Expanding Social Health Protection in Cambodia: an assessment of the current coverage potential, gaps, and social equity considerations

Kolesar R., Pheakdey S., Jacobs B., Chan N., Yok S., Audibert M. (2019) *Études et Documents,* n° 3, CERDI.









Background

- Cambodia has experienced more than two decades of strong economic growth averaging 7.7% between 1995-2017 (World Bank 2018);
- About 4.5 million people (~28% of the population) remain near-poor and vulnerable to falling back into poverty when exposed to economic and other shocks (World Bank 2018);
- Vulnerability to poverty has increased as a large proportion of the population is concentrated at the bottom of the wealth distribution (ADB 2014);
- The existing health coverage schemes can collectively cover about 4.7 million Cambodians (~30% of the population) (MOH 2018);
- MOH aims to increase coverage to 8.12 million or 50% of the population by 2020 (MOH 2016).

HEF Extensions

- Prakas 404 MEF/MOL/MOH (October 2017) HEF expansion to informal workers:
 - <8 hours;
 - Part-time;
 - Casual;
 - Seasonal.
- **Press Release MOL (December 2017)** HEF expansion to special categories:
 - Informal worker;
 - Village chief;
 - Deputy village chief;
 - Village assistant;
 - Commune council;
 - Professional sport practitioners.
- **Notification Letter MOH 001 (January 2018)** HEF expansion to special categories
 - Cyclo drivers.

Key questions

- How many people do not yet have a coverage mechanism and who are they?
- Who is benefiting the most from the current expansion efforts focused on workers and employees?
- How many informal workers are already eligible for coverage under the recent HEF expansions?
- What would be an equitable approach to premium contribution amounts?

Methods

- Secondary analysis of 2016 CSES data and other sources (Demographic and Health Survey, MOP population estimates, etc...)
- 3,839 households and 11,359 individual working age adults
- Identify employment groups to align with the health insurance coverage landscape
- Univariate and bi-variate statistics
- Assess a fair and equitable contribution using 4 approaches

Figure 1. Population proportion estimates for vulnerable (nonincome related), employment, and residence groups

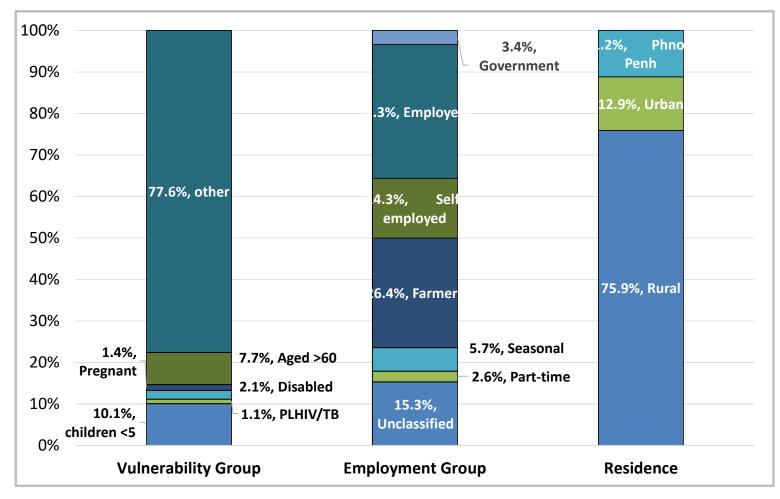


Figure 2. Proportional distribution of total income by wealth quintile

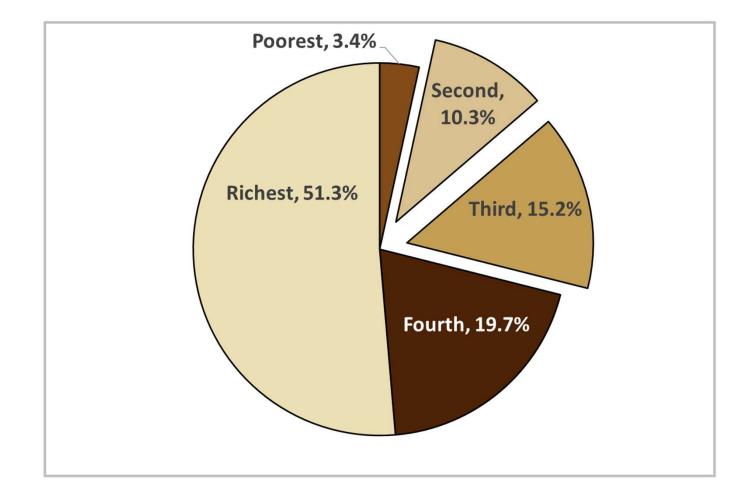


Figure 3. Employment category by wealth quintile among working age adults

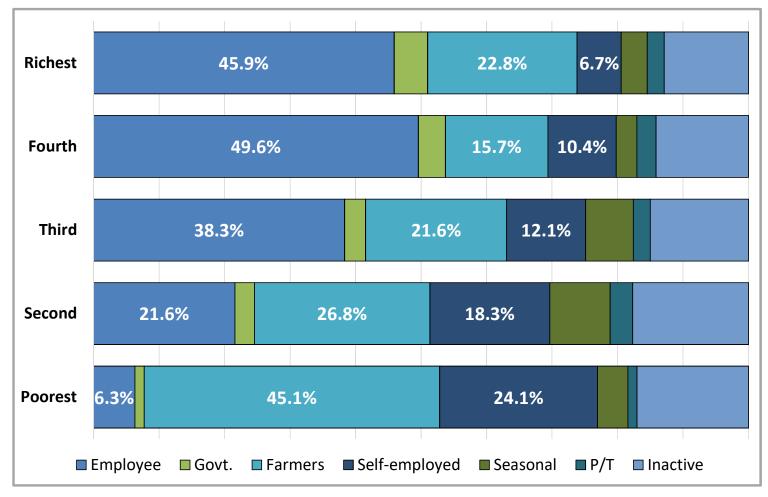
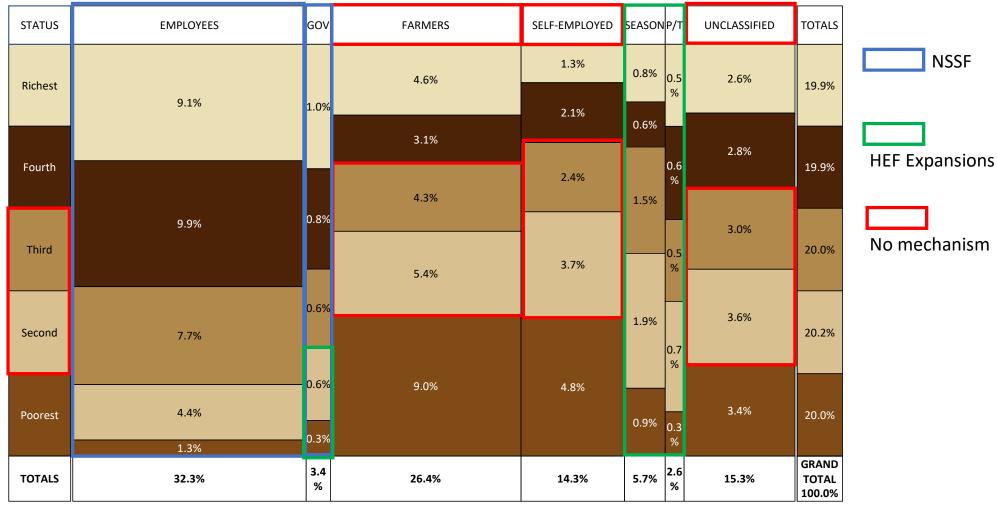


Figure 4. Population proportions by wealth quintile and employment group among working age adults



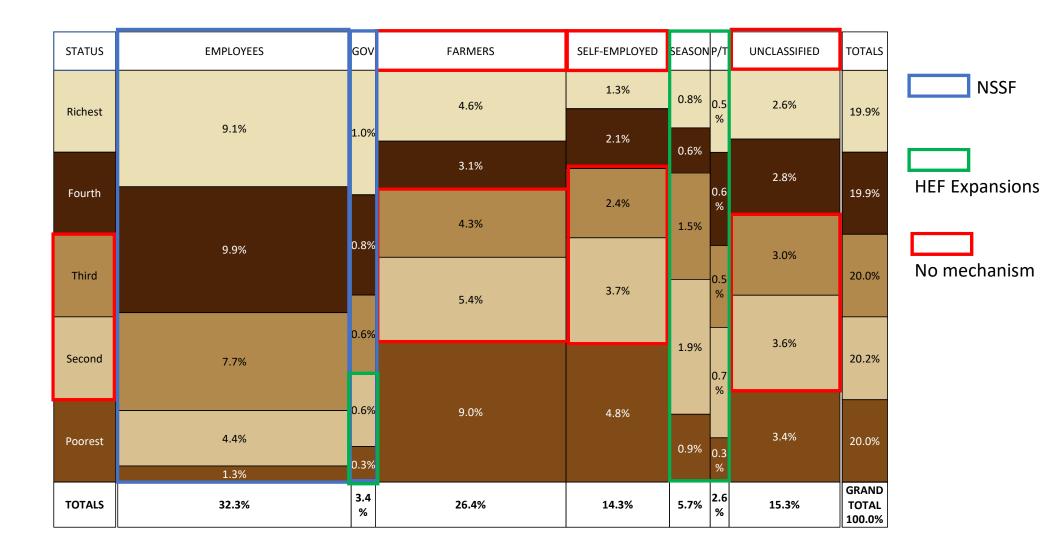


Figure 5. Monthly individual effective income by wealth quintile with averages and distances to the poorest quintile in USD

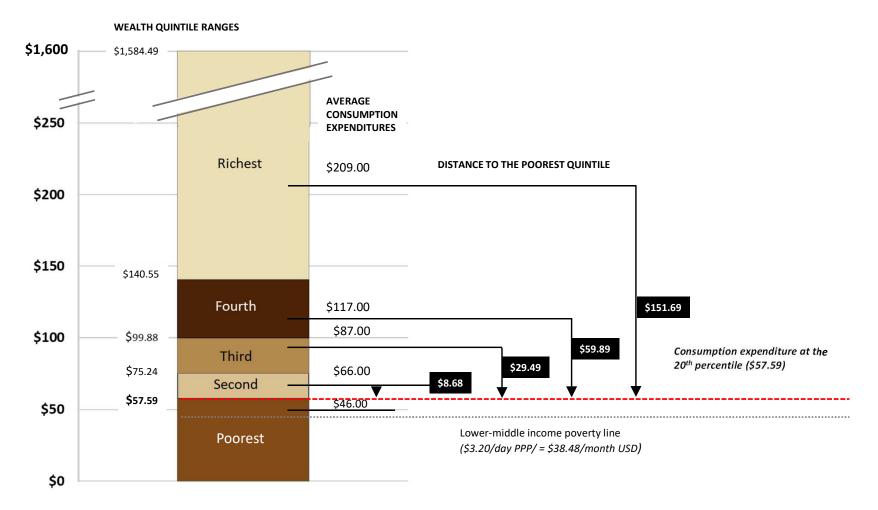
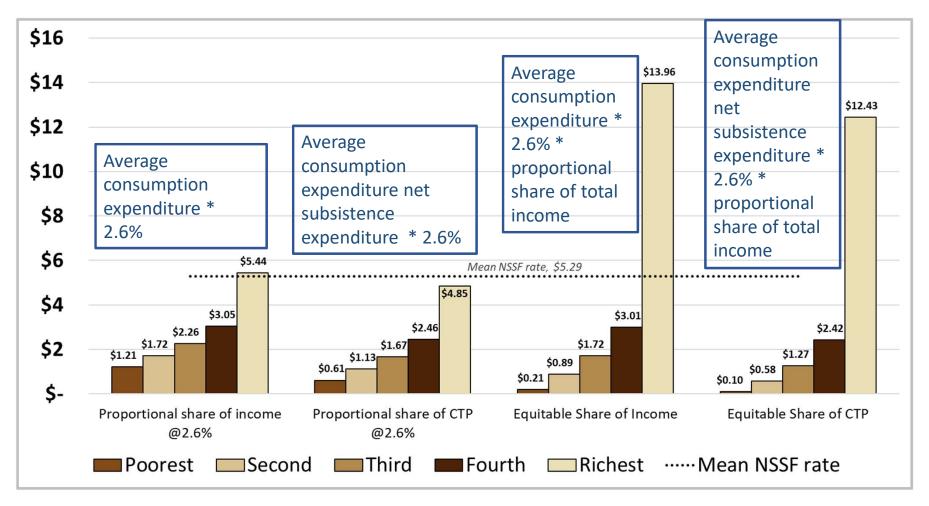


Figure 6. Proportional and equitable individual health insurance premium estimates (monthly) by wealth quintile



Conclusions

- Current health coverage expansion efforts to formal employees is likely to primarily benefit individuals from higher income HHs;
- Recent directives to expand HEF coverage to part-time and seasonal workers have limited potential: leaving significant gaps, particularly among vulnerable groups, farmers, and the self-employed;
- Capacity to pay (CTP) among individuals in the 2nd and 3rd wealth quintiles is limited;
- A fair and equitable approach to individual, monthly healthcare contribution payments would only amount to \$0.58 - \$1.72 US (2nd quintile) and \$1.27 - \$2.26 US (3rd quintile);
- The collection cost could potentially exceed the amount collected, particularly among the informal sector.