle Rs or US$]	____________________RsUS$		
15	In the household, how often is money put aside for savings?	Daily	1	
		2-3 times a week	2	
		Weekly	3	
		Monthly	4	
		Yearly	5	
		No fixed pattern	6	
		Never	7	
		Other (specify)________________________	8	
		Don't know	88	
16	Has your household ever had a loan or sold your valuable goods like jewelries, TV, etc.?	Yes	1	2-88 →Q18
		No	2	
		Don't know	88	
17	What did you have the loan or sell your valuable goods for? PLEASE ASK FOR THE BIGGEST LOAN IF MULTIPLE LOANS WERE TAKEN	Food	1	
		Rent, water, electricity	2	
		Children's education	3	
		Health expense	4	
		Marriage	5	
		Funeral	6	
		House/land	7	
		Equipment/materials for work	8	
		Other (Specify)________________________	9	
		Don't know	88	
18	Does anyone in your family belong to a community organization?	Yes	1	2-88 →Section C
		No	2	
		Don't know	88	

19	What is the type of the organization?	Community development	1	
		Agriculture	2	
		Health financing	3	
		Religion	4	
		Business	5	
		Other (Specify)________________	6	
		Don't know	88	
20	Approximately how many people belong to the organization?	Specify the number:______________		

C) Utilization of Health Services

No.	Question	Coding Categories		Skip to
INSTRUCTION: Q21-Q32 are asking about **the most recent illness episode** in your family.				
21	Did you/your family member seek care from a health facility/ personnel?	Yes	1	2→Q23 88→Q33
		No	2	
		Don't know	88	
22	When was the most recent illness episode about? [In days, weeks, months or years]	______________________ __ago		All→Q24
23	Why did you/your family member not seek care from a health facility/ personnel? [PROBE: Any other reason?] [RECORD ALL MENTIONED]	Don't know where to go/ whom to ask	1	All→Q33
		Too far	2	
		Too expensive	3	
		No time	4	
		Fear of being rejected	5	
		Not allowed by family/ relatives	6	
		Poor quality of care	7	
		Not felt the need	8	
		Have heard that people there are not well behaved	9	
		Others (Specify)________________	10	
24	Where did you/your family member go for the health services? If you/your family member went to more than one health facility, please cheese all and place the number in order besides the name of the health facility. IF UNABLE TO DETERMINE WHETHER THE FACILITY IS PUBLIC OR PRIVATE, WRITE THE NAME OF THE FACILITY/ PLACE BELOW. ________________ (Name of the facility) ________________ (Place)	**Public medical sector:**		11-22 →Q26
		Central hospital (in Phnom Penh)	1	
		Provincial hospital	2	
		District hospital	3	
		Health center	4	
		Health post	5	
		Government dispensary	6	
		Other public sector health facility	7	
		Private medical sector:		
		Private hospital – tertiary to secondary	11	
		Private clinic	12	
		Private paramedic	13	
		Traditional healer	14	
		Pharmacy/drugstore	15	
		Traditional birth attendant (TBA)	16	
		NGO or Trust hospital/clinic	17	
		Other private sector facility	18	
		Home treatment	21	
		Other (Specify) ______________	22	

25	If you/your family member mainly used the government facility, what is the impression about the service?	Highly satisfied	1	All→Q27
		Partially satisfied	2	
		Unsatisfied	3	
		Highly unsatisfied	4	
		Don't know	88	
26	If you/your family member did not use the government facility, why did you/your family member not go to a government facility? [PROBE: Any other reason?] [RECORD ALL MENTIONED]	No nearby government facility	1	
		Government facility's business hours/service time not convenient	2	
		Health personnel often absent	3	
		Fear of being rejected	4	
		Health personnel's attitude rude/not kind	5	
		Waiting time too long	6	
		Not clean	7	
		Poor quality of care	8	
		No drugs/medication	9	
		Non availability of bed	10	
		Other (Specify)________________	11	
		Don't know	88	
27	Did you/your family member need to be referred to another hospital?	Yes	1	2-88 →Q31
		No	2	
		Don't know	88	
28	Were you/your family member referred to another hospital?	Yes	1	2→Q30 88→Q31
		No	2	
		Don't know	88	
29	How did you/your family member go to the referral hospital?	Family member sent to the hospital	1	All→Q31
		Relative or friend sent to the hospital	2	
		Was referred by the ambulance	3	
		Other (Specify) ________________	4	
		Don't know	88	
30	Why did you/your family member not seek care from the referred health facility? [PROBE: Any other reason?] [RECORD ALL MENTIONED]	Don't know where to go/ whom to ask	1	
		Too far	2	
		Too expensive	3	
		No time	4	
		Fear of being rejected	5	
		Not allowed by family/ relatives	6	
		Poor quality of care	7	
		Not felt the need	8	
		Have heard that people there are not well behaved	9	
		Others (Specify)________________	10	
31	Did you/your family member have experience of not being able to receive health service in the most recent illness episode?	Yes	1	2→Q33
		No	2	
32	Why were you/your family member not able to receive it? [PROBE: Any other reason?] [RECORD ALL MENTIONED]	No personnel	1	
		No drugs/medication	2	
		Personnel's attitude was rude/not kind	3	
		Could not pay for the fee	4	
		Took long time affecting work	5	
		Others (Specify)________________	6	
		Don't know	88	

INSTRUCTION: Q33-Q36 are general questions on health service utilization of your family.				
33	What is your general impression on the health care at a government facility?	High quality and trustworthy	1	
		Satisfactory	2	
		Acceptable	3	
		Low quality	4	
		Other (Specify)______________	5	
		Don't know	88	
34	How far is the nearest health facility from your house? [Time and means are also accepted] e.g. 20 minutes by motorcycle	Within 1 km	1	
		1-2 km	2	
		2-5 km	3	
		More than 5 km	4	
		Not sure	88	
35	What is the nearest public health facility?	Provincial hospital	1	
		District hospital	2	
		Health center	3	
		Health post	4	
		Other______________	5	
		Don't know	88	
36	What are the main problems in relation to the access to health care of your family members? [MULTIPLE RESPONSES POSSIBLE]	Expenses	1	
		No facilities nearby	2	
		Do not know where to go	3	
		Taking long time	4	
		Poor quality of care	5	
		Attitude of health workers not good	6	
		Fear for health care	7	
		No problems	8	

E) Social health protection system

No.	Question	Coding Categories		Skip to
37	Is anyone in this household covered by a social health protection scheme?	Yes	1	2-88 →Q51
		No	2	
		Don't know	88	
38	What type of social health protection scheme? [PROBE: Any other type?] [RECORD ALL MENTIONED] [HAVE THEM SHOW THEIR INSURANCE CARD]	National Social Security Fund (NSSF)	1	1-4, 6-88 →Q41
		National Social Security Fund for Civil Servants (NSSF-C)	2	
		Health Equity Fund (HEF)	3	
		Community Based Health Insurance (CBHI)	4	
		Private Insurance	5	
		Others (Specify)______________	6	
		Don't know	88	
39	What is the name of the private insurance company?	Specify______________		

No.	Question	Response	Code	Skip
40	What is the social health protection about?	Health insurance	1	
		Work injury	2	
		Pension	3	
		Other_______________	4	
		Don’t know	88	
41	Do you have an ID Poor card? [HAVE THEM SHOW THEIR ID POOR CARD]	Yes	1	1 or 88 →Q44
		No	2	
		Don’t know	88	
42	Have you ever applied for ID Poor card, but not received it, yet?	Yes	1	2→Q44
		No	2	
43	How long have you been waiting for?	Less than 3 months	1	
		3-6 months	2	
		6-12 months	3	
		More than 1 year	4	
		Don’t know	88	
44	Have you/your family member made use of the health insurance scheme to get any service so far?	Yes	1	2-88 →Q48
		No	2	
		Don’t know	88	
45	What illness/condition did you or your family member use it for the most recent illness?	Fever, diarrhea, cough	1	
		Injuries	2	
		Tuberculosis	3	
		Diabetes, hypertension	4	
		Other chronic conditions	5	
		Pregnancy/child-birth related	6	
		Hospitalization	7	
		Surgery	8	
		Accident/emergency	9	
		Traditional medicine and homoeopathy	10	
		Others (Specify)_______________	11	
		Don’t know	88	
46	When was the most recent episode about? [In days, weeks, months or years]	_______________ago		
47	How did you feel when you/your family member used the health insurance scheme?	Grateful and necessary for our lives	1	
		Complicated	2	
		Inconvenient	3	
		Other_______________	4	
48	Do you know which hospitals you/your family member are eligible to use the insurance scheme? [YES→PROVE: LET THEM TELL]	Yes	1	
		No	2	
49	Have you/your family member ever failed to use health insurance at a health facility?	Yes	1	2→Q51
		No	2	

No.	Question	Response	Code	Skip
50	What were the reasons that you/your family member could not use the health insurance?	Not aware of the coverage at that time	1	
		Did not bring the card	2	
		Told ineligible	3	
		Personnel refused for some reason	4	
		Told that the specific service was not covered under this scheme	5	
		Payment was anyway requested	6	
		Others (Specify)___________	7	
		Don't know	88	
INSTRUCTION: Q51-56 are only for those who answered 2 or 88 for Q37. Those who answered 1 for Q37 should skip to Q57.				
51	Do you know what health insurance is? [HAVE THEM EXPLAIN ABOUT INSURANCE.] POINTS: Words to be mentioned: "premium," "benefit," and "co-payment."	Yes, I know what health insurance is	1	1, 4→Q53
		I know something about health insurance scheme	2	
		I don't know much about health insurance	3	
		I know nothing about health insurance.	4	
52	What do you not know about health insurance?	Specify___________		
53	Would you like to join a health insurance scheme?	Yes	1	2→Q56 88→Q57
		No	2	
		Don't know	88	
54	What kind of health insurance scheme would you like to join?	Government health insurance	1	88→Q57
		Community health insurance	2	
		Private health insurance	3	
		Don't know	88	
		Other___________	4	
55	Why would you like to join the above health insurance scheme?	Good reputation	1	All→Q57
		No premium	2	
		Can receive better health service	3	
		Others (Specify)___________	4	
		Don't know	88	
56	Why would you not like to join any health insurance scheme?	Don't understand	1	
		Don't trust	2	
		Don't use health service	3	
		Others (Specify)___________	4	
		Don't know	88	
INSTRUCTION: Q57-64 are general questions on social health protection.				
57	Has anyone in your family ever joined any informal health insurance group?	Yes	1	2-88 →Q59
		No	2	
		Don't know	88	
58	What is the system of the health insurance?	Specify___________		

59	Government Health insurance provides you free medical treatment at a health facility, free medicine, and free transportation to go to the hospital. How much would you be willing to pay for the health insurance per person per year?	Not willing to pay	1	
		Up to 10,000 Rs	2	
		Up to 30,000 Rs	3	
		Up to 50,000 Rs	4	
		Up to 80,000 Rs	5	
		Over 80,000	6	
60	If a pagoda operated the health insurance with the same benefit as the one mentioned above, would you be willing to join?	Yes	1	2→Q62
		No	2	
61	How much would you be willing to pay for the pagoda insurance per person per year?	Not willing to pay	1	
		Up to 10,000 Rs	2	
		Up to 30,000 Rs	3	
		Up to 50,000 Rs	4	
		Up to 80,000 Rs	5	
		Over 80,000	6	
62	Is there any other association that you wish to see operating a health insurance scheme?	Yes	1	2→Q64
		No	2	
63	What is the association?	Women's association	1	
		Agriculture association	2	
		Business association	3	
		Friends' circle	4	
		Others (Specify)____________________	5	
		Don't know	88	
64	If the government requires civil registration for the purpose of health insurance, would you be willing to?	Yes	1	
		No	2	
		Don't know	88	

END OF THE QUESTIONNAIRE

Japan Study Tour Participants

No.	Name & Title	Ministry
1	H.E. Prof. Oum Samol, Under Secretary of State	Ministry of Health
2	Dr. Lo Veasnakiry, Director of Department of Planning and Health Information	Ministry of Health
3	Dr. Chon Sinoun, Chief of Quality Assurance Office, Hospital Service Department	Ministry of Health
4	H.E. Nguon Sokha, Secretary of State	Ministry of Economy and Finance
5	Mr. Pheakdey Sambo, Head of Pension Division, Insurance and Pension Department	Ministry of Economy and Finance
6	Mr. Mak Vichetsackda, National Economist, Macroeconomic and Fiscal Policy Department	Ministry of Economy and Finance
7	Mr. Oeung Kim Unn, Deputy Director of Department of Civil Registration	Ministry of Interior
8	Mr. Heng Sophannarith, Deputy Director of Health Insurance Division	Ministry of Labour and Vocational Training
9	Mr. Maun Chansarak, Director of Social Planning Department and Deputy Director of the ID Poor Programme	Ministry of Planning
10	Mr. Tan Veng Thieng, Deputy Director of Identification of Poor Households Department	Ministry of Planning
11	Mr. Meas Vou, Deputy Director of National Social Security Fund for Civil Servants	Ministry of Social Affairs, Veterans and Youth Rehabilitation

Japan Study Tour Program

Date	Time	Programme	Lecturer	Venue
14 Dec. (Mon)	10:30～11:45	Courtesy call to JICA HQ	JICA (Human Development Dep.)	JICA HQ （Room111）
	11:45～12:45	（Lunch）		
	12:45～13:15	（JICA HQ→Ministry of Health, Labour and Welfare (MHLW)）		
	13:30～17:00	Lecture： Social Security System and Health Care / Insurance System in Japan	Ministry of Health, Labour and Welfare Dr. Tanimura	MHLW
15 Dec. （Tue）	9:30～12:00	Lecture： Path to Universal Health Coverage (Experiences and Lessons from Japan)	National Graduate Institute for Policy Studies（GRIPS） Prof. Shimazaki	GRIPS (Meeting room 1A)
	12:00～13:00	（Lunch）		
	13:00～14:00	Lecture： Conditions of UHC and Japan's success	GRIPS Prof. Shimazaki	GRIPS (Meeting room 1A)
	13:00～16:30	Lecture： National Health Insurance, and Other Insurers	GRIPS Prof. Hoshida	
	16:30～17:00	Question and Answer	GRIPS Prof. Shimazaki Prof. Hoshida	
16 Dec. （Wed ）	10:00～12:00	Field visit： Operation of National Health Insurance at Local Government office	Tax and Citizen Service Division, Kyonan Town, Chiba Prefecture	Kyonan Town, Chiba Prefecture
	12:00～13:00	（Lunch）		
	13:00～15:30	Field visit： Operation of health service delivery in the remote area	Kyonan Town Hospital, Chiba Prefecture	Kyonan Town Hospital, Chiba Prefecture
17 Dec. （Thu）	10:00～12:00	Lecture： Health service delivery in the remote area	GRIPS Prof. Hoshida	JICA HQ (Room229)
	12:00～13:00	（Lunch）		
	13:00～15:00	Lecture： IT System for Social Health Protection	Hitachi, Ltd.	JICA HQ (Room229)
	15:00～17:00	Preparation for tomorrow's presentation by each Ministry	—	
18 Dec. （Fri）	9:30～12:00	Presentation： Lesson learned by each Ministries	Survey team	JICA Tokyo International Center (TIC)
	12:00～13:00	（Lunch）		
	13:00～17:00	Discussion： Lessons from Japan's experience and application of the lessons to Cambodia	Survey team	JICA Tokyo International Center (TIC)

Thailand Study Tour Participants

No.	Name & Title	Organization
1	H.E. Prof. Oum Samol, Under Secretary of State	Ministry of Health
2	Dr. Lo Veasnakiry, Director of Department of Planning and Health Information	Ministry of Health
3	Dr. Chon Sinoun, Chief of Quality Assurance Office, Hospital Service Department	Ministry of Health
4	H.E. Nguon Sokha, Secretary of State	Ministry of Economy and Finance
5	Mr. Pheakdey Sambo, Head of Pension Division, Insurance and Pension Department	Ministry of Economy and Finance
6	Mr. Mak Vichetsackda, National Economist, Macroeconomic and Fiscal Policy Department	Ministry of Economy and Finance
7	Mr. Oeung Kim Unn, Deputy Director of Department of Civil Registration	Ministry of Interior
8	Mr. Heng Sophannarith, Deputy Director of Health Insurance Division	Ministry of Labor and Vocational Training
9	Mr. Tan Veng Thieng, Deputy Director of Identification of Poor Households Department	Ministry of Planning
10	Mr. Sar Kosal, Deputy Director of Identification of Poor Households Department	Ministry of Planning
11	Mr. Meas Vou, Deputy Director of National Social Security Fund for Civil Servants	Ministry of Social Affairs, Veterans and Youth Rehabilitation
12	Dr. Say Ung, Director of Food Security and Nutrition and Health Department	Council for Agriculture and Rural Development (CARD)

Attachment 6

Thailand Study Tour Program

Date	Time	Session	Lecturer	Venue
1 Feb (Mon)	9:00 ～ 9:30	**Courtesy Call (Ministry of Public Health)**	Dr. Somsak Akksilp, Deputy Permanent Secretary, Ministry of Public Health (MoPH)	MoPH
	9:30 ～ 10:30	**Historical Development of Social Health Protection System and Health Policies in Thailand** - Country profile (Health status) - Three public health protection schemes (CSMBS, SHI, UCS) - System design of Thai UHC - Benefit package development - Achievement of Thai UHC - Contributing factors - Key challenges	Dr. Phusit Prakongsai, Director, Bureau of International Health, MoPH	
	10:30 ～ 12:00	**Health Service Delivery System in Thailand** - Evolution of modern health system - Health service system - Health finance management of hospital in MoPH - Service plan	Dr. Pornpet Panjapiyakul, Deputy Director, Bureau of Health Administration, MoPH	
		(Lunch)		
	13:00 ～ 15:00	**Collaboration and Cooperation among Ministries and/or Sectors** - Institutional arrangement of UHC - Governance structure of UHC - Participation in UHC	Ms. Wilailuk Wisasa, Manager, Bureau of International Affairs for Universal Health Coverage National Health Security Office (NHSO)	MoPH
	15:00 ～ 16:30	**Financing for health promotion and disease prevention in Thailand** - Background of innovative financing for health promotion - Financing health care and health promotion - Innovative financing for health promotion - Thailand case study	Ms. Shaheda Viriyathorn, Research Assistant, International Health Policy Programme	
2 Feb (Tue)	9:00 ～ 9:30	**Courtesy Call (National Health Security Office)**	Ms. Netnapis Suchonwanich, Deputy Secretary General, NHSO	NHSO
	9:30 ～ 10:30	**Overview of Universal Health Coverage : Thailand Experience** - Background for UHC in Thailand - System design and Governance structure of NHSO - Benefit package development - Managing providers and protecting UCS - Budgeting and payment methods of the UCS - IT system in NHSO	Ms. Netnapis Suchonwanich, Deputy Secretary General, NHSO	
	10:30 ～ 12:00	**Achieving Universal Health Coverage - Lesson learned from Thailand** - Strategic planning - Health service provider registration - Beneficiary enrolment - Fund management - Health service quality control - Consumer protection	Ms. Netnapis Suchonwanich, Deputy Secretary General, NHSO	
		(Lunch)		
	13:00 ～ 14:00	**Health Technology Assessment (HTA) in Thailand** - Using Health Technology Assessment (HTA) in Thailand - Role of HTA on the development of essential medicine list - Case studies on drugs, medical devices, and public health program assessment	Ms. Inthira Yamabhai, Senior Researcher, Health Intervention and Technology Assessment Program (HITAP), MoPH	NHSO
	14:00 ～ 15:00	**UCS Fund Management** - Fund Allocation and Reimbursement - E-Claim system - Payment & Reimbursement method	Col. Panomwan Bunyamanop, Director, Bureau of Fund Allocation and Reimbursement, NHSO	

2 Feb (Tue)	15:00 ～ 16:00	**Monitoring & Evaluation of UCS** - Evaluation system on UCS - Source of data for M&E - Example of UCS Monitoring - Patient utilization and health service result	Ms. Kanjana Sirikomol, Director, Bureau of Health Information and Outcome Evaluation, NHSO	NHSO
3 Feb (Wed)	9:00 ～ 10:30	**Compulsory Social Security Scheme** - Introduction and Historical Background - Social Security Act - Administration - Coverage - Source of Fund - Contribution rates - Current benefits - Medical care provision	Ms. Rangsima Preechachard, Labour Specialist (Senior Professional Level), Social Security Office, Ministry of Labour	MoPH
	10:30 ～ 12:00	**Civil Servant Medical Benefit Scheme (CSMBS)** - Background - Principle - Reimbursement - Problem - Solutions/Policy recommendations	Ms. Monnaporn Benjaporn, Fiscal Analyst, Medical Welfare Division, The Comptroller General's Department, Ministry of Finance	
		（Lunch）		
	13:00 ～ 15:30	**Thai Health Promotion Foundation (ThaiHealth)** - Overview - Budget, Revenue, Expenditure - Governance structure - Funding strategy - Monitoring mechanism - Activities	Dr. Supreda Adulyanon, Chief Executive Officer, ThaiHealth、Mr. Rungsun Munkong , International Relations Officer, Senior Professional Level, Partnership and International Relations Section, ThaiHealth	ThaiHealth
4 Feb (Thu)	9:30 ～ 12:00	**Samut Songkram Hospital（Provincial Hospital）** - General Information - Health Service - Hospital profile - Primary care unit profile	Dr. Suttipong Sirimai, Hospital Director	Samut Songkram Hospital
		（Lunch）		
	13:00 ～ 15:00	**Amphawa Hospital（Community Hospital）** - General Information - Health resource - Financial - Hospital profile - Chronic disease management	Dr. Vararn Wangjitchien, Hospital Director	Amphawa Hospital
5 Feb (Fri)	9:00 ～ 10:00	**Sight-seeing at NHSO (Call Centre, Pharmacy, etc.)**	Ms. Wilailuk Wisasa, Manager, Bureau of International Affairs for Universal Health Coverage, NHSO	NHSO
	10:00 ～ 12:00	**Wrap-up Meeting** **- Presentation by the study team on what they learnt from this study visit and how to utilize/apply the gain knowledge for Cambodia**	Dr. Phusit Prakongsai, Director, Bureau of International Health, MoPH Ms. Wilailuk Wisasa, Manager, Bureau of International Affairs for Universal Health Coverage	

Cambodia Workshop Participants

No.	Name	Organization	Position
Government			
1	**H.E. Prof. Eng Huot**	Ministry of Health	Secretary of State
2	**H.E. Prof. Oum Samol**	Ministry of Health	Under Secretary of State
3	**Dr. Lo Veasnakiry**	Ministry of Health	Director of Department of Planning and Health Information
4	**Dr. Sok Kanha**	Ministry of Health	Deputy Director of Department of Planning & Health Information
5	**Dr. Chon Sinoun**	Ministry of Health	Chief of Quality Assurance Office, Hospital Service Department
6	**Mr. Chan Sayn**	Ministry of Health	Director, Ligislation Department
7	**H.E. Nguon Sokha**	Ministry of Economy and Finance	Secretary of State
8	**Mr. Pheakdey Sambo**	Ministry of Economy and Finance	Head of Pension Division, Insurance and Pension Department
9	**Mr. Mak Vichetsackda**	Ministry of Economy and Finance	National Economist, Macroeconomic and Fiscal Policy Department
10	**Mr. Keo Ouly**	Ministry of Planning	Director of Identification of Poor Household Department
11	**Mr. Sar Kosal**	Minstry of Panning	Deputy Director (ID Poor Programme)
12	**H.E. Samheng Boros**	Ministry of Social Affairs, Veteran, and Youth Rehabilitation	Under Secretary of State
13	**Mr. Meas Vou**	Ministry of Social Affairs, Veteran, and Youth Rehabilitation	Deputy Director of National Social Security Fund for Civil servants (NSSF-C)
14	**Mr. Chea Sokha**	Ministry of Social Affairs, Veteran, and Youth Rehabilitation	Officer, National Social Security Fund for Civil servants (NSSF-C)
15	**Mr. Heng Sophannarith**	Ministry of Labour and Vocational Training	Deputy Director of Health Insurance Division NSSF
16	**Mr. Oeung Kim Unn**	Ministry of Interior	Deputy Director of Department of Civil Registration
17	**Dr. Say Ung**	Council for Agriculture and Rural Ddevelopment (CARD)	Director of Food Security and Nutrition and Health Department
Development Partners			
18	**Dr. Somil Nagpal**	World Bank	Senior Health Specialist
19	**Ms. Nareth LY**	World Bank	Health Operations Officer
20	**Dr. Etienne Poirot**	UNICEF	Chief of Health
21	**Pauline Ye Ahn**	UNICEF	Consultant
22	**Ms. Priya Agarwal-Harding**	Joint Programme Interface Group (JPIG)	Program Facilitator, Second Health Sector Support Program
23	**Mr. Eijiro Murakoshi**	WHO	Consultant for Health Financing
24	**Mr. Mo Mai**	WHO	WHO country office national consultant
25	**Mr. Bernd Schramm**	GIZ	Social Health Protection Programme, Manager
26	**Dr. Bart Jacobs**	GIZ	Social Health Protection Programme, Policy Advisor
27	**Song Chhiay**	GIZ	Advisor
28	**Prof. Dr. Staffer Flend**	GIZ	Professor
29	**Ms. Vera Minnik**	Voucher Management Agency	Project Director
30	**Dr. Chantha Chak**	USAID	Health Systems Strengthening Team Leader, Office of Public Health and Education
31	**Mr. Tapley Jordanwood**	University Research Co., LLC (URC)	Chief of Party, USAID Social Health Protection Project
32	**Ms. Hasselmann Viviane**	Swiss International Development Agency	Program Officer - Health and Governance
33	**Dr. Kouland Thin**	Swiss International Development Agency	Consultant in Health and Development Economics
34	**Ms. Chan Sorya**	Agence Francaise de Development (AFD)	Project Officer
35	**Ms. Ok Malika**	ILO	National Programme Officer
36	**Mr. Mao Dina**	KOICA	Program officer

NGOs			
37	**Mr. Nuon Seila**	Social Health Protection Association (SHPA)	Acting Executive Director
38	**Ms. Luy Theary**	Social Health Protection Association (SHPA)	Training Coordinator
39	**Dr. Long Leng**	Action For Health (AFH)	Executive Director
40	**Mr. Ieng Theang**	Action For Health (AFH)	Program Coordinator
41	**Mr. Phuong Sam On**	Sahakum Theanea Rab Rong Sokhapheap Srok Pratekbat Angkor Chum (STSA) , Siem Reap	Director
42	**Mr. Ly Vanndy**	Cambodian Health Committee (CHC), Siem Reap	Team Leader - Siem Reap Scheme
43	**Thoung Visal**	Cambodian Health Committee (CHC)	SHO - PM
44	**Mr. Mut Nin**	Cambodian Health Organization (CHO),	Executive Director
45	**Mr. Sam Oeun**	Buddhism For Health (BFH), Takeo	Managing Director
46	**Mr. Phoung Pheakdey**	Groupe de Recherche et d'Echanges Technologiques (GRET)	Social Health Protection Technical Advisor
47	**Mr. Chhon Hok**	Family Health Development (FHD)	SHP Program Manager
48	**Mr. Ouch Sokly**	Pursat Community Health Support Fund Association (PCHSFA)	Executive Director
49	**Mr. Vang Sovann**	Poor Family Development (PFD)	Program Manager
50	**Ham Hak**	Women Organization for Modern Economy and Nursing (WOMEN)	TA
51	**Dr. Moul Vanna**	Action for Health Development (AHEAD)	Executive Director
52	**Bou Saleen**	Action for Health Development (AHEAD)	OD Coordinator
53	**Ms. Bunmey Yat**	Population Council	Senior Manager - Policy
JICA and EoJ			
54	**Mr. Yonamine Moriyasu**	Embassy of Japan in Cambodia	Second Secretary
55	**Mr. Itsu Adachi**	JICA Cambodia Offie	Chief Representative
56	**Ms. Aya Mizusawa**	JICA Cambodia office	Senior Program Officer
57	**Mr. In Sophearun**	JICA Cambodia Office	Program Officer
58	**Ms. Kyoko Sakurai**	JICA HQ	Human Development Department, Health Group 2, Health Division 3
59	**Dr. Makoto Tobe**	JICA HQ	Senior Advisor (Health Financing / Health Systems)
60	**Ms. Haruyo Nakamura**	Global Link Management (GLM)	Resercher
61	**Mr. Yasuo Sumita**	Global Link Management (GLM)	Resercher
62	**Associate Proffesor. Junya Hoshida**	National Graduate Institute for Policy Studies (GRIPS)	Associate Professor
63	**Dr. Siyan Yi**	Khmer HIV/AIDS NGO Alliance (KHANA)	Director

Cambodia Workshop Program

Day 1	International and Cambodian Experiences on Social Health Insurance	
8:30 – 9:00	Registration	–
9:00 – 9:30	Opening Remarks	H.E. Prof. Oum Samol, Unser Secretary of State, MOH, Mr. Adachi Itsu, Chief Representative, JICA Cambodia Office
9:30 – 9:45	Introduction	Ms. Haruyo Nakamura, JICA Survey Team
9:45 – 10:30	Japan's Informal Sector Social Health Insurance	Profesor Junya Hoshida, GRIPS
10:00 – 10:15	(Tea break)	–
10:45 – 11:45	・Overview of "Going Universal" – How 24 developing countries are covering people from the bottom up ・Japan-World Bank Partnership Program	Dr. Somil Nagpal, Senior Health Specialist, World Bank
11:45 – 12:45	Lessons learnt from the Study Tours to Japan and Thailand. 15 minutes (+Q&A 5 min) for each presentation:	(1) Dr. Lo Veasnakiry, MoH (2) Mr. Mak Vichetsackda, MEF (3) Dr. Kouland Thin, SDC
12:00 – 13:00	(Lunch)	–
13:45 – 14:30	JICA's assistance in increasing social health insurance coverage of the informal sector	Dr. Makoto Tobe, Senior Advisor in Health Financing/Health Systems, JICA
14:30 – 17:00 (Tea Break)	Cambodian experience: Success factors and challenges experienced with the schemes in terms of population coverage, drop-outs, financial protection, operations of the schemes, etc. (1) Health Equity Funds (2) Health Insurance (3) Community-based health insurance	(1) Dr. Sok Kanha, MoH (2) Mr. Heng Sophannarith,NSSF (3) SHPA (Social Health Protection Association), AFH, CHC & STAT Facilitated by Dr. Bart Jakobs, GIZ
Day 2	**Informal Sector Social Health Insurance in Cambodia**	
8:30 – 9:00	Registration	–
9:00 – 10:00	"Survey of People's Attitude/Perception toward Health Services and Health Protection/Insurance in Kampong Cham and Siem Reap, Cambodia"	Ms. Haruyo Nakamura, JICA Survey Team
10:00 – 10:15	(Tea break)	–
10:15 – 12:00	Small Group discussions: Requirements for Cambodia: - what are the gaps in Cambodia to make Informal Sector Social Health Insurance operational ? (1) Target groups (2) Stakeholders/ Inventory of actors (3) Financial sources (4) Means of promotion (5) Linkage between HEF and the insurance/ Integration of voucher scheme (6) Institutional Arrangement (7) Policy, legal requirement	All participants
12:00 – 13:00	(Lunch)	–
13:00 – 16:00 (Tea Break)	Presentations and Discussions - Presentations from each group - Way-forwards - Role of Development Partners	All participants Wrap-up by Dr. Lo Veasnakiry, MoH
16:00	Closing Remarks	H.E Prof. Eng Huot, Secretary of State for Health, Ministry of Health

*All programs were facilitated by Dr. Siyan, Yi

Kingdom of Cambodia
Nation – Religion – King

LOGO
Ministry of Heath

Hospital Name:......................

QUESTIONNAIRES FOR PATIENT

Date-Month-Year:.........../............20.....

Name of Interviewer:...............................

1. Profile of Patient

-Name: ....age..........................sex...............nickname...............................mariage status..................................

-In case patient unable for interview, interviewee name is ....who is a relative of patient ....

-Date-Month-Year of Hospitalizations............../.............../...............Type..........................Bed#.................code of patient........................

-Current address of patient: ....village/group...................community....................commune/sangkat................district................

province/city......................................Tel (if available)... Name owner of telephone..

For migrant population /or who have two different addresses please fill in an additional form below:

-Address of household/clients: village/group............................community.....................commune/sangkat.................district.................

province/city......................................Tel (if available)... Name owner of telephone..

☞Do you know the sponsor principle for poor patient by the Government prior any of your hospitalization Yes ☐ No ☐

☞Do you hope to get benefits from this principle prior any of your hospitalization Yes ☐ No ☐

2. Family Economic Situation

1. Family Member

N	Name	Nickname	Age	Sex	What are you in family	Career	Education	Remark
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

2. House	Description	Point
a/roof	leaf, thatch, patent fabric	0
	Tile, Zinc, Fibre Ciment	1
b/Wall	leaf, thatch, bamboo, no wall, scirpus	0
	Wood	1
	Brick, Ciment	2
c/Floor	Not available	0
	Trellis	1
	Plank	2
	Ciment/Sanitary Ware	3
d/condition	Shabby	0
	Average	1
	Good/Better	2

3. Electrionic Material Available	Point
a/Radio (N/A)	0
b/Disc cassette player, tv (white /black)	1
c/TV (color)	2
d/High radio frequency	3

4. Electric Energy	Point
a/ N/A /or Lamp Kerosene	0
b/Battery lower or equal 50mah	1
c/Battery higher 50mah /purchase electricity	2
d/Own electric generator	3

5. Transportation mean/available of transportation	Point
a/N/A	0
b/small bicycle – small boat	1
c/horse carriage – cow carriage	2
d/boat with moto engine	3
e/vehicle – two wheel tractor	4
7. Agricultural Materials	
a/N/A	0
b/plough	1
c/cow/buffalo/horse for drag	2
d/Pumps	3
e/tractor/plowing machine	4
9. Daily Income	Point
a/under 2,000 riels	0
b/from 2,000 – 4.000 riels	1
c/from 4,100 – 8,000 riels	2
d/from 8,100 – 16,000 riels	3
e/over 16,000 riels	4
10. Family Situation	Point
a/old age/disabled/orphanage from 02 persons	0
b/old age/disabled/orphanage from 01 person	1
c/N/A	2
12. Expenditure on treatment over the last 1 year	Point
a/over 500,000 riels	0
b/from 200,000 riels	1
c/from 200,000 riels	2

6. Land Production	Point
6.1 Size	
a/N/A	0
b/less than 1ha	1
c/from 1 – 2ha	2
d/from 2 – 5ha	3
e/Over 5ha	4
6.2 Quality	
a/quality type 3	0
b/quality type 2	1
c/quality type 1	2
8. Livestock	Point
a/N/A	0
b/1 big pig or chicken/duck less than 30unit	1
c/2 big pig or chicken/duck less than 30 unit	2
d/goat/sheep from 2units/cow/buffalo/horse 1unit	3
e/cow/buffalo/horse from 02 units	4
11. Final Illness	Point
a/over 30 days	0
b/from 15 days to 30 days	1
c/from 5 days to 15 days	2
d/less than 5 days	
13. Does your family ever borrow money when the family or household member is sick	Point
a/Yes ever borrowed	0
b/never	1

3/ Evaluation sheet of interviewer

....

....

....

....

....

....

4/ Total Score

The result upon interview shown that the patient Pro-Poor ☐ Poor ☐

.....................date........../..................20

Signature of Interviewer

Remark:

a/ Score point from 0 – 10 : Pro-Poor

b/ Score point from 11 – 18: Poor

c/ Score point over or equal 19 : Reject

I declar that the answers given above are correct if those answers are different from the fact, the organization/or NGO have the right to freeze all aid, and I guarentee to pay all costs since organization/or NGO that have been supported.

Finger Print / Signature of patient/relatives

អង្គការអភិវឌ្ឍន៍សុខភាពគ្រួសារ

Family Health Development

"ធ្វើការរួមគ្នាដើម្បីការរស់រានប្រសើរឡើងរបស់ជនក្រីក្រ និង ជនក្បែរបន្ទាត់ក្រីក្រ"

អាស័យដ្ឋាន: ៣៦A ផ្លូវ ៤៧៦ សង្កាត់ទួលទំពូង២ ខណ្ឌចំការមន រាជធានីភ្នំពេញ ប្រទេសកម្ពុជា

ទូរស័ព្ទ: ០២៣ ៩៩៦ ៨៥៦/០៩២ ៧៤៦ ០០៤

អ៊ីម៉ែល: info@fhd-cambodia.org

គេហទំព័រ: www.fhd-cambodia.org

កម្មវិធីគាំពារសុខភាពសង្គមគាំទ្រដោយ:

អង្គការ អ.ស.គ ជាអង្គការក្រៅរដ្ឋាភិបាលក្នុងស្រុកដែលបានបង្កើតឡើងក្នុងឆ្នាំ២០០២ និង ចុះ បញ្ជីនៅក្រសួងមហាផ្ទៃនៅឆ្នាំ ២០០៨។ ឆ្នាំ ២០០២ អង្គការ អ.ស.គ បានធ្វើការជាមួយក្រសួងសុខាភិបាល អាជ្ញាធរមូលដ្ឋាន សហគមន៍ និង ដៃគូនានា ដើម្បីផ្តល់សេវាមូលនិធិសមធម៌ដល់ជនក្រីក្រក្នុងរាជធានីភ្នំពេញ ។

ទស្សនវិស័យ និង គុណតម្លៃស្នូល

សព្វថ្ងៃនេះ អង្គការ អ.ស.គ កំពុងប្រតិបត្តិ កម្មវិធីគាំពារសុខភាពសង្គម ដែលមាន**គម្រោងមូលនិធិសមធម៌សុខភាព និង គម្រោងធានាសុខភាព** ទូទាំងរាជធានីភ្នំពេញ។

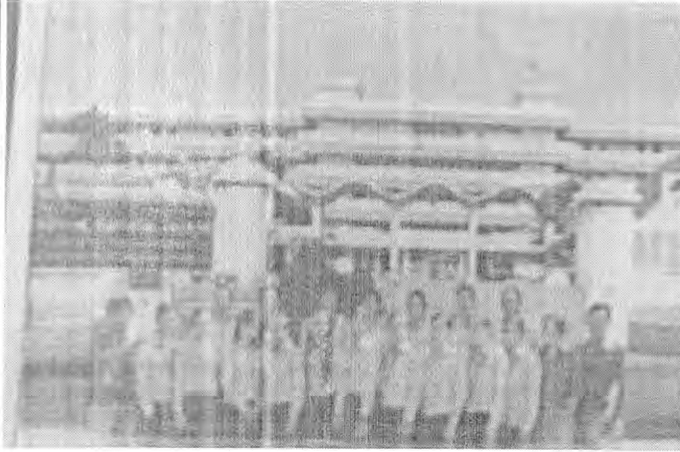
កម្មវិធីគាំពារសុខភាពសង្គម បានសហការជាមួយមន្ទីរពេទ្យដៃគូក្នុងការអនុវត្តគម្រោង ដូចជា មន្ទីរពេទ្យថ្នាក់ជាតិចំនួន ០២ មន្ទីរពេទ្យបង្អែកចំនួន ០៤ និង មណ្ឌលសុខភាពចំនួន ២៦ កន្លែង ដូចខាងក្រោម៖

១. មន្ទីរពេទ្យមិត្តភាពខ្មែរ-សូវៀត
២. មន្ទីរពេទ្យព្រះកុសុមៈ
៣. មន្ទីរពេទ្យបង្អែកពោធិ៍ចិនតុង
៤. មន្ទីរពេទ្យបង្អែកសម្តេចឪ
៥. មន្ទីរពេទ្យបង្អែករាជធានីភ្នំពេញ
៦. មន្ទីរពេទ្យបង្អែកមានជ័យ
៧. គ្រប់មណ្ឌលសុខភាពក្នុងរាជធានីភ្នំពេញ

ដើម្បីឆ្លើយតបនឹងគោលដៅ និងគុណតម្លៃស្នូលរបស់ខ្លួន អង្គការ អ.ស.គ ប្តេជ្ញាថា គ្រប់អតិថិជនរបស់គម្រោងមូលនិធិសមធម៌សុខភាព និង ធានាសុខភាព នឹងទទួលបានការសម្របសម្រួល និងយកចិត្តទុកដាក់ពីបុគ្គលិករបស់ខ្លួន ដែលប្រចាំនៅមន្ទីរពេទ្យនីមួយៗ ប្រកបដោយប្រសិទ្ធភាព។

ទទួលបានការគាំទ្រក្នុងការស្វែងរកសេវាសុខភាព និង ពេលមានបញ្ហាទំនាក់ទំនង ពីបុគ្គលិកអង្គការ នៅក្នុងមន្ទីរពេទ្យ

Family Health Development
"Together enhancing better live for poor people and poverty line"



Address: 36A Street 476 Sangkat Tuol Tom Pong2, Khan Chamcarmorn, Phnom Penh
Tel: 023 996 856/092 746 004
Email: info@fhd-cambodia.org
website: www.fhd-cambodia.org

Social Health Protection Project is supported by:

Logo MoH Logo GRET

Family Health Development (FHD) is local non-governmental organization established in 2022 and registration at Ministry of Interior in 2008. In 2002 FHD has in collaboration work with the Ministry of Health, local authority, community and other development partners to provide the equity fund services for poor people in Cambodia.

Vision and core value:

- Good relationship
- Clear objecti
- Commitment
- Respectful
- Loyalty

Currently FHD is operating Social Health Project such as Health Equity Fund and Health Insurance in Cambodia.

Social Health Protection project is collaborate with partners hospital to implementing program such as 2 national hospital, 4 referral hospitals and 26 health centers in the following:

1. Khmer Soviet Friendship Hospital
2. Preh Kosmak Hospital
3. Pochentong referral hospital
4. Norodom Sihanouk referral hospital
5. Phnom Penh referral hospital
6. Mean Chey referral hospital
7. All operational districts in Phnom Penh

To response our vision and its core value, FHD commit that all clients/patients of health equity fund and health insurance will benefit from organization's staff in term of good collaboration and effective at each of hospital

Receiving the support in seeking health service and correspondence from organization's staff in the hospital

Need to know Health Equity Fund

What does the project objective?
Provide free access with its quality to public service (health system), for people who has ID-poor and equity fund.

What are the benefits of equity fund project?

- Get a support for all access to health service and once having trouble in communication.
- Free of charge for care and medical service once any relative being used a treatment service at health center and national hospital
- Support :

Transportation fee Care giver get 5000 riels per day

- Funeral contribution (60000 riels)

Who is the client of health equity fund project?

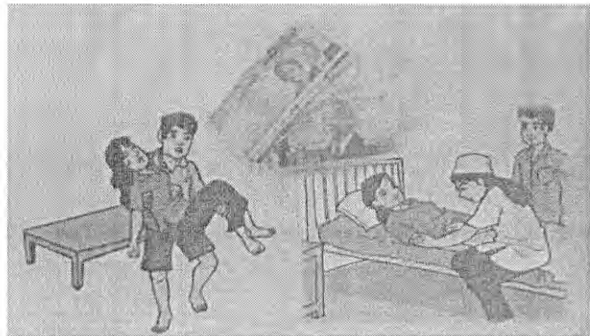
- Poor people who have ID poor and equity fund's ID
- Poor people who do not have their own financial to cover the treatment fee in hospital

Need to know the Health Insurance Project

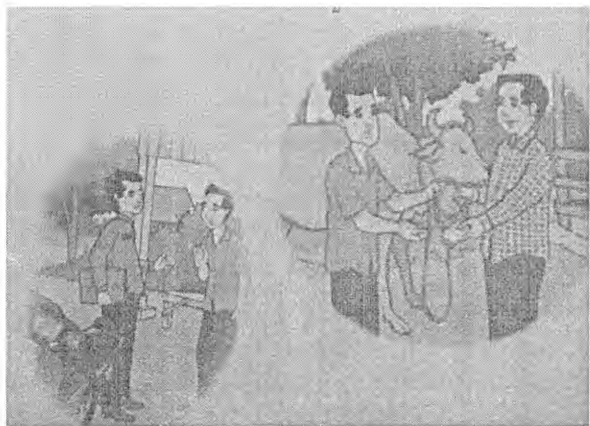
Health Insurance Project is to protect patients through high expenditure on treatment service and receive better health service with quality

Why need to have the health insurance?

We're all folks does not know in advance if you will have the sickness or accident and whether it would be taken place within how much amount of budget we will spend.

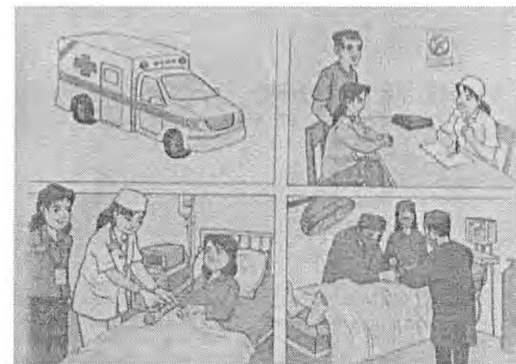


Health care and treatment are high cost and you would face a trouble to lose your property/assets or falling into poverty due to its sickness.



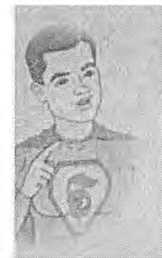
Protect our health, Protect our property/assets.

Health Insurance benefits for members



You will get those services for free of charge

Over thousands family members live in Phnom Penh that enroll as a membership



And you, why waiting for?

HURRY UP!!!

Reasonable of special package based on your demand

For more detail info please contact:

✆ 092 74 60 04

☑ កញ្ចប់អត្ថប្រយោជន៍

❖ ផ្តល់សោហ៊ុយធ្វើដំណើរពីផ្ទះទៅមណ្ឌលសុខភាពនិងត្រលប់ទៅផ្ទះវិញ

☑ អ្នកទទួលផល

❖ ចាស់ជរាក្រីក្រអាយុចាប់ពី **៦០ឆ្នាំ** មានប័ណ្ណសមធម៌និងប័ណ្ណដែលផ្តល់ដោយ អង្គការព្រះពុទ្ធសាសនា ដើម្បីសុខភាព

❖ ជនពិការក្រីក្រ (**មានកំរិតពិការចាប់ពី ពិការដៃ ជើងម្ខាង ពិការភ្នែកម្ខាងឬទាំង២ គថ្លង់ វិកលចរិត និងគមខ្វង**) មានប័ណ្ណសមធម៌ និង ប័ណ្ណដែលផ្តល់ដោយអង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាព

ការគ្រប់គ្រងគម្រោងមូលនិធិសមធម៌សហគមន៍

❋ គម្រោងគ្រប់គ្រងផ្ទាល់ដោយសហគមន៍រួមមាន:

✓ អាជ្ញាធរដែនដី សាសនា ព្រះសង្ឃ វិហារឥស្លាម ប្រជាពលរដ្ឋក្នុងសហគមន៍ និងផ្នែកសុខាភិបាល។

❋ គម្រោងនេះគៀរគរមូលនិធិតាមរយៈ:

✓ ដាក់ហិបតាមវត្ត សាលារៀន

✓ សាលាឃុំ និងទីប្រជុំជន

✓ ធ្វើបុណ្យផ្កា

✓ បដិភាគពីវត្ត/វិហារឥស្លាម

✓ សប្បុរសជននានា

Attachment 11

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កម្មវិធីគាំពារសុខភាពសង្គម

(PAC Card)

អង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាព ដោយមានការឧបត្ថម្ភពីរាជរដ្ឋាភិបាលកម្ពុជា និង ម្ចាស់ជំនួយនានាតាមរយៈក្រសួងសុខាភិបាល បាននិងកំពុងអនុវត្តគម្រោង២ រួមមាន: មូលនិធិសមធម៌ថ្នាក់ជាតិ និង មូលនិធិសមធម៌សហគមន៍។

❶ គម្រោងមូលនិធិសមធម៌ថ្នាក់ជាតិ

គាំទ្រគម្រោងដោយ:

ត្រួតពិនិត្យការអនុវត្តន៍គម្រោងដោយ: URC Cambodia

គម្រោងប្រតិបត្តិនៅក្នុង ខេត្តកំពត និង កែប

Implemented by giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

② មូលនិធិសមធម៌សហគមន៍

☑ គោលបំណង:

❖ ជួយប្រជាពលរដ្ឋងាយរងគ្រោះបំផុតដូចជា: ***មនុស្សចាស់ជរា*** និង ***ជនពិការ*** អោយទទួលការថែទាំសុខភាពបានសមស្របតាម រយៈការផ្តល់នូវកញ្ចប់អត្ថប្រយោជន៍បំពេញបន្ថែមលើកញ្ចប់អត្ថប្រយោជន៍មូលនិធិថ្នាក់ជាតិខាងលើ។

❖ លើកកម្ពស់ការចូលរួមរបស់សហគមន៍និងគណនេយ្យភាពសង្គមដើម្បីភាពប្រសើរឡើងនៃគុណភាពសេវាសុខាភិបាលសាធារណៈ។

គម្រោងនេះអនុវត្តផ្ទាល់ដោយ: សហគមន៍ក្នុងតំបន់ ព្រមទាំងមានការគាំទ្រផ្នែកបច្ចេកទេស និង ហិរញ្ញវត្ថុ ដោយ អង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាព និង កិច្ចសហប្រតិបត្តិការកម្ពុជា-អាល្លឺម៉ង់ តាមរយៈ អង្គការ GIZ ។

➢ អ្នកទទួលផល

ប្រជាពលរដ្ឋក្រីក្រដែលមានប័ណ្ណសមធម៌និងប័ណ្ណដែលផ្តល់ដោយអង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាព។

➢ កញ្ចប់អត្ថប្រយោជន៍

ប្រជាពលរដ្ឋក្រីក្រដែលមានប័ណ្ណសមធម៌និងប័ណ្ណដែលផ្តល់ដោយអង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាពនឹងទទួលបានកញ្ចប់អត្ថប្រយោជន៍ដូចជា:

១. នៅមណ្ឌលសុខភាព

សមាជិកនឹងទទួលបាន:

- ព្យាបាលដោយឥតគិតថ្លៃដោយមូលនិធិសមធម៌ជាអ្នកបង់ជំនួស
- ទទួលបានសោហ៊ុយធ្វើដំណើរសម្រាប់ស្ត្រីសំរាលកូន

២. នៅមន្ទីរពេទ្យស្រុក/ខេត្ត

ដោយមានលិខិតបញ្ជូនពីមណ្ឌលសុខភាពសមាជិកនឹងទទួលបាន:

- ព្យាបាលដោយឥតគិតថ្លៃដោយមូលនិធិសមធម៌ជាអ្នកបង់ជំនួស
- របបអាហារ ១ថ្ងៃ ៥,០០០រៀល
- សោហ៊ុយធ្វើដំណើរទៅ-មក

៣. នៅមន្ទីរពេទ្យថ្នាក់ជាតិ

សមាជិកនឹងទទួលបានសោហ៊ុយធ្វើដំណើរនិងការសម្របសំរួលបញ្ជូនបន្តដើម្បីអោយប្រតិបត្តិករទីនោះជួយគាំទ្របន្តដូចនៅមន្ទីរពេទ្យថ្នាក់ខេត្តដែរ។

<u>បញ្ជាក់:</u> ករណីមិនចាំបាច់មានលិខិតបញ្ជូនពីមណ្ឌលសុខភាពរួមមាន:

☑ *គ្រោះថ្នាក់ចរាចរ សំរាលពិបាក ការថែទាំក្រោយវះលូត ការបញ្ឈប់កំណើតអចិន្ត្រៃយ៍ ប្រភេទជំងឺមួយចំនួនទៀតដែលមិនអាចព្យាបាលនៅថ្នាក់មណ្ឌសុខភាព*

☑ *ពីផ្ទះអ្នកជម្ងឺទៅកាន់មណ្ឌលសុខភាពឆ្ងាយជាង **១០គ.ម** ហើយផ្ទះរបស់គាត់មកមន្ទីរពេទ្យបង្អែកមានចម្ងាយជិតជាង*

☑ *ផ្ទះអ្នកជំងឺគ្មានមណ្ឌលសុខភាពគ្រប់ដណ្តប់*

លេខទូរស័ព្ទទំនាក់ទំនង:

☎ ខេត្ត កំពត: ០៣៣ ៦ ៩៤៨ ៨០០   ☎ ខេត្ត កែប: ០៣៦ ៦ ៥៤៥ ៧៧៧

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

SOCIAL HEALTH PROTECTION PROJECT

Kingdom of Cambodia
Nation Religion King
Equity Fund Card

ID Poor Project
This ID is free of charge Code 2 1 0 5 0 3 1 2 - 0 2 8 6 Data Collection Period 7
Province|District|Comm Family Code Date: 30/05/2014

Province: Takeo	District: Kos Andeth	
Commune: Prey Kla	Village: Banteay Kjay	
Family Name: Benh Phom	Sex: Male	Year Birtl 1943

Category: 2

Description of Equity Fund

Photo

Regconize by Commune Chief

Priority Assess Card for Health Service
(PAC Card)

This ID free of charge
Province Takeo District: Kos Andeth Village: Ta Hean
Code 0 7 0 7 1 6 0 3 - 0 9 0 2

Issue Date 1/10/2014
Expire Date 30/09/2015
Category: Poor I

Family Name: Meas Rotha Sex: Male Year Date: 1963

N	Family Membe	Sex:	Age	N	Family Memt	Sex	Age
1	Un Eang	Male	1966	6	Choa Gnea	Male	1994
2	Nganh Veoun	Female	1969	7			
3	Ouch Ngeung	Female	1927	8			
4	Un Chany	Female	1992	9			
5	Un Tom	Female	1997	10			

Family Finger Print

Equity Fund Implementor

Buddhism for Health received the support from Cambodia Government and donors through Ministry of Health and being implementing two projects including National Equity Fund and Community Equity Fund.

1. National Equity Fund

Supported by:

Project Monitoring by:

Project operate in Kampot and Kep province

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

2. Community Equity Fund

Photoo

☑ Objective

- Helping the most vulnerable people such as elderly age and people with disabilities to receive an appropriate health care through providing an additional of package's benefit of national package benefit fund above.

- Promote community participation and social accountability in order to improve the quality of public health services.

The project is carried out directly by the local community as well as technical and financial support from Buddhism for Health and under Cambodian-German Cooperation through GIZ.

➢ Beneficiaries

Poor people who have an equity fund's ID and voucher provided by Buddhism for Health.

➢ Benefits Packages

Poor people who have an equity fund's ID and voucher provided by Buddhism for Health will receive benefits packages hereby:

1. Health Center

Membership will receive

- Free access for treatment covered by health equity fund
- For pregnancy and delivery women will receive the cost of transportation

2. District/Province Hospital

With a letter referred from health center, membership will get an advantage in the following:

- Free access for treatment covered by health equity fund
- Receive a daily meal allowance 5,000 riels.
- Transportation cost

3. National Hospital

Memership will receive transpotation cost and referral fees in order that field operator continue to support as alike as provincial hospital

Remark: In case does not have a letter referred from health center

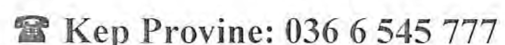
☑ *Car accidents, difficult in delivery, post- abortion care, permanent tied ovaries and any type of diseases that cannot be treated at health center.*

☑ *From patient home to health center far over 10km while their home close to referral hospital*

☑ *Do not have health center covered in the areas where patient live.*

Contact Number:

☎ Kampot Provine: 033 6 948 800



☎ Kep Provine: 036 6 545 777

☑ Benefits Package

- ❖ Support round trip of transportation fee from patient house to health center

☑ Beneficiaries

- ❖ Elder age people 60 who has equity fund's ID and voucher provided by Buddhism for Health
- ❖ Poor people with disabilities such as (disabled arm disability, one leg disabilty, blind eye(s), deaf, psychiatrist and kyphosis) who have equity fund's ID and voucher provided by Buddhism for Health.

Project Management of Community Equity Fund

❈ The project is managed directly by community itself such as:

✓ local authority, religious, monks, islam church, local community people and health sector

❈ The project is mobilized resources through:

- ✓ Diplay chest to each pagoda and public school
- ✓ Commune council and public area
- ✓ Traditional celebration (Bon Pkar event)
- ✓ Pagoda counterpart / islam church
- ✓ Charities

Hospital Name: .....Khmer Soviet Friendship Hospital .... Prakas No 809 on sponsor principle for poor household

QUESTIONNAIRES FOR PATIENT

POST-ID Patient Verification date: ..../.........../

Date-Month-Year interview :............/............/

Name of Interviewer:................................

1. Profile of Beneficiaries Households/clients

-Name: ....age...........................sex...............nickname..............................family status..................................

-In case patient unable for interview, interviewee name is ....who is a relative of patient ....

-Date-Month-Year of Hospitalizations............../.............../...............Type..........................Bed#.................code of patient.......................

-Current address of patient: ....village/group...................community....................commune/sangkat................district................

province/city.......................................Tel (if available)... Name owner of telephone..

For migrant population /or who have two different addresses please fill in an additional form below:

-Address of patient: village/group..............................community.....................commune/sangkat.................district.................

province/city.......................................Tel (if available)... Name owner of telephone..

☞Do you know the sponsor principle for poor patient by the Government prior any of your hospitalization Yes ☐ No ☐

☞Do you hope to get benefits from this principle prior any of your hospitalization Yes ☐ No ☐

2. Family Economic Situation

1. Family Member

N	Name	Nickname	Age	Sex	What are you in family	Career	Education	Remark
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

2. House	Description	Point
a/roof	leaf, thatch, patent fabric	0

3. Electrionic Material Available	Point
a/Radio (N/A)	0

	Tile, Zinc, Fibre Ciment	1
b/Wall	leaf, thatch, bamboo, no wall, scirpus	0
	Wood	1
	Brick, Ciment	2
c/Floor	Not available	0
	Trellis	1
	Plank	2
	Ciment/Sanitary Ware	3
d/condition	Shabby	0
	Average	1
	Good/Better	2

b/Disc cassette player, tv (white /black)	1
c/TV (color)	2
d/High radio frequency	3

4. Electric Energy	**Point**
a/ N/A /or Lamp Kerosene	0
b/Battery lower or equal 50mah	1
c/Battery higher 50mah /purchase electricity	2
d/Own electric generator	3

5. Transportation mean/available of transportation	**Point**
a/N/A	0
b/small bicycle – small boat	1
c/horse carriage – cow carriage	2
d/boat with moto engine	3
e/vehicle – two wheel tractor	4
7. Agricultural Materials	
a/N/A	0
b/plough	1
c/cow/buffalo/horse for drag	2
d/Pumps	3
e/tractor/plowing machine	4
9. Daily Income	**Point**
a/under 2,000 riels	0
b/from 2,000 – 4.000 riels	1
c/from 4,100 – 8,000 riels	2
d/from 8,100 – 16,000 riels	3
e/over 16,000 riels	4
10. Family Situation	**Point**
a/old age/disabled/orphanage from 02 persons	0
b/old age/disabled/orphanage from 01 person	1
c/N/A	2
12. Expenditure on treatment over the last 1 year	**Point**
a/over 500,000 riels	0
b/from 200,000 riels	1
c/from 200,000 riels	2

6. Land Production	**Point**
6.1 Size	
a/N/A	0
b/less than 1ha	1
c/from 1 – 2ha	2
d/from 2 – 5ha	3
e/Over 5ha	4
6.2 Quality	
a/quality type 3	0
b/quality type 2	1
c/quality type 1	2
8. Livestock	**Point**
a/N/A	0
b/1 big pig or chicken/duck less than 30unit	1
c/2 big pig or chicken/duck less than 30 unit	2
d/goat/sheep from 2units/cow/buffalo/horse 1unit	3
e/cow/buffalo/horse from 02 units	4
11. Final Illness	**Point**
a/over 30 days	0
b/from 15 days to 30 days	1
c/from 5 days to 15 days	2
d/less than 5 days	
13. Does your family ever borrow money when the family or household member is sick	**Point**
a/Yes ever borrowed	0
b/never	1

3/ Evaluation sheet of interviewer

....

....

....

....

....

....

4/ Total Score

The result upon interview shown, beneficiaries/clients Pro-Poor ☐ Poor ☐ Average Poor ☐

....................date........../.................20

Signature of Interviewer

Remark:

a/ Score point from 0 – 10 : Pro-Poor

b/ Score point from 11 – 14: Poor

b/ Score point from 15 – 18: Average Poor

c/ Score point over or equal 19 : Reject

I declar that the answers given above are correct if those answers are different from the fact, the organization/or NGO have the right to freeze all aid, and I guarentee to pay all costs since organization/or NGO that have been supported.

Finger Print / Signature of beneficiary/client/relatives

REMINDER FOR THE PATIENTS:

1. Always bring your insurance card whenever you go to Health Center or Referral Hospital.
2. Make sure that insurance card is still valid.
3. Make sure you have referral letter when you go the hospital
4. Contact the MHI staff if you have any questions or need clarification.

THINGS THAT ARE NOT COVERED BY MHI

- Waiting period of 1 year is applied for elective surgery
- No cosmetic surgery
- No payment for vertical programs (HIV/ TB/ EPI etc.)
- No specialized services like eye and dental care, hemodialysis, physical devices (e.g. hearing aids, glasses, crutches etc.)
- No payment for pre-existing chronic diseases or non communicable diseases.
- No treatment in private clinics.

HOW TO ENROLL TO MHI?

Type 1: Individual Enrolment

- ☺ CHC promoter and Volunteers (VIV) register clients, take photos, CHC produces insurance card and collects the premium.

Type 2: Group Enrolment

- ☺ One responsible/ focal person for MHI is selected by the group and makes list of MHI clients.
- ☺ Agrees on the date for CHC to take photos of MHI members of the group.
- ☺ CHC takes photos and produces insurance card.
- ☺ The focal person in the group collects money, gives it to CHC and distributes the insurance cards to members.

Be Insured, Be Healthy

CONTACTS

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Mobile: 098-773-281

CHC-MHI Social Worker/Nurse
Mobile: 088-683-0880

With Micro Health Insurance, NOTHING to worry about health expense. MHI will pay for it...

Micro Health Insurance

Be Insured, Be Healthy

FREQUENTLY ASKED QUESTIONS

What is health insurance?

It is a way to make health care predictable and affordable. It is a tool to decrease uncertainty. *"We don't know when we are getting ill, how severe our illness is & how much it will cost".*

What is Micro Health Insurance (MHI)

It is a non for profit, voluntary pre-payment schemes that target the people who can afford to pay the insurance premium.

What is the PURPOSE of CHC-MHI?

a. To improve equitable access to health care at public health facilities in SRP OD.
b. To create a safety net against catastrophic health expenditure.
c. To actively participate in improving the quality of services in public health facilities.

Why should we buy MHI?

a. High health care costs are the main cause of impoverishment in Cambodia.
b. High health care costs force people to borrow money, to sell land or livestock or to take children out of school
c. High health care costs are responsible that in Cambodia in each year more than one hundred thousand households are facing impoverishment due to costs of illness. These are 4.3% of the Cambodian population. Another 3.8% of the population got indebted because they had to pay for their medical treatment.
d. 60% of farmers who recently lost their land had sold it because of health expenses in their family.

Two types of enrolment into MHI?

Type 1: Individual Enrolment

- All family members must enroll into MHI
- Premium has to be paid according to family size in family book.
- Relatives that lives with the family can also enroll to MHI, as long as they are living in the same house.

Type 2: Group Enrolment (minimum Of 10 members)

- All staff working in NGO/ Hotel or other small business must enroll into MHI.
- All members of associations (e.g. farming cooperatives/ producer groups) must enroll into MHI
- NGOs can select groups of beneficiaries to enroll into MHI.
- Family enrolment is possible depending on discussion within the group.

How much does MHI cost you?

Siem Reap MHI		
Validity	Amount in USD	Amount in Riel
6 months	$ 4 per person	16,000
12 months	$ 7.5 per person	30,000
Discount(1year)	$ 0.5/ person	2,000
Discount(6mos)	$ 0.25/ person	1,000

What are the BENEFITS of CHC-MHI?

Members can use services at contracted Public Health Facilities without additional payment. The following benefits are included:

A. MEDICAL SUPPORT	
1	HEALTH CENTER SERVICES
2	REFERRAL HOSPITAL SERVICES
B. NON MEDICAL SUPPORT	
3	FUNERAL ASSISTANCE
4	TRANSPORTATION ASSISTANCE

A. MEDICAL SUPPORT

1. HEALTH CENTER SERVICES

- Consultation, Examinations, Procedures with the contracted Health Centers
- *Essential Eye Care*
- First Aide/simple treatment of Injuries caused by an accident
- Simple test (Dipstick/ Rapid test)
- Clients' referral to Referral Hospital (if needed)
- And all other services that includes in the Guideline Book of the MoH of the Kingdom of Cambodia on the set Minimum Package Activities (MPA)

2. REFERRAL HOSPITALSERVICES

- Consultation, Examinations, Treatment, Procedures with the Referral Hospital
- Confinement/ Hospitalized
- Diagnostic tests/ Laboratory Test
- *Basic Eye & Dental Care*
- And all other services that includes in the Guideline Book of the MoH of the Kingdom of Cambodia on the set Complementary Package of Activities (CPA)

B. NON MEDICAL SUPPORT

3. FUNERAL ASSISTANCE

- 50,000Riel for every loss of life of the insured family.

4. TRANSPORTATION ASSISTANCE

- Reimbursement of travel costs for insured clients from Health Center to Referral Hospital (only with referral letter from HC except for emergency cases)
- Reimbursement for travel costs between CPA2 and CPA3 RH (In patient only)
- Round trip transportation support for pregnant women for delivery at contracted Public Health Facilities including Kantha Bopa and Angkor Children Hospital (500R/km)

សេវាសុខភាព ដែលសមាជិកទទួលបាន២៤ម៉ោង

សូមទំនាក់ទំនងទូរស័ព្ទ

ស្រុកគិរីវង់,បូរីជលសារ,ទ្រាំង,កោះអណ្ដែត
0977 403 218. 032 69 00 729

ស្រុកត្រាំកក់: 092 822 284, 032 6500688

ស្រុកបាទី: 012 342 211, 0326 456 111

ស្រុកសំរោង,ព្រៃកប្បាស,អង្គរបូរី
097 222 6662, 032 666 6013

ក្រុងដូនកែវ: 0976 212 122, 032 65 00 913

តារាងប្រាក់ភាគទាន សំរាប់ផលិតផលទី៣

គិតជា(រៀល)

ទំហំគ្រួសារ	បង់៦ខែ	បង់ ១ឆ្នាំ
1	26,400	52,800
2 ទៅ 4	64,800	129,600
5 ទៅ 7	79,800	159,600
8 ឡើង	97,200	194,400

បញ្ជាក់:
- សំរាប់សមាជិកចុះឈ្មោះថ្មី បង់៦ខែនឹងទទួលបានការបញ្ចុះ ៥%។
- សំរាប់សមាជិកចុះឈ្មោះថ្មីបង់១ឆ្នាំនឹងទទួលបានការបញ្ចុះតំលៃ១៥%។
- សំរាប់សមាជិកចាស់ចូលតដោយប្តូរ ផលិ តផល បង់៦ខែ នឹងទទួលបាន ការបញ្ចុះ ១០% បង់ពេញ១ឆ្នាំបញ្ចុះតំលៃ 20%។

រចនាសម្ព័ន្ធ សេវាសុខភាព សាធារណៈ

មណ្ឌលសុខភាពដែលនៅជិតបំផុត

បញ្ជូនបន្ត

មន្ទីរពេទ្យបង្អែកស្រុក

មានរថយន្តសង្គ្រោះក្នុងករណីសង្គ្រោះបន្ទាន់

បញ្ជូនបន្ត

មន្ទីរពេទ្យខេត្តតាកែវ

មានរថយន្តសង្គ្រោះក្នុងករណីសង្គ្រោះបន្ទាន់

បញ្ជូនបន្ត

មន្ទីរពេទ្យថ្នាក់ជាតិ(មិត្តភាពខ្មែរសូវៀត ភ្នំពេញ)

Attachment 14

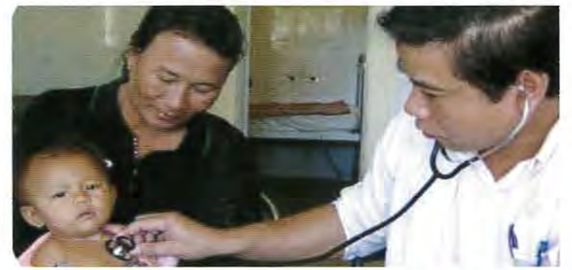
អង្គការព្រះពុទ្ធសាសនាដើម្បីសុខភាព

ក្រសួងសុខាភិបាល

គំរោងធានារ៉ាប់រងសុខភាពសហគមន៍

មានធានារ៉ាប់រងសុខភាពគឺចំណាយតិច ទទួលអត្ថប្រយោជន៍ច្រើន

ឈប់បារម្ភពីការចំណាយច្រើនលើការព្យាបាលថែទាំសុខភាពទៀតហើយ!



មានធានារ៉ាប់រងសុខភាព គឺសំរាប់បង្ការនូវហានិភ័យនៃការចំណាយដ៏ច្រើនលើសលប់លើបញ្ហាសុខភាព

ចូលជាសមាជិកធានារ៉ាប់រងសុខភាព
គឺជាការជួយគ្នាទៅវិញទៅមក

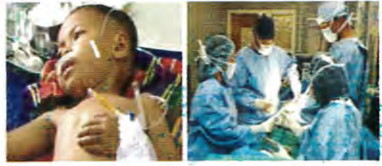
ថ្ងៃនេះយើងមិនឈឺ យើងក៏សប្បាយចិត្ត ព្រោះយើងបានជួយ
សមាជិកផ្សេងទៀតដែលជួបគ្រោះភ័យដោយសារជំងឺ
បើថ្ងៃក្រោយ យើងឈឺត្រូវការចំណាយច្រើន
យើងក៏មិនបារម្ភព្រោះមានសមាជិកទាំងអស់ចាំជួយយើងវិញ។

អាសយដ្ឋានស្នាក់ការកណ្ដាល: ភូមិ.ក៏ពង់ ឃុំ.ព្រះបាទជាន់ជុំ ស្រុក.គិរីវង់ ខេត្ត.តាកែវ
ទូរស័ព្ទ Tel: 032 69 00 729, 0326903 630
Email: bfh.pro.mgt@gmail.com

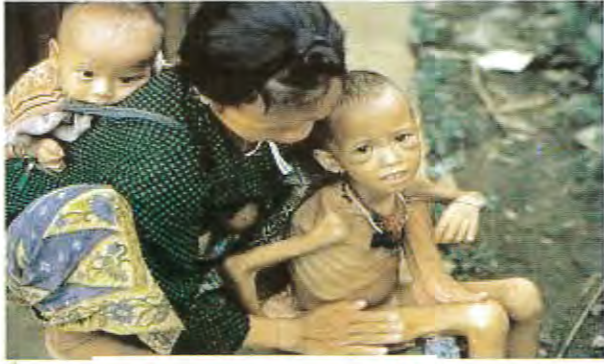
គ្មានធានារ៉ាប់រងសុខភាព

ចំណាយច្រើនលើសលប់ គិតជាមធ្យមក្នុងម្នាក់ ប្រមាណជា:**១០០,០០០៛** សំរាប់ការព្យាបាលថែ ទាំសុខ ភាព ក្នុងមួយឆ្នាំៗ។ ក្នុងករណីមានជំងឺធ្ងន់ធ្ងរ ឬរហូតដល់ការវះកាត់ធំៗ លោកអ្នកនឹង**ចំណាយអស់ជាច្រើនលានរៀល** រហូតអាចលក់ទ្រព្យសម្បត្តិ ដីស្រែចំការ ដែលជាកត្តាប្រឈមនឹងការធ្លាក់ខ្លួនក្នុងភាពក្រីក្រ ។

អ្នកមិនមែនជាសមាជិកធានារ៉ាប់រង



ប្រឈមក្នុងការចំណាយច្រើនពេលមានជំងឺ



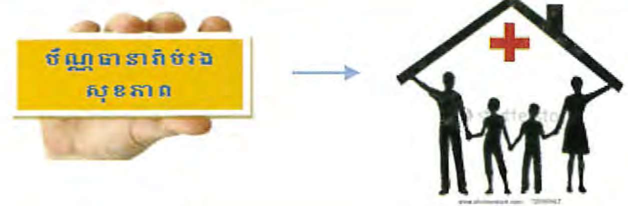
ធ្លាក់ខ្លួនក្រដោយសារជំងឺ

មានធានារ៉ាប់រងសុខភាព

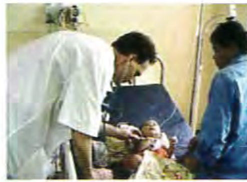
ចំណាយតិចតួច ជាមធ្យមក្នុងម្នាក់ត្រឹមតែ: **១៦,០០០៛ ទៅ ២៤,០០០៛** សំរាប់ចុះឈ្មោះចូលជាសមាជិក ដើម្បីទទួលសេវាព្យាបាលថែទាំសុខភាពតាំងពីថ្នាក់មណ្ឌលសុខភាព មន្ទីរពេទ្យបង្អែកស្រុក មន្ទីរពេទ្យខេត្តតាកែវ រហូតដល់ មន្ទីរពេទ្យជាតិមិត្តភាពខ្មែរសូវៀត ភ្នំពេញ បានពេញមួយឆ្នាំ ដោយឥតកំណត់ រួមទាំងការធានាជំងឺធ្ងន់ៗស្ទើរតែគ្រប់ប្រភេទ និង ការវះកាត់ធំ ព្រមទាំងសេវាព្យាបាលជាច្រើនទៀតដែលមាននៅតាមមន្ទីរពេទ្យខាងលើ ។

លើសពីនេះទៀត លោកអ្នកនឹងទទួលបាននូវការឧបត្ថម្ភទាំងផ្នែកហិរញ្ញវត្ថុ និង ផ្នែកសង្គមជាច្រើនថែមទៀត ព្រមទាំងមានបុគ្គលិកគ្រូពេទ្យរបស់អង្គការនៅចាំជួយសំរបសំរួលសេវាថែមទៀត ដូចដែលមានចែងលំអិតក្នុងកញ្ចប់អត្ថប្រយោជន៍ធានារ៉ាប់រងសុខភាព។

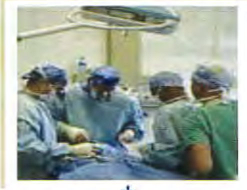
ករណីជំងឺធ្ងន់ធ្ងរ រហូតដល់ វះកាត់ធំៗ លោកអ្នក**ក៏មិនចាំបាច់ចំណាយអ្វីបន្ថែមទៀតឡើយ**។



ចូលជាសមាជិកធានារ៉ាប់រងសុខភាពជាការលើកកំពស់សាមគ្គីភាពសង្គមខ្មែរ



មិនបារម្ភលើការចំណាយថវិកាពេលមានបញ្ហាសុខភាព



សន្សំសំចៃថវិកាបានច្រើន

លើសពីនេះបើប្រៀបធៀបទៅនឹង អ្នកគ្មានធានារ៉ាប់រងសុខភាព

កញ្ចប់អត្ថប្រយោជន៍សំរាប់សមាជិកធានារ៉ាប់រងសុខភាព

I-សេវាព្យាបាលថែទាំផ្នែកវេជ្ជសាស្ត្រ

1-សេវាសុខភាពនៅមណ្ឌលសុខភាព: សំរាលកូន,ពិគ្រោះ ជំងឺទូទៅ , ពិនិត្យផ្ទៃពោះ, ពន្យារកំណើត,វះកាត់តូចនិងសេវាផ្សេងៗ និងមានរថយន្តសង្គ្រោះបន្ទាន់ បញ្ជូនទៅមន្ទីរពេទ្យថ្នាក់ស្រុក(ក្នុងករណីបន្ទាន់)

2-សេវានៅមន្ទីរពេទ្យបង្អែកស្រុក: ពិគ្រោះផ្នែកភ្នែក,ផ្នែកធ្មេញ, សំរាកពេទ្យវះកាត់ធំ(មន្ទីរពេទ្យ CPA2),សំរាលដោយការវះកាត់,សេវាអមគ្លីនិក(វិភាគឈាមរកមេរោគគ្រប់ប្រភេទ, ថតអេកូសាស្ត្រថតកាំរស្មីអិកដោយគ្រូពេទ្យជំនាញ) និងមានរថយន្តសង្គ្រោះបន្ទាន់បញ្ជូនទៅមន្ទីរពេទ្យខេត្តតាកែវ (ក្នុងករណីបន្ទាន់)។

3-សេវានៅមន្ទីរពេទ្យខេត្តតាកែវ: ពិគ្រោះព្យាបាលដោយវេជ្ជ:បណ្ឌិតឯកទេស (ផ្នែកមាត់ធ្មេញ ច្រមុះ បំពង់ក ត្រចៀក និង ផ្នែកបាត) វះកាត់ធំស្ទើរគ្រប់ប្រភេទ (វះកាត់តឆ្អឹង, សំរាលដោយការវះកាត់...) និងសេវាអមគ្លីនិក (ស្កេនផ្នែកក្បាល) ដែលពិនិត្យព្យាបាលដោយវេជ្ជបណ្ឌិតឯកទេសជំនាញ និង មានរថយន្តសង្គ្រោះបន្ទាន់ក្នុងករណីត្រូវបញ្ជូនបន្ទាន់ទៅសង្គ្រោះនៅមន្ទីរពេទ្យថ្នាក់ជាតិ។

4-សេវានៅមន្ទីរពេទ្យថ្នាក់ជាតិ (មិត្តភាពខ្មែរសូវៀតនៅភ្នំពេញ)
ជំងឺសង្គ្រោះបន្ទាន់ ការវះកាត់ធំស្ទើរគ្រប់ប្រភេទ ព្យាបាលជំងឺ គ្រោះថ្នាក់ចរាចរបែកបាក់សរីរ:ធ្ងន់ធ្ងរ និងការព្យាបាល ផ្នែក ប្រព័ន្ធប្រសាទ ព្រមទាំងការព្យាបាល ដោយប្រើប្រាស់ឧបករណ៍វេជ្ជសាស្ត្រ និង វិទ្យាសាស្ត្រទំនើបៗដែលនាំចូលពីបរទេស ។

II- អត្ថប្រយោជន៍បន្ថែម

- សមាជិក ទទួលបានសោហ៊ុយធ្វើដំណើរ 20,000 រៀល ករណីសំរាកព្យាបាលនៅមន្ទីរពេទ្យខេត្តតាកែវ(លើកលែងសមាជិកក្នុងតំបន់ស្រុកប្រតិបត្តិដូនកែវ)។
- សមាជិក ទទួលបានសោហ៊ុយធ្វើដំណើរ 80,000 រៀល ករណីសំរាកព្យាបាលនៅមន្ទីរពេទ្យគន្ធបុប្ផា សំរាប់កុមារ យុក្រោម១៨ឆ្នាំ។
- សមាជិក ទទួលបានសោហ៊ុយធ្វើដំណើរ 80,000 រៀល ករណីសំរាកព្យាបាលនៅមន្ទីរពេទ្យមិត្តភាពខ្មែរសូវៀត(ក្នុងករណីបន្ទាន់មានរថយន្តសង្គ្រោះបន្ទាន់ដឹកអ្នកជំងឺដោយឥតគិតថ្លៃ) ។
- មានបុគ្គលិក គ្រូពេទ្យរបស់អង្គការនៅចាំជួយសំរបសំរួលសេវា។
- បច្ច័យបុណ្យសព(ចូលរួមរំលែកទុក្ខក្នុងករណីអស់សង្ឃឹម)។

Health Services that members receiving 24 hours

Contact

Kirivong District, Borey Chul sar, Treng, Kos Andeth
Tel: 097 7 403 218, 032 69 00 729

Srok Tram Kok: Tel 092 822 284, 032 6500688

Batie District: Tel: 342 211, 032645611

Samrong District, Prey Kabas, Angkor Borey
Tel: 097 222 6662, 032 666 6013

Daun Keo City: 097 6 212 122, 032 6500913

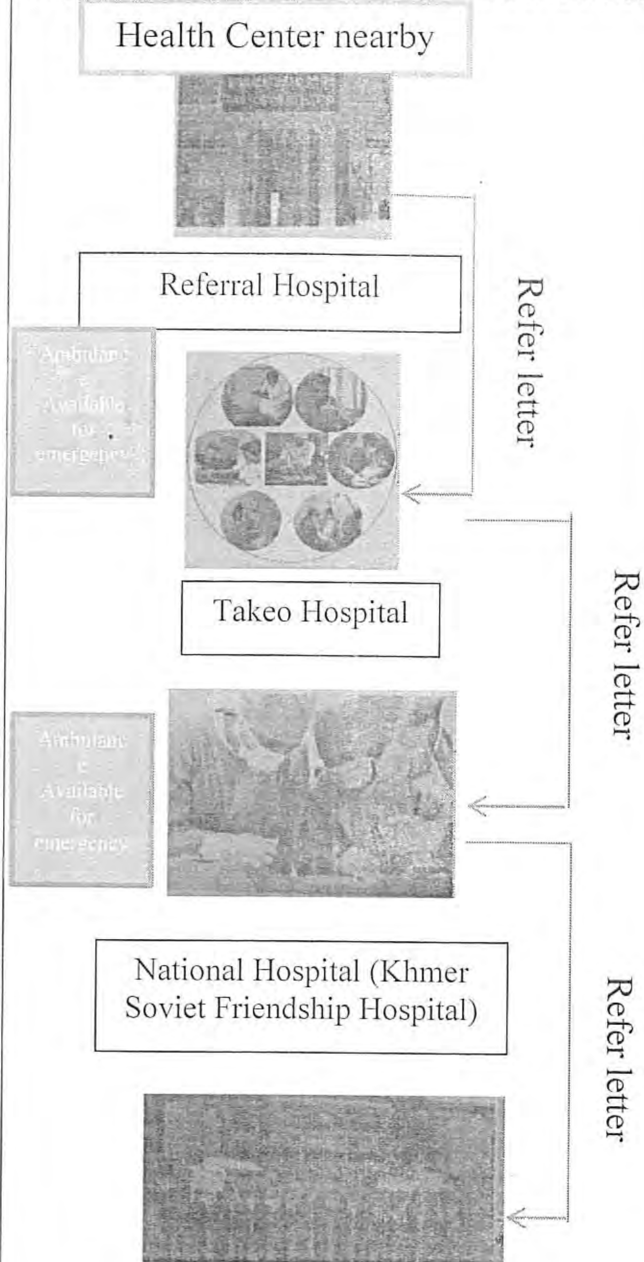
Table contribution product 3 (in riels)		
Size in family	6 months	1 Year
1	26,400	52,800
2 to 4	64,800	129,600
5 – 7	79,800	159,600
From 8 up	97,200	194,400

Remark:

- New member enrollment pay for 6 month plan will get 5% discount
- New member enrollment pay for 1 year plan will get 15 discount

Existing member renew a plan by pay for 6 month plan will get 10% discount and 1 year plan will get 20% discount

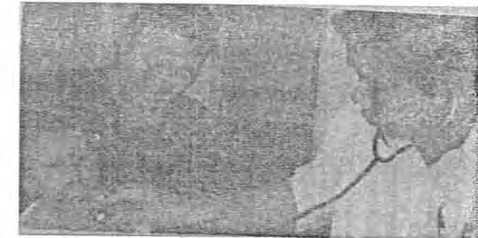
Organizational Structure of Public Health Service



OMMUNITY HEALTH INSURANCE PROJECT

Having the health insurance is less expense and receives more benefits

No longer to worry for the expanse on health care and treatment



Health Insurance is to prevent the risk of a multitude of spending on health issues

Membership is mutual health insurance
Today we are not sick, we are happy because we can help other members who are at risk from diseases
Later, once we are sick, we are not to worry much since having other members help us back

Address: Kampong Village, Preh Bat Chorn Chom, Kirivong, Takeo
Tel: 032 69 00729, 0326903630

Without Insurance

Overwhelming of expenditure in average cost around 100,000 riels each year on health care and treatment and for some case of serious illness or major surgery, you would spend over million riels force to get your farmland property to be sold, those are the risk factors that will fall into poverty

You are not a membership of this insurance

Face many challenges for all expense once having illness

Fall into sickness

With Insurance

Less expenditure in average cost around 16,000 – 24,000 riels for membership enrollment to access on free health care and treatment from health center, district referral hospital, Takeo provincial hospital to Khmer Soviet Friendship Hospital in Phnom Penh for one year including different type of serious illness, and major surgery together with other kind of service from the above hospital.

Moreover, you will get a support in term of financial care together with social contribution, and also availability of the organization's medical staff remembers ready to help and coordinate services as stated in detail on health insurance benefit package

Health Insurance's

To be a membership of health insurance is to promote a social Khmer Solidarity

No worry of spending on health problem

Happiness Family

Fall into sickness

Health Insurance Benefits Pakage for membership

I-Medical care and treatment services

1. Health service at health center: maternity, general counseling, pregnancy service, contraception, small surgical and available of ambulance to district hospital (emergency)
2. District referral hospital: counseling section on eyes, dentists, surgery (hospital PAC2) delivery birth by surgical services at the clinic (blood test for all type of viruses, echography and X-Rey), and available of ambulance transport to hospital in Takeo (in case of emergency).
3 Hospital in Takeo
Treatment by expert of medical doctor including (dental, ear, nose, throat and bottom section) large surgery in all most of categories such as (bone surgery, and delivery by surgery), following services at the clinic such as (head scanning), those are examined by medical experts and the availability of ambulance in case of emergency immediately sent to national hospital.
4 National Hospital Services (Khmer Soviet Friendship Hospital)
The services such as an emergency case, a large scale of surgeries, serious of traffic accidents and physiological treatment within the use of medical devices and modern science facilities that imported from abroad.

II – The additional benefits
- Members are able to get transportation fees 20,000 riels once having stayed at Takeo Hospital (excluded member in Daun Keo Operational District)

- Members are able to get transportation fees 80,000 riels once having stayed at
Kunthakbopha Hospital for children under ages 14.

- Members are able to get transportation fees 80,000 riels once having stayed at Khmer Soviet Friendship Hospital (Case of emergency, there is available of ambulance to be transported for free)

- We have hospital and NGO's staff ready to support for those services.

- Funeral contribution (sharing condolence)

គំរោងប័ណ្ណសុខភាពវគ្គ២

កម្មវិធីអភិវឌ្ឍន៍របស់រាជរដ្ឋាភិបាលកម្ពុជា សហហិរញ្ញប្បទានដោយសាធារណរដ្ឋសហព័ន្ធអាល្លឺម៉ង់ តាមរយៈធនាគារអភិវឌ្ឍន៍អាល្លឺម៉ង់ KfW

Voucher Management Agency

EPOS
Health Management

គំរោងប័ណ្ណសុខភាពជួយស្ត្រីក្រីក្រដោយពុំគិតថ្លៃ

គោលបំណងសំខាន់នៃគំរោងប័ណ្ណសុខភាព

- ជួយប្រជាជនពិសេសស្ត្រីក្រីក្រអោយមានលទ្ធភាពប្រើប្រាស់សេវាថែទាំសុខភាពមាតានិងកុមារដោយពុំគិតថ្លៃ
- កាត់បន្ថយការឈឺនិងស្លាប់របស់ម្តាយនិងកុមារ

តើគំរោងប័ណ្ណសុខភាពជួយគាំទ្រនិងឧបត្ថម្ភអ្វីខ្លះដល់ស្ត្រីនិងក្រុមគ្រួសាររបស់គាត់?

១-ជួយចេញថ្លៃសេវាសុខភាព

ក).មាតុភាពគ្មានគ្រោះថ្នាក់-ស្ត្រីមានផ្ទៃពោះ

- ការពិនិត្យផ្ទៃពោះមុនសំរាល លើកទី១ លើកទី ២ លើកទី ៣ និងលើកទី៤
- ការសំរាលកូនធម្មតានៅមណ្ឌលសុខភាព-ការសំរាលកូនលំបាកនៅមន្ទីរពេទ្យ រួមទាំងការសំរាលកូនដោយការវះកាត់
- ការថែទាំក្រោយការសំរាលនិងការថែទាំក្រោយការរលូត

ខ).ការពន្យារកំណើត

- ការផ្តល់ប្រឹក្សាផែនការគ្រួសារនិងការពន្យារកំណើត
- ការដាក់ (ឬ ដក) កងក្រោមស្បែកនិងកងក្នុងស្បូន
- ការវះកាត់ចងបំពង់បង្ហូរមេជីវិតបុរសនិងចងដៃស្បូនស្ត្រី

គ).ការរំលូតដោយសុវត្ថិភាព និងដាក់កងក្រោយរំលូត
(ទាំងអ្នកមាននិងអ្នកក្រីក្រអាចទទួលសេវានេះដោយឥតគិតថ្លៃ)

២-ជួយចេញថ្លៃធ្វើដំណើរៈ គ្រប់សេវាទាំងអស់

៣-ជួយឧបត្ថម្ភថ្លៃអាហារ និងការគាំទ្រផ្នែកសង្គមផ្សេងៗទៀត

សារអប់រំសុខភាពស្ត្រីមានផ្ទៃពោះស្តីពីការថែទាំមុនសំរាល ការសំរាល និងការថែទាំក្រោយសំរាល

គ្រប់ស្ត្រីមានផ្ទៃពោះ គួរទៅពិនិត្យផ្ទៃពោះនៅមណ្ឌលសុខភាពយ៉ាងហោចអោយបាន៤ដងមុនពេលសំរាលៈ

តើពេលណាគួរទៅពិនិត្យផ្ទៃពោះ ?

ក្រោយការបាត់រដូវចុងក្រោយភ្លាម(បាត់រដូវភ្លាមទៅមណ្ឌលសុខភាព!) ឬ ប្រាកដថាខ្លួន មានផ្ទៃពោះ បើពុំមានបញ្ហាអ្វី ជាចំបងទេគ្រប់ស្ត្រី មានផ្ទៃពោះគួរទៅមណ្ឌលសុខភាពរៀងរាល់បីខែម្តងចាប់ពីបាត់រដូវ។

ផលប្រយោជន៍នៃការពិនិត្យផ្ទៃពោះមុនសំរាលៈ

- ស្ត្រីទទួលបានថ្នាំជាតិដែកការចាក់ថ្នាំបង្ការការពិនិត្យឈាមដែលមានសារៈសំខាន់ចំពោះសុខភាពម្តាយនិងទារក។

- អាចអោយគ្រូពេទ្យឬ ឆ្មបរកឃើញនូវរោគសញ្ញាគ្រោះថ្នាក់ដូចជាជម្ងឺបំរ៉ុងក្រឡាភ្លើង ជម្ងឺស្លេកស្លាំង ជម្ងឺកង្វះជីវៈជាតិ និងជម្ងឺផ្សេងៗទៀត ហើយធ្វើការព្យាបាលបានទាន់ពេលវេលា
- កាត់បន្ថយការឈឺនិងស្លាប់របស់ម្តាយនិងទារកពេលសំរាល

រោគសញ្ញាគ្រោះថ្នាក់ពេលមានផ្ទៃពោះ

ស្ត្រីមានផ្ទៃពោះគួរទៅមណ្ឌលសុខភាព ឬ មន្ទីរពេទ្យអោយបានឆាប់ បើមានរោគសញ្ញាដូចខាងក្រោមៈ

ហើមជើងខ្លាំង

ឈឺក្បាល-ស្រវាំងភ្នែក

ក្តៅខ្លួនខ្លាំង

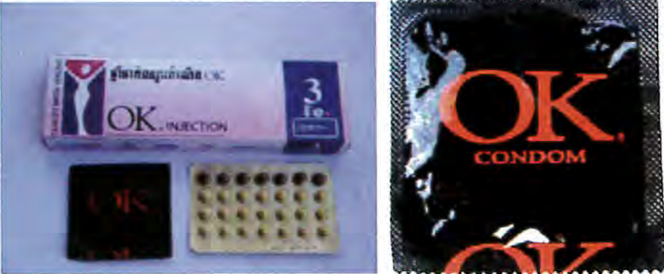
ធ្លាក់ឈាម ឬ បែកទឹកភ្លោះមុនពេលឈឺពោះសំរាល

គ្រប់ស្ត្រីមានផ្ទៃពោះទាំងអស់ គួរទៅពិនិត្យផ្ទៃពោះ សំរាល និងថែទាំក្រោយសំរាលនៅមណ្ឌលសុខភាព!

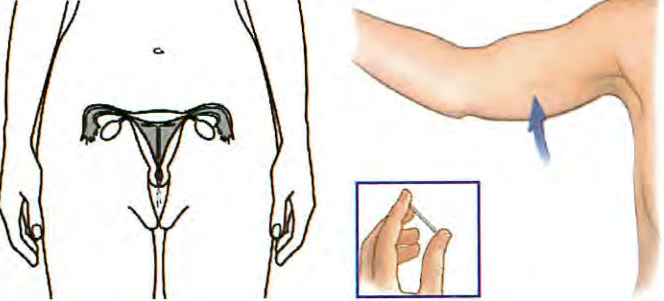
សារអប់រំសុខភាពស្ត្រីពីផែនការគ្រួសារ និង ការពន្យារកំណើត

តើមធ្យោបាយពន្យារកំណើតមានអ្វីខ្លះ?

១).មធ្យោបាយពន្យារកំណើតរយៈពេលខ្លី : ស្រោមអនាម័យ ថ្នាំគ្រាប់ និង ថ្នាំចាក់វាមានប្រសិទ្ធភាពខ្ពស់ បើលេប ឬ ចាក់ ទៀងទាត់តាមការកំណត់របស់គ្រូពេទ្យ



២).មធ្យោបាយពន្យារកំណើតរយៈពេលវែង: កងដាក់ក្រោមស្បែកនិងកងដាក់ក្នុងស្បូន វាមានប្រសិទ្ធភាពចាប់ពី ៣ ទៅ ១០ ឆ្នាំ



៣).ការបញ្ឈប់កំណើតជាអចិន្ត្រៃយ៍ : ការចងបំពង់បង្ហូរមេជីវិតបុរស និង ការចងដៃស្បូនស្ត្រីក្រោយការវះកាត់ស្ត្រីនិងបុរសមិនអាចមានកូនទៀតទេ!

ផលប្រយោជន៍នៃការពន្យារកំណើត:

- អាចអោយស្ត្រីមានកូនតាមការចង់បានមិនមែនដោយចៃដន្យ
- ធ្វើអោយម្តាយមានសុខភាពគ្រប់គ្រាន់: ការមានកូនរង្វើលធ្វើអោយម្តាយមានសុខភាពល្អ និងមានលទ្ធភាពគ្រប់គ្រាន់ក្នុងការចិញ្ចឹមកូនអោយមានសុខភាពល្អ
- ការមានកូនតិចធ្វើអោយកូនមានឱកាសក្នុងការរៀនសូត្របានច្រើននិង ខ្ពង់ខ្ពស់
- អាចជួយបង្កើនប្រាក់ចំណូលនិងប្រាក់សន្សំសំរាប់គ្រួសារ

ព័ត៌មានសំខាន់ដែលស្ត្រីគ្រប់រូបគួរយល់ដឹងពីការពន្យារកំណើត!

- សឹងតែគ្រប់មធ្យោបាយពន្យារកំណើតទំនើបទាំងអស់មានប្រសិទ្ធភាព សុវត្ថិភាព និងសមស្របចំពោះស្ត្រីក្នុងវ័យបន្តពូជ!
- ការពន្យារកំណើតគ្មានគ្រោះថ្នាក់ គ្មានផលប៉ះពាល់ធ្ងន់ធ្ងរដល់សុខភាពម្តាយនិងផលប៉ះពាល់ដល់លទ្ធភាពនៃការមានកូននៅពេលអនាគតទេ!
- ស្ត្រីគ្រប់រូបនឹងមានកូនឡើងវិញពេលឈប់ប្រើប្រាស់មធ្យោបាយពន្យារកំណើតមិនអចិន្ត្រៃយ៍ដូចជាថ្នាំលេប ថ្នាំចាក់កងដាក់ក្រោមស្បែកនិងកងដាក់ក្នុងស្បូន លើកលែងតែការបញ្ឈប់កំណើតជាអចិន្ត្រៃយ៍
- ផលប៉ះពាល់នៃការប្រើប្រាស់ថ្នាំលេប-ចាក់-កងដាក់ក្រោមស្បែក-កងដាក់ក្នុងស្បូនអាចមានតិចតួចនិងបាត់ទៅវិញក្រោយការប្រើប្រាស់មួយរយៈពេលខ្លីក្រោយមកដូចជា:
- រដូវផ្លាស់ប្តូរតិចតួច (មិនទៀងទាត់ គ្មានរដូវ ឬ ធ្លាក់ឈាមតិចតួច)
- ឈឺក្បាល-វិលមុខ

ព័ត៌មានលំអិតសូមពិគ្រោះយោបល់ជាមួយគ្រូពេទ្យ ឬ ឆ្មប ជំនាញនៅមណ្ឌលសុខភាព

សារអប់រំស្តីពីការរំលូតកូនដោយសុវត្ថិភាព

- ការរំលូតកូនដែលស្ត្រីនិងក្រុមគ្រួសារមិនចង់បានពេលកូនក្នុងផ្ទៃ (គភ៌)មានអាយុក្រោម១២អាទិត្យ ជាការស្របច្បាប់យោងតាមច្បាប់នៃការរំលូតកូនរបស់ព្រះរាជាណាចក្រកម្ពុជា
- ការរំលូតកូនដោយខ្លួនឯង ឬ ដោយគ្រូពេទ្យគ្មានជំនាញជាប្រការគ្រោះថ្នាក់បំផុត និង គួរចៀសវាង!
- ស្ត្រីគ្រប់រូបគួរចៀងសវាងការរំលូតកូនច្រើនដងដូចនេះសូមប្រើមធ្យោបាយពន្យារកំណើតភ្លាមៗក្រោយការរំលូត!
- ស្ត្រីនិងក្រុមគ្រួសារ គួរទៅពិគ្រោះយោបល់ជាមួយគ្រូពេទ្យ ឬ ឆ្មប ជំនាញមុននឹងធ្វើការសំរេចចិត្តធ្វើការរំលូតកូន

លេខទូរស័ព្ទ:..

Project: Health sheet to poor women with free of charge

Objectives:

- Help people especially poor women for ability utility service maternal and child with free of charge
- Reduce illness and mortality of mother and child

What is the project support and provide assistance to women and their families?

1- Pay for service fee

A/ Safe motherhood-pregnant women

- Antennal care 1 (ANC1), ANC2, ANC3, ANC4
- Normal delivery at health center-complexity delivery at hospital including surgical
- postnatal and post abortion care

B/ Family planning counselling and birth spacing

- Insert or remove: implant and Intra-uterus device (IUD)
- Sterilization: men and women

C/ Safe abortion and inserting (implant and IUD) after abortion-fee both poor and rich persons

2- Transportation fee: All services

3- Food support and other social support

Message health education with pregnant women on ANC, delivery, and PNC

All pregnant women should get ANC at health center at least 4 times before delivery

When should to get ANC?

After absent menstruation (absent menstruation then go to HC soon) or ensure has pregnancy. If no problem happening, should go HC in regular 3 months after absent menstruation

Advantage of ANC:

- Women can get iron tablet, vaccination, blood control that are useful for pregnancy women and fetus

-Physicians or midwife can detect dangerous signs like pre-eclamsia, pale, malnourish, and other diseases then can provide treatment on time.

-Reduce illness and mobility of mother and child

Signs of dangerous during pregnancy

Pregnant women go to health center or hospital while have the below signs

Swollen at leg — Headache, Visual problem

High fever — bleeding or rupture before labor

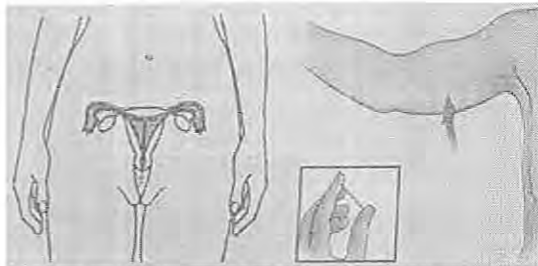
All pregnant women should go to HC for ANC, deliver, and PNC

Message for family planning and birth spacing

What are methods of birth spacing?

1- Short term methods: condom, pill, injection that have high effective-if take or inject as physician order

2- Long term methods: implant and IUD that have effective 3-10 years



3- Permanent method: sterilization for men and women. Cannot give birth anymore.

Advantage of birth spacing

- Can help women have wanted pregnancies-not unwanted
- To be enough healthy mother: not often pregnancy then mothers have healthy and have ability to feed child to be healthy
- Not many children then children get higher education
- Can help to increase income and save for family

Important information that all women should know on birth spacing

- Almost modern birth spacing methods have effective, safe, and appropriate for reproductive age women
- Birth spacing has no dangerous, no sever affect to mothers and impact to ability in fecondation in future
- All women will have pregnancies after stop using not-permanent-contraceptive like pill, injection, implant, and IUD-except sterilization.
- Pill, injection, implant, IUD have minor ability affect

and disappear in shortly after start using like

- Menstruation bleeding change to minor (irregular, absent menstruation, or minor bleeding)
- headache

Please contact physician or trained midwife for detail information

Message on safe abortion

- Abortion that woman and family don't want fetus has age less than 12 weeks is legal, according to law on abortion in Cambodia
- Self-abortion or aborted by non-trained provider is higher risky and should avoid
- All women should not get many abortions. So, should suddenly get birth spacing after abortion
- Women and family should go to meet physicians or trained midwife before decide get abortion.

Telephone number:...................

Operate by:	**Transportation fee**
Collaboration support by: giz	For poor elderly ages and disability person by using the service at health center. People use this voucher are able to get some benefits such as:
Community Equity Fund (pagoda islam church and charity etc.)	➢ Free access for treatment and counseling (for those having equity fund's ID and ID poor) at the health center, provincial/district referral hospital and national hospital including Khmer Soviet Friendship Hospital. ➢ Provide transportation cost for treatment at health center ➢ Information related health care in particular chronic disease. This voucher validity until date ....month.....................year

☐ No ID Poor ☐ ID Poor (Card Number..) ☐ Disability

Name: ....(Nick Name)..age......................year

From village.................................Commune......................................District...................................Province ....

Health Center...Operational District...

Distance from village to Health Center..........................Km

Date.............Month..............Year............... **Finger print and issuer a voucher** **Finger print receiver**

(This form fill in by the issuer)

Counseling and Treatment at Health Center	
.... DD-MM-YY of counseling &treatment	Patient Name...age...................year................. ☐ Disability
Service..	Live in village.......................commune.......................District.........................Province...................
Please asking the allowance for transportation cost	Health Center..Operational District...
(Form fill in by Health Center)	Type of service..
	Distance from village to Health Center..............................Km Allowance ....Riels
	Date.........................Month.......................Year....................
	Finger Print's patient **Signature and name of the offer allowance**

Guideline on using this voucher

- Bring this voucher every time you are access for treatment at Health Center
- Shown this voucher to the health center's staff to check to enable receiving counseling, treatment and support of transportation fees
- This voucher only usable in which health center that have been contracted within Social Health Protection project
- Require to keep safe of this voucher and do not write or delete anything or any other correction over its voucher
- In case loss of the voucher please inform to the project's staff as quickly as possible
- In some reason of voucher holder violate or using this voucher improper, the project have right to revoke accordingly

Remark

Person with disable without having equity fund and ID Poor require to pay service by themselves

The project disburse only both way of the transportation fees.

Further information please contact: Kampot province 033 694 88 00, Kep Province 036 6545 777

PKMI SOLUTIONS

HEALTH INSURANCE

Health Insurance covers your health expenditures from pre-hospitalization consultations to post-hospitalization care in case of illness or accident.

PKMI offers optional coverage for maternity, ambulatory services (OPD) and annual medical check-up.

PERSONAL ACCIDENT INSURANCE

Personal Accident Insurance provides benefits to insured in case of accident. PKMI covers your medical expenses for accidental injury and provides monetary compensation in case of permanent disability or death.
PKMI extends its coverage from a nationwide to a worldwide scale and from non-working hours only to 24h/7.

TERM LIFE+ INSURANCE

Term Life+ Insurance provides your family with monetary compensation in case of non-accidental and accidental death. The capital is fixed and defined at the signature of the contract.

CREDIT LIFE INSURANCE

Credit Life Insurance provides families with loan protection and guarantees to settle the loan to the creditor in case of death. PKMI will be responsible for the loan pay-off and the insured's heirs will be debt free.

> ***"LEADING THE CAMBODIAN MICRO-INSURANCE MARKET BY PROVIDING PRODUCTS ADAPTED TO THE NEEDS, THE UNDERSTANDING AND THE BUDGET OF EVERYONE"***

PKMI STRENGTHS

EXPERTISE

More than 100 years in France
More than 10 years in Cambodia

CUSTOMER-ORIENTED

Staff in 21 provinces in Cambodia
24/7 Free Hotline
Information meeting for clients

SIMPLICITY

No medical test for subscription
Medical treatment without advance payment

EFFICIENCY

Complete solution for Health and Life insurance
Adaptable products and prices
Fast claim settlement

PRÉVOIR GROUP
A CENTURY OF EXPERTISE

Prévoir Group is an independent, privately owned French insurance group founded in 1910. It is specialized in Life and Health insurance targeted to low and middle-income households.

PKMI
1st MICRO-INSURER IN CAMBODIA

Prévoir (Kampuchea) Micro Life Insurance Plc. PKMI, subsidiary of Prévoir Group, is the first Micro Insurance company in the Kingdom of Cambodia.

It was registered as a Public Limited Company on 14 July 2011 with the registration number: Co.1677 E/2011 by the Ministry of Commerce and licensed by the Ministry of Economy and Finance.

PKMI, in line with its mother company's social positioning and origins, is proud to be part of the micro insurance sector's development in Cambodia.

OUR CORE VALUES

- **COMMITMENT**: We strive to educate people on insurance, design products and processes easy to understand and conduct in villages health campaigns on risks prevention.
- **PROXIMITY**: We are present in each province and are organized with the idea of creating a personalized and quality relationship with each of our clients.
- **TRUST**: We believe in our partners and team members as much as they believe in PKMI.
- **COOPERATION**: We build strong and long term relationship with partners: Corporates, MFI and Health Facilities
- **CUSTOMER FOCUS**: We continually monitor and study our client's needs, thus enabling us to create and develop products specifically tailored and adapted to our insured.
- **TEAMWORK**: We are a unified team of professionals and specialists in insurance that ensures PKMI's development and sustainability.

HEALTH & LIFE INSURANCE FOR GROUP

STANDARD BENEFIT SCHEDULE

HEALTH INSURANCE

		Classic	Silver	Gold	Platinum
IN CASE OF HOSPITALIZATION					
Pre-hospitalization	Max per event - Max period 10 days before hospitalization	20	40	70	100
Post-hospitalization	Max per event - Max period 90 days	20	30	50	80
Hospital General Fees	Max per event	150	350	500	800
Surgical Fees	Max per event	500	1000	1500	2000
In-hospital Doctor Visits	Max per day - Max period 90 days	10	15	20	40
Daily Cash Allowance (Public Hospitals only)	Max per day - Max period 90 days	5	5	10	10
Ambulance	Max per event	20	30	50	80
ROOM & BOARD					
Ordinary Room	Max per day - Max period 90 days	10	20	30	50
Intensive Care Room	Max per day - Max period 21 days	50	75	100	150
IN CASE OF ACCIDENTAL MINOR INJURY					
Outpatient Care	Max per event	30	70	150	300
IN CASE OF BIRTH (BY THE INSURED OR HIS LEGAL SPOUSE)					
Birth Benefit	Max per event	150	250	350	450

PERSONAL ACCIDENTAL INSURANCE

		Classic	Silver	Gold	Platinum
Accidental Death/Disability	Max per year	2000	3000	4000	5000

TERM LIFE INSURANCE

		Classic	Silver	Gold	Platinum
Non-Accidental Death	Max per year	250	500	750	1000

OPTIONAL COVERAGE (only for group with more than 10 employees)

		Classic	Silver	Gold	Platinum
Option Maternity	Max per year	300	500	700	900
Option Outpatient Care	Max per year	50	100	150	200
Option Medical Check-up	Once per year	*Covers Laboratory Tests Physical Examination and Counselling*			

WHY CHOOSE PKMI?

EXPERTISE

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More than 10 years in Cambodia

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Staff in every province
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Information meeting for clients

SIMPLICITY

No medical test for subscription
Medical treatment without advance payment

EFFICIENCY

Complete solution for Health and Life insurance
Adaptable products and prices
Fast claim settlement

#106, Street 95, Boeung Trabek, Phnom Penh Cambodia | Contact: +855 (0)23 22 33 60 - Fax: +855 (0)23 22 00 56 | www.pkmi.asia

TERM LIFE+ INSURANCE FOR GROUP

STANDARD BENEFIT SCHEDULE

TERM LIFE+ BENEFITS

		Classic	Silver	Gold	Platinum
Non-Accidental Death	Max per year	2000	3000	4000	5000
Accidental Death	Max per year	2000	3000	4000	5000
OPTION BENEFIT					
Accidental Death	Max per year	2000	3000	4000	5000

WHY CHOOSE **PKMI**?

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PERSONAL ACCIDENT INSURANCE FOR GROUP
STANDARD BENEFIT SCHEDULE

PERSONAL ACCIDENT BENEFITS

		Classic	Silver	Gold	Platinum
Accidental Death and Permanent Disability	Max per year	2000	3000	4000	5000
Medical Expenses linked to the Accident	Max per event	200	300	400	500

OPTION FUNERAL BENEFIT

		Classic	Silver	Gold	Platinum
Capital in case of non-accidental death	Max per year	150	150	150	150

WHY CHOOSE **PKMI**?

EXPERTISE
More than 100 years in France
More than 10 years in Cambodia

CUSTOMER-ORIENTED
Staff in every province
24/7 Free Hotline
Information meeting for clients

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No medical test for subscription
Medical treatment without advance payment

EFFICIENCY
Complete solution for Health and Life insurance
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- ROOM FEES
- DOCTOR VISITS
- MEDICAL EXPENSES IN CASE OF MINOR INJURY
- AMBULANCE
- CHILD BIRTH (NEW BENEFIT)
- ACCIDENTAL DEATH
- NON-ACCIDENTAL DEATH

ADVANTAGES FOR EMPLOYERS

Improve your performance by protecting your employees
Attract and retain qualified people
Outsource the medical risk and administrative management

ADVANTAGES OF EMPLOYEES

Access to high quality health services
Secure their income and have a peaceful mind

WHY CHOOSE PKMI?

EXPERTISE:

100 years in France
Team with 10 years experience in insurance in Cambodia

CUSTOMER ORIENTED:

Customer support in 25 provinces in Cambodia
Education training for your employees
On-site visits during hospitalization

SIMPLICITY:

No discrimination
No medical test for subscription
Cashless service in more than 100 hospitals everywhere

EFFICIENCY:

Complete solution for Health and Life Insurance
Adaptable products and prices

Last updated 10/05/2012

Form 4

HOUSEHOLD QUESTIONNAIRE FOR IDENTIFICATION OF POOR HOUSEHOLDS

SECTION A

(INTERVIEWER: Please fill in before going to interview the household)

1. ID Code:

								—				
Province		District		Commune		Village			Household			

2.	Name of head of household:	
3.	Capital Province:	
4.	Municipality District Khan:	
5.	Commune Sangkat:	
6.	Village:	

(INTERVIEWER: Please fill in just before starting the interview)

7.	Address of interviewee ((house №, street name/№, if exist):	
8.	Name of interviewee (adult):	
9.	Interview date:	____/____/201__
10.	Interviewer's name:	
11.	Does the head of household have a national ID card? What is the ID number?	ID Card No.

DATA ENTRY TEAM TO FILL IN:

12. Name of Data Entry Clerk:	
13. Date of data entry:	____/____/201__

Poverty Category Calculation:	Poverty Level 1: 59 to 68 points Poverty Level 2: 45 to 58 points Other: 0 to 44 points	Total score from Page 7	

NEEDS DISCUSSION BY VILLAGE REPRESENTATIVE GROUP	

SECTION B: DETAILED INFORMATION ABOUT HOUSEHOLD MEMBERS

(INTERVIEWER: Please explain that "only people who share meals from the same pot, or share expenses for food, are considered as one household. Please record all details for all household members.)

	a. Name (surname and first name)	b. Nick Name	c. Relationship to head of household (e.g. head of household, husband/wife, child, nephew/niece)	d. Sex	e. Year of birth	f. Age in full years (if less than 1 year, please write "0")	g. Main activity/ occupation of each household member
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							

SECTION C:

House Situation: ***(INTERVIEWER: Ask Q1 for information but not for scoring)***

Q1. Is this house the property of your household? Or does your household rent it from other people?

(INTERVIEWER: Do not read out)	*(INTERVIEWER: Please tick one circle below)*
Not own house and pay rent	☐
Not own house but don't pay rent	☐
Own house or live with parents	☐

Q1 NO SCORE

Q2. Main construction material of the house's roof. ***(INTERVIEWER: Observe—do not ask)***

(INTERVIEWER: Do not read out)	POINTS
- Thatch, palm leaves, plastic sheet, tarpaulin or other soft materials **- OR not own house (rent-free, or paying rent)**	**8**
Corrugated iron	**4**
Tiles, fibrous cement, or concrete	**0**

Q2 SCORE

Q3. Main construction material of the house's exterior walls. ***(INTERVIEWER: Observe—do not ask)***

(INTERVIEWER: Do not read out)	POINTS
- Saplings, bamboo, thatch, palm leaves, or other soft materials **- OR not own house (rent-free, or paying rent)**	**4**
Wood, sawn boards, plywood, corrugated iron	**2**
Cement, bricks, concrete	**0**

Q3 SCORE

Q4. General condition of the house. ***(INTERVIEWER: Observe—do not ask)***

(INTERVIEWER: Do not read out)	POINTS
- In dilapidated condition **- OR not own house (rent-free, or paying rent)**	**4**
In average condition, liveable	**2**
In good condition and safe	**0**

Q4 SCORE

Q5. ***(INTERVIEWER: Ask and observe)***: How many meters by how many meters is the floor area of your house?

(INTERVIEWER: Do not read out)	POINTS
- 20 meters square or less **- OR not own house (rent-free, or paying rent)**	**4**
21-50 meters	**2**
51 meters or more	**0**

Q5 SCORE

Q6a. Which activity is the main income source for your household: growing rice or other crops or orchard; fishing; or other activities?

Growing rice or other crops or orchard	☐	→ *Ask Q6b*
Fishing	☐	→ *Ask Q6c*
Other activities	☐	→ *Ask Q6d*

Ask only one question

Q6 SCORE *(Interviewer must write the score for only one question: Q6b, Q6c or Q6d)*

(Interviewer: Ask only one of these three questions)

(INTERVIEWER: Ask only households that grow rice, other crops or an orchard as the main source of income)***

→ **Q6b** How many *ar* of land does your household use for growing rice, other crops or an orchard? (Please include your own land, land rented from others, and land around the house.)

Unit calculation	NUMBER OF AR		*(Interviewer: do not read out)*	SCORE
1 kong ≈ 10 ar 1 ha ≈ 100 ar 1 ar = 100 m^2 1 rai ≈ 16 ar	☐☐☐	=	From 0 to 20 ar	**8**
			From 20 to 50 ar	**4**
			Over 50 ar	**0**

(INTERVIEWER: Ask only households for whom fishing is the main source of income)***

→ **Q6c.** What types of fishing equipment do you have? (not including boats)

(INTERVIEWER: Do not read out) Fishing equipment	Quantity	Size and quality
☐ Line hooks	☐☐	
☐ Throw net	☐☐	
☐ Set net	☐☐	
☐ Drag net	☐☐	
☐ Other *(please specify the types of equipment):*	☐☐	

	(INTERVIEWER: Do not read out)	POINTS
(INTERVIEWER: Please make your own judgment of the quantity size and quality of the equipment listed above)	None or very little equipment and in poor condition	8
	Little equipment and in fair condition	4
	Enough equipment and of good quality	0

(INTERVIEWER: Ask only households for whom "other activities" are the main source of income for the household)***

→ **Q6d.** What activity provides the main source of income for your household?

(INTERVIEWER: Do not read out)	SCORE
Work as labourer, supported by others, beg, etc	8
Micro business, skilled labourer or job with monthly permanent wage	4
Medium- or large-size business	0

(Interviewer: Ask only one of these questions, NOT both)

*(***INTERVIEWER: Ask only households living on land (not on water)*

Q7a. For households living on land. Does your household have pigs? goats? cows? buffaloes? horses? How many..? (count weaners and older). Among these animals, how many do you share *(provas)* with others? ***(INTERVIEWER: Please write the number of animals in the boxes below. Count any animal which is provas as only half an animal.)***

Pigs	☐☐	Cows	☐☐	Buffaloes	☐☐
Goats	☐☐	Horses	☐☐		

And does your household raise fish for sale? Yes☐ No☐

(INTERVIEWER: Do not read out)	POINTS
☐ No pigs or goats ☐ No cows, buffaloes or horses ☐ NO fish raising for sale	10
☐ 1-3 pigs ☐ OR 1-5 goats ☐ OR 1-2 cows, buffaloes or horses ☐ NO fish raising for sale	5
☐ 4-9 pigs ☐ AND/OR 6-19 goats ☐ AND/OR 3-9 cows, buffaloes or horses ☐ AND/OR does fish raising for sale	0
☐ 10 or more pigs ☐ AND/OR 20 or more goats ☐ AND/OR 10 or more cows, buffaloes or horses (total)	Disqualify

*(***INTERVIEWER: Ask only households living on water)*

Q7b. For households living on water. Does your household have pigs? How many are weaners and older? Among these pigs, how many do you share *(provas)* with others? ***(INTERVIEWER: Please write the number of pigs in the boxes below. Count any pig which is provas as only half an animal.)***

Pigs	☐☐

And does your household do fish raising for sale? Yes☐ No☐

(INTERVIEWER: Do not read out)	POINTS
☐ No pigs ☐ No fish raising for sale	10
☐ 1-3 pigs OR fish raising for sale, but not both	5
☐ 4 or more pigs ☐ AND/OR does fish raising for sale	0

Q7 SCORE *(INTERVIEWER: Write the score for Q7a OR Q7b, NOT BOTH)*

Q8. (This question focuss on the Food ability) During the last 12 months, did your household owe rice or borrow rice from other people? For how many months?

Number of months		(INTERVIEWER: Do not read out)	POINTS
☐☐	=	8-12 months	8
		3-7 months	4
		0-2 months	0

Q8 SCORE

Q9a. ***(INTERVIEWER: Please write down the total number of household members by checking the table of all household members in Section B of the questionnaire)*** ☐☐

Q9b. How many persons in your household **cannot** produce an income (because of young or old age, school pupil, poor health, disability, looking after children, or any other reasons)? ☐☐

(INTERVIEWER: Do not read out)	POINTS
More than half of all household members	8
Equal to or less than a half, but more than one quarter of all household members	4
Equal to or less than one quarter of all household members	0

Q9 SCORE

Q10. Does your household have ... ? How many?

(INTERVIEWER: Please write the number of assets in each box below)			
small radio? ☐	stereo? ☐	colour TV? ☐	video camera? ☐
large radio? ☐	B&W TV? ☐	video player/ karaoke machine? ☐	mobile telephone? ☐
water pump? ☐	threshing machine? ☐	rice milling machine? ☐	generator? ☐
battery charger? ☐			

(INTERVIEWER: Do not read out)	POINTS
Nothing or one small radio	6
Large radio OR black and white TV OR mobile telephone	3
Colour TV and/or stereo and/or video player/karaoke machine and/or water pump	0
Video camera or threshing machine or rice milling machine or generator	Disqualify

Q10 SCORE

Q11. Does your household have any means of transport? How many?

(INTERVIEWER: Please write the number of means of transport in each box below)			
bicycle? ☐	horse/oxen cart? ☐	kou yon? ☐	small rowboat or canoe (no motor)? ☐
motorbike? ☐	motorbike remorque? TUK TUK? ☐	car/van/ truck? ☐	boat with motor? ☐
tractor? ☐			

(INTERVIEWER: Please calculate the approximate total value of all forms of transportation)	*(INTERVIEWER: Do not read out)*	POINTS	Q11 SCORE
	(total value less than 150,000 riel) ☐ No means of transportation ☐ OR one old bicycle only ☐ OR one small, old rowboat or canoe	8	
	(total value from 150,000 to less than 500,000 riel) ☐ Old bicycle ☐ Very old motorbike ☐ Old horse or oxen cart ☐ Old, medium-size rowboat (without motor)	4	
	(total value over 500,000 riel) ☐ Bicycle in fair condition ☐ Motorcycle in fair condition ☐ New horse/oxen cart ☐ New, large rowboat or canoe OR boat with motor ☐ Motorbike remorque ☐ Kou yon (hand tractor)	0	
	(very high total value) ☐ Tractor ☐ Car/van/truck	Disqualify	

(VILLAGE REPRESENTATIVE GROUP: Please total up all the points from the right-hand column and write the total in the TOTAL SCORE box to the right. SPECIAL NOTE: If any household had animals or assets which earned the "Disqualify" score, please write "DISQUALIFIED" in the box to the right. This means that a household will be given a Total Score of zero.)

TOTAL SCORE

SECTION D: ADDITIONAL HOUSEHOLD INFORMATION FOR CONSIDERATION BY VILLAGE REPRESENTATIVE GROUP

Q12. During the last 12 months, did your household suffer from any major problems or crises that caused your household to lose income, have a shortage of food, sell assets, or borrow money?

YES ☐ (Let respondent describe the situation)
NO ☐ (Interviewer: skip to Q13a)

(INTERVIEWER: Do not read out)		*Please describe*
Serious illness/death of household member(s)	☐	
Loss of work of household member	☐	
Serious illness/death of animal(s)	☐	
Seriously reduced crop production	☐	
Theft of property	☐	
Other	☐	

Q12

Could this situation cause a reduction in living standard?

YES ☐
NO ☐

If "yes", please also tick at the bottom of the first page of the questionnaire

Q13a. How many children in this household are 6-11 years of age? Please tell their names.
(INTERVIEWER: Please look at Table in Section B and then write the number of children aged 6-11 in the box on the right. If there are no children of aged 6-11, write "00" and go to Q14 ☐☐

Write the names of the children here
....
....
....
....

Q13b. How many of the children aged 6-11 years that you just mentioned, missed school for at least 1 month in the last 12 months? (except vacations) ☐☐

(INTERVIEWER: Ask this question if any children missed school in Q13b)
Q13c. For what reason did these children not go to school?

(INTERVIEWER: Do not read out)	*Tick in the circle(s)*
Serious illness	☐
Work for others for money or for food	☐
Domestic work or taking care of young siblings	☐
Long distance to school	☐
No money for school fees or uniform	☐
Other (please specify)..	☐

Q13

Does this situation show that this household is poor?

YES ☐
NO ☐

If "yes", please also tick at the bottom of the first page of the questionnaire

Q14. SPECIAL HOUSEHOLD CIRCUMSTANCES WHICH CAUSE REDUCTION IN LIVING STANDARD

(INTERVIEWER: Please re-check whether this household has any special circumstances which make them vulnerable)

(INTERVIEWER: Do not read out)	*Tick in the circle(s)*
Severely disabled head of household or spouse of head of household (unable to earn income, or spends money for treatment)	☐
Head of household or spouse of head of household who is chronically sick (unable to earn income, or spends money for treatment)	☐
All adults of the family are elderly, over 60 years of age and no labour forces	☐
Divorced or widowed head of household with three or more children who are all under 12 years of age and no labour force	☐
No adults (persons aged 18 years or older) living in the household who provide support to the household	☐
Other *(INTERVIEWER: Please record the details of the situation)*	☐

Q14

Could this situation cause a reduction in living standard?

YES ☐
NO ☐

If "yes", please also tick at the bottom of the first page of the questionnaire

Q15. SPECIAL HOUSEHOLD CIRCUMSTANCES WHICH CAUSE IMPROVEMENT IN LIVING STANDARD

Q15a. In the last 12 months, has your household received assistance from children or other relatives?

NO ☐ YES ☐ ☐ What kind of assistance was this?

(INTERVIEWER: Do not read out)		
Food	☐	What is the approximate monetary value per month? ....
Money	☐	Approximately how much per month? ....
Other	☐	Please specify..

Q15b. In the last 12 months, were there any other circumstances that improved the living standard of your household?

(INTERVIEWER: Please probe)		
Sell land	☐	What was the approximate monetary value? ....
Other	☐	Please specify..

Q15

Could this situation cause an improvement in living standard?

YES ☐
NO ☐

If "yes", please also tick at the bottom of the first page of the questionnaire

Q16. *(INTERVIEWER: Please consider whether there are any responses or information that is suspicious or untrue?*

Nothing suspicious ☐

Suspicious ☐ ☐ Please specify..