Social Security and Social Policies in Cambodia

By Chea Chantum & Dr Hildegard Lingnau[1]

1. The Right to Social Security

The Universal Declaration of Human Rights (1948) states in Article 22, "Everyone … has the right to social security" and in Article 25 "the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

The right to social security was subsequently incorporated in several human rights treaties, especially in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 9 of the ICESCR provides "the right of everyone to social security, including social insurance".

According to the Committee on Economic, Social and Cultural Rights of the UN Economic and Social Council (2008: 2), the right to social security encompasses the right to access and maintain benefits without discrimination in order to secure protection from:

- lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age or death of family member;
- unaffordable health care;
- insufficient family support, particularly for children and adult dependants.

Beyond self-help and privately run schemes, measures that are to be used to provide social security benefits mainly include:

- contributory or insurance-based schemes such as social insurance, which generally involve compulsory contributions from beneficiaries, employers and sometimes the state;
- non-contributory universal or targeted social assistance schemes.

While the elements of the right to social security vary according to circumstances and conditions, nine principal branches should be covered: health care, sickness, old age, unemployment, employment injury, family and child support, maternity, disability, survivors and orphans (*ibid:* 5).

All states have a core obligation to ensure the satisfaction of minimum essential levels of the right to social security (*ibid:* 16). This requires the state:

- to ensure access to a social security scheme that provides a minimum level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs and the most basic forms of education;
- to ensure the rights of access to social security on a non-discriminatory basis, especially for disadvantaged and marginalised individuals and groups;
- to protect existing social security schemes from unreasonable interference;
- to adopt and implement a national social security strategy and action plan;
- to take targeted steps to implement social security schemes, particularly those that protect disadvantaged and marginalised individuals and groups;
- to monitor the extent of the realisation of the right to social security.

According to modern understanding of human rights law, there are three obligations (*ibid:* 13ff).

- The obligation to respect requires that the state refrain from interfering directly or indirectly with the enjoyment of the right to social security.
- The obligation to protect requires that the state prevent third parties from interfering in any way with the enjoyment of the right to social security.
- The obligation to fulfil requires that the state adopt necessary measures, including the implementation of a social security scheme, directed towards the full realisation of the right to social security.

The obligation to fulfil can be subdivided into the obligations to facilitate, promote and provide:

- The obligation to facilitate requires the state to take positive measures to assist individuals and communities to enjoy the right to social security (recognition of the right within the national political and legal systems, adoption of a national social security strategy and a national social security plan of action to realise this right etc).
- The obligation to promote obliges the state to take steps to ensure that there is appropriate education and public awareness concerning access to social security schemes.
- The obligation to provide requires the state to

1 Chea Chantum is director of the Social Planning Department and Dr Hildegard Lingnau is a senior adviser in the Ministry of Planning. The authors would like to thank Mr Julian Hansen, Mr Gijs Koop and Ms Nina Siegert for helpful information.

establish non-contributory schemes or other social assistance measures to provide support to those individuals who are unable to make sufficient contributions for their own protection.

In reality, however, little progress has been made in terms of realisation of the right to social security: 80 percent of the global population currently lacks access to formal social security (*ibid:* 3).

2. The Cambodian Reality

Cambodia has a population of nearly 14 million people, which is growing by nearly 2 percent per year. Half of the population is under the age of 20. Around 80 percent of the population and 90 percent of the poor live in rural areas. The gross domestic product per capita is about USD594 (2007). In 2007, 30.1 percent of the population lived below the national poverty line (Ministry of Planning 2008). According to a comparative study recently commissioned by the Asian Development Bank, the Cambodian social protection index is 0.18, which ranks Cambodia 25th out of the 31 Asian and Pacific countries for which it has been calculated (ADB & Halcrow Group 2007: 20). This ranking is much lower than the Asian average of 0.36, but comparable to Cambodia's human development index and GDP per capita rankings. In brief, most Cambodians "have no safety net when they fall ill and lack the resources to cover the costs of obtaining appropriate treatment" (*Cambodia Daily,* 22 October 2008).

According to a comparative study recently commissioned by the Asian Development Bank, the Cambodian social protection index is 0.18, which ranks Cambodia 25th out of the 31 Asian and Pacific countries for which it has been calculated.

Very often the only social safety net that most Cambodians can rely on is their families. The Cambodian Demographic and Health Survey (RGC 2006) gives some insights into Cambodian families:

- The average household size is five persons. Rural households are slightly smaller than urban households.
- One quarter of households are headed by women.
- Seventy-nine percent of children under the age of 18 live with both their parents.
- Women do not have a lot of say in decisions on major issues affecting themselves and their families. Even marriages are decided more by the parents than by the future husband and wife (especially in rural areas); 52 percent of women do not participate at all in the choice of their husband.

There is little formal social protection, and very few and limited social services are provided by the state, and "the formal social security system which in many other countries constitutes the major element of social protection spending … brings little benefit to the poor" (ADB & Halcrow Group 2007: 20). Much more important for the needy and the poor is targeted social protection expenditure. In this regard, the situation does not look as bad as one might expect: According to the ADB study, out of the total expenditure on social protection (estimated to be around USD78 million, 1.4 percent of GDP), 60 percent (i.e. USD48 million) benefits the poor. Compared to a poverty level of around 30 percent, this indicates a high degree of pro-poor targeting of social expenditure programmes (*ibid*).

Most social protection schemes, however, very much rely on NGOs and international donors. This is even more the case with regard to health care. Those who cannot afford to pay the user fees depend very much on charity hospitals run by NGOs (*Cambodia Daily,* 22 October 2008). Public health care centres and hospitals suffer from low public funding and low salaries and incentives, which negatively impact service delivery (RGC 2008a). Luckily, a number of different health financing mechanisms are now emerging and expanding. Among them are the health equity fund (HEF) system, which helps poor people to access health services, community-based health insurance (CBHI) for the informal sector and compulsory social health insurance (SHI) for the formal sector. This is of highest importance given that illness is a key reason for falling into poverty (World Bank 2006:xii).

3. Social Policies

Existing Cambodian social policies and schemes are under the authority of several ministries. The table shows that Cambodian social policies not only target the groups mentioned in the "nine principal branches of social security" and the "seven key social protection target groups", but also include the poor in general, youth, victims of natural disasters, veterans, people affected by drug abuse, victims of trafficking, female victims and homeless people. However, there is little evidence that underemployed persons, pregnant women, post-partum women or survivors are taken into consideration.

In recent years, progress has been made in social

Nine Principal Branches of Social Security (UN Economic and Social Council 2008)	Seven Key Social Protection Target Groups (ADB & Halcrow 2007)	Cambodian Social Policy Priorities
health care		• free health care for the poor (HEF) • CBHI for the informal sector • compulsory SHI for the formal sector
sickness	sick people	• free health care for the poor (HEF) • CBHI for the informal sector • compulsory SHI for the formal sector
old age	elderly people	National (Civil Servant) Social Security Fund & NSSF
unemployment	unemployed people	National Strategic Development Plan
	underemployed people	
employment injury		National (Civil Servant) Social Security Fund & NSSF
family and child support		• female-headed households • child welfare and youth rehabilitation
maternity		
disability	disabled people	disabled people
survivors and orphans		orphans
	poor people	poor people (National Strategic Development Plan, IDPoor …)
	children with special needs	child welfare and youth rehabilitation
		emergency relief aid for victims of natural disasters and calamities like floods, drought or fire
		retirement pension for public servants
		veterans
		people affected by drug abuse
		victims of trafficking
		female victims
		homeless people

policies. Some major developments are (Ministry of Planning 2008):

- The poverty rate came down from 34.7 percent in 2004 to 30.1 percent in 2007. The ADB study explicitly states that there is "a high degree of pro-poor targeting of social expenditure programmes and it reflects the considerable efforts by the government, NGOs and international donors to target social protection programs at the poor" (ADB & Halcrow 2007: 20).
- A number of health and social security financing mechanisms are now emerging and expanding.
- The Identification of Poor Households Programme (IDPoor) has been established.
- The draft Law on Protection and Enhancement of Amputees' Rights has been sent to the National Assembly for approval.
- The Cambodian Veterans Association has been established, aimed at enhancing solidarity and mutual care and improving living conditions of veterans.
- Thousands of children in conflict with the law, drug addicts and hundreds of homeless people and street children have benefited from health and education services, vocational training and re-integration into communities.
- Along with the establishment of centres for victims of trafficking, non-discriminatory rehabilitation and health care education services have been provided to workers and victims of sexual trafficking.
- The number of homeless has been reduced.

However, big challenges remain.

- The coverage ratios for key target groups are

generally low: "The coverage rate for social assistance programs was 16 percent of the poor population but ratios for other key target groups were all below 10 percent indicating the absence of significant programs for these groups" (ibid).

- The biggest challenge is to provide health care and social security for the many poor.
- An immediate challenge is targeted subsidies or tax exemptions for essential commodities to counterbalance the effects of increasing food prices.

4. Some Initiatives in Detail

Health care is one of the most important features of social security: "State parties have an obligation to guarantee that health systems are established to provide adequate access to health services for all. In cases in which the health system foresees private or mixed plans, such plans should be affordable …" (UN Economic and Social Council 2008: 5)

Cambodia has encountered difficulties in financing health care and providing social health protection out of the government budget. As initial steps, it adopted the Master Plan for Social Health Insurance in 2005 and the Health Financing Strategic Framework in 2008. It is hoped that a new Master Plan for Social Health Protection (RGC 2008a) will lead to a unified social health protection system and universal health coverage.

Social securities initiatives and policies include HEF, CBHI, SHI and NSSF as well as IDPoor.

4.1. Health Equity Funds

Probably the most important initiative in the provision of social services is the HEF system, which intends to help poor people to access health services by paying providers to deliver health care to those who cannot afford the normal fees. HEFs constitute the primary social health protection scheme for the poor and vulnerable.

There have been experiments with different types of schemes for several years. In 1996, the adoption of the National Charter on Health Financing provided a legal framework for different health financing schemes. Formal user fees were piloted in several government health facilities in 1997. The aim of user fees is to generate regular extra revenues and facilitate good management. An exemption system was part of the schemes to allow access for the poorest. Today almost all public health facilities charge user fees. The exemption system, however, has not been functioning satisfactorily.

Due to this, HEFs were introduced in 2000 to improve access for the poor. Eligible beneficiaries are identified either at the community level before health care demand (pre-identification) or at the health facilities through interviews (post-identification). Eligible patients get full support for user fees and partial or full support for transport and other costs during hospitalisation. Experience so far shows that HEFs improve access to health services by the poor.

HEFs became an integral component of the Health Sector Strategic Plan (2003–07), the National Poverty Reduction Strategy (2003–05) and later the National Strategic Development Plan (2006–10). In parallel, the Ministry of Health developed the National Equity Fund Implementation and Monitoring Framework (September 2005). Moreover, the Ministry of Health and the Ministry of Economy and Finance jointly issued a prakas for the allocation of government funds to national hospitals and operational district offices to subsidise health services for the poor (November 2006).

Probably the most important initiative in the provision of social services is the HEF system, which intends to help poor people to access health services by paying providers to deliver health care to those who cannot afford the normal fees.

Fee exemptions for poor patients through HEFs are now being provided in 37 operational districts (up from 17 in 2004). The Health Sector Plan 2008–15 aims to expand HEFs to cover the entire country.

HEFs have proved very useful for helping the poor to access health services and for socio-economic development in general. The main challenge now is countrywide scaling-up to provide access to all poor people.

4.2. Community-Based Health Insurance

Another important development is community-based health insurance schemes. CBHI targets the informal sector, which includes 85 percent of the population (Ministry of Economy and Finance 2008). Most people in the informal economy, especially in rural areas, are not covered by any form of social health protection (RGC 2008a). The only exceptions are districts where CBHI schemes exist.

CBHI involves private, non-profit, voluntary pre-payment. It mainly targets people who live just above the poverty line and can afford to pay the premium.

The main challenge is the scaling-up of CBHI to nationwide coverage.

4.3. Social Health Insurance and National Social Security Funds

For the public and the private formal sector, social security will be provided through (compulsory) SHI. There is one plan of the Ministry of Social Affairs, Veterans and Youth Rehabilitation targeting public servants and one plan of the Ministry of Labour and Vocational Training targeting the formal sector. SHI is funded by the government through the National Social Security Funds (NSSF) through deductions from the civil service payroll and through employer contributions (0.8 percent of the payroll tax). There are two funds.

The National (Civil Servant) Social Security fund of the Ministry of Social Affairs, Veterans and Youth Rehabilitation targets civil servants, i.e. the public sector. It was approved in February 2008 and will cover (from 2009) pensions, disability or loss of working capability, maternity, traffic accidents, work injuries and death (RGC 2008b).

The fund of the Ministry of Labour and Vocational Training targets private sector employees. It was approved in March 2007. In a first step, the NSSF will compensate for workplace injuries. From 2010, it will include medical insurance and from 2012, retirement pensions (*Phnom Penh Post,* 19 August 2008).

In order to improve social security for people employed in the formal sector, SHI needs to be further harmonised (especially with regard to benefits) and regulated (especially the legal framework and implementation) (RGC 2008a). The NSSF also needs to expand to cover the informal and self-employed private sectors. This includes rural people, who in most cases are not employed by anyone and therefore have no one to make NSSF contributions on their behalf.

4.4. Identification of Poor Households Programme

The government in 2005 assigned the Ministry of Planning to lead in developing and implementing nationally standardised procedures for identifying poor households. A national working group was established, and in 2006 the Identification of Poor Households Programme (IDPoor) was established with technical support from the German government through GTZ. Prior to this, there had been efforts to conduct poverty-oriented development planning and service provision targeted at the poor, but no coordinated approach for identifying potential beneficiaries and making this data available to service providers. Each institution developed and applied its own procedures and criteria.

The main purposes of IDPoor are:

- to develop and implement standardised procedures for identification of poor households;
- to expand coverage to all rural areas (criteria for urban areas have not yet been developed) as resources permit, through integration into the routine tasks of commune councils and their support structures;
- to provide accurate information on poor households to enable service providers to target the poor more effectively.

Data provided by IDPoor can and are being used for a wide range of services and assistance, including: free or subsidised health services through HEFs or CBHI, scholarships for poor pupils and students, social land concessions, agricultural services and cash transfer programmes.

IDPoor identifies households by location and a unique number, and provides data on each household member, including name, sex, year of birth and relationship to head of household. Photos are taken and equity cards issued to poor households. All data are entered into a national database.

The process consists of several main steps:[2]

- training of actors (especially commune coordinators and village representative group members elected by villagers);
- interview of households using a standard questionnaire;
- display of a draft list of poor households;
- village consultation and consideration of villager suggestions and complaints relating to the draft list;
- review and approval of the list by the commune council;
- entry of data by the provincial Department of Planning into the database of poor households;
- distribution of equity cards to poor households. These cards help service providers quickly to identify poor households. The cards also help to raise the awareness of the poor that they can claim their rights, i.e. that they can seek out services and assistance and assert their eligibility to receive them.

Poor households can be assigned to poor level 1 (very poor) or poor level 2 (poor). These categories are based on the questionnaire scores and a consideration of special circumstances. The proportions of households falling into the two categories have been calibrated to reflect approximately the 2004 Cambodian Socioeconomic

2 For more details see www.mop.gov.kh/ProgramsProjects/IDPoor/tabid/154/Default.aspx.

Survey results (with some allowance for variation over time). Level 1 roughly corresponds to those households under the CSES food poverty line, while level 2 approximately equates to households between the food poverty line and the poverty line. On average, about one-third of households are classified as poor 1 or 2.

As of October 2008, the Ministry of Planning had implemented IDPoor in Oddar Meanchey, Siem Reap and Kratie (whole provinces) and three operational districts in Kompong Cham and two in Prey Veng province. In 2009, it will conduct IDPoor in two more operational districts in Kompong Cham and one each in Banteay Meanchey and Pursat, and in all of Kampot, Kompong Thom and Svay Rieng provinces. In addition, HEF operators and their partners have been implementing the procedures in Kompong Chhnang, Pursat, Battambang, Banteay Meanchey and Kompong Cham and will extend to at least Preah Vihear, Ratanakkiri, Mondolkiri and Koh Kong provinces in 2009. Subject to funding, IDPoor will extend throughout rural areas as a nationwide programme and carry out updates every two years.

5. Conclusions and Recommendations

Social security and social policies in Cambodia are in their infancy. To ensure social protection for the entire population, there is still a long way to go. High GDP growth and projected revenues from oil and gas may allow the government to increase social spending, invest in social development and further develop redistributive policies to ensure health care and social services for all.

One major element will be the establishment of a health insurance system, and preferably the unification of existing schemes under a national umbrella. Fragmented schemes are not very effective. Streamlining under a national umbrella would allow much better risk pooling and cost sharing. Such a system needs appropriate funding mechanisms—a premium paid by employers, with some co-payment by workers and/or by the government through taxes. The Master Plan for Social Health Protection that is being drafted right now will try to tackle many of the challenges. Its goal is "to develop and implement a sustainable national system for social health protection that will ensure social health protection coverage to all, priority for the poor …"

Other upcoming challenges are:

- to continue and improve pro-poor policies;
- to develop redistributive policies;
- to increase social sector expenditure;
- to scale up HEF systems countrywide;
- to scale up CBHI;
- to implement effectively the SHI and the NSSF;
- to extend coverage of the standardised procedures for identification of poor households and increase the use of this data for targeting of services and assistance;
- to implement the programme on social land concessions;
- to increase the coverage of micro-credit programmes;
- to implement more food for work programmes;
- to continue and broaden targeted social sector interventions for groups that need special attention.

The challenge consists of progressively realising the right to social security without discrimination of any kind.

References

ADB & Halcrow Group (2007): Scaling Up of the Social Protection Index for Committed Poverty Reduction, Vol. 2: Summary of Country Reports (London: Halcrow China Limited)

Ministry of Economy and Finance (2008): "Draft Sub-decree on Microinsurance" (Phnom Penh: RGC)

Ministry of Planning (2008): The National Strategic Development Plan Mid Term Review (Phnom Penh: RGC)

Ministry of Social Affairs, Veterans and Youth Rehabilitation (2004): Action Programs of the Ministry of Social Affairs, Veterans and Youth Rehabilitation 2004-2008 (Phnom Penh: RGC)

Royal Government of Cambodia (2002): Law on social security schemes for persons defined by the provisions of the labour law (Phnom Penh: RGC)

Royal Government of Cambodia (2006): Cambodia Demographic and Health Survey 2005 (Phnom Penh: RGC)

Royal Government of Cambodia (2008a): Draft Master Plan for Social Health Protection (Phnom Penh: RGC)

Royal Government of Cambodia (2008b): Sub-decree on Establishment of the National Social Security Fund (Phnom Penh: RGC)

UN Economic and Social Council Committee on Economic, Social and Cultural Rights (2008): The Right to Social Security, General Comment No. 19 (New York/Geneva: United Nations)

World Bank (2006): Cambodia: Halving Poverty by 2015? Poverty Assessment 2006 (Phnom Penh: World Bank)