



Cambodia Development
Resource Institute



Research for stronger health systems post conflict

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Briefing

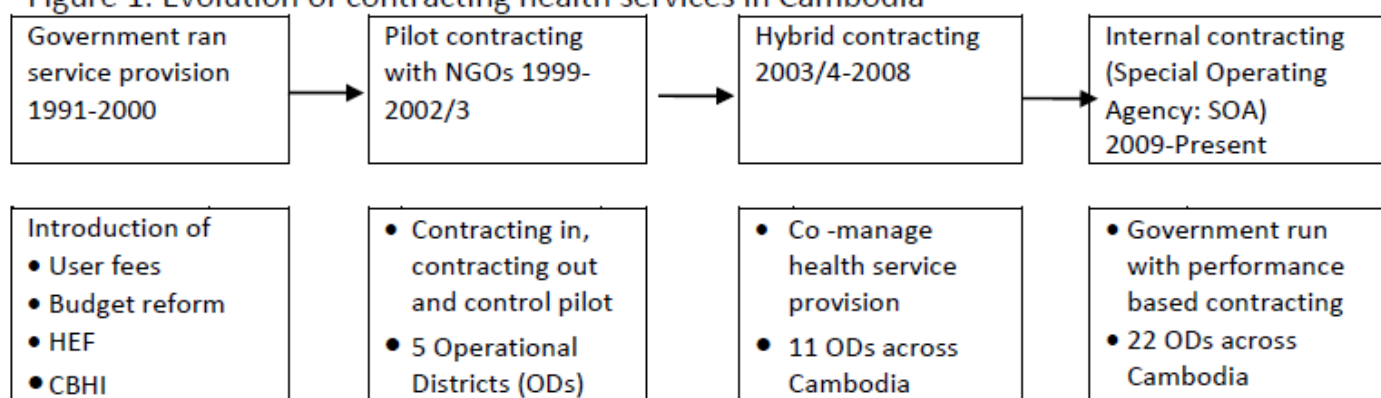
From public to private and back again: Lessons Learned from Internal Contracting in Cambodia

Introduction

This briefing note provides a summary of research done by the Cambodia Development Resource Institute on health contracting in Cambodia, which identifies key points relating to the impact of the Special Operating Agency (SOA) model on service coverage and equity. This research was done as part of the ReBUILD Research Programme Consortium. Full details of the research methodology and wider findings can be obtained from the CDRI ReBUILD research team, and will be produced in the Research Report, due to be published in April 2015.

Over the last two decades, Cambodia has implemented several policy initiatives and interventions designed to bring about improvements in health service delivery. In order to enhance efficiency of health service delivery and health outcomes, while harnessing the principle of market economy, a number of contracting models have been piloted and implemented. Figure 1 illustrates the main features of these models.

Figure 1: Evolution of contracting health services in Cambodia



The study aimed to address gaps in the research on the new contracting arrangement in Cambodia and the process of contracting. First, it sought to understand the change process in health contracting arrangements in Cambodia by identifying the drivers for change. Second, it documented the implementation processes of the current SOA contracting model. Third, it examined the implications of the SOA on service coverage and equity.

Methods

The study was carried out in four districts, located in different provinces, where SOA has been implemented since 2009/10. In depth interviews were conducted with managers of SOA and health facilities, and with health care providers from referral hospitals and health centres. Key informant interviews were conducted with representatives of the Ministry of Health (MoH) and donors. Using data from the Annual Health Statistic report for the four provinces which include the study districts, over the period 2009 to 2012, trends in full immunization of children under 1, antenatal care, deliveries by trained professionals and deliveries at health facilities were analysed. Systematic comparison was made between SOA and non-SOA districts to respond to the a priori hypothesis that SOA districts should perform better than non-SOA districts (and the province average).

Key Findings

1. Effects of SOA on delivery of services

Ownership of the district health services: Managers described ownership as a key benefit of being an SOA, enabling them to be more innovative with autonomy to make decisions and manage district healthcare staff.

Behaviour of health managers and workers: SOA has had a positive effect on behaviour of health managers and workers in the districts, as a result of the incentive sharing process and monitoring mechanisms. Staff were more likely to wear full uniforms, be punctual, be more responsible and committed to their role, be on standby 24 hours and be friendlier towards clients. There were improvements in cleanliness of facilities.

Private practice: Government employees conducting private practice is not banned in SOAs as long as this is out of government hours and does not interfere with meeting targets. SOA does not provide enough incentives to prevent private practice. Staff, particularly specialists, may leave their government job, if unable to conduct private practice.

2. Challenges in implementing SOA

Difficulties in achieving targets set in the contracts: (1) Targets are set using population data which is seen as unreliable (overestimation of the population and inaccuracies due to migration in and out of the district). (2) As baseline data on utilisation was too high and did not reflect the real situation, targets were set too high. (3) There is competition between facilities: each has a target to achieve and therefore tries to attract clients to their facility. As there is a limited number of clients, some facilities cannot meet their targets.

Monitoring: There are infrequent visits by the central monitoring team due to lack of time, few incentives to travel and limited capacity. The PHD should conduct quarterly monitoring visits to the districts. In reality this happens once or twice a year because of lack of specific budget for monitoring SOAs, general monitoring budget being too small for the planned frequency of visits, and lack of incentives for PHD officials from the SOA for monitoring work. SOA managers regularly monitor the facilities in their districts including availability of staff and services being provided, and do spot checks within the community to verify the data at the facility. However, SOA managers rarely sanction the facility managers or staff when they find mistakes.

3. Effects of SOA on service coverage and equity

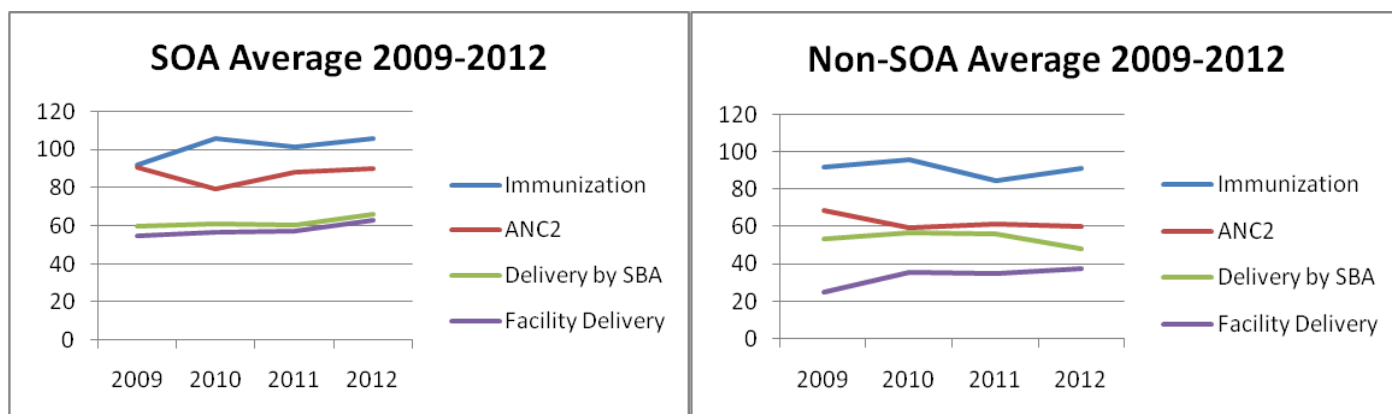
Secondary data analysis of service coverage: SOA versus non-SOA districts

The levels and trends of coverage of the four indicators in the 13 SOA districts were compared with the 10 non SOA districts in the four study provinces. The average of the 23 districts in the four provinces was used as an overall benchmark of performance.

There were numerous problems with the data, particularly for immunization and antenatal care where there were a large number of reported rates in excess of 100% (42 for immunisation rates and 10 for antenatal care coverage). One possible explanation is the inward movement of people seeking care who are resident in other districts, thus inflating the denominator but not the numerator of the coverage rate. However, the application of uniform provincial or national ratios to district populations to estimate the number of children under 1 or the number of pregnant women may be another factor (for example, the assumption that 2.95% of the population of one Province each year are pregnant women). If the actual figures are greater than the assumed figures, the true coverage rate may be significantly lower. In addition to these systematic problems, there were many examples of scarcely credible values or changes in the data. For example, there was an apparent collapse in coverage in one district 2011-12, if the data are to be believed, with the rate of deliveries by a skilled birth attendant (SBA) falling by nearly two thirds, from 88% to 33%.

Comparing the average of the 13 SOA districts across the four provinces with the average of the 10 non-SOA districts, there were similar initial levels of immunisation coverage, but SOA coverage of deliveries by SBA was higher than by non-SOA. And SOA coverage of antenatal care and deliveries in a health facility was much higher (Figure 2). SOA districts performed better on average than non SOA districts on immunisation and antenatal care for 2009-12, with coverage levels falling in non-SOA districts for both indicators.

Figure 2: Comparison of average coverage rates between SOA/non-SOA districts in selected provinces



SOA districts achieved a 10% increase in deliveries by SBA 2009-12 in contrast to a 10% fall in non-SOA districts over the same period. However, if one district (with scarcely credible data) is excluded, the nine remaining non-SOA districts have an increase of 13% 2009-12 (not shown in the graphs above). Finally, non SOA districts achieved a much greater increase in deliveries in a health facility than SOA districts.

Overall, secondary data suggests SOA districts outperformed non-SOA ones for immunisation and antenatal care but the reverse was true of deliveries in health facilities and (probably) also of deliveries by SBA. However, the secondary data also shows that there is selection bias, with SOA districts already well performing on designation. There are further difficulties in interpreting the secondary data and attributing observed improvements in service utilization: SOA districts are better resourced than non-SOA, although their margin of advantage is declining as the value of the Service Delivery Grant falls. Alongside the contracting process, there have been other interventions operating in the provinces such as the Government Midwifery Scheme, Health Equity Fund, Community Based Health Insurance Scheme, and the Reproductive Health Voucher Scheme.

Equity analysis

There was data on the number and proportion of eligible poor in receipt of health services and exempted from user charges. But with one exception, they were only available for SOA districts, making a comparison of the performance of SOA and non-SOA (in terms of extending coverage to the poor) impossible .

Key informant, manager and health worker perceptions

Participants reported that service utilization has increased in districts where SOA was introduced and gave several reasons (see Table 1). They also perceived increases in use of services by the poor. Three main reasons were highlighted: all SOA districts are also equipped with Health Equity Funds (HEF) which allow the poor to use services without paying fees; SOA has improved the attitudes of health workers, who behave well towards all clients irrespective of socio-economic status; and facilities are open 24 hours.

Table1: Reasons for increases in service utilization in SOA districts

MoH representatives and donors	Health managers and providers
Public have more trust in the SOA facilities	Improved public trust in health facilities – provide better quality of care (improved staff attitude and better treatment)
Facilities are now open for 24 hours per day	Staff being available 24 hours per day
Staff are more punctual and stay at facilities because of incentives attached to punctuality and availability of services	Increased community awareness, due to the outreach programmes, of the availability of and need for services
Staff have received more training since being in SOA and this has improved the services that they deliver	Clear contracts with targets for provision of services, incentives and monitoring in the SOA scheme
	Low service fees because of HEF and CBHI

Most interviewees had a very positive view of the impact of SOA contracting arrangements on service delivery but the secondary data present a more nuanced picture. The majority of respondents, quite understandably, were principally focused on, and informed about, developments within their own district and less aware of the performance of non-SOA districts and of wider determinants of service delivery. Consequently, most respondents were not fully aware that some of the same trends of increased service delivery experienced in their districts were also to some extent experienced in non-SOA districts. They were generally not aware of the advantages of SOA districts, in being already better performing districts on designation, and in being better resourced.

Conclusions

- SOA can enhance some aspects of performance of health care providers through adherence to work regulations stipulated in contracts and rewarded with incentives. Improved care quality has improved public trust in the health facilities, contributing to the perceived increase in service utilisation.
- There is some very weak evidence that SOA districts may perform better than non-SOA districts over the period 2009-12. However, clear selection bias and existence of factors such as greater resources available to SOA districts and parallel initiatives, particularly the nationwide midwifery scheme, pose considerable problems of attribution of the observed improvements in health indicators.
- Managing contracts in SOA is a complex process requiring capacity in planning and monitoring at different levels in the health system. Failure to establish cost-effective management and performance monitoring could undermine effectiveness of service delivery.

Recommendations

1. A robust evaluation of SOA performance whereby SOA districts and non-SOA but similarly funded districts are compared.
2. If a systematic study fails to find evidence that SOA are effective and value for money, other models of financing should be considered.
3. If the experiment with SOAs is judged to have been successful the model could be extended to other health districts in Cambodia and operational improvements made based on evidence from this and other research.
4. Improvements in operation of SOA include: strengthening monitoring by the central and provincial levels; having reliable baseline data for specific performance indicators.
5. A review of the data used for evaluating SOA, so that more robust and reliable data can be used to monitor and evaluate performance.

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