2006 | ASIAN DECENT
2015 | WORK DECADE

International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION
INITATIVES IN EAST ASIA

CAMBODIA:

SKY HEALTH INSURANCE SCHEME

"BUILDING A SUSTAINABLE AND REPLICABLE HEALTH INSURANCE MODEL"

ILO Subregional Office for East Asia

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st, 2006) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role had to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative experiences that could contribute to the progressive extension of health protection to all. One such innovative and promising approach is the progressive development in Cambodia of a nation-wide health insurance model that now extends its coverage to both informal and formal economy workers.

BACKGROUND

Ranked 129 among 177 countries listed on the United Nations Human Development Index (HDI), Cambodia remains one of the poorest countries of East Asia. 35% of the population lives below the poverty line. The country is predominantly rural but faces a rapidly growing urban sector, and a widening of income disparity. The informal sector represents around 90% of the population.

To finance their health costs, 80% of Cambodians use savings, go into debts or sell assets. Health costs financing households is mainly out of pockets payments: approximately US$ 25 per capita per year, which stands among one of the highest in the world.

In comparison, the level of government health spending remains low (1% of GPD, approximately US$ 4 per capita per year) and the donor funding remains essential (US$ 8 per capita per year). Hence, Cambodian households are extremely vulnerable to health shocks.

Today, although a social protection system doesn't exist in Cambodia, the government is strongly involved in launching one: In March 2005, the Ministry of Health approved a Masterplan, which proposes the following structure for health protection:

- Compulsory Social Health Insurance for formal sector economy;
- Voluntary health insurance for informal sector;

- Social assistance for the destitute by using health equity fund.

On March 2, 2007, the Prime Minister signed a sub-decree establishing a National Social Security Fund[1] (NSSF). The NSSF is a public self-financing establishment separate from a government ministry and will be governed by a Board, with tri-partite representation. The "health" component of this fund should be implemented by 2010[2] .

French NGO GRET (Groupe de Recherches et d'Echanges Technologiques) has been active in Cambodia for 20 years and works in several fields of economic development (agriculture, micro-finance, and water sanitation).

GRET launched a micro-finance program in 1991 that progressively turned into a financially viable, legally recognized micro-finance institution called AMRET. From this experience, GRET realized that a health insurance product would be relevant to protect poor rural households against severe health expenses, as a complement to micro-credit (a high proportion of non reimbursement of loans was due to health problems in the family).

GRET therefore launched in 1998 an experimental rural health insurance project in two Cambodian provinces (Kandal and Takeo). The project is known as SKY, which is an acronym for "Insurance for our Families" in Khmer language.

The program objectives can be summarized as follows:

- To secure incomes and assets of Cambodian households by limiting the economic consequences of large health expenditures;
- Facilitate households' access to appropriate quality health care both at primary and secondary levels;
- Thus, effectively prevent severe health risks, particularly for the most vulnerable;
- To increase awareness on health insurance and to contribute to the development of national policy on Social Health Protection

TARGET POPULATION

SKY has no specific target population. Every household living in the catchments area of a SKY contracted health center can join the scheme on a voluntary basis. Majority of SKY membership (80%, 12,906) comes from the rural areas but SKY is also accessible in Phnom Penh, with 2,563 members registered today.

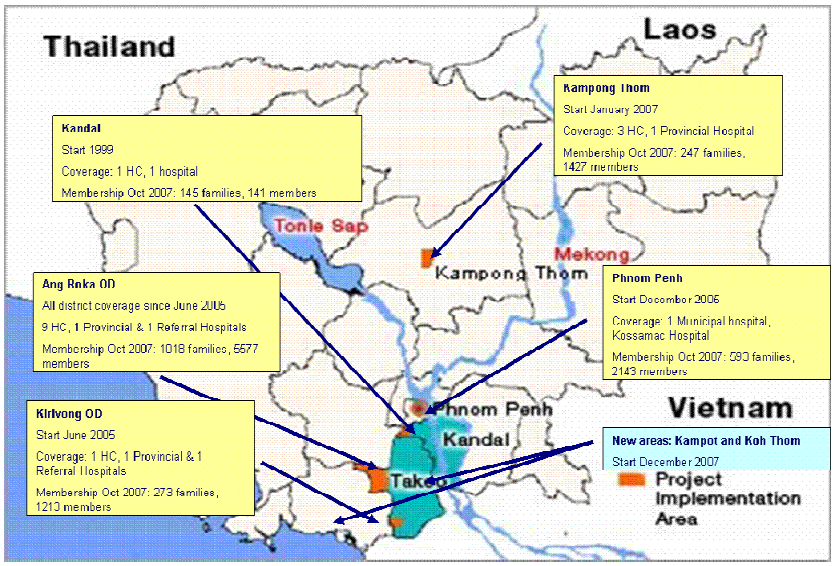
SKY insurance mainly attracts "not-so-poor" households. Indeed, the poorest of the poor cannot afford the SKY monthly premium and are sometimes covered by other health social assistance programs, such as equity funds.

The wealthiest groups of the population are not attracted by public health providers and prefer to look for treatment in the private sector.

The scheme is currently active in 6 Districts spread over 4 provinces and in Phnom Penh.

[1] . « Sub-decree concerning the establishment of a social security fund », No. 16 GRD, March 02, 2007

[2] . Declaration of Mr. Ouk Samvithyea, Director of the Department of Social Security, Ministry of Labour, and Vocational Training at the ILO/GMAC workshop on social security, June 21, 2006.



ORGANIZATION

No legal framework exists for micro insurance activities in Cambodia. The Ministry of Economy and Finance is drafting a sub-decree on micro-insurance that should be released soon. SKY is still a project managed by GRET, but is organized as a private not- for- profit structure.

The program implementation relies on tasks sharing between the Head Office and Field teams. While technical functions related to insurance are centralized in the Head Office, the field team ensures high proximity with members and close relationship with health providers. Thus, Insurance agents and Members Facilitators are in charge of insurance promotion, premium collection, new member's enrolment, and in welcoming and orientation of patients in health facilities. Communities' participation is achieved through the Insurance Consultative group.

Head Office	General Management / Follow up of activities Human Resource Department SIG management (members and medical data registration and follow up) Technical insurance functions (risk evaluation, pricing) Accountancy/Financial department
Field Team	SKY agents recruited at the community level ensure: SKY promotion Money Collection Health Facility follow up Feedback from members
Insurance Consultative Group	One SKY representative per village Gathered every 6 months to share feedback and present SKY results

THE INSURANCE PLAN

Eligibility

Registration is opened to everyone, without restriction on pre existing disease or age. Family coverage is mandatory.

Exclusions from Benefit Package

- Long term treatment for chronic diseases;
- Hospitalization for non priority surgeries (plastic surgery, dental surgery…);
- Basic dental care, basic eye examination, glasses, hearing aids and cosmetic surgery or plastic surgery;
- High-cost surgery (i.e open-heart surgery, organ transplant

Plan Benefits

The scheme provides whole care coverage without any limitations. Following are the offered services:

- Access to primary health care at health center level including prescribed drugs;
- Access to specialized Out-Patient consultation and para-clinic tests (laboratory, ultra sound, X ray…) at district and provincial level, after referral;
- Hospitalization stay with drugs and all related para-clinic tests, after referral;
- All ante and post-natal care, simple and complicated deliveries after a waiting period of 6 months;
- Grant for member funeral expenses (ranging from $ 12 to $ 24 in rural area and $ 60 in urban area and body transportation costs;
- Emergency transportation grant: $ 5

No ceilings are applied given that public health facilities work with a user fees system.

Pre-existing diseases are also covered by the scheme.

Premium Rates (Per month, in Riels ($1 = 4,000 Riels)

1. SKY premium rates by family size, in rural areas

Family Size	Old Zone	New Zone
1 person	2,500	4,000
2-4 persons	5,500	7,500
5-7 persons	7,500	9,500
8+ persons	9,000	11,000

General Overview

Starting date	1998
Ownership profile	NGO
Target group	Poor families
Outreach	Phnom Penh city and 6 rural districts
Intervention area	Rural and urban
Risks covered	Health & funeral expenses
Premium Insured/Year	Rural: Average $ 4 Urban: Average $ 9
Co-contribution	No
Total premium	Rural: Average $ 4 Urban: Average $ 9
No of insured	15,500

Operational Mechanisms

Type of scheme	In-house
Insurance company	No
Insurance year	Open throughout the year
Insured unit	Family
Type of enrolment	Voluntary
One-time enrolm. fee	2 months for reserve
Premium payment	Monthly installments
Easy payment mechanisms	Advance payment recommended
Waiting period	6 months for elective surg 3-6 months for delivery
Indirect subsidy	Yes

Scope of Health Benefits

Tertiary health care	
Hospitalization	
Deliveries	
Access to medicines	
Primary health care	

Level of Health Benefits

Hospitalization	No ceilings applied – Pre. existing diseases covered
Other services	Emergency transportation

Service Delivery

Prior H. check-up	No
Tie up with HP	Public HP
Type of agreement	Formal agreement
N° of associated HP	28 HC / 9 RH
Co-payment	No
HC service payment	Cashless
Additional Financial Ben.	Funeral expenses

Table 2. SKY Premium rates by family size and sector type, in urban area

Family Size	Informal	Semi Formal	Formal*
1 person	8,000	12,000	18,000
2-4 persons	12,000	16,000	24,000
5-7 persons	16,000	20,000	28,000
8+ persons	20,000	22,000	32,000

**50% minimum of the premium is paid by the employer*

Plan Distribution

Registration is opened all through the year and promotion is conducted every first week of the month in all districts where SKY is working. Insurance policy is suscribed for a 6 month cycle. Households pay their premium on a monthly basis, before the 20th of each month to be covered from the 1st of the following month. For new family registering, an additional 2 months premium are required as reserves, that can be used in the cycle in case of payment difficulties. Advance payments are encouraged with discount for at least 6 months payment.

Service Delivery

SKY contracts as a priority public health providers, who are on a monthly basis paid by a capitation mechanism (a predetermined fixed amount per member). Health providers agree on minimum conditions to comply with (quality of services, no discrimination, long opening hours ...). Contracts are renegotiated every year. The scheme relies on a three-level health care system : SKY contracts in all zones public health centers, district hopital and provincial hospital. The scheme currently contracts 28 health centers and 9 Hospitals. Members must seek treatment in the health facilities linked to their zone. The referral system has to be respected to access to a higher health care facility.

Administration

The global administration of the scheme is handled by SKY head office management.

MAIN ACHIEVEMENTS

Global Achievements

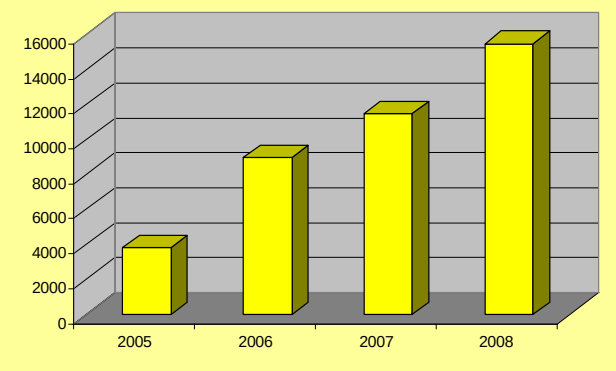
GRET was the first implementer of Social Health Insurance in Cambodia. The pilot phase of the scheme (1999-2005) allowed the testing of different products and design of a benefit package for rural households. Thus, the pilot phase enabled SKY:

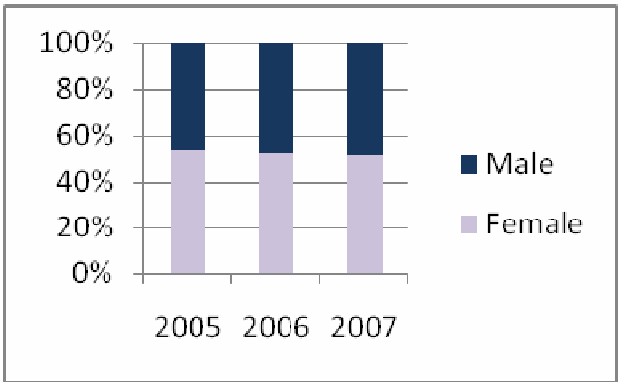
- To provide large insurance services suiting households financial capacity;
- To set up operational procedures and a skilled team, both at head office and field level, to implement the program;
- To develop effective partnerships with public health facilities.

Since 2005, the model has stabilized, which enabled SKY to start its expansion phase. The scheme is now active in 6 Districts and in Phnom Penh.

Coverage

The scheme had enrolment of 15,500 members in April 2008. While membership increased very slowly in 2007 in rural areas (due to a 25% increase of premium in March), the launching of the scheme in two new rural zones currently boosts the membership rise since the beginning of 2008 (+38% between December 2007 and April 2008).





Services Provided

Total number of services provided

In parallel with increasing membership increasing, the total number of services delivered by contracted health facilities increased between 2006 and 2007.

Number of primary health care consultations, OPD and IPD services covered by SKY in 2006 and 2007 are given in the table below:

	2006	***2007***
Total Primary health care consultation	23,520	33,619
Total Specialist consultations	2,556	4,152
Total hospitalization	508	791

Annual Contact Rate

Mean annual contact per member in 2007 stand at 3.2 for primary health care, 0.115 for OPD and 0.035 for IPD

IPD Admission

10.4% of the urban members were hospitalized in 2007 and 7.8% in rural areas.

Indirect Subsidy

The actual level of premium includes a 31% margin, which is still not sufficient to cover the running costs, at the present level of membership. The scheme is currently being subzidized by GTZ (German technical Cooperation) and AFD (French Agency for Development) to fill the financial gap.

Administration Costs

The total administration costs (including salaries, trainings, running costs, promotion costs, equipments) planned for 2007 were $155,000. At its current level of membership, financial sustainability is not achievable and the scheme needs external support until its membership reaches a level that would allow for full financial sustainability. This should be achieved however within the next five years.

CHALLENGES

The insurance plan has still to address the following main challenges:

- Scale up the programme is now a key priority in order to decrease the present subsidy level;
- Health case and retain membership;
- In the same way, SKY endeavours to develop innovative approaches, such as linkage with other payment mechanisms, in order to reach the poorest households;
- Increasing awareness among all stakeholder and improved understanding of insurance principles and mechanisms remain key issues to be addressed

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme targeting the disadvantaged groups. Evidence also suggests that building efficient linkages between community-based initiatives and governmental programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages	
Financing:	No
Operations:	No
Service Delivery:	☺
Governance:	No
Policy Planning:	☺
Legal Framework:	☺

In close collaboration with the Ministry of Health, the SKY scheme has already taken a leading role in the design, testing and development of various health protection mechanisms.

Its immediate development plans – linking up with Equity Funds and the new intervention in the garment sector - are clearly aimed at further expanding its already broad linkage experience.

1. Financing

The actual level of premium covers all medical expenses and a small part of administration and management costs. The deficit is financed by external donors. From May 2008, a new linkage experience will be launched in the Kampot Province: Government will finance SKY health insurance for all poor families in the province (around 11,000 persons). If this experience proves successful, it could be extended to other provinces.

2. Operations

In rural areas, the local operations are conducted by SKY staff. In the urban area, SKY works with a partner NGO, which is in charge of SKY promotion among their target populations. However, results are not as satisfying as expected: partner NGOs are not always focused on insurance, and insurance principles and follow up activities are complex to understand. This NGO partnership strategy still needs to be reinforced

3. Service Delivery

All medical services are provided by public health facilities. Before starting its activities, SKY carries out quality assessment of all public health providers operating in the area and only contracts the facilities showing a high standard level of care.

Whenever possible, SKY works in partnership with NGOs or cooperation agencies involved in improving quality of public health facilities.

4. Governance

Management is carried out by SKY head office. For cultural reason, SKY works as a private non for profit organization and did not choose to be organized as a mutual benefit society system. But the involvement of the members is ensured through the Insurance Consultative Group, gathered every 6 months.

5. Policy Planning

As the first implementer of what is known as a Community Based Health Insurance (CBHI) scheme, SKY has contributed to numerous works on building policies.

SKY encouraged the creation of the Inter-ministerial Committee on Health Insurance known as the Social Health Insurance Group, which is chaired by a MoH Secretary of State. A technical sub-committee (ILO, WHO, GTZ, GRET) of this Group meets regularly, and discusses issues raised by the SKY experience and the global approach of insurance.

In 2005, the Social Health Insurance Group drafted guidelines for registering and setting up insurance initiatives, inspired by SKY experience. This document lays out conditions for establishing and operating insurance programs. It also lays out “good practices” for project implementation.

6. Legal Framework

Up to now, micro-insurers in Cambodia do not have legal framework to implement their program. The Ministry of Finance has involved GRET in discussions regarding the preparation of a sub-decree defining the conditions for micro-insurance operations. This sub-decree defines micro-insurance by activity (small premium amounts in particular), and calls for official accreditation of micro-insurers. Discussions on the sub-decree involved the Ministry of health as well, so as to have one streamlined approval process. A preliminary version is currently circulating among the different stakeholders (authorities, civil society representatives, health care providers) and should be finalized based on their comments in 2008.

CONCLUSION

The SKY initiative has already gained a long experience in the provision of health insurance benefits at the local level. Building on this experience, it is now ready and willing to look at a new nation-wide challenge. During the last year, discussions have been initiated between GRET and the Garment Manufacturers Association in Cambodia (GMAC), on the relevance of introducing social health insurance for the garment sector. From these discussions GRET and GMAC have agreed that setting-up a health insurance scheme for salaried workers could provide an adequate solution to address the needs of both the workers and the employers.

This Social Health Insurance scheme can be seen as a temporary measure until health care for salaried workers will be covered by the National Social Security Fund in 2010. Hence, the Social Security Department of the MOLVT and the NSSF should be closely associated with the project.

The target population would be the salaried workers of the Kingdom Cambodia, working in the formal sector, estimated at 350,000 persons, mainly located in Phnom Penh during the initial phase. Premium will be co-paid by workers and employers, to comply with the provision of the future NSSF. Extensive benefit package covering both basic, maternal, child, and advanced health care will be offered to members.

GRET and GMAC will be the two founders and board members of the new entity. From the outset, they will fully manage the program. The new co-managed entity will be fully independent from SKY, which will make available appropriate tools and process allowing for the progressive development of the new scheme.

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