Contracting for Public Health Service Delivery: Insights from Health Workers

Background

The reconstruction of Cambodia's health system over the last 20 years has taken extraordinary efforts, starting from an almost non-existent base with the health infrastructure in ruins and fewer than 50 trained doctors (Ovesen and Trankell 2010). Significant investment from government and its development partners in 1989-1995 supported implementation of the first health sector reform (HSR) in 1991-94. That was quickly followed by HSR Phase 2 in 1995-98, when the Health Coverage Plan and Health Financing Charter were established and user fees introduced at public health facilities (MOH 2007).

Efforts to speed up the recovery of the rural health system and improve health services delivery led to the emergence of contracting for specific public health services in 1999. Contracting evolved in three phases. First, from 1999 to 2003, external contracting was piloted in five health districts (two districts tested contracting out and three tested contracting in). Health services especially maternal and child health services improved, health service coverage expanded and inequitable access and out-of-pocket health expenditure declined, but at a cost almost twice that incurred by standard districts (Bhushan et al. 2007).

Phase two in 2004-08 involved a form of hybrid contracting in 16 health districts, in 11 of which several international NGOs were contracted to provide management services. At the same time, provincial health departments, with support from Belgian Technical Cooperation, engaged five other districts in performance contracts. Both models featured performance contracts, incentives and monitoring, and building local health management capacity (Keovathanak and Annear 2011; MOH 2007).

The third phase culminated in the current Special Operating Agencies (SOA), a form of internal contracting that builds on Cambodia's broad public administration reform to improve service delivery, enhance pay and employment, develop institutional and human resource capacity, and promote information and communication technologies (Vong 2013). Under the umbrella of the Ministry of Health

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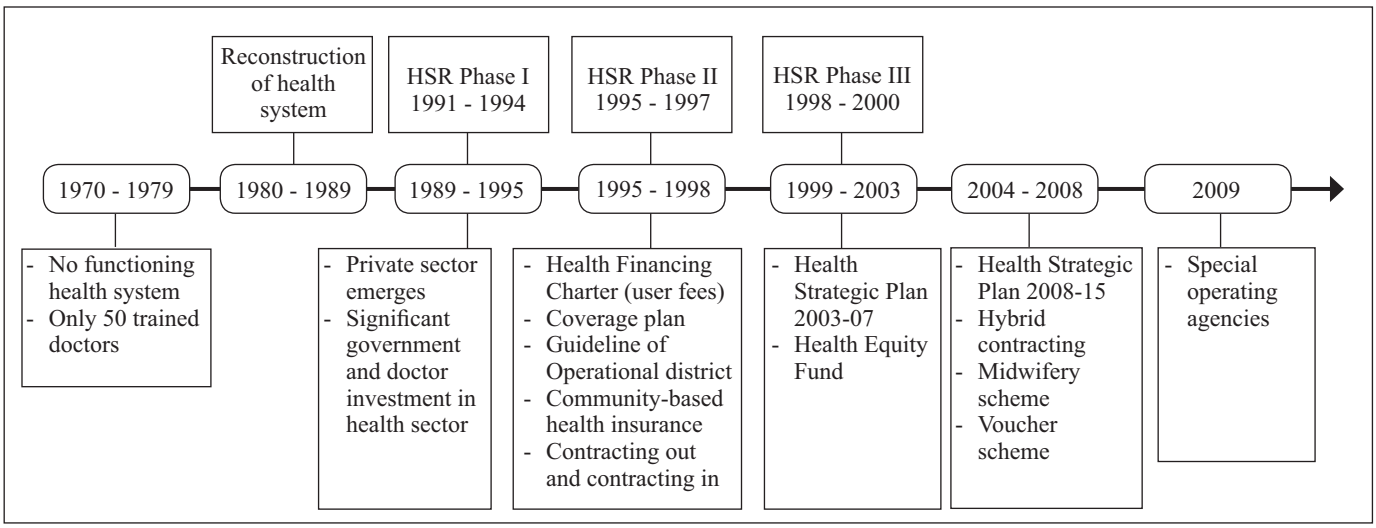
Figure 1: Health policy development in Cambodia



Source: Adopted from MOH 2007; Ovesen and Trankell 2010

(MOH), SOA contracts operate at four levels. The MOH contracts provincial health departments, which serve as commissioners. They contract operational districts (ODs), which, in turn, contract health facilities under their supervision. And health facility managers contract individual healthcare providers for specific services. Thirty SOA had been established by the end of 2010 and a further six scaled up by 2013 (MOH 2014). Importantly, these internal contracting arrangements allow provincial health departments to contract SOAs directly.

Few studies have focused on the outcomes of SOA implementation. The scheme has been explored as a means for improving district health management and services delivery (Khim and Annear 2013), and a quantitative nationwide survey has compared the use of SOA and non-SOA health facilities (World Bank 2013). Yet no assessment has so far been made of health workers' perceptions of the principles and benefits of SOA. Clearly, there is a knowledge gap that needs to be addressed.

An understanding of health workers' perceptions, motivation and satisfaction with their working environment is essential to improve both health worker retention (Witter et al. 2011) and health system performance (Chirdan et al. 2009). Drawing on a seven-year ReBUILD (Research for Building Pro-poor Health Systems during Recovery from Conflict) project on health contracting in Cambodia,[1] this paper looks at three aspects of SOA service delivery contracts: benefits for individual health workers, effects on health workers'attitudes and behaviours, and challenges to meeting contractual obligations and strategies to overcome them.

Research methods

Consistent with the literature (e.g. Pope and Mays 1995; Malterud 2001), a qualitative research approach was used to generate information about contracting and reflect the experiences and perspectives of health workers. We wanted to see SOA implementation through the eyes of health workers and managers to understand their viewpoints (Bryman 1988). In-depth interviews were held from March to June 2013 with 27 health managers and workers in four SOA districts, namely Memut, Peariang, Samrong and Bati. These districts were selected because of their current involvement in the SOA scheme, experience of contracting with NGOs (e.g. for primary or secondary care), geographical area and the services covered. Informed consent was obtained from each interviewee before beginning an interview. Framework analysis provided a systematic, rigorous and transparent approach to interpret and code the data collected (Ritchie et al. 2003). Emerging themes identified in interview transcripts were then grouped into clusters for detailed analysis.

Findings

Perceived benefits of working with SOA

Reported benefits were incentives such as salary top-ups and bonuses, training and capacity building, enhanced local ownership of district management, more transparent procedures, and private practice opportunities.

Incentives and bonuses paid to health managers and workers may be quite small but nonetheless supplement low civil servant salaries and thus help to sustain livelihoods. In the words of a health worker, "The benefits for health centre staff are not much but [help] supplement their daily livelihoods, so it is quite a big amount for them." And another clearly looked upon these incentives as a reward for professional commitment: "We work hard but we also receive incentives as well." On the downside, some participants felt that over-reliance on incentives provided by SOA could have a negative effect, undermining health workers' ability to work independently: "It's good in some ways, but … we just sit and wait for money and have no motivation to use our initiative and work independently."

Capacity building opportunities via SOA were appreciated by both health managers and workers who were confident that their capacity had improved as a result. Some health facilities are allocated budget that managers can use to provide training for health workers. A health centre manager explained, "By joining SOA, we get a bigger budget from the Ministry of Health to provide incentives to staff and provide training for them." Other participants confirmed that health workers now have more capacity building opportunities through various training courses: "The benefit of SOA is that it has provided a lot of training. Every member of staff has been sent on some kind of training course."

1 The ReBUILD programme is being undertaken by a research consortium with funding support from the Departmen t for International Development, UK (DfID). The project will run until March 2017.

Local ownership of district management was stressed as another key benefit of the SOA scheme. SOA health managers now get the chance to lead, work independently, make their own decisions and allow flexible working. They can be more innovative, do not have to follow rigid procedures and have authority over district staff. For example, they can resolve staff problems and fine or discipline poorly performing staff. One manager emphasised, "… with SOA, the operational district takes the lead and is in charge of decision making on how services should be improved, unlike under previous contracting arrangements."

Transparent procedures featured as a positive outcome, particularly district health management. All health workers interviewed were aware of the contract and understood how incentives are calculated and allocated among service providers.

Fewer restrictions on private practice are another boon. SOA managers are empowered to enable flexible working arrangements, and regulations allow private practice outside of stipulated duty hours.

> It's a bit easier than before [when contracting with NGOs]. We can take some time to see our patients outside. When we are busy outside, we just inform our department to make sure there are hospital staff on standby. We can go out for a while to make house calls and just ask another colleague to take our place. The current system is better for staff ...

Despite the freedom to supplement income through private practice, some participants asserted that the SOA scheme could increase health professionals' commitment to the public health system.

> SOA provides incentives so that our staff can earn enough money without working outside [private practice]. This means that our staff work in this facility only, and that makes our hospital strong.

Effects of SOA on health workers' behaviour

Study participants noted positive changes in the behaviour of health workers in SOA districts. Highlighted were improved punctuality, reduced absenteeism from duty, a continuous 24 hour service, better attitudes towards patients regardless of poor or non-poor status, and a better quality of care.

> Before, in consultation we just asked a few things, and then wrote out a prescription. But under contract with SOA, we have to measure blood pressure and body temperature and note these on the [patient's] record …
>
> If a patient has a fever, we have to do a blood test before we can give a prescription. Before SOA, we would take short cuts [for treatment] ... there was no monitoring from higher up, there were no incentives, [we] were lazy too, that's why …
>
> In my department, if patients had only a simple illness, we didn't use to check any signs; for example, there was no need to diagnose a headache. But now we have to diagnose patients properly, for every illness, and we have to record the diagnosis on the patient's health record with our signature—in the past, we didn't do this. Now, we have to sign many more documents.

That said, some health workers maintained that the SOA scheme has played only a small role in improving quality of care and that adherence to standard procedures and a code of ethics was instilled through previous contracting with NGOs.

Perceived challenges and coping strategies

Reaching the targets set out in SOA contracts was identified as a main challenge facing district health management. Participants explained that despite working hard they sometimes failed to achieve targets. Many were concerned that they might have ever higher targets to reach, while others felt that targets should be raised to encourage health workers to provide more services, particularly because the population is growing.

Several reasons why health facilities struggle to reach contractual targets were highlighted. First, inaccuracies in district population estimates make target setting problematic. A general assumption is that district populations are growing. Yet, as health managers reported, population size is affected by migration and population growth may have been slower than anticipated: "Population growth [in the district] had been overestimated and was lower than [expected] because of the number of people migrating to another place."

Second, baseline data used to generate SOA targets does not accurately reflect the use of health facilities. Thus targets were set at too high a level, as stressed by an SOA manager, "... when they did [started] it, they did not do the study to collect baseline data but to check the specificity of data so

that we could settle on this or that number. So, when we started, we used unreliable non-validated data as our baseline."

Competition among health facilities for patients in the district is a third reason for missing targets. Some participants reported that each health facility has its own target to achieve. But the limited number of patients means that not all health facilities can meet their targets, a point illustrated by a facility chief:

> The main issue facing my place is that the outpatient department is underused. People tend to go to the closest facilities, and those facilities hang onto their patients as they have target indicators to fulfil as well. In other words, the population around here hasn't changed, but people have more health centres to go to.

Strategies to help meet contractual targets reported by participants in all four study areas involve monthly community outreach activities. Health workers make house calls to conduct consultations, antenatal examinations and distribute medicines; these visits help boost data reporting in an attempt to fulfil targets. But there are challenges to doing outreach work. A shortage of health centre staff means that only vaccination workers can go to the community. In addition, health centres are usually too busy and cannot spare staff to travel to the community.

Conclusion

In sum, the study findings reflect a positive view among health managers and workers of working under SOA service delivery contracts. It is not feasible, however, to generalise the benefits and effects of SOA based on a perception study alone. Nonetheless, this study provides useful insight into the perceptions and experiences of SOA managers. These insights can contribute to a better understanding of factors influencing health workers' motivation and job satisfaction, and inform further interventions to improve health worker retention and health service delivery at subnational level.

References

Bhushan, Indu. Erik Bloom, David Clingingsmith, Rathavuth Hong, Elizabeth King, Michael Kremer, Benjamin Loevinsohn and J. Brad Schwartz. 2007. "Contracting for Health: Evidence from Cambodia." Accessed 30 Nov 2012, www.brookings.edu/views/papers/ kremer/20060720cambodia.pdf.

Bryman, Alan, ed. 1988. *Doing Research in Organizations*. London: Routledge.

Chirdan, O.O., J.T. Akosu, C.L. Ejembi, A.P.Bassi and A.I. Zoakah. 2009. "Perceptions of Working Conditions amongst Health Workers in State-owned Facilities in Northeastern Nigeria."*Annals of African Medicine* 8(4): 243-249. doi: 10.4103/1596-3519.59579.

Keovathanak, Khim, and Peter Leslie Annear. 2011. " The Transition to Semi-Autonomous Managment of District Health Services in Cambodia: Assessing Purchasing Arrangements, Transaction Costs and Operational Efficiencies of Special Operating Agencies."*Improving Health Sector Performance: Institutions, Motivations and Incentives – The Cambodia Dialogue,* edited by Hossein Jalilian and Vicheth Sen, 45-75. Singapore: ISEAS.

Khim, Khim, and Peter Leslie Annear. 2013. "Strengthening District Health Service Management and Delivery through Internal Contracting: Lessons from Pilot Projects in Cambodia." *Social Science & Medicine* 96: 241-249.

Malterud, K. 2001. "Qualitative Research: Standards, Challenges, and Guidelines."*Lancet* 358(9280): 483-488.

MOH (Ministry of Health). 2007. *Cambodia Health Information System: Review and Assessment*. Phnom Penh: MOH.

MOH. 2014. *Annual Heath Financing Report 2014*. Phnom Penh: MOH.

Ovesen, Jan, and Ing-Britt Trankell. 2010. *Cambodians and Their Doctors: A Medical Anthropology of Colonial and Postcolonial Cambodia*. Copenhagen: NIAS.

Pope, Clive C., and Nicholas Barron Mays.1995. "Qualitative Research: Reaching the Parts Other Methods Cannot Reach: An Introduction to Qualitative Methods in Health and Health Services Research."*British Medical Journal* 311:42-45.

Ritchie, Jane, and Jane Lewis, eds. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.

Vong Sreytouch. 2013. "Contracting Arrangements in Cambodia's Health Sector – Some Trends."*Annual Development Review 2012-13*, 33-42. Phnom Penh: CDRI.

Witter, Sophie, Bui Thi Thu Ha, Bakhuti Shengalia and Marko Vujicic. 2011. "Understanding the 'Four Directions of Travel': Qualitative Research into the Factors Affecting Recruitment and Retention of Doctors in Rural Vietnam." *Human Resources for Health* 9(1). Accessed 8 Jul 2015, www.human-resources-health.com/content/9/1/20.

World Bank. 2013. *Cambodia 's Rural Health Markets.* Washington, DC: World Bank, Human Development Unit & East Asia and Pacific Region.