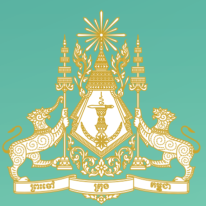

KINGDOM OF CAMBODIA
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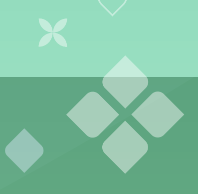
Royal Government of Cambodia



ROADMAP TOWARDS

UNIVERSAL HEALTH COVERAGE IN CAMBODIA

2024-2035

Prepared by the National Social Protection Council
April, 2024

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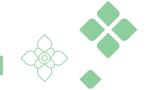
PREFACE

Over the last three decades, the development of the health system in Cambodia has witnessed the remarkable strides, reflected in the increased uptakes of the healthcare utilization which has resulted in the steady improvement in the people's healthcare status. Some key health indicators provide a clear testament, which includes: **(1)** essential service coverage index at around 58% in 2021 wherein reproductive, maternal, newborn and child health sub-index is at around 74%, infectious disease 65%, non-communicable disease 64%, service capacity and access 37%; **(2)** reduction of out-of-pocket health expenditure to 60% in 2020; **(3)** gradual increase in life expectancy; and **(4)** declining maternal, infant, and child mortality rate. Meanwhile, the social health protection system has been implemented and expanded over time and currently approximately 7 million people or roughly 41% of the total population in Cambodia has been covered by both the Health Equity Fund (HEF) and Social Security Schemes on Healthcare.

These outstanding and progresses have not accidentally occurred, but resulted from long-standing and unwavering efforts of the Royal Government of Cambodia of all the previous legislatures of the National Assembly to promote the welfare of Cambodian people and consider it to be one of the utmost priorities through placing high attention on the continued strengthening of the health sector and social protection system. Based on the existing accomplishments and legacy of the wise and visionary leadership of Samdech Akka Moha Sena Padei Techo **HUN SEN**, the current government under my leadership fervently commits to accentuating the reform priorities through strengthening the health and social health protection systems, which is succinctly defined in the Pentagonal Strategy-Phase I and the 1st Priority Policy Program on **"Expanding healthcare services towards the universal health coverage"** as well as the key intervention measures for the health sector, aimed at strengthening the capacity of health centers and referral hospitals in terms of improving quality, safe, efficient, and equitable health service delivery.

Given the current circumstances coupled with rapidly evolving and intertwined health sector and social protection systems, the Royal Government issued the **"Roadmap Towards Universal Health Coverage in Cambodia 2024-2035"** to be in line with the National Social Protection Policy Framework. The roadmap identifies key policy measures to define the path towards Universal Health Coverage (UHC) in a multisectoral and multidimensional manner with a focus on promoting the quality of healthcare services without incurring financial hardships. This roadmap is considered a guiding strategic document for the strategic investment and implementation of the relevant policy reform directions to gradually move towards UHC over the next 12 years by defining priority strategic policy directions aimed at strengthening the quality of health service delivery capacity in both



public and private sectors, increasing effective coverage of social health protection, and promoting multisectoral actions to improve social determinants of health, which addresses evolving healthcare needs of Cambodian people and strengthen financial risk protection.

Universal Health Coverage is not only a consideration on health condition of citizens, but it is also a strategic investment to develop human capital in order to promote social welfare, equity, economic growth, and human dignity. In addition, UHC is also a major contributor or a potent impetus to transforming Cambodia into a higher middle-income economy in 2030 and a high-income economy in 2050. Nonetheless, such a path towards UHC is utterly complex, which warrants wise and innovative leadership, good governance, and inclusive partnership.

In this regard, I encourage all relevant ministries-institutions, particularly the Ministry of Health, development partners, private sectors, and stakeholders to coalesce and join hands in implementing the roadmap with the spirit of accountability through further developing and implementing the detailed strategic and action plans in sync with the key strategic policy directions identified in the roadmap to ensure the effective and successful implementation to make **Universal Health Coverage a reality for Cambodian people.** I strongly hope that the successful implementation of the roadmap will bring about good health, improved living condition, and rising welfare of all Cambodian people with commendable applauses and appreciation both domestically, regionally and beyond.

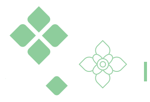
On behalf of the Royal of Cambodia, I deeply appreciate and highly value the concerted efforts of the National Social Protection Council, chaired by **H.E. Akka Pundit Sopheacha AUN PORNMONIROTH**, Deputy Prime Minister, Minister of Economy and Finance as well as the invaluable contribution from the Ministry of Health, under the leadership of **H.E. Prof. CHHEANG RA**, Minister and the General Secretariat for the National Social Protection Council as a technical and coordinating body of the National Social Protection Council, together with ongoing supports and cooperations from the relevant ministries/institutions, development partners, civil society organizations to culminate in the materialization of this worthwhile roadmap.

Phnom Penh, April 12, 2024

Prime Minister

(Signature and Seal)

Samdech Moha Borvor Thipadei Hun Manet



EXECUTIVE SUMMARY

"The Roadmap towards Universal Health Coverage in Cambodia 2024-2035" is designed in line with the National Social Protection Policy Framework and the Concept Note on the path toward Universal Health Coverage in Cambodia adopted by the National Social Protection Council at the meeting on March 30, 2022.

Based on the achievements so far in both the health sector and social health protection system, as well as in-depth analysis of the current challenges and future vision, the Roadmap defines the strategic path to Universal Health Coverage (UHC) in Cambodia from 2024 to 2035 through mapping out the strategic actions and priority targets in a multisectoral manner with the gradual development of the social health protection system and strengthening the capacity to deliver health services in both public and private sectors aimed at reducing out-of-pocket health expenditure as well as increasing efficiency in health expenditures. The roadmap defines three specific targets which include: (1) Expanding the population coverage under the social health protection system to 80% out of the total population, (2) Achieving at least 80% of the essential health service coverage index, and (3) Reducing out-of-pocket health expenditure to at most 35% of the total health expenditure.

The roadmap entails the policy reform directions along with the three fundamental dimensions, as well as the supporting and enabling factors below:

Dimension 1: Population Coverage under the Social Health Protection System

Prioritizing the efforts to increase effective coverage of the existing social health protection schemes and further expanding the coverage to other uncovered population groups gradually through the strategic directions which include increasing effective coverage of the Health Equity Fund and the Social Security Schemes on Healthcare, assessing and evaluating effective coverage under the social health protection system, transforming the Voluntary Social Security Scheme on Healthcare into the mandatory scheme coupled with defining the financing mechanism, expanding the coverage to the

remaining uncovered population groups, and managing membership transition between the Health Equity Fund and the Social Security Schemes on Healthcare.

Dimension 2: Essential Health Service Coverage

Prioritizing the expansion of essential health services that are of good quality and responsive to the population's needs, particularly the primary healthcare services wherein priority policy reform directions will be set out. It includes strengthening the regulation of private health services at all levels, launching an independent healthcare accreditation system and arranging the framework implementation with the engagement from both public and private sectors, expanding and strengthening the capacity to deliver essential health services, especially primary healthcare based on the people-centered integrated care approach, strengthening and expanding the specialized and emergency health services, strengthening the management mechanism and distributing the essential medicines, strengthening and fostering the consistency of referral system and gatekeeping, harmonizing the social health protection benefit packages, promoting community participation in health service delivery, enhancing human resources in the health sector, promoting multi-sectoral actions to improve determinants of health, etc.

Dimension 3: Financial Risk Protection and Health Financing

Prioritizing the efforts to reduce the population's out-of-pocket health expenditure and enhance efficiency of health expenditures through increasing budget allocation and enhancing efficiency and effectiveness of health expenditure; institutionalizing the health programs and performance-based budgeting; budget allocation based on the healthcare needs and equity; and galvanizing the autonomy of the health service providers in managing resources and ensuring accountability; increasing demand-side financing gradually, and implementing strategic purchasing in the social health protection system, etc.

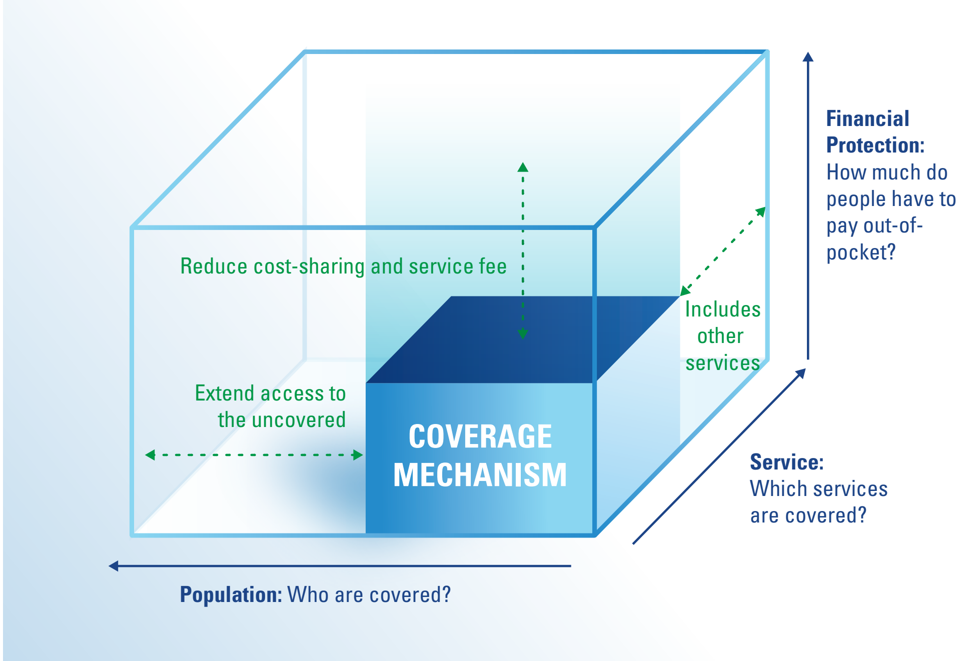
Enabling Factors

Emphasizing the multisectoral factors which characterizes the collaboration and support to the implementation of the aforementioned strategic policy reform directions along with the three fundamental dimensions above. It includes a permanent governance mechanism for UHC, capacity building for relevant stakeholders and institutions, communication and outreach mechanisms, legal framework establishment, digitalization to support the journey towards UHC, and monitoring and evaluation of the progress towards UHC and the roadmap implementation.

INTRODUCTION

Universal Health Coverage (UHC) is the global commitment of all the country members of the World Health Organization (WHO) to provide quality and equitable healthcare services to their citizens without financial challenges. This global commitment is also highlighted in the WHO's Global Health Report, particularly its inclusion in the Sustainable Development Goals - the third goal "ensuring healthy lives and promoting well-being for all ages". The concept of UHC is to ensure that all people have access to the full range of quality health services anywhere when needed without financial hardship. The services include health promotion, prevention, treatment, rehabilitation and palliative care.

Advancing Universal Health Coverage requires particular attention to three key dimensions, including population coverage under the social health protection system, essential health service coverage, and financial risk protection and health financing. These three dimensions are closely interrelated and intricately intertwined. Therefore, the path towards UHC requires the introduction of the effective and coherent policy measures between the three key dimensions as the policy decisions on one dimension will affect the achievement of the other two dimensions. Overall, UHC can be illustrated in a diagram called "UHC Cube" as shown in Figure 1 below:

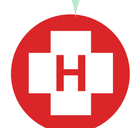


The Royal Government of Cambodia is strongly committed to strengthening the social health protection system and the path towards UHC by endorsing the "Sustainable Development Goals (SDGs)" and adopting the localized "Cambodian Sustainable Development Goals (CSDGs)". In this context, the Royal Government is committed to achieving UHC by highlighting the key elements in numerous national strategy and policy documents such as the Rectangular Strategy-Phase 4 and the Pentagonal Strategy-Phase 1, the National Strategic Development Plan 2019-2023, the Health Strategic Plan 2008-2015 and 2016-2020, the National Social Protection Policy Framework 2016-2025, and the Strategic Framework and Programs for Economic Recovery in the Context of Living with COVID-19 in the New Normal 2021-2023.

In regards to the journey towards UHC, Cambodia has achieved a remarkable success in improving many key health outcomes over the past two decades, including higher coverage of maternal and child health services, increased coverage of essential health services, declining mortality rate of maternal, newborn and children under age five years, the implementation of national immunization programs and eradication of diseases such as polio, neonatal tetanus, measles, mumps, and lymphatic filariasis, the implementation of the National Tuberculosis Control Program, malaria control, etc. Based on these results and progresses, Cambodia realizes the importance of developing a roadmap to chart policy measures in a multi-sectoral and multidimensional manner and in line with the country's contexts and resources available in order to achieve the ultimate goal of the UHC - that is – an access to good quality healthcare services when needed and without financial vulnerability, which will promote an equitable distribution of resources in society; and improve efficiency, harmony, and social solidarity.

CHAPTER

1



Progress Towards Universal Health Coverage in Cambodia

1.1 Overview of the Progress Towards UHC in Cambodia

One of the six priority policy programs of the Royal Government of the Seventh Legislature of the National Assembly focuses on "Expanding healthcare services towards the universal health coverage". The path towards UHC has also been included in several national strategic documents and policies such as the Rectangular Strategy-Phase 4, the Pentagonal Strategy-Phase I, the National Strategic Development Plan 2019-2023, the Health Strategic Plan 2008-2015 and 2016-2020, as well as the National Social Protection Policy Framework and the Strategic Framework and Programs for Economic Recovery in the Context of Living with Covid-19 in a New Normal 2021-2023.

As mentioned above, the progress towards UHC is an essential policy agenda of the Royal Government of Cambodia, which requires innovations in the health sector, both public and private, as well as in other relevant national institutions.

Currently, civil servants, retired civil servants, veterans, and private sector employees are covered under contributory social security schemes. Under the Sub-Decree No. 270 dated August 28, 2023, the National Social Security Fund (NSSF) has also implemented the Voluntary Social Security Scheme on Healthcare, which covers dependents of the NSSF members and the self-employed . Meanwhile, poor households and some target groups of the population are covered by the Health Equity Fund (HEF). Through the Inter-Ministerial Prakas No. 603 MEF.PRK.GS-NSPC dated September 15, 2023, the Royal Government also decided to expand the HEF to cover At-Risk households. By the end of 2023, the total number of the Cambodians covered by the social health protection system is about 7 million, equivalent to 41% of the total population.

In general, this roadmap builds on the existing accomplishments in the health sector and reform initiatives in health financing implemented by the Ministry of Health and other stakeholders since the 1990s. Policy options outlined in the roadmap will be implemented gradually from 2024 to 2035 to build the foundation and pave the way towards UHC in Cambodia.

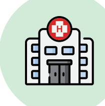
The process of developing this roadmap is premised on the Concept Note on the Path towards UHC in Cambodia, which was officially approved by the National Social Protection Council on March 30, 2022. Recognizing the social and economic importance of accelerating the path to UHC in Cambodia, the National Social Protection Council established the Technical Working on Developing a Roadmap towards UHC in Cambodia through the Decision Letter No. 058 MEF dated January 20, 2022, which is composed of representatives from relevant ministries and institutions. The Technical Working Group then organized a series of consultative meetings with all stakeholders, development partners and civil society organizations to draft the roadmap.

1.2. Health Sector Development in Cambodia

The health sector reform has resulted in a shift from administrative structure-based healthcare system into population- and geography-based healthcare system. As a consequence, the current health system is organized into three levels: national, municipal/provincial, and operational district levels. The public health system in Cambodia is interconnected at the three levels, as well as community level, which can be depicted as follows:

A. Health Center and Health Post

Provide a Minimum Package of Activities (MPA) that focuses on a defined set of essential health services.



B. Referral Hospital

Divided into three categories of hospitals depending on geography, demography, and capabilities and accessibility of health service delivery. Referral Hospitals at Operational District level provide Complementary Packages of Activities Level 1 (CPA1) or Level 2 (CPA2), while Provincial Referral Hospitals provide Complementary Packages of Activities Level 2 (CPA2) or Level 3 (CPA3).

C. National Hospital

Provide an advanced Complementary Packages of Activities (CPA+)

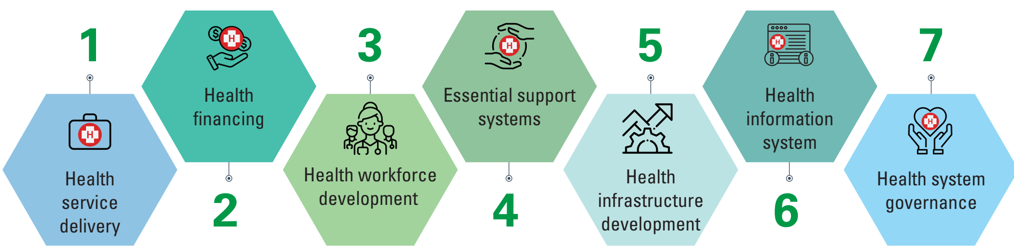
In addition, Kantha Bopha Hospital – one of the national hospitals providing free maternal and pediatric care and treatment for pregnant women and children under 15 – is financed by the various sources of generous donations from Her Majesty Queen Mother Samdech

Preah Mahaksatrey **Norodom Monineath Sihanouk**, the Royal Government of Cambodia, the Swiss Government, the Cambodia Red Cross, the Swiss Kantha Bopha Foundation, the proceeds of ticket sales at the Angkor Archaeological Park (2$ per ticket), and philanthropic donations from the public through the Kantha Bopha Foundation of Cambodia. In the meantime, private health facilities have proliferated markedly.

The Ministry of Health has identified two strategic priorities for health system interventions as follows:

1. Expanding coverage and providing comprehensive healthcare services to all citizens across the country
2. Increasing coverage under the social health protection system to reduce financial hardships and increase financial risk protection for people, especially poor and vulnerable, when accessing healthcare services.

Health institutions at all levels in the health system have implemented a series of health strategic plans, focusing on seven interconnected strategic areas:



Such efforts and investment in the health sector have incrementally improved the health service delivery capacity and innovations in the health sector, presenting Cambodia with a multiplicities of noticeable health outcomes. Although there was a slight decline in health service coverage between 2020 and 2022 due to negative impacts of the COVID-19 pandemic, the key achievements, namely health service delivery capacity and innovations in the health sector, have paved the way for UHC in Cambodia as follows:

1. Progress on essential health service coverage index on average was approximately 58% in 2021, in which the sub-index on reproductive, maternal, newborn, and child health was 74%, infectious diseases 65%, non-communicable diseases 64%, and service capacity and access 37%.
2. Out-of-pocket health expenditure was 64% in 2019 and declined to 60% by 2020. The proportion of the population with household expenditures on health greater than 10% of total household expenditure or income was 17.6% in 2019 and decreased to 12.1% in 2021. The proportion of the population with household expenditures on health greater than 25% of total household expenditure or income was 4.8% in 2019 and dropped to 3.7% in 2021. The proportion of the population with household

expenditures on health greater than 40% of total household expenditure or income was 5.3% in 2019 and decreased to 4.2% in 2021. The proportion of the population who fall into poverty due to healthcare expenditure was 4.2% in 2019 and decreased to 3.7% in 2021.

3. From 2014 to 2022, out of 1,000 live births, it was observed that
   - Newborn mortality rate dropped from 18 to 8 deaths,
   - Infant mortality rate dropped from 28 to 12 deaths, and
   - Under-five mortality rate dropped from 35 to 16 deaths.

4. Hospital mortality rates were generally between 0.7% and 0.8% of the total number of hospitalized patients between 2018 and 2022, although rising slightly to 1.4% in 2021, which include also the number of Covid-19-related deaths.

5. From 2018 to 2022, the Ministry of Health has developed a set of 102 Health Center Accreditation Standards, a set of 365 Cambodia Hospital Accreditation Standards, and Minimum Standards of Care for Private Health Facilities and has prepared a Healthcare Quality Improvement Handbook for Implementing the Accreditation Standards for Hospitals and Health Centers.

6. The assessment of 25 Municipal-Provincial Health Departments, 103 Operational Health Districts, 118 Referral Hospitals (CPA1, CPA2, CPA3) and 1,253 Health Centers showed that the hospital quality assessment score increased from 60.89% in the third quarter of 2019 to 81.32% in the first quarter of 2022. Health center quality assessment scores increased from 64.34% in the third quarter of 2019 to 81.95% in the first quarter of 2022.

7. For delivery (% of expected births), the proportion of deliveries attended by healthcare professionals increased from 87.29% in 2018 to 93.33% by 2020.

8. The Comprehensive Emergency Obstetric and Newborn Care (C-EmONC) service is available at 42 facilities, including cesarean delivery. The Basic Emergency Obstetric and Newborn Care (B-EmONC) service is available at 137 health facilities.

9. Currently, the National Immunization Program has regularly provided 12 vaccines to children under 1 year old to prevent Tuberculosis (BCG), Diphtheria, Pertussis, Tetanus, Polio, Rubella-Measles, Hepatitis B, Pneumococcal (PCV13), and HPV vaccine against cervical cancer for girls under 12 years old. Vaccination coverage of diphtheria-pertussis-tetanus-hepatitis B-pneumonia-meningitis 3-dose (DPT-HepB-Hib3) for children under 1 year old maintained a high rate of over 95% in the last 10 years.

10. As of 2022, there are 234 health centers and 52 family health clinics that provide Sexual Transmitted Infection (STI) screening services. Voluntary Confidential Counselling and Testing (VCCT) centers have increased from 69 in 2018 to 71 in 2022, which are also capable of providing HIV care and treatment.

11. The National Tuberculosis Control Program presently maintains 100% TB coverage in all referral hospitals, health centers, and some of the health posts across the country with a network of 220 tuberculosis (TB) testing laboratories and 88 facilities with Xpert machines.
12. Malaria decreased from 64,534 cases in 2018 to 4,053 cases in 2022, or a decrease of 93.7% between 2018 and 2022, or a decrease in the incidence rate of 3.83 per 1,000 population to 0.24 per 1,000 population.
13. In 2022, there were 125 cases of chikungunya fever, with 45 cases of women infected and no deaths.

In addition, during the COVID-19 pandemic, under the wise and bold leadership, and precise and timely approach of **Samdech Techo HUN SEN, former Prime Minister**, Cambodia made a myriad of outstanding strides in the fight against the global pandemic including:

1. The national COVID-19 vaccination campaign, which ran from February 10, 2021 to December 31, 2022, recorded data on the four doses of the COVID-19 vaccine with a total of 45,226,576 doses (37 854 653 doses administered by the Ministry of Health and 7 371 923 doses administered by the Ministry of National Defense).
2. Polymerases Chain Reaction (PCR) testing capabilities have been enhanced, coupled with the widespread use of rapid testing for COVID-19 antibodies in both public and private sectors. Sample testing laboratories in 16 capitals and provinces were capable of testing 7,000 to 8,000 tests per day and 10,000 to 12,000 tests per day in the event of a large-scale outbreak.
3. Sample-testing laboratories in 16 capitals and provinces were able to conduct 7,000-8,000 tests per day and 10,000-12,000 tests per day by September 2021.
4. The network of quarantine centers had been expanded, especially at the western border provinces of the country, along with the expansion of quarantine locations to private locations and home quarantine.
5. There are 79 hospitals for COVID-19 treatment, and 145 COVID-19 treatment centers with 43,764 beds for mild symptoms and 13,179 reserved beds by September 2021.
6. As of September 2021, there are 21,019 doctors and medical staff working in hospitals and treatment centers.
7. COVID-19 medication (Molnupiravir and Paxlovid) is used in hospitals/treatment centers to facilitate an affordable access to healthcare while the standard operating procedures on COVID-19 treatment and care were also updated.

1.3. Health Financing

1.3.1. Supply-Side Health Financing

The Public Financial Management Reform Program has been implemented in four consecutive phases, in which the Ministry of Health and health institutions at all levels have been actively involved from the outset with the following phases:

- Phase 1 "A More Credible Budget" on December 5, 2004,
- Phase 2 "Effective Financial Accountability" on December 3, 2008,
- Phase 3 "The Royal Government of Cambodia (RGC) Policy Agenda Becoming Fully Affordable and Prioritized" on March 21, 2016,
- Phase 4 "RGC Managers Becomes Fully Accountable for Program Performance" from 2021 to 2025.

Generally, in the health sector, all health institutions prepare and submit expenditure plans which entails current expenditures, essential medicine supply costs, and other investments, to central levels so that the national budget negotiation can take place and subsequent budget allocation to the health sector can be decided and made. In addition, the Royal Government has increased the budget allocation to health centers and referral hospitals at all levels according to clear criteria for performance improvement without conditions. Currently, the process of decentralization and de-concentration in the health sector in terms of resource management has been transferred to the sub-national level (with the exception of budget for Health Equity and Quality Improvement Project which is administered by the Ministry of Health). The banking system has been used to transfer funds directly to each health facility while performance-based budget aimed at improving health service quality with specific evaluation mechanisms is also put in place.

Moreover, public health facilities are permitted to charge service fees from patients when using healthcare services, coupled with fee exemption policy, whereas the mechanism remains yet to be entirely efficient, especially at national hospital level, due to high user fees charged. Of the total user fees, 60% is used to incentivize health workers at the facility, 39% is to support the operating costs, and 1% is channeled back to the state budget. In addition, some public health facilities may have some direct supports from development partners.

1.3.2. Demand-Side Health Financing

Demand-side health financing mechanism refers to health facility financing through reimbursement of services used by the target groups of the population at the public health facilities in accordance with applicable regulations and at the contracted private health facilities. The funding that health facilities receive from this mechanism depends

on the actual services provided to the target groups of population, as defined in the Inter-Ministerial Prakas No. 327 KP/KBSS between the Ministry of Labor and Vocational Training and the Ministry of Health on the Social Security Schemes on Healthcare operated by the NSSF and in the Inter-Ministerial Prakas No. 497 MEF/ PRK between the Ministry of Economy and Finance, the Ministry of Labor and Vocational Training and Ministry of Health on Health Equity Fund.

Demand-side financing plays an important role in enhancing and incentivizing health facilities to make further efforts to provide better quality and efficient services because such financing depends entirely on the outcomes of the actual healthcare service delivery. Currently, demand-side financing mechanism includes the HEF, the Social Security Scheme on Occupational Risk and Healthcare, as well as voluntary health insurance schemes, offered by private operators and entities for individuals, groups and households.

A. The Health Equity Fund

The HEF has been established to provide healthcare coverage to individuals from the poor households with the equity card so that they could receive both medical benefits at public health facilities and non-medical benefits that include travel allowance, food allowance for care-takers and funeral allowance. As of December 2023, the HEF covers about 706,280 households with the equity card, which is equivalent to about 3 million people.

In January 2018, the Royal Government has expanded the HEF coverage to other target groups of the population, financed entirely by the national budget, including informal workers, village chiefs and village deputies, Commune-Sangkat council members, athletes, tri-cycles and motor driver association, cyclo drivers, and demining experts and staffs of Cambodia Mine Action Center. These target groups have only been covered on medical benefits. As of December 2023, these target groups of approximately 99,417 were covered.

At the same time, through the Inter-Ministerial Prakas no. 356 MEF / BrK. GS-NSPC dated June 19, 2023, the Royal Government has expanded the HEF coverage to persons working in entertainment services in the informal sector, especially women working at disco clubs, KTV, beer garden, and massage facilities. As of December 2023, the entertainment workers in the informal tourism sector of approximately 3,217 were identified.

In addition, through the Inter-Ministerial Prakas No. 603 MEF.Brk.GSNSPC dated September 15, 2023, the Royal Government has decided to expand the HEF coverage to At-Risk Households. At-risk household is the target group of the population situating near the poverty line and with a similar economic status to the IDPoor households (IDPoor 1 and IDPoor 2), in which the Royal Government is responsible entirely for all expenses on the beneficiaries' behalf. There are about 491,243 households or 1,821,056 people who have been identified as members of the At-Risk households through the mechanism of the Ministry of Planning, and thereby are entitled to healthcare benefits of the HEF.

B. The Social Security Schemes on Healthcare

The Social Security Schemes on Healthcare for All Individuals Working Under the Provisions of the Labor Law (worker-employee) has been implemented at the end of 2016, with the NSSF as the operator. Workers and employees are entitled to both medical benefits and cash benefits. The medical benefits include medical care and treatment at all public and private health facilities that have signed contracts with the NSSF. As of December 2023, there are approximately 1.5 million employees covered under the Social Security Schemes on Healthcare.

On the other hand, the Social Security Schemes on Healthcare for civil servants has been implemented in early 2018. Civil servants are entitled to the same medical benefits as workers and employees, except for the maternity benefits - which shall be offered directly by their respective organizations and institutions where the civil servants work - and daily allowance for the entire treatment in the form of no deduction of salaries. As of December 2023, about 400,800 civil servants, retired civil servants and veterans have been covered.

C. The Social Security Schemes on Occupation Risk

The Social Security Schemes on Occupational Risk are established with the purpose of providing the insurance for all accidents which the target groups of the population suffer while working at their workplace, commuting to and from the workplace, and experiencing occupational diseases.

The Social Security Scheme on Occupational Risk for All Individuals Working under the Provisions of the Labor Law has been implemented since November 2008 with the NSSF as the operator, and the contribution is solely paid by the employers. As of December 2023, approximately 1,494,500 individuals in the formal sector have been covered under the Social Security Scheme on Occupational Risk.

The Social Security Scheme on Occupational Risk for Individuals in Public Sector has been implemented since early 2021, with the contribution entirely paid by the Royal Government. As of December 2023, this scheme has covered 274,800 civil servants.

D. The Voluntary Social Security Scheme on Healthcare

Through the Sub-Decree No. 280 dated August 28, 2023 on the Conditions, Formalities and Procedures for the Implementation of the Voluntary Social Security Scheme on Healthcare, the Royal Government has launched the Voluntary Social Security Scheme on Healthcare for the self-employed and dependents of NSSF members, in which the contribution is the sole responsibility of the members who have regular wages, and is set based on the rate determined by the actuarial valuation conducted by the professionals. As of January 2024, the Voluntary Social Security Scheme on Healthcare has covered the target groups of the population of about 134,600 individuals.

1.4. Challenges

Despite the remarkable progresses made so far, the health system and social health protection system in Cambodia continue to face a number of challenges. This roadmap is intended to thoroughly identify key challenges as well as solutions to pave the way towards UHC.

1.4.1. Social Health Protection Population Coverage

The social health protection system currently covers more than 41% of the total population in Cambodia, which means more than 50% of the population is not yet covered due to two main factors: (1) legally covered population who are yet to be registered and (2) the population who are not yet legally covered by the system.

A. Registration System for Population in the Formal Sector

Of more than 50% of the total population who is yet to be covered by the social health protection system, 16% has already been covered by relevant regulations, but has not been enrolled. In fact, the coverage of all individuals working under the provisions of the labor law under the Social Security Schemes on Healthcare and Occupational Risk, especially workers and employees of the small and medium enterprises, are not yet fully implemented. The awareness and willingness of the employers to register their employees in the social security system are also limited, while private health insurance companies cover merely a limited number of people who can afford.

B. Registration under the Health Equity Fund

Criteria, procedures, and assessment competencies for evaluating and identifying poor people in order to obtain the equity card are seen as complex, which can pose a risk for identification accuracy (the risk that better-off citizens receive the equity card whereas the actual poor or near poor people do not). Even limited is the monitoring and evaluation of the dynamics where poor households graduate from poverty so that the equity card validity can be terminated. The registration procedure for the issuance of the HEF Card for informal workers is voluntary and associated with complex identification, administrative documentation, registration and issuance. Meanwhile, the promotion and awareness of the target groups on HEF benefits also remains limited, resulting in low effective coverage.

C. The Fragmentation of Existing Schemes

The fragmentation across the current social health protection schemes limits the potential degree of risk redistribution amongst the population groups. In fact, the HEF covers distinct population groups with different benefits. In particular, the Social Security Schemes on Healthcare currently covers civil servants, retired civil servants, veterans, and private

employees through mandatory scheme, as well as the self-employed and dependents of NSSF members on a voluntary basis. This fragmentation results in an inequitable distribution of resources and services among different groups of people who work or run businesses differently or have different economic statuses.

1.4.2. Essential Health Service Coverage

Though Essential Health Service Coverage index in Cambodia in 2019 stood at around 60%, Cambodia has a number of areas to further develop in order to strengthen and expand essential health services, which includes health service delivery capacity related to communicable diseases (CD) and non-communicable diseases (NCD), diagnostics, improved sanitation, adherence to Minimum Package of Activities and Complementary Package of Activities, updating social health protection system benefit packages, strengthened gatekeeping policy and referral system, enhancement and management of health workforce, etc.

A. Health Service Delivery

There are some areas related to access and capacity of quality health service delivery compared to international standards, which Cambodia considers as areas of improvement. Essential health service coverage index in Cambodia at 58% in 2021 is still low. Health service delivery capacity related to communicable diseases, diagnostics and treatment of tuberculosis and hepatitis, and improved sanitation shall be further strengthened.

Some public health facilities still face challenges in terms of governance, service delivery, human resource, and capacity to deliver services in accordance with the Guideline for MPA and CPA, which causes the citizens, especially the IDPoor households under the HEF, to turn to private health facilities, consequently translating into increased out-of-pocket expenditures.

Current MPA and CPA do not adequately address new healthcare needs such as chronic diseases, NCDs, mental illness, rehabilitation, elderly care, and care for people living with disabilities, etc. Based on a WHO report in 2022, NCDs accounted for 22.5% of premature deaths for Cambodians aged between 30 and 70 years old. The four main NCDs are namely cardiovascular diseases, diabetes, chronic respiratory disease and cancer.

B. Social Health Protection Benefit Packages

Benefit packages of the HEF and the Social Security Schemes on Healthcare operated by the NSSF are not yet sufficiently harmonized. In addition, reimbursement rates of both schemes are different in some medical cases. Particularly, the NSSF does not reimburse public health providers for some priority health services within fee exemption policy set forth by the Ministry of Health including vaccination, HIV/AIDS, tuberculosis, and malaria.

The Guidelines on MPA and CPA does not state specifically the conditions upon which specific types of essential medicines are prescribed for any specific services. The benefit packages of the HEF and the Social Security Schemes on Healthcare do not specify types of medicines prescribed attached with precondition of reimbursement, and do not set the conditions for health facilities to issue prescriptions either. Moreover, reimbursement to health facilities under the HEF and the Social Security Schemes on Healthcare does not clearly define whether prescriptions shall be issued or not. Nonetheless, both schemes currently do not have a mechanism to monitor and observe the treatment protocols yet.

C. Gatekeeping Policy, Referral System and Regulations of Private Health Providers

The HEF requires the use of referral system starting from primary care level. On the contrary, the Social Security Schemes on Healthcare operated by the NSSF does not set the conditions on the use of referral system, which encourages the NSSF members to seek healthcare at contracted health facilities of their preference whereas currently many NSSF members prefer private health facilities, and high level hospitals or the national hospitals. This adversely affects efficiency and effectiveness of primary care level of the health system and the capacity to handle an influx of patients of high level hospitals or the national hospitals.

In addition, private health facilities in Cambodia represent a significant proportion of the health sector, and have been growing rapidly. In 2022, private health facilities accounted for 16,181 compared to 1,648 public health facilities. Since regulatory framework on private health facilities remains weak, the predominant utilization of private health facilities by the general public raises a grave concern, especially with regards to overprovision, overpricing, and service quality issues. Moreover, regulations of licensing of private health facilities have a room for improvement, especially on quality assurance requirements and regular monitoring mechanism, to ensure all private health facilities comply with necessary conditions and existing regulations.

D. Strengthening Quality of Healthcare Services and Health Workforce

One of the factors which hinders quality of healthcare services is the lack of health workforce. Additionally, a mechanism to review compliance with the Clinical Practice Guidelines has not yet been completely implemented. Meanwhile, the Guidelines on MPA and CPA, especially the Clinical Practice Guidelines, have been compiled and implemented, albeit without a clear governance mechanism.

In 2022, an average health personnel of 7.4 are allocated to each health center; this figure is close to the indicator set in the guidelines of the Ministry of Health which require each health center to have between 8 to 10 personnel. Nonetheless, health workforce allocation between urban and rural areas remains the key challenge while in reality health personnel are concentrated in urban areas, especially in Phnom Penh.

In addition, dual practice in both public and private health sectors is common among health workers and health professionals in Cambodia. The overriding concern is the lack of regulations and clear mechanism to manage such practice, which adversely affects the entire public health system, especially the absence of health personnel during the official working hours in the public health facilities, the urge to refer patients to use private health facilities where they are working for, etc.

1.4.3. Financial Risk Protection and Health Financing

Although out-of-pocket health expenditure (OOPE) in Cambodia dropped from 64% in 2019 to 60% in 2020, the rate remains high, possibly posing financial risks for patients when seeking healthcare services. Some challenges, which are worthy of responses, include the reduction of OOPE, strengthening demand-side financing through the social health protection system, strengthening the roles of the private sector especially with regards to the supply of medicines and medical equipment, harmonization of the benefit packages under the social health protection system, mechanisms to manage the supply essential medicines, medical devices and equipment, etc.

A. Government Expenditure in the Health Sector and Current Out-of-Pocket Health Expenditure

The government budget allocated to the health sector increased by 49,73% from 1,393,974 million KHR in 2018 to 2,087,196 million KHR in 2022. Furthermore, the share of government expenditure on the social health protection system accounted for around 3% of the total health expenditure; and this figure is still considered low compared to other countries in the region. The statistics indicate that Cambodia has a number of areas to improve in order to accelerate the progress towards UHC which requires thorough considerations on health financing reform which reflects tax regime situation in Cambodia.

Additionally, OOPE rate in Cambodia remains high, standing at around 60% compared to the current total health expenditure in Cambodia. OOPE is an inefficient and inequitable source of financing, which put a major hindrance on an access to needed healthcare services of the people. Between 2009 and 2019, OOPE of one household on average amounts to about 405 USD annually, most of which is spent in the private sector. Impoverishment due to healthcare spending is observed among the 2nd and 3rd wealth quintiles, which indicates that the majority of households who graduate from the poverty, still continue to face challenges in terms of income security.

B. The Roles of Private Sector

Private health insurance companies, which offer health insurance products for those who can afford to pay premium on a voluntary basis, play a complementary role in the social health protection system. Yet, the private health insurance products – seen as inequitable –

cover only a small number of the population. Moreover, health service delivery offered by the private sector has noticeably flourished and absorbed a considerable proportion of OOPE incurred by households. Also, medicines available in the market nowadays are not sufficiently regulated through a legal enforcement mechanism, and a rigorous price ceiling setting mechanism. This adversely affects the financial status of households since many people observably prefer seeking healthcare in the private sector and purchase medicines over the counter.

C. Reform of Public Health Facilities

The Ministry of Health has strengthened health service delivery system through continued and consistent investment in health facilities especially health centers and referral hospitals. Transforming national hospitals into public administrative institutions possibly presents a critical financial risk for citizens whenever they seek care and pay service fees directly given that the social health protection coverage remains limited nowadays. In addition, this reform requires abundant resources amidst limited national budget for the health sector.

Concurrently, the setting of service fees - paid directly by patients - differs across the regions and health facilities even though the Ministry of Health advises that the service fees should be revised based on the principle of affordability by the public and the support from the local authority.

D. Benefit Packages and Different Service Reimbursement Rates of the Social Health Protection System

The HEF and the Social Security Schemes on Healthcare apply the same case-based payment; however, reimbursement rates differ, which possibly gives rise to health service delivery-related discriminations, providers' tendency to carter more to beneficiaries of the schemes with favorable payment conditions, etc. Also, the setting of service reimbursement rates nowadays is not yet developed based on a comprehensive costing unit review.

E. Policy on the Supply of Essential Medicines, Medical Equipment and Devices

Medicines, medical equipment and devices are supplied through a centralized system under the national procurement procedure. However, some health facilities still continue facing challenges on the lack of essential medicines, medical equipment and devices over certain periods of time and on specific disease burdens. This causes some health facilities to turn to direct medical purchases in the event of shortages, late supply, or lack of specific medicines supplied by the Central Medical Store (CMS) in order to refill the stocks and ensure the sustainability of health service delivery.

CHAPTER

2

The Development of the Roadmap towards Universal Health Coverage in Cambodia

2.1. Scope of the Roadmap

The Social Protection Policy Framework identifies the path towards UHC as a core vision. The roadmap towards UHC in Cambodia thoroughly underscores the intertwined connections between the country visions set forth in several national policy documents which include the Pentagonal Strategy Phase I, National Strategic Development Plan, Post-Covid Pandemic Economic Recovery Plan, and other Strategic Plans of the Ministry of Health. This roadmap reflects a resolute commitment of the Royal Government for all the previous Legislatures of the National Assembly to ensuring that Cambodians' rights to healthcare are guaranteed as stipulated in the Constitution.

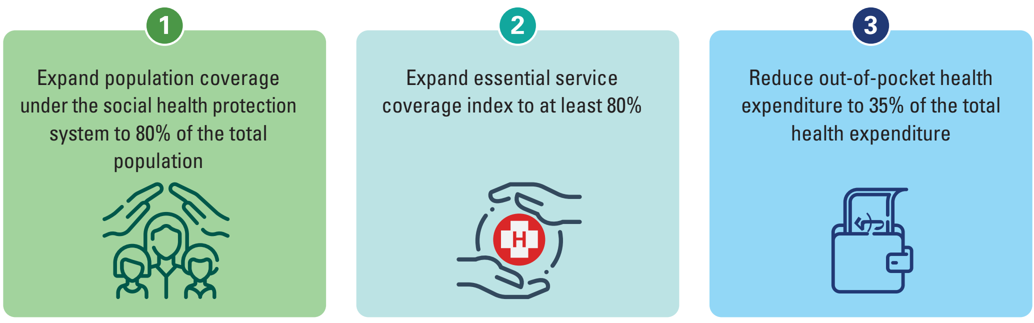
The social health protection system in Cambodia has undergone various stages of piloting health financing interventions namely contracting-in, contracting-out, performance-based health financing, Midwifery Incentive Scheme, and demand-side interventions such as the Health Equity Fund, Community-Based Health Insurance, and Reproductive Health Vouchers, etc. In addition to such efforts and experiences, the National Social Protection Framework also underlines the essence of improving the social health protection system and the path towards UHC in a systematic, multisectoral, and inclusive manner.

The roadmap introduces strategic policy directions along all the three fundamental dimensions as well as enabling factors to pave the way towards UHC in Cambodia. In this regard, the roadmap serves as a guide to prioritize strategic directions and reflects domestic resource settings and development contexts of Cambodia. The roadmap also identifies key objectives and roles and responsibilities of relevant institutions; and charts a strategic, phased, and gradual journey towards UHC in Cambodia.

The main objective of the roadmap is **" to define a strategic path towards UHC in Cambodia between 2024 and 2035 through introducing strategic policy directions and priority objectives in a phased manner"**

2.2. Specific Objectives of the Roadmap

The roadmap towards UHC in Cambodia identifies THREE main objectives as follows:



2.3. Characteristics of the Reform towards UHC

1. Universality

The roadmap embraces 'universality' - extending healthcare benefits to all citizens with a priority focus on people from the poor households and vulnerable population aimed at improving equity and inclusion.

2. Improving Social Health Protection and Increasing Healthcare Efficiency

The roadmap prioritizes strengthening and expanding the existing social health protection system in order to cover additional population groups gradually. Moreover, the reform towards UHC is also focused on strengthening health service delivery capacity and exploring the possibility of increasing comprehensive and quality essential health services to citizens based on existing investments.

3. Gradualism

The roadmap will contribute to cementing a foundation for progressing toward UHC in Cambodia in the long run in a multi-sectoral, multi-dimensional, and comprehensive manner. The roadmap is a document that shows strategic directions, leaving room for relevant ministries and institutions to develop operational and strategic plans to implement gradually.

4. Risk pooling

Reforms toward UHC is aimed at promoting and reviewing the feasibility of fostering a common risk pool under a single fund in order to enhance financing solidarity amongst target groups of the population.

5. Inclusive Benefit Packages

The social health protection benefit packages shall be developed based on thorough analysis and rigorous consultation, which takes into account actual healthcare needs of communities with a priority on gradual coverage expansion in accordance with government budget affordability and socio-economic situations. The benefit packages shall be subject to continued update to ensure the delivery of comprehensive care, which include also community-based health education and promotion, prevention, treatment, rehabilitation, and palliative care.

6. Strategic Purchasing

Reforms toward UHC shall promote strategic purchasing approach which takes into account expected health outcomes, healthcare needs, efficient and effective spending, and accountability. This approach requires the social security operator to attach the performance of the social security schemes to relevant information and data on health service delivery performance and shifting healthcare needs in the country.

7. Good Governance and Accountability

Reforms towards UHC shall promote good governance and accountability through effective cooperation and coordination among relevant ministries/institutions in order to jointly accelerate the journey towards UHC, get informed of the progresses towards UHC, and establish monitoring and evaluation mechanism on priority strategic policy directions defined in the roadmap to ensure a transparent implementation.

8. Integrated Information Management System

The development and use of interoperable Information, Communication, and Technology (ICT) system, as well as inclusive recording, storage and content development is imperative in promoting an efficient management and implementation of the social health protection system. Relevant information about coverage of health insurance schemes by private companies shall also be integrated into ICT system under UHC in Cambodia.

2.4. Key Principles of the Reform towards UHC

The implementation of priority strategic policy directions defined in the roadmap shall be in accordance with the following principles:

1. Right to healthcare

Article 72 of the Constitution of the Kingdom of Cambodia states, "The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public

hospitals, infirmaries and maternities. The State shall establish infirmaries and maternities in rural areas."

2. Equity

Ensure fairness for all citizens through the delivery of an efficient healthcare services based on population needs as well as guarantee that an access to healthcare services shall not depend on the capacity to pay user fee of households.

3. Social Solidarity

Promote risk pooling under the social health protection system to ensure cross-subsidization among schemes in order to maintain solidarity among families, communities and society at large.

4. Quality of care

The health sector shall ensure a quality standard of healthcare service delivery which is accessible, effective, and efficient, which ultimately promotes health outcomes, and addresses healthcare needs of the population.

5. Efficiency

Promote value for money of strengthening the effectiveness of the management and operation of healthcare service delivery in the health sector.

6. Financial Sustainability

Promote financial sustainability through diversifying resource sources and enacting measures to guarantee an efficient management of the health sector.

7. Flexibility and Resilience

Ensure flexibility and resilience of the roadmap implementation in due considerations of domestic and external situations, which warrants an update and revision of strategic policy directions defined in the roadmap.

8. Family Principle

Ensure that all household members shall be covered under the social health protection system.

CHAPTER

3

Elements of the Roadmap

The Roadmap towards UHC in Cambodia sets forth priority strategic policy directions along the three fundamental dimensions, namely **1-** population coverage under the social health protection system with 5 strategies, **2-** essential health service coverage with 14 strategies, and **3-** financial risk protection and health financing with 6 strategies, coupled with enabling factors with a total of 5 strategies depicted in the graph below.

Image 2: Elements of the Roadmap

Dimension 1 – Population Coverage under the Social Health Protection System

1. Enhancing Effective Coverage of the Health Equity Fund
2. Enhancing Effective Coverage of the Social Security Schemes on Healthcare
3. Reviewing and Evaluating the Existing Population Coverage under the Social Health Protection System
4. Expanding the Social Health Protection Coverage to Remaining Target Groups of the Population
5. Managing Membership Transition between the Health Equity Fund and the Social Security Schemes on Healthcare

Dimension 2 – Essential Health Service Coverage

1. Reinforcing Regulation of Private Health Sector at All Levels
2. Preparation and implementation of Healthcare Accreditation System
3. Strengthening Regulations of Dual Practice
4. Enhancing the Capacity of Health Service Provision
5. Strengthening and Expanding Essential Health Services, Particularly Primary Healthcare Services
6. Promoting Community Participation in Health and Multisectoral Actions
7. Strengthening and Expanding Essential Specialized and Emergency Services
8. Strengthening Referral System and Implementing Gatekeeping Policy
9. Strengthening Compliance with International Health Regulations (IHR)
10. Enhancing Drug Management and Supply system Strengthening Pharmaceutical Market Regulation
11. Strengthening Essential Laboratory Services
12. Developing a Standard Benefit Package for the Social Health Protection System
13. Strengthening Tax Policies and Regulations of Health Products

Dimension 3 – Financial Risk Protection and Health Financing

1. Increasing Budget Allocation for the Health Sector
2. Increasing the Efficiency and Effectiveness of Health Expenditures
3. Rebalancing Between Supply- and Demand-Side Financing
4. Optimizing Efficiency and Effectiveness of Demand-Side Financing
5. Introducing Regulations of the Price Ceiling of User Fees
6. Public Awareness Raising

Enabling Factors

1. Governance Mechanism

2. Capacity Building for Relevant Institutions and Stakeholders Defined in the Roadmap

3. Legal Framework

4. Communication Strategy for UHC

5. Digitalization for UHC

6. Monitoring and Evaluation of the Implementation of the Roadmap

3.1. Dimension 1 – Population Coverage under the Social Health Protection System

This dimension focuses on enhancing effectiveness of the social health protection coverage aimed at ensuring that the covered population access quality healthcare services and are guarded against financial risks maximally, as well as that subsequent coverage expansion can gradually unfold to cover additional remaining uncovered population groups.

3.1.1 Enhancing Effective Coverage of the Health Equity Fund (HEF)

Strengthen effective coverage of the Health Equity Fund for poor households and target groups of the population defined in the existing applicable legal instruments as well as expand coverage of the HEF to At-Risk Households defined in Inter-Ministerial Prakas 603 SHV.PK.GS dated September 15, 2023. This necessitates the implementation of the following innovative strategies:

- Establish a mechanism to regularly assess and track how HEF beneficiaries use healthcare services in order to identify gaps in service delivery and access, quality, and other associated issues. This will allow key stakeholders to be informed early on and take appropriate actions.
- Enhance beneficiaries' and communities' awareness of health-related issues, the HEF benefit package, disease prevention and management measures, and the availability and accessibility of essential health services at all care levels, particularly primary healthcare.
- Consistently improve the provision of essential health services by emphasizing quality and ethics to cater to the shifting healthcare needs of beneficiaries.
- Set up a mechanism to reduce out-of-pocket health expenditures and address other healthcare seeking-related challenges, especially among the most vulnerable population groups such as the old-aged, people living with disabilities, minorities, etc., through continued improvements of the benefit package, both medical and non-medical, as well as appropriate provider payment mechanisms and rates.
- Enhance the On-Demand IDPoor (OD-ID) mechanism to ensure inclusiveness of all eligible target groups of the population and improve efficiency, accuracy, transparency, and accountability, through (1) consistently improving the quality of data and identification tools, (2) strengthening the capabilities of local implementers, particularly commune/ district administration and relevant stakeholders, (3) conducting public awareness

campaigns regarding the OD-ID process, eligibility criteria, entitlements, and benefits of the Equity Card, and (4) establishing a community feedback mechanism on quality of OD-ID, and increasing public awareness of the use of Public IDPoor App, especially among relevant community workers and health service providers, with a focus on the functions for feedback and complaints collection, as well as submitting applications for OD-ID interviews.

The above-mentioned actions shall be in sync with the implementation of other actions in the dimension 2 of the roadmap.

3.1.2. Enhancing Effective Coverage of the Social Security Schemes on Healthcare

Strengthen effective coverage of the Social Security Schemes on Healthcare operated by the NSSF, especially for civil servants, private employees and their dependents, and the self-employed through the following priority actions:

- Enhance collaboration between the NSSF, Ministry of Interior, and Ministry of Civil Service to enhance registration of dependents of the NSSF members
- Enhance collaboration between the NSSF, the Ministry of Industry, Science, Technology and Innovation to promote the registration of the self-employed in line with the Strategic Framework on Developing Informal Economy 2023-2028
- Establish an incentivization mechanism and enhance promotional activities of the NSSF at ministries/institutions, enterprises, companies – which register their employees in the Social Security Schemes on Healthcare – on the characteristics, conditions, and essence of the Voluntary Social Security Scheme on Healthcare through the use of user-friendly communication tools which effectively foster a deep awareness of the target groups of the population.
- Enhance collaboration with sub-national administrations and strengthen social security inspection at factories, enterprises, and companies in order to strengthen compliance with the obligation to register in the social security schemes in line with applicable legal instruments, and establish an incentivization mechanism to promote registration of the NSSF dependents, especially the private employees and the self-employed.
- Finetune the registration procedure and adopt user-friendly digital solutions to simplify enterprise and employee registration in the Social Security Schemes on Healthcare, ensuring timely issuance of the NSSF card.

3.1.3. Review and Evaluate the Existing Population Coverage under the Social Health Protection System

Review and evaluate the implementation of the existing Social Security Schemes on Healthcare for target groups of the population identified earlier, particularly the Voluntary Social Security Scheme on Healthcare, as a basis for enhancing effective social health

protection coverage for these population groups. The National Social Protection Council shall coordinate analyzing and evaluating the feasibility of transforming the Voluntary Social Security Scheme on Healthcare into a mandatory scheme or on an automatic basis by taking into considerations the following measures:

- Coordinate consultations for inputs from ministries/institutions and relevant stakeholders
- Conduct a financial implications assessment that considers both the national budget's affordability and contributions from the target groups of the population
- Analyze and identify risk factors that arise from the potential revisions of the contribution models, coupled with a risk mitigation strategy
- Develop strategies to strengthen the reinforcement of legal and regulatory instruments to support the coverage expansion and undertake extensive awareness-raising campaigns.
- Progressively enhance the identification and registration mechanisms to become more user-friendly and accurate.
- Define financing models for expanding coverage with the following options:
    a. The financing model, which is based on premium collection from beneficiaries together with the state's partial subsidies, being implemented by some countries, such as Vietnam, China, etc.
    b. The financing model, which is based on general tax revenue, is commonly referred to as the Universal Coverage Scheme (UCS) in Thailand and other countries that have already reached the UHC
    c. Other financing models that are most suitable for the socio-economic contexts of Cambodia.

The transition from the Voluntary Social Security Scheme on Healthcare to a mandatory scheme shall be done gradually in order to avert risks and offer sufficient time for capacitating relevant stakeholders to ensure effective social health protection coverage with a view to progressing towards UHC.

3.1.4. Expanding the Social Health Protection Coverage to Remaining Target Groups of the Population

Based on the results of the above-mentioned evaluation, the NSPC shall implement a phased approach to identify and register other remaining uncovered population groups, and extend social health protection coverage to the uncovered population groups.

Priority population groups at this stage include students and university students, trainees of Technical and Vocational Education and Training (TVET), farmers, informal workers, migrants, monks, minorities, people aged 60 and above, etc. The NSPC shall thoroughly consider the appropriate financing models to support these coverage waves, taking into

account two scenarios that align with the country's socio-economic profile. In the event of pleasant socio-economic situations, a tax-based financing model could be considered. However, in the event of unpleasant socioeconomic situations, contribution-based financing in combination with partial subsidies from the government could be considered.

3.1.5. Managing Membership Transition between the Health Equity Fund and the Social Security Schemes on Healthcare

Membership data for the Social Security Schemes on Healthcare and the HEF shall be transferable to reflect the dynamically changing livelihoods of beneficiaries in accordance with the evolving country's socio-economic situations. In this regard, it is necessary to establish a mechanism that will facilitate the transfer of membership across the entire social health protection system, specifically between the HEF and the Social Security Schemes on Healthcare, to ensure transparency and accuracy. This mechanism will contribute to addressing the changing membership status of beneficiaries within the social health protection system, which ultimately results in smooth progress and the dynamics of the social health protection coverage.

3.2 Dimension 2 – Essential Health Service Coverage

This dimension focuses on improving and expanding the provision of quality essential health services to meet the population's needs. It also supports the expansion of population coverage under the social health protection system, as outlined in the Dimension 1.

3.2.1. Reinforcing Regulations of Private Health Sector at All Levels

Review the licensing and relicensing procedures of private health facilities and providers at all levels. The licensing and relicensing criteria shall be subject to compliance with the requirements of the minimum standards of care for private health facilities and the Continuing Professional Development (CPD) for healthcare providers to ensure health service quality and professional practices. Regular inspection and monitoring mechanisms will be strengthened and implemented in a transparent manner, with a stringent enforcement of the law on unethical and unlawful practices. In the long run, it will be necessary to update the minimum standards and incorporate clinical practice guidelines to ensure alignment with the healthcare accreditation system. Checks and balances within the inspection and monitoring mechanism will be reinforced to ensure the transparent and effective execution of this role and function.

3.2.2. Preparing and Implementing of Healthcare Accreditation System

The preparation and implementation of the healthcare accreditation system will be driven by the establishment of a "Healthcare Accreditation Commission," which is responsible for developing standards and assessing the quality of national health services. This commission shall be fully independent in performing its functions, both technically and financially. Accredited public and private health facilities under this system that meet the predefined quality standards are eligible for contracting under the social health protection system, which includes the HEF and the Social Security Schemes on Healthcare operated by the NSSF.

3.2.3. Strengthening Regulations of Dual Practice

Review the dual practice regulatory mechanisms to enhance discipline in the public health facilities' provider performance, in accordance with the Law on the Common Statute of Civil Servants and other applicable legal and regulatory instruments, with an aim to prevent conflicts of interest. In addition, the emphasis will also be on enhancing the reinforcement of quality standards and professional scope of practice, adhering to designated working hours at public health facilities, and preventing the attraction of patients from public to private health facilities.

3.2.4. Enhancing the Capacity of Health Service Provision

Assess and evaluate the current state of the overall health system capacity, taking into account both the physical infrastructure and human resources of public health facilities, as well as the role of the private sector in social health protection service provision. Following this study, a framework on **"Private Sector Engagement"** shall be established and implemented. The framework sets out essential guidelines on the interactions, coordination, and partnership mechanisms between the private sector and relevant government institutions at both the national and sub-national levels to improve the quality of health services. Meanwhile, a strong emphasis is also on the development of human resources in the health sector. This entails improving the trainings on both soft and hard skills, as well as ensuring the appropriate quantity and quality of health worker allocation to meet the evolving population healthcare needs.

Continue the development of quality competency-based education; in-service training will be based on training needs assessment under the National Health Quality Enhancement and Monitoring Tool – Phase II (NQEMT-II) and other relevant assessments. Selected human resource management tools will be applied in order to increase health workforce productivity. These tools include an annual individual work plan, performance appraisals, and incentive schemes with specialized training opportunities, particularly for health workers working in remote areas with limited coverage and high disease burdens.

3.2.5. Strengthening and Expanding Essential Health Services, Particularly Primary Healthcare Services

Continue to strengthen and progressively expand essential health services to fulfill the healthcare needs of populations arising from shifting demographics, epidemiologies or disease burdens, and climate change. Continue to improve reproductive, newborn, child, and maternal health, as well as strengthen and gradually expand the treatment and management services of the main non-communicable and communicable diseases, as well as the necessary interventions, especially at primary healthcare and referral hospitals, through an integrated people-centered health service approach. Further necessary improvement is needed in the areas of rehabilitative, pallative, and long-term care. The care of the elderly and people with disabilities will be further developed and integrated into community and home-based care. These require deploying properly trained personnel, supplying adequate medicines and medical supplies, improving infrastructure, and advancing information technology and digital health. Meanwhile, the minimum package of activities (MPA) and complementary package of activities (CPA), together with the list of essential medicines and clinical practice guidelines, will be periodically updated and implemented effectively.

The expansion of essential health services shall be done through the existing "performance-based financing model" for expanding coverage of non-communicable diseases (diabetes, hypertension, cervical cancer, etc.). The expansion of these services will additionally take into account the demographics, geography, equity, gender, decentralization and deconcentration, health economic evaluation, and the availability of the national budget.

3.2.6. Promoting Community Participation in Health and Multisectoral Actions

Community participation will be enhanced by integrating health and social services and utilizing digital technology to boost health education, nutrition programs, community and home-based care, public health risk surveillance, and identifying and referring the target groups of the populations to get timely, appropriate care. Improving the environment, latrines, an access to clean water and sanitation, and waste management in order to mitigate potential risks of infectious diseases. The active participation of local officials, namely at the commune/Sangkat level, together with community volunteers, is necessary. These initiatives will be integrated into the respective investment plans of the commune/Sangkat, and district/city.

Community and user feedback mechanisms pertaining to quality of healthcare and social health protection services will be strengthened to improve service quality on a regular basis. Furthermore, household surveys, such as the Cambodian Socio-Economic Survey (CSES), will incorporate questionnaires pertaining to the quality of health services. This will allow for the collection of data on citizen perceptions on healthcare service quality, which will serve as a foundation for developing evidence-based strategies and interventions aimed at consistently enhancing the quality of service.

Basic health literacy, encompassing aspects such as hygiene and sanitation practices, environmental health, and preventive measures for diseases such as cancer, diabetes, etc., will be incorporated into the appropriate levels of the general educational curriculum spanning from early childhood education to high school levels. This intervention aims to stimulate behavior change in individuals to adopt a healthy lifestyle and enhance their self-care, contributing to the mitigation of the possible hazards associated with major communicable and non-communicable diseases.

In addition, multisectoral actions and approach to "Health in All Policies" will be enhanced and implemented to improve determinants of health, such as environmental health, food safety, animal health, climate change, housing, rural and urban development, transportation, road safety, pedestrians, employment, gender, law, and income security, all of which have an impact on public health.

3.2.7. Strengthening and Expanding Essential Specialized and Emergency Services

Upgrading selected eligible provincial hospitals to regional specialized hospitals, with an aim to increase an access to specialized care services, relieving overcrowding in national hospitals, and improving cost-effectiveness. Strengthening and expanding specialized care and emergency services, including surgery and paraclinical services, in appropriate tiers of the healthcare system, guided by scientific data.

Conducting a feasibility study on investing in and developing Centers of Excellence in selected hospitals at the regional and national levels. These centers would focus on providing advanced specialized care in areas such as cardiology, oncology, ophthalmology, bariatric surgery, neurology, and more. The ultimate goal is to improve the quality of healthcare in the country, build trust among citizens in the local health system, and reduce the need for seeking medical treatment abroad.

3.2.8. Strengthening Referral System and Implementing Gatekeeping Policy

Existing referral systems will be enhanced by implementing a two-way referral mechanism, referral networks, coordinating continuum of care, leveraging digital technologies, and reinforcing the regulations of ambulance services. Simultaneously, the gatekeeping policy, a principle aimed at promoting and reinforcing adherence to referral system regulations, will be established and put into effect via the provider payment mechanisms of the NSSF and HEF. This will initially focus on non-emergency healthcare services at the appropriate levels of the health system, without compromising technology and service quality. Incentivization measures will be developed to encourage appropriate referrals to align with the referral system's procedure. Specific dis-incentivization measures will be established and enforced to discourage inappropriate referrals or self-referrals and to avoid bypassing of the designated levels of health institutions. These measures may include ineligibility for certain parts of the non-medical benefits.

This gatekeeping policy will be formulated based on scientific evidence and successful practices from other countries that have contexts similar to Cambodia. Its purpose is to enable patients to receive needed health services at appropriate levels of care and timely life-saving interventions at the nearest health facilities. Additionally, it aims to enhance the efficiency of resource utilization in the health system.

3.2.9. Strengthening Compliance with International Health Regulations

Develop and implement a comprehensive National Action Plan for Health Security (NAPHS) aimed at combating emerging infectious diseases (such as animal-to-human transmission, food-borne diseases, Ebola and COVID-19, Mpox, and other global pandemics) and other potential public health emergencies, including floods, droughts, and chemical events. An annual review and evaluation will be conducted to assess the progress of implementing NAPHS by incorporating the One Health Approach into the process of assessment, reporting, and preparedness measures by the relevant institutions. Furthermore, the Joint External Evaluation (JEE) will be carried out every five years. These stated measures will provide an opportunity for relevant institutions to reflect on their shortcomings and improve their ability to respond effectively to potential emergencies.

3.2.10. Enhancing Drug Management and Supply system

Enhance the management mechanism, quality assurance, and distribution of essential medicines in the public sector to be more effective, along with establishing guidelines on the management of essential medicines as a guide to alleviate the shortage of essential medicines in public health facilities, particularly at health centers. Monitoring of drug dispensing throughout the health system will be strengthened, including the social health protection system, to ensure a rational use of medicines and the provision of high-quality care. The "Private Sector Engagement" framework will define the involvement of the private sector in the supply chain. In addition, a feasibility study on setting up Revolving Drug Funds will be conducted to address the Central Medical Store (CMS) potential supply gaps of essential medicines, especially those for the major non-communicable diseases. Moreover, an innovative incentive policy will be established to encourage local pharmaceutical enterprises to participate in the supply of quality and affordable medicines and equipment.

3.2.11. Strengthening Pharmaceutical Market Regulations

Establish flexible drug price ceilings consistent with regional and international market prices to avoid excessive pricing markup, which can be detrimental to the general population. Strengthen the governance and implementation of comprehensive national pharmaceutical policies to promote a rational use of medicines in both the public and private sectors, including minimizing antibiotics provided over the counter without a proper prescription, combating counterfeit medicines, and eliminating unqualified drug sellers. In addition, efforts will be focused on monitoring substandard health products and the active pharmacovigilance of drugs and health products on the market.

3.2.12. Strengthening Essential Laboratory Services

Review and update the policy on national laboratory services and the national strategic plan for medical laboratory services with the goal of enhancing laboratory systems and standards of laboratory quality control to ensure patient safety, especially in operational district (OD) referral hospitals, and to support the provision of primary healthcare services.

Consistently train and develop the capacity of laboratory personnel to use new technologies and enhance infrastructure, equipment maintenance, and laboratory information management systems, with the objective of contributing to improving quality health service provision. Simultaneously, the framework for "Private Sector Engagement" will also provide mechanisms for enabling collaboration with the private sector to fill potential gaps in laboratory and diagnostic services.

3.2.13. Developing a Standard Benefit Package for the Social Health Protection System

Develop a standard benefit package as a basis for harmonizing benefit packages of the HEF and the Social Security Schemes on Healthcare operated by the NSSF. Developing the standard benefit package will take into account factors such as epidemiological data or disease burdens, costing, availability and accessibility of health services, financial risk protection measures, equity, cost efficiency, and balancing macroeconomic and financial situations to prioritize an efficient allocation of resources. In the medium to long term, the Health Technology Assessment (HTA) will be used to inform the effectiveness of subsequent updates to the standard benefit package.

3.2.14. Strengthening Tax Policies and Regulations of Health Products

Strengthen the implementation of tax policies and regulations of unhealthy products as a policy tool for stimulating people's behavioral change towards the consumption of products that have a negative impact on health, including alcohol, tobacco, sugary beverages, and other products that affect their health. This necessitates a study of the financial risks associated with consuming these products, and the burden of diseases that will result from current consumption behavior, existing regulations, and other relevant aspects to support the intersectoral dialogue with the relevant ministries and institutions on policy options at a later stage.

3.3 Dimension 3 – Financial Risk Protection and Health Financing

This dimension aims to reduce the population's out-of-pocket health expenditure and foster financial sustainability by increasing resource mobilization and modifying policies to enhance resource management in the health sector in an effective, efficient, equitable, and transparent manner. Improving public financial management (PFM) in the health sector aligns with the national budget reform strategy and the public financial management reform program. Strategic purchasing will be applied to increase cost efficiency and effectiveness, promote the provision of high-quality healthcare services, and reduce unnecessary expenses.

3.3.1. Increasing Budget Allocation for the Health Sector

Improving the quality of performance-informed budget planning, which includes the prioritized activities as outlined in the Action Plan of the Roadmap towards UHC in Cambodia, serves as the basis for budget negotiations and leads to an increase in the national budget allocation to the health sector. Simultaneously, efforts will be made to strengthen the coordination mechanism between the Royal Government, national and international donors, and development partners. This will facilitate the mobilization of financial and technical resources to foster synergy in supporting Cambodia's progress towards UHC. Furthermore, the Royal Government will achieve increased national revenue by implementing tax policies on unhealthy products that negatively impact public health, as well as other potential tax mechanisms that align with Cambodia's socio-economic trends and international best practices, particularly those implemented in countries with contexts similar to Cambodia. These will increase the national revenue and enable the Royal Government to widen fiscal space for the health sector as it progresses towards UHC in Cambodia.

3.3.2. Increasing the Efficiency and Effectiveness of Health Expenditures

In order to ensure the efficiency, effectiveness, transparency, and accountability of healthcare expenditures, the Royal Government will focus on the following measures, including: (1) Improving supply-side financing by transitioning from input-based budgeting to performance-informed budgeting, aligning with the Budget System Reform Strategy. This includes allocating budgets for expanding prioritized healthcare services, as outlined in Dimension 2; (2) Enhance the procurement of medicines and medical equipment,

aligning with international best practices and a regional collaborative approach to procurement; (3) Strengthen both technical and financial audits; (4) Enhance the social accountability mechanism by allowing citizen participation in monitoring health facilities' performance and budget utilization; (5) In the medium to long term, institutionalize health program budgets and reallocate based on population's prioritized health service needs, and equity, as well as enhance the autonomy of service providers in managing resources and ensuring accountability through result-based financing.

Simultaneously, the success of the aforementioned reforms hinges on capacity building, which involves organizing pertinent training programs to enhance the ability of public officials, both at the national and sub-national levels, to handle public financial management, including short- and medium-term budget planning, financial management information systems, procurement, cost control management, financial statements, and performance reporting.

3.3.3. Rebalancing Between Supply-Side and Demand-Side Financing

Cambodia's public health system is heavily reliant on supply-side financing, which entails allocating resources from the Ministry of Health's global budget to public health facilities at all levels. So far, the public health system has made substantial progress as a result of this financing model. Nevertheless, given Cambodia's progress towards UHC, it is imperative to reconsider health financing strategies, particularly in relation to the significance of demand-side financing.

The demand-side financing has significantly improved the quality of services, especially for public health facilities, as demonstrated by the experience of implementing provider payment mechanisms under the HEF and NSSF. Consequently, the consideration of the allocation of resources in the health sector will be meticulously reconsidered in light of rebalancing between the two financing modalities to ensure the efficiency of national budget expenditures, including a review of regulations of user fee revenue allocation for health facility's operating costs and staff incentives. In this regard, the annual budget for the health sector shall prioritize the expansion of the social health protection system to cover people in the informal economy with funds from premium contributions and state subsidies, derived from general tax revenues.

3.3.4. Optimizing Efficiency and Effectiveness of Demand-Side Financing

To achieve UHC, it is crucial to prioritize the adoption of strategic purchasing within the social health protection system. This will lead to enhanced service quality and cost-effectiveness by focusing on the following key activities:

- **Conducting a feasibility study on integrating the Social Security Schemes on Healthcare operated by the NSSF:** In addition to defining a standard benefit package for the entire social health protection system, as outlined in Dimension 2, the first priority will start with pooling funds amongst the Social Security Schemes on Healthcare operated by the NSSF, which include public sector employees, retired civil servants, and veterans, as well as formal sector employees. The next priority will be to pool additional funds of other target groups of the population who will enroll in the Social Security Schemes on Healthcare, through either mandatory or automatic coverage. The main goal is to increase the capacity to redistribute the funds, reduce fragmentation, stimulate cross-subsidization, and leverage the purchasing power of social security operators to increase the efficiency, effectiveness, and equity of the provision of quality health services, which consequently contributes to accelerating UHC.
- **Harmonizing provider payment mechanisms and benefit packages:** Varying provider payment rates between the HEF and NSSF could potentially lead to discrimination in health service provision, which is one of the main causes of the population's reluctance to seek health services under the HEF. This, in turn, can lead to financial burdens on poor and vulnerable families. There are several other factors that hinder the provision of high-quality services at health facilities. These include substantial gaps in payment rates between health centers and referral hospitals for similar services, lower payment rates for non-communicable diseases such as diabetes and hypertension that do not fully reflect the costs, the absence of differentiation in payment rates between treatment cases with and without drug provision, and payment mechanisms and rates that appear to neglect the needs of patients in need of integrated care and treatments for multiple illnesses, particularly the elderly and people living with disabilities. In this respect, the National Social Protection Council will collaborate with the Ministry of Economy and Finance, the Ministry of Health, and the NSSF to look into the possibility of addressing the above-mentioned issues as well as gradually adjusting provider payment rates for the two schemes. In the short to medium term, case-based payment rates will be subject to quality assessment results under the National Health Quality Enhancement and Monitoring Tool, with the possibility of expanding this scope to the national hospital level. In the medium to long term, the National Social Protection Council will initiate the implementation of mixed-provider payment mechanisms. These mechanisms – which could take the mixed forms of a capitation payment mechanism for outpatient services, diagnostic-related groups for inpatient services, and more – shall be complementary in order to stimulate quality, cost-effectiveness, and a higher level of financial risk protection. The effective implementation of the aforementioned activities relies on the development of information and communication technology systems, which encompass functions like interoperability, harmonization with the International Classification of Diseases, automated quality assessment, and fraud detection. Meanwhile, the National Payment Certification Agency will take lead in setting up the Health Technology Assessment system to periodically determine and update the standard benefit package and payment rates.

- **Agreement with private health service providers within the social health protection system:** The Social Security Regulator (SSR) shall regulate and oversee the implementation of the agreement regarding the provision and utilization of private health services in the social health protection system. Additionally, the SSR will periodically assess the criteria for entering into this agreement based on the defined quality standards accredited by the upcoming healthcare accreditation system. Moreover, demographic and geographical factors are crucial in mapping, selecting, and entering into agreements with private health facilities to guarantee that the health service provided meets the actual needs of the population with assured quality.

3.3.5. Introducing Regulations of the Price Ceiling of User Fees

User fee tariffs, excluding those for the NSSF and HEF, are complex and varied in both public and private health facilities. Health service fees should reflect actual costs, taking into account the state of the health system, health outcomes, and people's livelihoods. To avoid excessive charges, the Ministry of Health will establish the standard fees for both public and private health facilities as the basis to regulate price ceiling of user fees. Every health facility, either public or private, shall publicly display the user fee tariffs for patients.

3.3.6. Public Awareness Raising

The efforts will focus on raising awareness of the entitlements to the social health protection system, an access to healthcare services, and health education on the risk of over-the-counter antibiotic misuse, etc. These activities will contribute to increasing utilization of health services and have the potential to reduce out-of-pocket health expenditures. Additionally, appropriate mechanisms will be defined and implemented to deter patients from informal borrowing at high interest rates for medical treatment purposes. The National Social Protection Council will work closely with the Ministry of Health, the NSSF, and relevant institutions to launch nationwide awareness campaigns. At the same time, the sub-national mechanisms for the above-mentioned aspects will be further strengthened through the following activities:

- Regular meetings of Village Health Support Groups, Commune / Sangkat's Committee for Women and Children, Health Center Management Committee.
- HEF monitors conduct monthly household spot-checks with randomly selected patients using a sampling method. The NSSF's agents visit patients in hospital wards. The findings of the above activities will be reported to their respective leaderships for appropriate actions, as well as to the Provincial and District Health Financing Committees chaired by the respective deputy governors in charge of health to discuss during quarterly meetings to take corrective actions in a timely manner. Minutes of this committee meeting will be prepared within five working days after the meeting and distributed to members and other relevant stakeholders.

3.4. Enabling Factors

Alongside the strategies identified in the above three fundamental dimensions, the roadmap also identifies a handful of catalytic factors which address multisectoral and multidimensional considerations to propel the progress towards UHC successfully as planned.

3.4.1. Governance Mechanism

Complexities and interconnectivities in social protection are the major reason behind the Royal Government of Cambodia's decision to establish the National Social Protection Council in 2017 to function as a policy coordinator in social protection. Likewise, the path towards UHC is a sub-system of social protection which is intertwined and multidimensional, and requires a central coordinating mechanism to ensure a successful implementation. In this regard, the National Social Protection Council shall establish the **Sub-Committee on Universal Health Coverage in Cambodia** under its Executive Committee in order to steer and coordinate an implementation of the roadmap as well as monitor, and evaluate progress of all policy directions, strategies, and interventions which are outlined in the roadmap. This sub-committee comprises representatives from Ministry of Health, Ministry of Labor and Vocational Training, Ministry of Economy and Finance, Ministry of Planning, National Social Security Fund, National Payment Certification Agency, and other ministries and institutions as well as representatives of health service providers and beneficiaries.

Functions and responsibilities of each ministry and institution, which will be the leading and supporting institutions in implementing the roadmap, are clearly identified in the action plan in Annex II. The action plan details specific leading and supporting institutions, and a clear time frame. The Sub-Committee shall report to the National Social Protection Council and the Royal Government of Cambodia regularly on progress of the implementation of the roadmap.

3.4.2. Capacity Building

To ensure that the progress towards UHC is effective and successful, capacity building for relevant institutions - ranging from policymaking to coordinating institutions, and to implementing institutions at both sub-national and national levels - is imperative. The sub-committee shall coordinate the development of capacity building plan for relevant institutions and stakeholders to guarantee that policy directions and interventions set forth in the roadmap are effectively and efficiently carried out.

3.4.3. Communication Strategy

Communication and awareness raising play a pivotal role in changing citizens' behavior on health promotion and contribution to the social health protection system. Wide understandings amongst the Cambodians about the social health protection system, health prevention, health promotion, consumption of medicines, among other things, is a precursor to their active support and engagement in the journey towards UHC.

Similarly, an inter-ministerial and cross-institutional communication, especially between and amongst implementing and supporting institutions identified in the action plan of the roadmap in Annex II, is indispensable so that the progress towards UHC is effective. In this respect, the sub-committee shall be a permanent inter-ministerial mechanism to collaborate, coordinate, monitor and evaluate progresses of the implementation of the roadmap, especially with regards to possible modifications or fine-tuning of policy directions in the roadmap to promptly adapt to changing circumstances and evolving situations.

Communication Strategy for UHC shall be predicated on the implementation and continued development of existing mechanisms in the health sector and social health protection. Since the journey towards UHC is multi-dimensional, the National Social Protection Broadcasting Mechanism (NSPBM) shall be the official mechanism to steer the coordination between ministries, institutions and stakeholders in pertaining to communications and awareness raising among the public on UHC in Cambodia. As such, the sub-committee shall review the possibility of revisiting existing strategic interventions in the NSPBM to reflect the particular characteristics, and nuances of UHC, which might include:

A. Expanding the composition of representatives of stakeholders concerning communication on UHC to, but not limited to, employees, social health protection beneficiaries, development partners, professional medical councils, community networks, health service providers from both sectors, universities, etc.

B. Strengthening skills and competence of technical officials and staffs working on communication related to the subject of UHC at relevant ministries and institutions.

C. Communicating about education content, key content, experiences, as well as progress of the implementation of the roadmap to relevant stakeholders.

D. Strengthening and expanding cooperation between UHC communication teams, and media and social media teams and agencies in the region and the globe.

E. Developing information, education and communication (IEC) materials on UHC

F. Promoting the engagement of the private sector in building capacity and skills related to communication and broadcasting to relevant stakeholders, and in supporting the implementation of Communication Mechanism for UHC in Cambodia at large

3.4.4. Legal Framework for UHC

Progress towards UHC demands a legal framework to render predictability, legitimacy, and an overriding standard to underpin the implementation of key policy directions in the roadmap. Hence, a comprehensive assessment on legal framework development for UHC in Cambodia will be conducted to generate evidence to support subsequent considerations on amending existing or enacting new legal instruments if needed. The assessment aims to analyze three major areas, namely (1) the role of existing legal instruments relevant with UHC, (2) the need to amend particular existing legal instruments, and (3) the need to enact new legal instruments to buttress the implementation of the strategic policy directions identified in the roadmap.

3.4.5. Digitalization for UHC

Digitalization is an impetus to enhancing efficiency in the implementation of key priority policy directions defined in the roadmap wherein key priorities are:

A. Promoting the use of digital solutions to promote identification, registration, and data management of key target groups of the population under the social health protection as well as reviewing the possibility of fostering interoperability with data systems of private health insurance companies

B. Implementing gradually Information Technology and Digital Health to increase efficiency and effectiveness of health service delivery especially at primary care level and referral hospitals.

C. Developing an automated claim certification function through strengthening Patient Management Registration System (PMRS) and Electronic Medical Record (EMR)

D. Engaging the private sector in support of digitalization for the health sector and social health protection system under the Private Sector Engagement Framework

E. Modernizing and functionalizing an interoperability of Information, Communication and Technologies (ICT) and Digital Health to support the implementation of strategic purchasing and claim management under the social health protection system

3.4.6. Monitoring and Evaluation of the Implementation of the Roadmap

To ensure that all strategic policy directions identified in the roadmap are implemented progressively, a monitoring and evaluation of the roadmap implementation is necessary to precisely and accurately attest the following three areas:

A. Implementation of relevant social assistance programs, social security schemes, and key interventions defined in the roadmap

B. UHC progress based on key indicators identified below, and

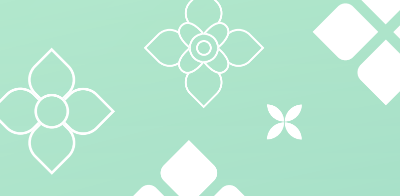
C. Progress of implementing the roadmap based on what are stipulated in the roadmap's action plan

As for the UHC progress, ongoing implementation of the roadmap will enable Cambodia to achieve certain progress in its UHC goals. To measure and evaluate such UHC progress in Cambodia, the sub-committee shall monitor and evaluate essential health service coverage index (Annex I), which could be subject to further improvement, and key indicators on health financing related to UHC such as:

- Current health expenditure compared to Gross Domestic Product (GDP)
- Percentage of government expenditure on health compared to the total government expenditures
- Percentage of population covered under the social health protection system
- Essential Health Service Coverage Index
- Percentage of the out-of-pocket health expenditure compared to the total health expenditure
- Proportion of impoverishing out-of-pocket health expenditure
- Proportion of catastrophic out-of-pocket health expenditure, among others.

To measure progress of the roadmap implementation, the roadmap puts in place an **"Action Plan of the Roadmap Implementation"** which spell outs policy directions and strategies in priority order, and a specific timeframe with succinctly identified responsible leading and implementing institutions (Annex 2). The sub-committee shall coordinate and report to the National Social Protection Council and the Royal Government of Cambodia regularly on the implementation progress of the roadmap's action plan.

CONCLUSION



Thanks to resolute commitment by the Royal Government for all the previous Legislatures of the National Assembly, especially the Royal Government for the 7th Legislature of the National Assembly under the precise and bold leadership of **Samdach Moha Borvor Thipadei HUN MANET** Prime Minister of the Kingdom of Cambodia, the Roadmap towards UHC in Cambodia is established as a guide for steering implementation and strategic investment in the journey towards UHC in Cambodia. Based on existing foundations and progresses in the health sector and social protection system as well as thorough envisioning of opportunities and challenges, the roadmap sets forth priority policy directions aimed at deeply strengthening and expanding health service delivery capacity in both the public and private sectors, increasing effectiveness and inclusiveness in the social health protection coverage, and enhancing multi-sectoral actions to promote social determinants of health gradually in order to correspond to changing population healthcare need and to reduce the incidence of financial risk, which consequently contribute to achieving the key objectives defined in the roadmap.

The development of the roadmap takes into account potential risk factors, both internal and external, which encompass conflict of interests, entrenched institutional complacency, changing economic and political situations namely economic crisis, pandemic, climate change, thorny geopolitical confrontations, among others, which adversely affect the socio-economic conditions of Cambodia at large, putting a strain on its progress towards UHC in Cambodia in particular. This warrants a regular analysis and evaluation of relevant risk factors and challenges through the governance mechanism called the Sub-Committee on UHC in Cambodia, through which decisions on finetuning relevant strategies early could be made to maximally mitigate negative repercussions and continue to accelerate the progress towards UHC as planned.

ANNEX I

Essential Health Service Coverage Indicators

Tracer area	Tracer indicator
Reproductive, maternal, newborn and child health	
1. Family planning	Demand satisfied with modern method among women 15–49 years who are married or in a union (%)
2. Pregnancy and delivery care	Antenatal care, four or more visits (ANC4) (%)
3. Child immunization	One-year-old children who have received 3 doses of diphtheria-tetanus- pertussis, hepatitis, and haemophilus influenza type b vaccines (DTP-HepB-Hib3), (%)
4. Child treatment	Care-seeking behavior for children with suspected pneumonia (%)
Infectious diseases	
5. Tuberculosis treatment (TB)	TB effective treatment coverage (%)
6. HIV treatment	People living with HIV receiving ART (%)
7. Hepatitis C detection and treatment	Proportion of diagnosed cases of Hepatitis C received treatment (%)
8. Neglected tropical disease (NTD) intervention	People living in areas where preventive chemotherapy is provided at least one NTD (%)
9. Water and sanitation	Households with access to at least basic sanitation (%)

Tracer area	Tracer indicator
Non-communicable diseases	
10. Prevention of cardiovascular disease	Prevalence of normal blood pressure, regardless of treatment status (%)
11. Management of diabetes	Mean fasting plasma glucose (FPG), (mmol/L)
12. Cancer detection and Treatment	Cervical and breast cancers screening among women aged 30–49 years (%)
13. Tobacco control	Adults aged ≥15 years not smoking tobacco in last 30 days (%)
Service capacity and access	
14. Health worker density	Health professionals per capita (w/threshold): physicians, psychiatrists and surgeons
15. Access to essential medicines	Proportion of health facilities with WHO-recommended core list of essential medicines available
16. Health Security	International core capacity index
Health Safety and Quality	
17. Patient satisfaction with health services	Patient satisfaction index (measuring patient's perceptions and experiences of healthcare services received)
18. Infection prevention and control in healthcare facilities.	Proportion of health facilities adhering to Infection Control Protocols and availability of personal protective equipment for health workers
19. Facility-level quality score	Average quality score of the combined key indicators of quality healthcare services achieved

ANNEX II

Action Plan of the Roadmap towards UHC in Cambodia

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
Dimension I: Population Coverage under the Social Health Protection System		45%	50%	55%	70%	80%	
1.1 Enhancing Effectiveness of Population Coverage under Health Equity Fund							
1.1.1.	Strengthen effective coverage of the HEF for poor households, At-Risk households, and other target groups of the population defined in existing applicable legal instruments	✓	✓	✓	✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** Ministry of Health (MoH), Ministry of Plaining (MoP), NPCA, Sub-national Administration
1.1.2	Strengthen ODID Mechanism through (1) continually updating data and identification tools, (2) strengthening the capacity of implementors especially commune/ district administration and relevant stakeholders, (3) organizing awareness raising campaigns for the public on the ODID process as well as eligible criteria, entitlements, and benefits of the Equity Card, and (4) establishing a mechanism for community feedback, and enhancing public awareness of the use of Public IDPoor App, especially amongst community workers and relevant health service ODID interview	✓	✓	✓	✓	✓	**Leading Institution:** MOP **Supporting Institutions**: NSPC, MoH, NPCA, and Sub-national Administration

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
1.1.2	providers on the function of collecting feedback and complaints, and submitting applications for						
1.2 Enhancing Effective Coverage of the Social Security Schemes on Healthcare operated by National Social Security Fund							
1.2.1	Strengthen effective coverage of the Social Security Schemes on Healthcare operated by the NSSF for civil servants, retired civil servants, veterans, private employees, the self-employed, and dependents of the NSSF members	✓	✓	✓	✓	✓	**Leading Institution:** NSSF of MoLVT **Supporting Institutions:** NSPC, MoH, Ministry of Interior, Ministry of Civil Service, Ministry of Industry, Science, Technology and Innovation (MISTI), Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSAVY), NPCA, and Sub-national Administration
1.3 Review and Evaluate the Existing Population Coverage under the Social Health Protection System							
1.3.1	Review and evaluate effectiveness of population coverage under the social health protection system especially the Voluntary Social Security Scheme on Healthcare		✓				**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, NPCA
1.3.2	Review the feasibility of transforming the Voluntary Social Security Scheme on Healthcare into a mandatory scheme		✓				**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoH, NPCA
1.3.3	Implement transformation plan of the Voluntary Social Security Scheme on Healthcare into a mandatory scheme gradually to prevent potential risks and to focus on building capacity of relevant stakeholders to support the transformation			✓	✓		Leading Institution: NSPC Supporting Institutions: NSSF of MoLVT

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
1.4 Expanding the Social Health Protection Coverage to Remaining Target Groups of the Population							
1.4.1	Expand the social health protection coverage to priority population groups namely students/ university students, Technical and Vocational Education and Training (TVET) trainees, farmers, workers in the informal sector, migrants, and people aged over 60, etc.		✓	✓	✓		**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, NPCA, Ministry of Economy and Finance (MEF), MoLVT, MoH, and MoP
1.4.2	Define a financing mechanism for expanding the social health protection coverage for the earlier identified priority population groups based on two scenarios of evolving socio-economic developments: (1) tax-based financing and (2) financing model based on a mixture of contribution from members and state subsidies			✓	✓		**Leading Institution:** NSPC **Supporting Institutions:** MEF, MoLVT, MoH, NSSF of MoLVT
1.4.3	Establish a mechanism to identify, register, and coordinate the social health protection coverage expansion to include the earlier identified priority population groups		✓	✓			**Leading Institution:** NSSF of MoLVT **Supporting Institutions:** NSPC, NPCA
1.4.4	Expand the social health protection coverage to the remaining uncovered population groups following the coverage waves of earlier identified priority population groups through mandatory schemes or automatic coverage mechanism based on evolving socio-economic conditions				✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, NPCA, MEF, MoLVT, MoH, MoP

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
1.5 Managing Membership Transition Between the Health Equity Fund and the Social Security Schemes on Healthcare							
1.5.1	Set up a mechanism to ensure membership transition of the entire social health protection schemes, that is, between the HEF and the Social Security Schemes on Healthcare operated by the NSSF to address changing membership status of both schemes	✓	✓				**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, NPCA
Dimension 2: Essential Health Service Coverage (Essential Health Service Coverage Index)		60%	64%	68%	75%	80%	
2.1. Reinforcing Regulation of Private Health Sector at All Levels							
2.1.1	Implement minimum standards of care for private health facilities	✓	✓	✓			**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.1.2	Attach the conditions to license and re-license private health facilities with a conformity with the minimum standards of care for private health facilities and continuing professional development (as for private health professionals)		✓	✓	✓	✓	
2.1.3	Conduct regular inspection and monitoring mechanism and implement of mini-mum standards of care and continuing professional development		✓	✓	✓	✓	
2.1.4	Update the minimum standards of car by integrating standards from Clinical Practice Guidelines and improve a conformity in order to foster consistency with accreditation system				✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.2. Preparation and Implementation of Healthcare Accreditation System							
2.2.1	Establish a "Healthcare Accreditation Commission" which is independent both in technical and financial aspects	✓	✓	✓			**Leading Institution:** MoH **Supporting Institutions:** NSPC, NSSF of MoLVT, NPCA
2.2.2	Define healthcare accreditation standards and evaluate private health facilities based on the standards		✓	✓			
2.2.3	Implement healthcare accreditation for both public and private health facilities under the social health protection system		✓	✓	✓	✓	
2.2.4	Update healthcare accreditation standards in accordance with regional and international standards				✓	✓	
2.3 Strengthening Regulations of Dual Practice							
2.3.1	Tighten adherence to the working hour and manage the cases of referring patients to private health providers in accordance with article 35 of the Law on Common Status of Civil Servants of the Kingdom of Cambodia, and other relevant applicable legal instruments	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.3.2	Implement applicable quality standards		✓	✓	✓	✓	
2.3.3	Strengthen the implementation of professional scope of practice			✓	✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.4 Enhancing the Capacity of Health Service Provision							
2.4.1	Evaluate the capacity of the overall health system which include physical infrastructure, and human resources of public health facilities, etc.	✓	✓				**Leading Institution:** MoH **Supporting Institutions:** NSPC
2.4.2	Establish and implement a "Private Sector Engagement" framework which defines essential guidelines on the interactions, coordination, and partnership mechanisms between the private sector and appropriate institutions at both the national and sub-national levels	✓	✓				**Leading Institution:** NSPC **Supporting Institutions:** MoH, NSSF of MoLVT, NPCA
2.4.3	Develop a plan on managing and developing health workforce and continually promoting the quality of competency-based education	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Ministry of Education, Youth and Sport, Sub-national Administration
2.4.4.	Arrange continued professional trainings, and refreshing trainings in terms of both hard and soft skills based on training need evaluation and National Quality Enhancement and Monitoring Tool (NQEMT) evaluation results	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-national Administration
2.4.5.	Strengthen the implementation of human resource management tools such as annual individual work plan, performance appraisal, and incentive schemes with specialized training opportunities, particularly for health workers working in remote areas with limited coverage and high disease burdens	✓	✓	✓	✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.5 Strengthening and Expanding Essential Health Services Especially at Primary Healthcare Level through Integrated People-Centered Health Services Based on Periodic Population Healthcare Need Assessment							
2.5.1	Continually improve reproductive, newborn, child and maternal health	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSSF of MoLVT, NPCA, NSPC, Sub-national Administration
2.5.2	Strengthen and gradually expand the treatment and management services of the main non-communicable and communicable diseases as well as the necessary interventions, especially at primary healthcare and referral hospitals	✓	✓	✓	✓	✓	
2.5.3.	Continually improve rehabilitative and palliative services at appropriate levels of care as well as consider the possibility of integrating elderly care and care for People living with Disabilities into community and home-based care	✓	✓	✓	✓	✓	
2.5.4	Develop a national policy on long-term care			✓	✓	✓	
2.5.5	Review the possibility of arranging plan on deploying properly trained personnel, supplying adequate medicines and medical supplies, improving infrastructure, and advancing information, technology, and digital health to strengthen the delivery of the earlier-mentioned healthcare services	✓	✓	✓	✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.5.6	Update the Minimum Package of Activities and Complementary Package of Activities, Essential Medicine List, and Clinical Practice Guidelines as well as strengthen their implementation	✓	✓			✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.5.7	Develop and Introduce performance-based financing for expanding essential health services with due considerations of demographics, geography, equity, gender, inclusion, de-concentration and de-centralization, Health Economic Evaluation, and the availability of the national budget	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, MEF, Sub-National Administration, NPCA
2.6 Promoting Community Participation in Health and Multisectoral Actions							
2.6.1	Enhance community participation in support of integrated health and social services such as health education, and utilizing digital technology to boost health education, nutrition programs, community and home-based care, public health risk surveillance, and identifying and referring the target groups of the population to get timely and appropriate care	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration, NSPC, NSSF of MoLVT, NPCA

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.6.2	Promote an access to clean water, sanitation and hygiene (WASH), and waste management to mitigate the risks of infections through an active participation from local officials namely at the commune/Sangkat level, together with community volunteers, together with integration into the respective investment plans of the commune/Sangkat and district/city	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Ministry of Rural Development, Sub-National Administration
2.6.3	Strengthen community and user feedback mechanisms pertaining to quality of healthcare and social health protection services, and incorporate questionnaires on the quality of health services into the Cambodian Socio-Economic Survey	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MoP, NSPC, NSSF of MoLVT, NPCA, Sub-National Administration
2.6.4	Integrate basic health literacy covering the subjects of hygiene, sanitation, clean water, environmental health, and preventive measures for key non-communicable and communicable diseases Into the general educational curriculum starting from primary to secondary education level	✓	✓			✓	**Leading Institution:** MoH **Supporting Institutions:** Ministry of Education, Youth and Sport, Sub-National Administration, NSPC

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.6.5	Enhance multisectoral actions and an approach to "Health in All Policies" aimed at improving determinants of health, namely environmental health, food safety, animal health, climate change, housing, rural and urban development, transportation, road safety, pedestrians, employment, gender, law, and income security, etc.	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC
2.7 Strengthening and Expanding Essential Specialized and Emergency Services							
2.7.1	Strengthen specialized care and emergency services, including surgery and paraclinical services, especially at district referral hospitals	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.7.2	Expand essential specialized care and emergency services at in appropriate tiers of the healthcare system, guided by specific data	✓	✓	✓	✓	✓	
2.7.3	Upgrade selected eligible provincial hospitals into regional specialized hospitals with an aim to increase an access to specialized care services		✓	✓	✓		
2.7.4	Conduct a feasibility study on investing in and developing Centers of Excellence in selected hospitals at the regional and national levels.				✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.8. Strengthening Referral System and Implementing Gatekeeping Policy							
2.8.1	Enhance existing referral system through implementing a two-way referral mechanism, referral networks, coordinating continuum of care, levera-ging digital technologies and reinforcing the regula-tions of ambulatory services, etc.	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, NSSF of MoLVT, NPCA, Sub-National Administration
2.8.2	Establish gatekeeping policy based on existing progresses in reforming the health sector especially at primary care level through introducing incentivization and dis-incentivization measures to strengthen a conformity with the policy	✓	✓	✓	✓	✓	
2.8.3	Introduce a mechanism to implement gatekeeping policy gradually in the social health protection system starting with a gatekeeping between provincial health facilities and national hospitals		✓	✓	✓	✓	
2.9 Strengthening Compliance with International Health Regulations							
2.9.1	Develop and implement a comprehensive National Action Plan for Health Security which incorporate One Health Approach, and evaluate the progress of the action plan implementation annually	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC
2.9.2	Cooperate with External Evaluators to conduct the Joint External Evaluation every 5 years in order to strengthen core capacity to respond to potential public health emergencies and incidences effectively		✓		✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.10 Enhancing Drug Management and Supply System							
2.10.1	Enhance the management mechanism, quality assurance, and distribution of essential medicines in the public sector to be more effective	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.10.2	Establish guidelines on the management of essential medicines as a guide to alleviate the shortage of essential medicines in public health facilities, particularly at health centers		✓		✓	✓	
2.10.3	Strengthen monitoring of drug dispensing through the health system as well as the social health protection system to ensure a rational use of medicines	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSSF of MoLVT, NPCA
2.10.4	Define the involvement of the private sector in the medicine supply chain within the "Private Sector Engagement" framework, and conduct a feasibility study on setting up Revolving Drug Funds to address the Central Medical Store (CMS) potential supply gaps of essential medicines, especially those for non-communicable diseases	✓	✓			✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, NSSF of MoLVT, NPCA, Sub-National Administration
2.10.5	Establish an Innovation Incentive Policy to encourage local pharmaceutical enterprises to participate in the supply of quality and affordable medicines and equipment				✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MEF

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.11. Strengthening Pharmaceutical Market Regulations							
2.11.1	Establish flexible drug price ceilings consistent with regional and international market prices			✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Ministry of Commerce, NSPC, NSSF of MoLVT, NPCA
2.11.2	Strengthen governance and implementation of comprehensive national pharmaceutical policies to promote a rational use of medicines in both the public and private sectors, including minimizing antibiotics provided over the counter without a proper prescription, combating counterfeit medicines, and eliminating unqualified drug sellers	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration, NSSF of MoLVT, NPCA
2.11.3	Strengthen a monitoring of substandard health products and the active pharmacovigilance of drugs and health products on the market	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.12. Strengthening Essential Laboratory Services							
2.12.1	Review and update the policy on national laboratory services and the national strategic plan for medical laboratory services		✓		✓		**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.12.2	Enhance laboratory system and standards of laboratory quality control to ensure patient safety, especially at operational district referral hospitals and to support the provision of primary healthcare services	✓	✓	✓	✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.12.3	Train and develop the capacity of laboratory personnel to use new technologies and enhance infrastructure, equipment maintenance, and laboratory information management system	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
2.12.4	Define a mechanism to enable the private sector to fill potential gaps in laboratory and diagnostic services under the "Private Sector Engagement" framework	✓	✓		✓		
2.13. Developing a Standard Benefit Package for the Social Health Protection System							
2.13.1	Develop a standard benefit package for the social health protection system, taking into account factors such as epidemiological data or disease burdens, costing, availability and accessibility of health services, financial risk protection measures, equity, cost efficiency, balancing macroeconomic and financial situations, and availability of the state budget	✓	✓		✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, NPCA, MoH
2.13.2	Utilize Health Technology Assessment (HTA) to inform the effectiveness of subsequent updates of the standard benefit package				✓	✓	**Leading Institution:** NPCA **Supporting Institutions:** NSSF of MoLVT, NSPC, MoH

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
2.14. Strengthening Tax Policies and Regulations of Health Products							
2.14.1	Strengthen the implementation of tax policies and regulations of unhealthy products as a policy tool for stimulating people's behavioral change towards the consumption of products that have a negative impact on health, including alcohol, tobacco, sugary beverages, and other products that affect their health	✓	✓	✓	✓		**Leading Institution:** NSPC **Supporting Institutions:** MEF, MoH
Dimension 3: Financial Risk Protection and Health Financing (Declining out of pocket health expenditure)		60%	57%	53%	43%	35%	
3.1. Increasing Budget Allocation for the Health Sector							
3.1.1.	Improve the quality of performance-informed budget planning, which include the prioritized activities as outlined in the Action Plan of the Roadmap towards UHC in Cambodia	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MEF
3.1.2.	Strengthen coordination mechanism between the Royal Government, national and international donors, and development partners to mobilize both financial and technical resources to foster synergy in supporting support Cambodia's progress towards UHC	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, MEF

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.1.3	Increase national revenue by implementing tax policies on unhealthy products that negatively impact public health, as well as other potential tax mechanisms that aligns with Cambodia's socio-economic trends and international best practices to increase fiscal space for the health sector to support the journey towards UHC			✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, MEF
3.2. Increasing Effectiveness and Efficiency of Health Expenditures							
3.2.1	Improve supply-side financing by transitioning from input-based budgeting to performance-informed budgeting which includes allocating budgets for expanding prioritized healthcare services, as outlined in Dimension 2		✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MEF
3.2.2.	Enhance the procurement of medicines and medical equipment, in accordance with international best practices and a regional collaborative approach to procurement	✓	✓	✓	✓	✓	
3.2.3.	Strengthen both technical and financial audits	✓	✓	✓	✓	✓	
3.2.4.	Enhance the social accountability mechanism by allowing citizen participation in monitoring health facilities' performance and budget allocation	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.2.5	Institutionalize health program budgets and reallocate based on the population's prioritized health service need and equity as well as enhance the autonomy of service providers in managing resources and ensure accountability through result-based financing	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions**: MEF, Sub-National Administration, NSPC
3.2.6	Build the capacity of public officials at both national and sub-national levels to handle public financial management, including short- and medium-term budget planning, financial planning, financial management information systems, procurement, cost control management, financial statements, and performance reporting	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MEF, Sub-National Administration,
3.3. Rebalancing Between Supply- and Demand-Side Financing							
3.3.1.	Rebalance between supply-side and demand-side financing to ensure the efficiency of national budget expenditure, which includes a review of regulations of user fee revenue allocation for health facility's operating costs and staff incentives	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** MEF, NSPC
3.3.2	Prioritize increasing demand-side financing which includes expanding population coverage under the social health protection schemes to cover workers in the informal sector through funds from premium contribution and state subsidies	✓	✓	✓	✓	✓	

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.4. Optimizing Efficiency and Effectiveness of Demand-Side Financing							
3.4.1	Pool funds under the Social Security Schemes on Healthcare operated by the NSSF			✓	✓	✓	**Leading Institution:** NSSF of MoLVT **Supporting Institutions:** NSPC, NPCA
3.4.2	Pool funds of other target groups of the population who will enroll in the Voluntary Social Security Scheme on Healthcare operated by the NSSF or through either compulsory or automatic coverage				✓	✓	
3.4.3	Review and adjust the reimbursement rates of the Social Security Schemes on Healthcare operated by the NSSF and the HEF which include, but not limited to, substantial gaps in payment rates between health centers and referral hospitals for similar services, lower payment rates for non-communicable diseases such as diabetes and hypertension that do not fully reflect the costs, the absence of differentiation in payment rates between treatment cases with and without drug provision, and payment mechanisms and rates that appear to neglect the needs of patients requiring integrated care and treatment for multiple illnesses	✓	✓		✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NPCA, NSSF of MoLVT, MoH, MEF

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.4.4	Subject case-based payment rates to quality assessment results under the National Health Quality Enhancement and Monitoring Tools, with the possibility of expanding this scope to the national hospital level		✓	✓	✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLTV, MoH, NPCA
3.4.5	Build the capacity of health service providers and improve patient information management system aimed at implementing mixed provider payment mechanisms where some appropriate health facilities will be selected for a feasibility study		✓	✓	✓		
3.4.6	Implement mixed provider payment mechanisms				✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLTV, NPCA, MoH
3.4.7	Improve information, communication, and technology which encompass functions like interoperability, harmonization with the International Classification of Diseases, automated quality assessment, and fraud detection			✓	✓	✓	**Leading Institution:** NPCA **Supporting Institutions:** MoH, NSSF of MoLTV, NSPC
3.4.8	Set up the Health Technology Assessment system periodically determine and update the standard benefit package and payment rates				✓	✓	**Leading Institution:** NPCA **Supporting Institutions:** MoH, NSSF of MoLTV, NSPC

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.4.9	Regulate and oversee the implementation of the agreement regarding the provision and utilization of private health facilities in the social health protection system. Regularly evaluate and revisit contracting criteria including an accreditation score, demographic, and geographical factors, etc.	✓	✓	✓	✓	✓	**Leading Institution:** Social Security Regulator **Supporting Institutions:** NSPC, NPCA, NSSF of MoLVT, MoH, Sub-National Administration
3.5. Introducing Regulations of the Price Ceiling of User Fees							
3.5.1	Establish the standard fees for both public and private health facilities as the basis to regulate price ceiling of user fees				✓		**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
3.5.2	Instruct every health facility, both public and private, to public display their user fee tariffs for patients for the sake of transparency	✓	✓	✓	✓	✓	
3.6. Public Awareness Raising							
3.6.1.	Promote an awareness raising among citizens on entitlements and benefits under the social health protection schemes, an access to healthcare services at all level of cares, and health education on the risk of over-the-counter antibiotics misuse.	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration
3.6.2	Define an appropriate mechanism to deter patients from informal borrowing at high interest rates for medical treatment purposes			✓	✓	✓	**Leading Institution:** Sub-National Administration, MEF **Supporting Institutions:** MEF, NPCA, NSPC, MoH

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
3.6.3	Strengthen the capacity of Village Health Support Groups, Commune / Sangkat's Committee for Women and Children, Health Center Management Committee, the Provincial and District Health Financing Committees, the HEF monitors, and the NSSF agents to implement the above-mentioned tasks efficiently	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** Sub-National Administration; NPCA; NSPC
Dimension 4: Enabling Factors							
4.1. Governance Mechanism							
4.1.1.	Establish a Sub-Committee on UHC in Cambodia under the Executive Committee of the NSPC to steer and coordinate the implementation of all policy directions, strategies and interventions set out in the roadmap	✓					**Leading Institution:** NSPC **Supporting Institutions:** Relevant ministries/ institutions
4.2. Capacity Building for Relevant Institutions and Stakeholders Defined in the Roadmap							
4.2.1	Build the capacity of relevant institutions and stakeholders to ensure that all policy directs, strategies and interventions identified in the roadmap are implemented effectively and efficiently	✓	✓		✓		**Leading Institution:** NSPC **Supporting Institutions:** Relevant ministries/ institutions

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
4.3. Communication Strategy for UHC							
4.3.1	Employ the existing National Social Protection Broadcasting Mechanism to steer coordination between ministries/institutions and stakeholders in pertaining to an awareness raising and communication on UHC	✓	✓	✓	✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** Relevant ministries/ institutions
4.4. Legal Framework for UHC							
4.4.1	Establish a legal framework to support the journey towards UHC in Cambodia			✓			**Leading Institution:** NSPC **Supporting Institutions:** Relevant ministries/ institutions
4.5. Digitalization for UHC							
4.5.1	Promote the use of digital solutions to promote identification, registration, and data management of key target groups of the population under the social health protection system as well as review the possibility of fostering interoperability with data systems of private health insurance companies	✓	✓	✓	✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** NSSF of MoLVT, MoH
4.5.2	Gradually implement Information Technology and Digital Health to increase efficiency and effectiveness in health service delivery especially at primary care level and referral hospitals	✓	✓	✓	✓	✓	**Leading Institution:** MoH **Supporting Institutions:** NSPC, NPCA, NSSF of MoLVT
4.5.3	Develop an automated claim certification function through strengthening Patient Management Registration System (PMRS) and	✓	✓	✓	✓		**Leading Institution:** NPCA **Supporting Institutions:** NSPC, NSSF of MoLVT, MoH

N	Strategies	Timeframe					Responsible Ministries/ Institutions
		2024	2025	2026	2027-2030	2031-2035	
4.5.4	Develop the Electronic Medical Record (EMR)						**Leading Institution:** MoH **Supporting Institutions:** NSPC, NSSF of MoLVT, NPCA
4.5.5	Engage the private sector in support of digitalization for the health sector and social health protection system within the Private Sector Engagement Framework	✓	✓				**Leading Institution:** MoH **Supporting Institutions:** NSPC, NSSF of MoLVT, NPCA
4.5.6	Modernize and functionalize an interoperability of Information, Communication and Technology and Digital Health to support the implementation of strategic purchasing and claim management under social health protection system	✓	✓	✓	✓	✓	**Leading Institution:** MoH, NPCA **Supporting Institutions:** NSSF of MoLVT, NSPC
4.6. Monitoring and Evaluation of the Implementation of the Roadmap							
4.6.1	Monitor and evaluate social assistance programs, social security schemes and key interventions defined in the roadmap	✓	✓	✓	✓	✓	**Leading Institution:** NSPC **Supporting Institutions:** Relevant ministries/ institutions
4.6.2	Monitor and evaluate progress of implementing the roadmap	✓	✓	✓	✓	✓	
4.6.3	Monitor and evaluate the progress of UHC goals through measuring key indicators identified in the roadmap	✓	✓	✓	✓	✓	

Note: *National Social Protection Council (NSPC), National Social Security of Ministry of Labor and Vocational Trainings (NSSF of MoLVT), National Payment Certification Agency (NPCA)*

ANNEX III

Glossary

1.	**Universal Health Coverage**	UHC is about ensuring that all people can access quality healthcare services when and where needed without financial hardship, which include a comprehensive range of service provisions from health promotion, to prevention, treatment, rehabilitation, and to palliative care
2.	**Competency-based training:**	A training approach which centers on skill and knowledge enhancement for specific professionals. This approach involves hands-on experiences and competence, which learners shall master. This approach also emphasizes an application of critical thinking, problem solving, and practical work through the use of appropriate, flexible and learner needs-driven means.
3.	**Accreditation:**	An official review process on health facilities to demonstrate their capacity and quality in conjunction with the regulations and quality standards, defined by an accreditation body.
4.	**Strategic Purchasing:**	Health financing strategy which links budgeting and financial incentives to provider performance (both quality and quantity), pre-determined by detailed information on healthcare service delivery and healthcare needs of the target groups of the population.
5.	**Capitation:**	A method of payment for medical services through which health service providers are reimbursed at a fixed rate for a defined timespan (normally 1 year) based on the total of number of people volunteering to be covered by those providers for specifically pre-defined healthcare services.
6.	**Standard Benefit Package:**	A standard benefit package in the social health protection system, which specifies a set of essential health services coverage, together with payment mechanism. This package shall be developed to ensure that all citizens access quality healthcare services when and where needed without financial hardship.

7.	**Home-Based Care:**	Healthcare or regular supportive care by a professional caregiver right at the residence of population groups namely the elderly, people living with severe disabilities, among others, based on specific criteria.
8.	**Primary healthcare:**	A society-wide approach to health which aims to ensure good health and well-being in response to population needs promptly through expansive range of service provisions from health promotion, to prevention, treatment, rehabilitation, and to palliative care, with a core focus on moving such services closer to the population residence.
9.	**Health Technology Assessment:**	A systematic and multidisciplinary evaluation of the cost-effectiveness, treatment safety, and impacts of the use of certain technologies or innovations for treatment, based on medical, social, equity, ethical and economic considerations. The purpose of this evaluation is to inform decision-makers of evidence-based inputs to ground their decisions on health priority settings, including health service coverage, payment mechanism, reimbursement rate setting, treatment protocols, medicines, and medical equipment.
10.	**Continuing Professional Development:**	A range of learning activities through which health professionals maintain and develop throughout their careers to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice.
11.	**At-Risk Households:**	Households who are at the risk of falling into poverty, and have at least 1 of the following vulnerability items, namely disability, children under 2 years, family member aged over 60 years, single female headed households, and households with members younger than 18 years and without members aged between 19-59.
12.	**Out of Pocket Health Expenditure:**	All direct household expenses including user fee, informal expenses, purchase of medicines, and other expenses to access healthcare. Out-of-pocket health expenditure also incorporates transport fee, and other travel-related costs, but excludes taxation and health insurance contribution.
13.	**Digitalization:**	The integration of information technologies to change business or operation model of ministries, institutions and entities, providing new revenue and value-producing opportunities in delivering healthcare services, with the aim of improving both quality and efficiency of the system.

14. Gatekeeping:	An arrangement in which the primary care providers or other levels of the health system controls access to the next level of care and coordinates the care journeyway for each patient. Gatekeeping is strengthened through the development and introduction of incentivization and dis-incentivization principles in the forms of benefit package design, provider payment mechanism, performance-based financing, etc.
15. Social Health Protection System:	A system designed to ensure access to quality, efficient, and equitable healthcare without financial hardship. The system is based on an international human rights framework such as the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights.
16. Value for Money:	An increase in the quantity or quality of output based on given inputs. Effectiveness of the health system refers to technical, productive, and allocative efficiencies, measured by existing resources in the health sector, in order to increase value for money.
17. Diagnostic-Related Group Payment Mechanism:	A method of payment which providers are paid for a similar procedure or diagnosis rather than the number of days of stay in hospital or case groups.
18. Case-Based Payment Mechanism:	A method payment in which providers are paid a fixed amount per case of receiving healthcare service, depending on patient and clinical characteristics. This mechanism is based purely on the quantity of services provided, not the expected health outcomes.
19. Mixed Provider Payment Mechanism:	Mixed provider payment mechanism can take the form of a complementary fusion of capitation, diagnostic-related groups, case-based payment, and others, which is aimed at stimulating quality of healthcare services, efficiency, and financial protection.
20. Public health:	A socio-political concept which focuses on improving health and well-being of citizens through health promotion, disease prevention, and other types of community-based health interventions.
21. Complementary Package of Activities:	A set of standards for referral hospitals level 1, 2, 3 and 3+ in Cambodia which refers to buildings, facilities, human resources, medical services, para-clinic services, and management.

22.	**Minimum Package of Activities:**	A set of standards for health centers in Cambodia which refers to buildings, facilities, human resources, medical services, para-clinic services, and management.
23.	**Essential health services (EHS):**	There is no single worldwide definition of "essential health services". Each country's list of EHS differs based on disease burden and priorities, as well as the cost and feasibility of implementing and delivering the services. In general, EHS include services related to sexual and reproductive health; maternal and newborn health; child health; immunization; nutrition; communicable diseases (such as tuberculosis, HIV, malaria, etc.); neglected tropical disease; communicable disease like diabetes, cardiovascular disease, etc.) emergency; and mental health.
24.	**Essential medicines:**	The pharmaceutical products (including vaccines) considered as important (or essential) and are defined in the "Essential Medicines List" specifically by competent authority to address general health conditions and promote affordable and efficient treatment based on each country context. The selection of essential medicines is based on evidence-based guidelines, enhanced efficiency of resource management, and healthcare quality improvement.
25.	**Supply Side Financing:**	A financing model that makes health funding or subsidies from various sources, including governments, directly available to providers for supporting the delivery of health services. For example, government allocate budget to hospitals to ensure they provide services to address population health needs.
26.	**Demand Side Financing:**	A financing model that makes funding or subsidies from various sources, including governments, directly available to people in need through a third-party payer so that people can afford, and pay for, health services.
27.	**Interoperability:**	A seamless data exchange between multiple information technology systems that are already interoperable necessary for automated functions of each system. Based on Healthcare Information and Management System (HIMSS), interoperability of information technology systems has four levels such as foundational, structural, semantic, and institutional levels.
28.	**Integrated People-Centered Health Services:**	An approach to providing healthcare services that consider individuals and communities as the core of the healthcare system, as well as enhancing self-care of the population. This approach emphasizes coordination and collaboration between healthcare providers, and integration of essential health services aimed at providing comprehensive, quality, and cost-effective care to meet the diverse population health needs.

4.1. Technical Working Group on Developing the Roadmap Towards Universal Health Coverage in Cambodia

Unofficial Translation

Decision on the Establishment of a Technical Working Group on Developing a Roadmap Towards Universal Health Coverage in Cambodia

Deputy Prime Minister, Minister of Economy and Finance
And the Chairperson of the National Social Protection Council

- Having seen the Constitution of the Kingdom of Cambodia;
- Having seen the Royal Decree N0. NS/RKT/0320/421, dated 30 March 2020, on the appointment and reshuffle of the Royal Government of the Kingdom of Cambodia;
- Having seen the Royal Decree N0. NS/RKT/091/925/, dated 06 September 2018, on the appointment of the Royal Government of the Kingdom of Cambodia;
- Having seen the Royal Kram N0. NS/RKM/0618/012, dated 28 June 2018, promulgating the Law on the Organization and the Functioning of the Council of Ministers;
- Having seen the Royal Kram N0. NS/RKM/0196/10, dated 24 January 1996, promulgating the Law on the Establishment of the Ministry of Economy and Finance;
- Having seen the Royal Decree N0. NS/RKT/0617/488, dated 15 June 2017, on the Establishment of the National Social Protection Council;
- Having seen the Sub Decree N0. 488 ONK.BK, dated 16 October 2013, on the Organization and Functioning of the Ministry of Economy and Finance;
- Having seen the Sub Decree N0. 75 ONK.BK, dated 25 May 2017, on the Amendment of the Sub Decree N0. 488 ONK.BK, dated 16 October 2013, on the Organization and Functioning of the Ministry of Economy and Finance;
- Having seen the Sub Decree N0. 03 ONK.BK, dated 8 January 2018, on the Establishment of the Executive Committee and the General Secretariat for the National Social Protection Council;
- Having seen the Sub Decree N0. 143 ONK.BK, dated 19 August 2021, on the Amendment of the Sub Decree N0. 03 ONK.BK, dated 08 January 2018, on the Establishment of the Executive Committee and the General Secretariat for the National Social Protection Council;
- As required by the National Social Protection Council;

Hereby decides

Article 1.-

Establish a Technical Working Group on Developing the Roadmap Towards Universal Health Coverage in Cambodia, which comprises:

No.	Name	Position	Role
1.	**H.E. Chan Narith**	Secretary General of the National Social Protection Council	Chair
2.	**H.E. Hok Kim Cheng**	Director General for Health of the Ministry of Health	Vice-Chair
3.	**Mr. Pheakdey Sambo**	Deputy Secretary General of the General Secretariat for the National Social Protection Council	Vice-Chair
4.	**H.E. Heng Sophannarith**	Deputy Director General of the National Social Security Fund	Member
5.	**Mr. Srey Vuth**	Deputy Director General of the General Department of Budget of the Ministry of Economy and Finance	Member
6.	**Mr. Yi Sothearith**	Deputy Director General of the General Department of International Cooperation and Debt Management of the Ministry of Economy and Finance	Member
7.	**Mrs. Hor Sovathana**	Deputy Director General of the Insurance Regulator	Member
8.	**Mr. Chhour Sopanha**	Director of the Department of Social Welfare of the Ministry of Social Affairs, Veterans, and Youth Rehabilitation	Member
9.	**Mr. Ir Por**	Deputy Director of the National Institute of Public Health	Member
10.	**Mrs. Sok Kanha**	Deputy Director of the Department of Planning and Health Information of the Ministry of Health	Member
11.	**Mr. Khob Meanrith**	Deputy Director of the Department of Budget and Finance of the Ministry of Health	Member
12.	**Mr. Voeun Vireak**	Chief of Health Quality Assurance Bureau of the Department of Hospital Services of the Ministry of Health	Member
13.	**Mr. Mok Vichetsackda**	Chief of Public Financial Policy Bureau of the General Department of Policy of the Ministry of Economy and Finance	Member
14.	**Mr. Phok Veasna**	Chief of Claim Certification Bureau of the Payment Certification Agency	Member
15.	**Mrs. Than Kennaroit**	Director of the Department of Social Security of the General Secretariat for the National Social Protection Council	Member

Article 2.-

The Technical Working Group is established to develop and draft the roadmap towards UHC in Cambodia based on the Concept Note on the Journey towards UHC in Cambodia, approved by the National Social Protection Council.

Article 3.-

Members of the Technical Working Group defined in article 1 of this decision letter shall attend meetings as required by the Chair. In the event of absence, the vice-chairs shall convene and lead the meetings, as assigned by the Chair.

The Technical Working Group has the right to invite representatives of ministries/institution, development partners, and the private sector to attend the meetings if necessary, and to seek coordination and cooperation from all relevant ministries/institutions of the Royal Government, development partners, and the private sector.

Article 4.-

The vice-chairs and members of the National Social Protection Council (NSPC); the chairs, vice chairs, and members of the Executive Committee for the NSPC; the Chief of the Cabinet; the General Secretariat for the NSPC; heads of all relevant institutions and entities; and the chair vice chairs, and members defined in article 1 above are entrusted with implementing this decision letter according to respective responsibilities upon the signing of the decision letter.

Thursday, January 20, 2022

Deputy Prime Minister

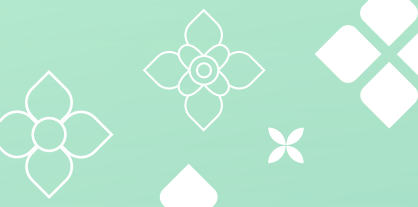
Minister of Economy and Finance

(Signature and Seal)

Akka Pundit Sapheacha AUN Pornmoniroth

Place of Receipt:

- In accordance with Article 4 “for implementation”
- Royal Gazette
- Archive



4.2. Support Team on Coordinating the Roadmap Development at the General Secretariat for the National Social Protection Council

No.	Name	Position
1.	**H.E. Pheakdey Sambo**	Deputy Secretary General of the General Secretariat for the National Social Protection Council and the Director General of the National Payment Certification Agency
2.	**Mr. Khean Tourk**	Deputy Secretary General
3.	**Mr. Sreng Sophornreaksmey**	Director, Department of Policy
4.	**Mr. Choeurng Theany**	Director, Department of Operational Support
5.	**Mr. Sam Sam Oeun**	Senior Specialist
6.	**Mr. Say Sivutha**	Senior Specialist
7.	**Mr. Chea Vanara**	Senior Specialist
8.	**Mr. Seab Dena**	Technical Officer
9.	**Mr. Lart Souy**	Technical Officer
10.	**Ms. Heang Kanhary**	Technical Officer
11.	**Mr. Tith Chamroeunreach**	Technical Officer
12.	**Mr. Hun Pich**	Technical Officer
13.	**Ms. Hang Ousa**	Technical Officer
14.	**Ms. Lao Kimrasmey**	Technical Officer

NATIONAL SOCIAL PROTECTION COUNCIL
SOCIAL PROTECTION IN CAMBODIA