ReBUILD Consortium

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Health systems development in conflict-affected states

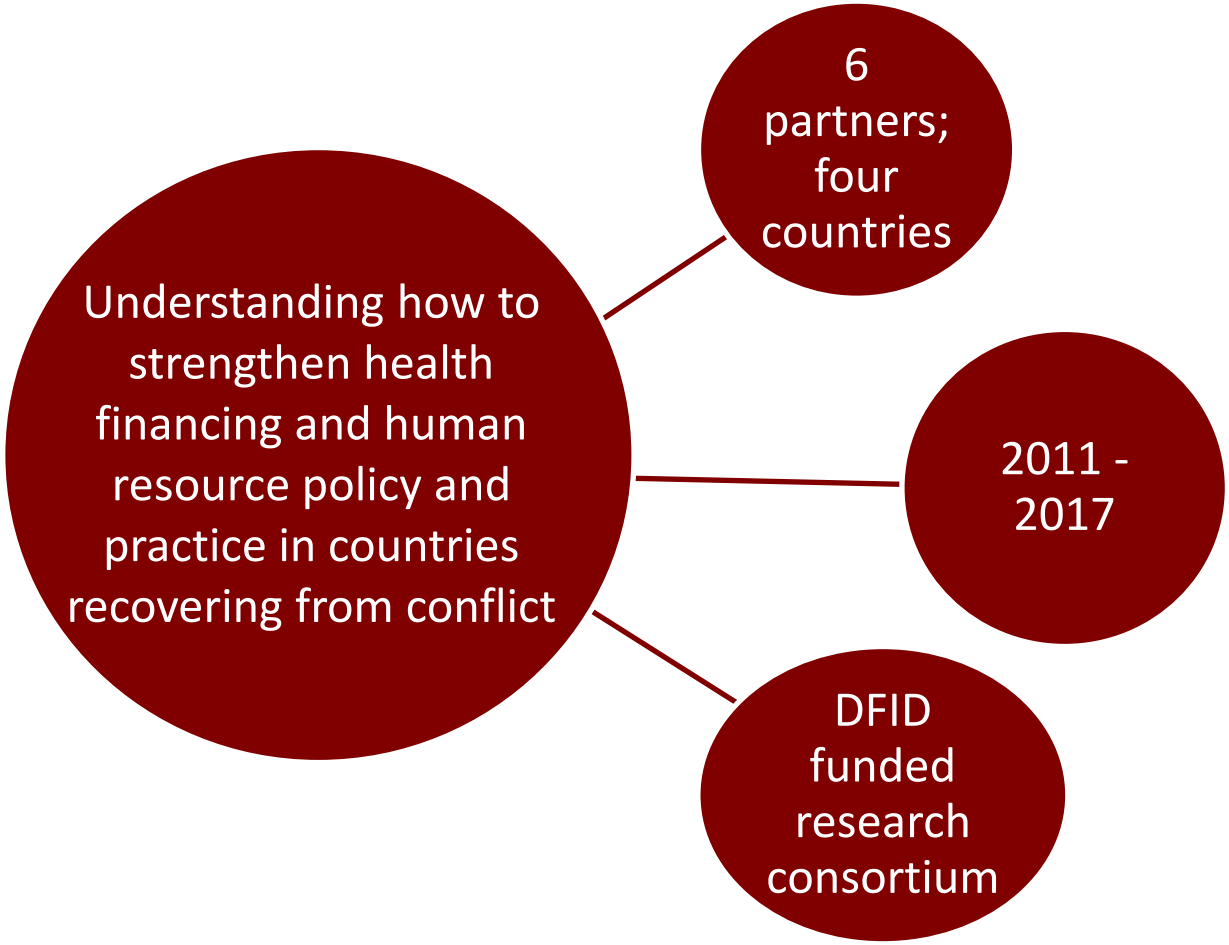
IHEA, Sydney, July 2013

Panel overview

The economics of health systems development in conflict - affected states

- Introduction to ReBUILD
- Impact of health financing policy on households in post-conflict Cambodia
- Health worker incentive environments in post-conflict Zimbabwe
- Evaluation of contracting in Sierra Leone and Cambodia
- Q&A - discussion

What is ReBUILD?



ReBUILD partners

Cambodia (CDRI), Sierra Leone (COMAHS), Uganda (MUSPH), Zimbabwe (BRTI), UK (LSTM) and (QMU)

Why focus on fragile & post-conflict states?

1. Need

- Fragile states are home to **one-sixth of the world's population**, but one-third of those living on less than US$ 1 per day
- More than **a third of maternal deaths worldwide** occur in a fragile state
- **Half of the children who die before age five** live in a fragile state
- Essential to **achieving MDGs**

2. Global externalities

- Seen also as reservoirs of disease, conflict and terrorism for region

3. Underinvestment

- However, fragile states receive around 40% less aid than predicted (Dollar and Levin, 2005)

Critique of existing literature on health financing in post-conflict countries

1. ***Timeframes*:** Focus of most existing literature is on immediate post-conflict period and on role of donors
2. ***Neglected topics*:** Insufficient attention to changing mix of financing mechanisms over time, how these affect equity and access, and other areas such as resource allocation/distribution, regulation, public financial management, personnel management, payment systems and incentives at facility and health worker levels
3. ***Methodological*:** Research methods are mixed and reflect the difficulty of collecting original data in many of these settings

Source: Witter, 2012, Social Science & Medicine

Key starting points of ReBUILD programme

Decisions made early post-conflict can steer the long term development of the health system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Impact of health financing policy on households during the period of conflict: Evidence from household survey data 2004-2009

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Introduction

History of conflict

Cambodia experienced civil unrest for more than two decades **1970 - 1993**

Peace was assumed when the UN sponsored for a national election in **1993**

Despite the successful election, the fractional fighting was broken up again in **1997**

A tension between the ruling party and oppositional party remained after a national election in **1998**

Death of KR leader in **1998**, remaining soldiers begin to defect to the government

True peace began early **1999**

Health system reforms

- Despite still in the conflict, health sector reforms began in 1991 under the Strengthening Health Systems Project
- Phase I (1991-1994): set up a clinic in a commune, a hospital in a district and a provincial hospital in provincial town
- This was not successful, as most clinics at commune levels were non-existent or no staff

Health system reforms (cont'd)

- Phase II (1995-1997): to decentralise primary health care to commune level through "District-based health system" also known as Operational District
- Phase III (1998-2000): a period of contracting health services to NGOs aiming to improve quality of health care and health financing for the poor
- User fee (1996), Community Based Health Insurance (1998) and Health Equity Funds (2000)

Literature Review

- User fees could help to control under-the-table charges, improve staff incentives, reduce out-of-pocket payments at the point of service, improve accountability and quality of service and raise facility utilisation levels. However, user fees have also deterred poor and vulnerable patients from seeking care.
- Health Equity Funds appears to reduce household health expenditure and health related debt, but its effect on poverty is not clear.
- Little known about the impact of Community Based Health Insurance.

Research objectives

- To examine how household expenditures (including poverty) and utilization of health services have been affected by health financing policies (user fee, health equity fund and community based health insurance) in Cambodia.

Data

- Household Survey Data
  - Cambodia Socio-Economic Survey 2004 and 2009
- Administrative Data
  - User Fee
  - Health Equity Fund
  - Community Based Health Insurance

	Province	District	Commune	Village	Household
2004	23	153	559	695	11825
2009	24	171	621	715	11971

Common Communes

	Province	District	Commune	Village	Household
2004	20	110	279	396	6356
2009	20	110	279	357	5454

Dropped samples

	Province	District	Commune	Village	Household
2004	3	43	280	299	5469
2009	4	61	342	358	6517

The sample size for treatment and control in full sample (policy was adopted before 2004)

User fee				Health equity funds				Community based health insurance			
	Without user fee	With user fee	Total		Without HEF	With HEF	Total		Without CBHI	With CBHI	Total
2004	4749	7076	11825	2004	11225	600	11825	2004	11715	110	11825
2009	4817	7154	11971	2009	11305	666	11971	2009	11841	130	11971
Total	9566	14230	23796	Total	22530	1266	23796	Total	23556	240	23796

The sample size for treatment and control--excluding observations effected by each policy in 2004 in common communes (i.e. policy was adopted after 2004)

User fee				Health equity funds				Community based health insurance			
	Without user fee	With user fee	Total		Without HEF	With HEF	Total		Without CBHI	With CBHI	Total
2004	933	1440	2373	2004	4716	1300	6016	2004	5927	359	6286
2009	807	1266	2073	2009	4067	1098	5165	2009	5105	299	5404
Total	1740	2706	4446	Total	8783	2398	11181	Total	11032	658	11690

Research methods

- **Descriptive Statistics**
- Two Part Model (2PM): To address an overabundance of zeros outcome variable.
- Two Stage Residual Inclusion (2SRI): To address endogeneity in the specific case of a binary endogenous variable with a binary outcome variable.

Research methods (cont'd)

- Basic empirical model:

$$outcome_i = \beta_0 + \beta_1 t + \beta_2 UF + \beta_3 UF \times t + \beta_4 X + \beta_5 Y + \beta_6 Z + \varepsilon_i$$

where

- **t** is a dummy variable indicating pre- and post-UF (t=0 for 2004 and t=1 for 2009);
- **UF** is a dummy for user fees (UF=1 if user fees implemented, 0 otherwise);
- **X** is a vector of individual covariates
- **Y** is vector for household covariates
- **Z** is a vector of community level covariates
- ε is the error term.

Research methods (cont'd)

- **Two Part Model (2PM)**
  - Part 1: OOP=1, if out of pocket payments are positive, OOP=0 otherwise. This uses probit estimation.
  - Part 2: OOP is a continuous variable equal to the size of the out of pocket payment only for those observations where payments are greater than zero. This part of the model uses generalised linear model estimation (GLM).

Descriptive statistics

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (UF)	Control	Intervention (UF)	Control	Intervention (UF)
Out-of-pocket (riels)	273.7	404.0	493.7	427.3	220.0	23.3
Out-of-pocket (% of total expenditure)	0.04	0.05	0.04	0.05	0.00	0.00
Catastrophic health expenditure (10%)	0.12	0.13	0.13	0.14	0.01	0.01
Catastrophic health expenditure (20%)	0.07	0.07	0.07	0.07	0.00	0.00
Catastrophic health expenditure (30%)	0.04	0.04	0.04	0.04	0.00	0.00
Poverty headcount	0.29	0.41	0.23	0.40	-0.06	-0.01
Observation	933	1440	807	1266		

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (HEF)	Control	Intervention (HEF)	Control	Intervention (HEF)
Out-of-pocket (riels)	298.4	410.0	435.0	315.5	136.6	-94.5
Out-of-pocket (% of total expenditure)	0.04	0.04	0.04	0.03	0.00	-0.01
Catastrophic health expenditure (10%)	0.12	0.14	0.11	0.10	-0.01	-0.04
Catastrophic health expenditure (20%)	0.07	0.07	0.05	0.05	-0.02	-0.02
Catastrophic health expenditure (30%)	0.04	0.04	0.03	0.02	-0.01	-0.02
Poverty headcount	0.38	0.28	0.35	0.33	-0.03	0.05
Observation	4716	1300	4067	1098		

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (CBHI)	Control	Intervention (CBHI)	Control	Intervention (CBHI)
Out-of-pocket (riels)	336.3	139.8	392.5	162.5	56.2	22.6
Out-of-pocket (% of total expenditure)	0.04	0.04	0.04	0.03	0.00	-0.01
Catastrophic health expenditure (10%)	0.12	0.14	0.13	0.08	0.01	-0.06
Catastrophic health expenditure (20%)	0.07	0.06	0.06	0.04	-0.01	-0.02
Catastrophic health expenditure (30%)	0.04	0.02	0.03	0.02	-0.01	0.00
Poverty headcount	0.36	0.36	0.33	0.47	-0.03	0.11
Observation	5927	359	5105	299		

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (UF)	Control	Intervention (UF)	Control	Intervention (UF)
Public health provider (number of visits)	0.17	0.33	0.26	0.30	0.09	-0.03
Private health provider (number of visits)	1.78	1.42	1.21	0.89	-0.57	-0.53
Non-medical provider (number of visits)	0.05	0.11	0.27	0.54	0.22	0.43
Observation	384	510	320	561		

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (HEF)	Control	Intervention (HEF)	Control	Intervention (HEF)
Public health provider (number of visits)	0.29	0.18	0.33	0.25	0.04	0.07
Private health provider (number of visits)	1.42	1.53	0.94	0.83	-0.48	-0.70
Non-medical provider (number of visits)	0.08	0.1	0.39	0.4	0.31	0.30
Observation	1675	511	1806	429		

	2004 (Baseline)		2009 (After intervention)		Change: 2004-2009	
	Control	Intervention (CBHI)	Control	Intervention (CBHI)	Control	Intervention (CBHI)
Public health provider (number of visits)	0.26	0.39	0.31	0.35	0.05	-0.04
Private health provider (number of visits)	1.45	1.29	0.94	0.64	-0.51	-0.65
Non-medical provider (number of visits)	0.09	0.07	0.39	0.25	0.30	0.18
Observation	2167	119	2206	84		

	2004 (Baseline)		2009 (After intervention)	
	Control	Intervention (UF)	Control	Intervention (UF)
Out-of-pocket (riels)	273.71	404.01	493.66	427.33
Out-of-pocket (% of total expenditure)	0.04	0.05	0.04	0.05
Catastrophic health expenditure (10%)	0.12	0.13	0.13	0.14
Catastrophic health expenditure (20%)	0.07	0.07	0.07	0.07
Catastrophic health expenditure (30%)	0.04	0.04	0.04	0.04
Poverty headcount	0.29	0.41	0.23	0.40
HHH gender (1=male)	0.76	0.81	0.80	0.79
HHH marital (1=married)	0.79	0.81	0.80	0.78
HHH educational level (1=no schooling)	0.27	0.28	0.16	0.28
HHH educational level (1=primary incomplete)	0.34	0.46	0.40	0.48
HHH educational level (1=primary complete)	0.21	0.19	0.22	0.17
HHH educational level (1=lower secondary complete)	0.09	0.05	0.13	0.06
HHH educational level (1=upper secondary complete)	0.03	0.01	0.01	0.00
Household size	5.09	5.09	4.99	4.79
Household members aged 0-4	0.44	0.49	0.43	0.46
Household members aged 5-9	0.54	0.61	0.47	0.57
Household members aged 10-14	0.69	0.73	0.55	0.56
Household members aged 15-64	3.23	3.04	3.33	2.97
Household members aged 65+	0.19	0.23	0.21	0.23
Wealth index (CPA)	2.30	-0.28	4.56	0.47
Consumption quintile (1=1st quintile)	0.16	0.24	0.13	0.24
Consumption quintile (1=2nd quintile)	0.16	0.24	0.13	0.24
Consumption quintile (1=3rd quintile)	0.16	0.23	0.16	0.22
Consumption quintile (1=4th quintile)	0.21	0.19	0.22	0.19
Consumption quintile (1=5th quintile)	0.32	0.10	0.35	0.10
Region (1=Phnom Penh)	0.53	0.00	0.51	0.00
Region (1=Other urban)	0.07	0.12	0.05	0.09
Region (1=Rural)	0.40	0.88	0.44	0.91
Observation	**933**	**1440**	**807**	**1266**

Multivariate Regression- OOP

VARIABLES	(1) uf probit	(2) glm	(1) hef probit	(2) glm	(1) cbhi probit	(2) glm
policy (=1 if policy is implemented)	-0.0400	383.3	-0.0213	222.2	-0.136*	-296.0
	(0.0647)	(358.3)	(0.0403)	(189.1)	(0.0703)	(340.3)
period (=1 if 2009)	-0.109*	514.7	0.0254	192.1	0.0182	104.8
	(0.0638)	(352.9)	(0.0281)	(129.3)	(0.0252)	(114.8)
impact of policy	0.0902	-450.5	-0.0341	-368.9	-0.271**	49.37
	(0.0796)	(436.6)	(0.0590)	(277.5)	(0.106)	(538.3)
Observations	4,398	4,398	11,091	11,091	11,599	11,599

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

Next

- Using CSES 1997 and 2009 to examine the impact of user fee on household expenditures and utilisation of health services.
- Addressing the endogeneity problem
- The final results of multivariate regression model are expected to come out at the end of this year.

Malaria patient in Cambodia 2009, PBS Newshour

Health worker incentives post-conflict – early ReBUILD findings from Zimbabwe

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Research aims and questions

To understand the evolution of incentives for health workers post-conflict and their effects

Research questions:

1. How have incentives evolved in the shift away from conflict in each country?
2. What influenced the trajectory?
3. What have been the reform objectives and mechanisms?
4. What are their effects (intended and unintended)?
5. What lessons can be learned (on design, implementation, and suitability to context)?

Main methods

Quantitative and qualitative data collection methods

Research tools	Cambodia	Sierra Leone	Uganda	Zimbabwe
1. Stakeholder mapping		√	√	
2. Document review	√	√	√	√
3. Key informant interviews	√	√	√	√
4. Life histories of health workers	√	√	√	√
5. Quantitative analysis of routine data	√	√		√
6. Survey of health workers		√		√

Background

- Zimbabwe is emerging from decade long economic, social and political crisis.
- Health sector has been and is still affected by this crisis.
- There is still a debate as to whether the crisis is over, or is still there but in a state of lull.
- In the crisis years(1997-2009) Zimbabwe's health sector experienced sharp decreases in funding in real terms:
  - Deterioration of health infrastructure
  - Loss of experienced health professionals
  - Drug shortages
  - Increased burden of disease and the attendant high demand for services.

- Drastic decline in the quality of health services available for the population (MoHCW/HSB 2010, GoZ, STERP, 2009, NHIFA Final report, 2012)
- The vacancy rates for cadres critical for Primary care services like doctors, Clinical Officers, Environmental Technicians and Officers, nurses and midwives were very high especially in rural areas

December 2007	Establishment	In Post	Vacancy Rate
Nurses/ MWs	17338	11822	38%
EHWs	2395	2395	52%
Drs	1761	660	63%
Cos	48	48	56%

Study participants and sampling methods

- Health sectors studied in three districts (rural and urban/better and under-served):
  - Government
  - Municipal/Rural District Council
  - Private
  - Mission
- KIIs (13), in-depth interviews (26) and career history participants (15) were selected purposively. The career history participants were long-serving HWs
- Provincial level staffing data was used to come up with some proportional measure to derive survey participants per cadre per site. The totals derived from this process were then further distributed by type of employer (total 227)
- Routine data (limited)
- Document review (less limited but still requiring considerable effort to access).

Response rates

- HWs who participated in the IDIs and career histories difficult to get in the private sector, especially doctors, midwives and clinical officers because there are few people who qualified because they were not full time.
- For the private sector it emerged that most of the doctors, nurses, midwives were government doctors doing locum or some extra work.
- Turnover meant that few of the doctors had been in place long enough to quality for career histories

Effects of the conflict/crisis on health workers

- Health workers were adversely affected like all workers in Zimbabwe.
- KIIs pointed out that between 2000 and 2009 HWs salaries were eroded to a point where drawing the salaries became a futile exercise , more costly to undertake than the monetary value of the salary.
- HWs in rural areas were affected adversely due to the higher transport cost to and from the urban centre where they had to travel to draw salaries from banking institutions.
- As a result HWs stopped attempting to get official salaries and at health facilities absenteeism became widespread.

Responses by Health Workers across the sectors

- As the crisis increased in severity HWs left their jobs (mostly in GoZ)
- Most of those that left had specialist training (midwifery, theatre training)
- Doctors went into private practice)
- Those that remained tried to cope by any means: (cases of drugs being sold at facilities which were meant to be supplied to patient for free were reported (largely in RDC/municipality facilities and government facilities)

HRH policy responses

Recruitment

- 2005 –creation of Health Services Board, but failure to establish it as separate commission; HSB understaffed (HSB, 2011)
- HRH expenditure fell from 2005 through 2007, with a complete collapse in human resource spending in 2008, when human resources spending accounted for 0.3 percent of the public health budget (Osika, 2010)
- No review of staffing norms, despite population movements (Sikhosana, 2005)
- Use of Cuban doctors to gap fill
- Introduction of Primary Care Nurses in 2007 to ensure staffing in rural areas – effectiveness reduced by recruitment delays
- Fellowship and scholarship programmes, as well as advanced training programmes, were introduced beginning in 2007 – harshness of crisis limited effectiveness; funding collapsed 2008 (Chimbari, 2008)

Source: Chirwa, 2013, Understanding health worker incentives in post-crisis settings: Zimbabwe document review

Retention & incentives policies

- Sub-Committee For Revamping the Health Sector Delivery system in Zimbabwe puts forward recommendations to increase recruitment and retention, 2008 – still not funded or implemented
- The policy to harmonise salaries and allowances in the public service beginning 1 May 2007 led to a lower salary award to the health sector, compared to the rest of the civil service
- Allowances for post-basic training and rural allowance also introduced at height of crisis but failed to keep pace with inflation
- Salaries increased in 2009 and 2011 but remain very low and the salary differentials between notches and grades remain very small
- Housing and transport in-kind benefits increased 2011
- All rural-based civil servants were awarded a rural allowance for the first time in 1996 – not effective as available to all sectors and too low
- Bonding of newly qualified nurses was first introduced in 1997 – later tightened but only delayed, did not stop, migration (Chikanda, 2010)

Retention and performance management

Human Resources Retention Policy introduced in 2010 with donor support. Grades C5 and above. Administered by external contractor. Stabilised workforce in short term, though divisive (evaluation of 2011). To phase out 2013

Performance management introduced 1995 – poorly implemented due to resistance in MOHSW, lack of funding, low capacity, lack of staff and lack of time to supervise and appraise (Chikanda 2010)

In 2005, results-based management introduced – being rolled out in 2012, spearheaded by HSB (HSB, 2011)

Responses by Municipalities

Municipality Site 1

- Applied to MoPLSW to change HWs' grades from those recommended by MoHCW & integrated HWs into the local government prescribed grading system. This substantially increased the salaries of HWs

Municipality Site 2

- An across the board allowance of 100 South African Rand to be paid to health workers in August 2008 over and above the official salary in local currency.
- In site two the municipality has in place a policy that bars any HW who resigned before 2009 from being reengaged in their facilities.
- KII noted that this helped retain staff, very few HWs left the municipality.

Responses by mission providers

- Two different mission providers were studied and the responses were similar:
  - Procured basic household items (food items) for health workers
  - HWs with children in Mission High schools close to the facility allowed HWs to pay school fees in instalments
- In both institutions there were relatively fewer problems of HW absenteeism and resignations

Effects on service delivery

Increased absenteeism

Increased number of HW suspended / dismissed as a result of misconduct

Poor service delivery as more time spent organising hearings

Conclusions – policy trajectory Zimbabwe

Attrition rates have reduced following the implementation of the short term retention scheme suggesting that incentives can work to retain skilled HRH if professionally managed.

However, in general staff numbers have been reduced through emigration to other countries and also internal migration to other sectors

- Policy measures have not been effective – one of the reason is the government has failed to deal with the political conundrum of singling out the health sector for special treatment – benefits across all civil service
- The MoHCW has never had the authority or the support of the key line ministries responsible, the MoF and the Ministry of Public Service, for ensuring that funds are made available for the review of HRH remuneration
- Lack of sustainable direct funding from government
- Lack of harmonisation of the retention scheme(s) in the entire sector
- Preferential treatment for the various professional categories in the public health sector (Doctors, Midwives, SCNs, PCNs, EHTS, EHOs)

- Training opportunities have become riddled with corruption, thus becoming a de-motivating factor
- The preferential treatment for the various professional categories in the public health sector is a cause of intra-professional rivalry and poor morale among other health workers
- The asymmetries in conditions of service among Govt, RDC and mission providers lag behind the municipal providers, hence HWs continue to leave Govt for the municipality
- Successive policies have lacked a consultative process and political buy in by other line ministries
- Lack of debate and access to data
  - Weak HRH information systems to monitor and keep track of what is happening at all operational levels with regards to HRH.

Child vaccination in Sierra Leone 2011, DFID UK

Contracting in conflict affected settings: evidence from Cambodia

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Background

- Health care contracting to external, non-government providers is common in immediate post-conflict situations because of the public sector's limited capacity for health service delivery (Witter 2012; Palmer et al. 2006)
- However, over time, the potential problems of external contracting in terms of ownership, accountability and sustainability may become more apparent
- Two of the ReBUILD countries, Cambodia and Sierra Leone, have employed contracting

Elements of ‘new public management’ and terminology

- Strengthening incentives
- Regulating the relationship between payer and provider through an explicit contract
- Increasing managerial autonomy

…are often implemented together but with different emphases on the different elements and with labels including ‘contracting’; ‘paying for performance’

Contracting in Cambodia

Pilot project 1999-2002

- Contracting in, contracting out and control were piloted
- The differences are the level of autonomy of management of public health facilities

Hybrid contracting 2004-2008

- Contracting-in in 11 districts
- Internal contracting in 5 districts

Internal contracting 2009-Present

- Special Operating Agencies: government run with performance based contracting

Special Operating Agencies: SOA

- 11 ODs formally contracted to NGOs became SOAs in 2009
- Another 11 ODs became SOAs in 2010
- Additional funds provided ('Service Delivery Grant') for HW incentives and other activities
- Contract between Provincial Health Department and SOA
- No under-the-table payments
- No private practice in public premises
- No pilfering of drugs

(Source: Khim and Annear, 2013)

The objectives are to:

Improve the quality and delivery of public health services in response to needs

Reorient the behaviour of healthcare providers towards the principles of motivation, loyalty, service and professionalism

Promote prudent, effective and transparent performance-based management

Develop sustainable service delivery capacity within public administration (MoH, 2009)

Contracting in Cambodia

- There is evidence of success of the earlier period of contracting:
  - Rapid expansion of coverage, contributing to a reduction in infant, child and maternal mortality (Bhushan et al, 2002)
- However, contracting-out districts had almost twice the recurrent costs of the non contracting districts
- While perhaps cost-effective, there were doubts as to the sustainability of this model

Study design

Objectives

- To understand the change process in contracting arrangements in the Cambodian health sector
- To document the processes of implementation of SOA
- To examine the implications of the SOA on service coverage and equity.

Methods

- Document review
- Analysis of existing data
- Key informant interviews at national and provincial level
- In depth interviews with managers and health care providers

Study sites

- 4 districts in 4 provinces:
  - Samraong in Oddar Meanchey
  - Memut in Kampong Cham
  - Pearaing in Prey Veng
  - Bati in Takeo
- Only two of the four Provinces (Kampong Cham and Prey Veng) include both SOA and non SOA districts

Analysis of existing data

- We used HMIS data to compare performance on three key indicators:
  - Antenatal care
  - Delivery by a trained professional
  - Delivery in a health facility

- We analysed rates of change of coverage between 2009, when the SOA system was introduced, and 2011, the most recent year for which there was comprehensive data

Limitations

- Difficulties in systematically identifying the impact of the SOA system:
  - No careful matching of contracting districts with similar non intervention, control districts
  - Many SOAs were previously contracting districts and, moreover, better performing districts
  - Greater resources available to SOA districts
  - Other programmes implemented at same time

Secondary data

- Suspicions about the quality of the HMIS data
- 20 of the 23 districts in the four provinces recorded a fall in ANC coverage between 2009-10 which appears to reflect problems in data collection rather than real changes in service provision
- However, these problems are common to both SOA and non SOA districts and thus are unlikely to significantly affect the comparison of the two

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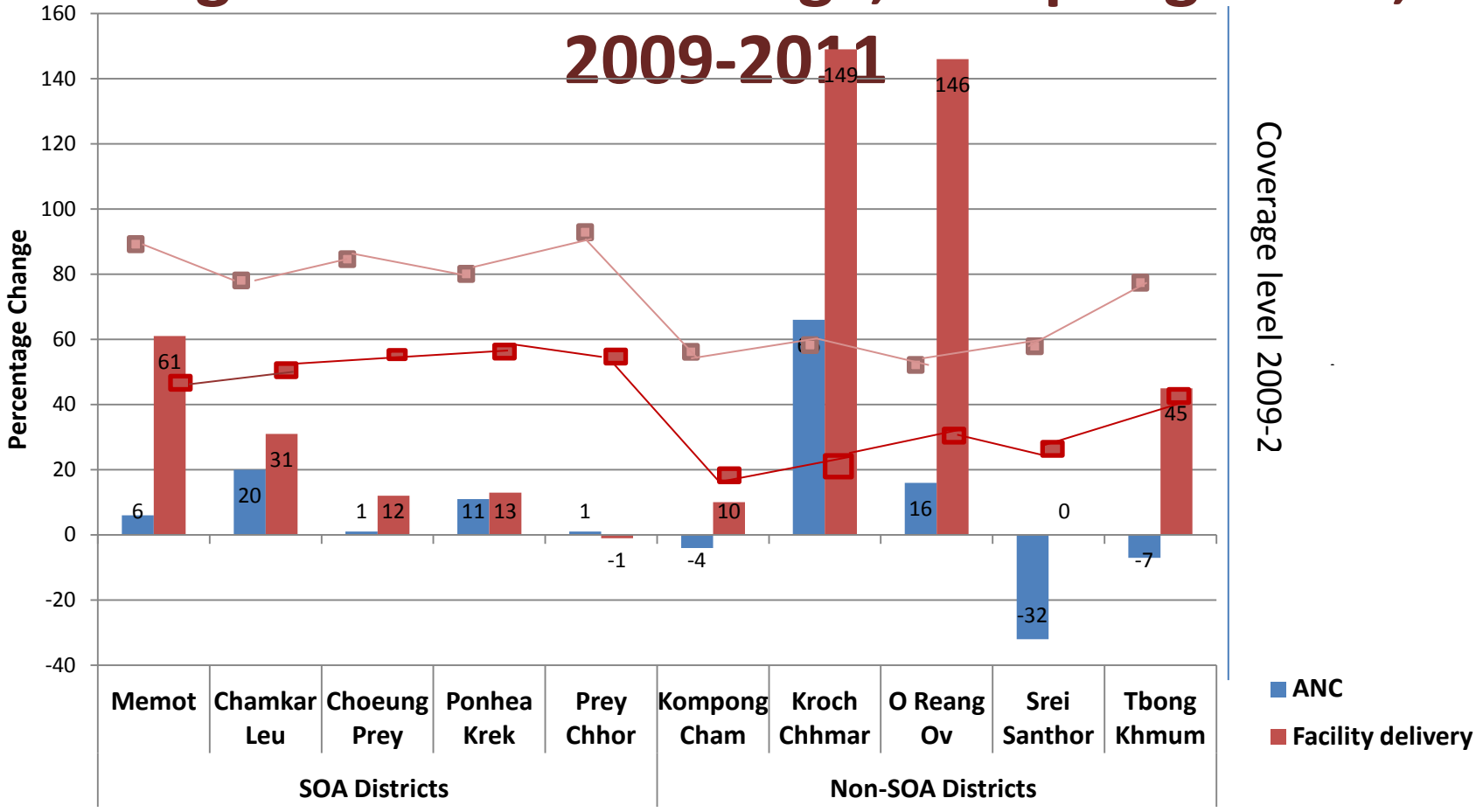
Change in service coverage, Kampong Cham, 2009-2011



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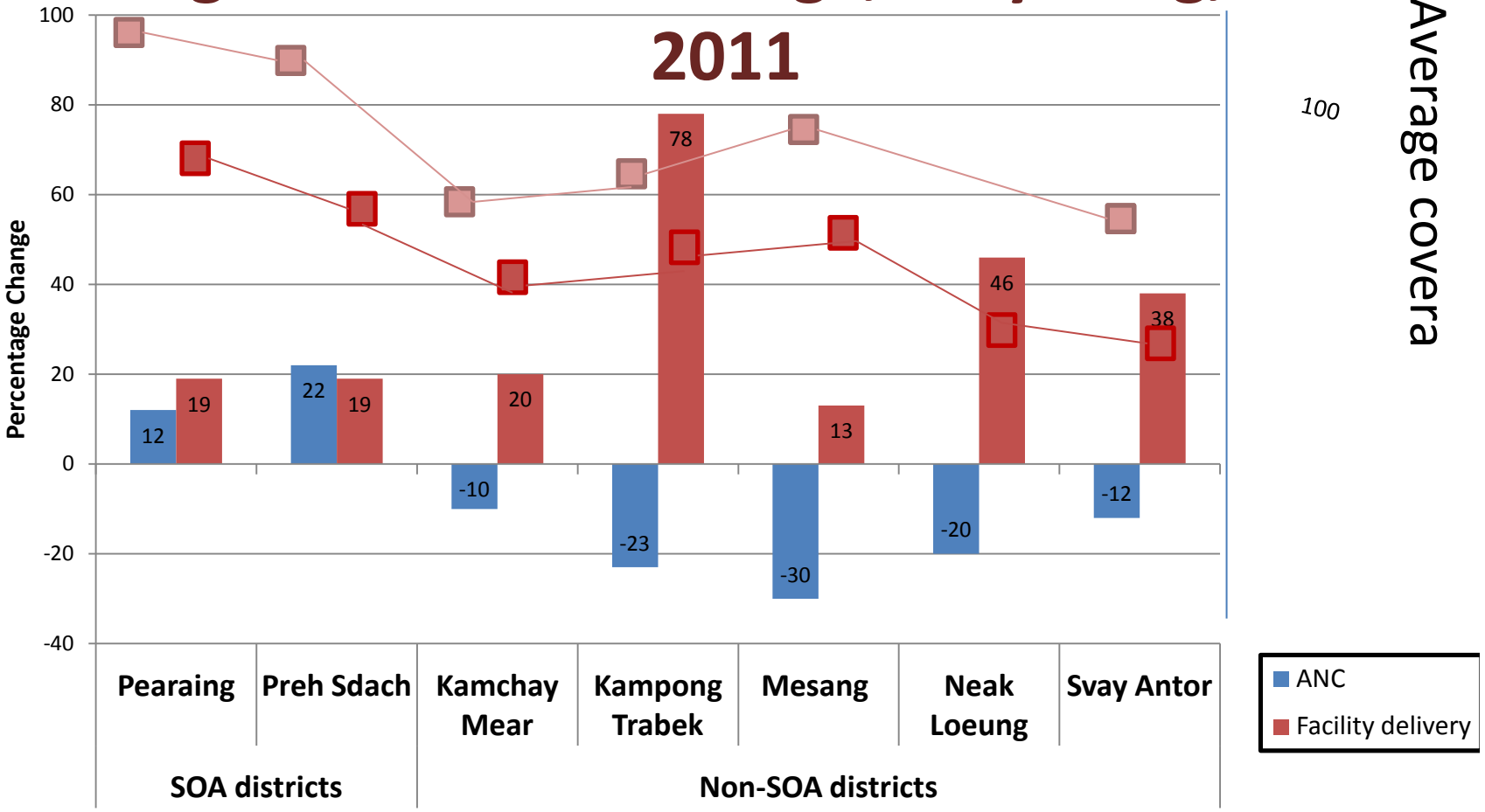
Change in service coverage, Prey Veng, 2009-2011



Impact of contracting on service provision

- Alongside the contracting process, there are a variety of other interventions implemented:
  - Midwifery scheme
  - Health Equity Fund (HEF) arrangement
  - Community Based Health Insurance (CBHI) scheme
  - Voucher scheme

- These also may have effects on the use of services, and particularly by the poorest groups (Vong, 2013)

Impact of contracting on service provision

- In Prey Veng Province, the additional interventions are present in Pearaing but not Preh Sdach (SOA districts)
  - Both districts show near identical increases in both delivery measures 2009-11
  - Preh Sdach has a greater increase in ANC coverage

- It is not possible to conclude that the SOA districts in the four provinces perform better or worse than non SOA districts over the period 2009-11

Key informant interviews and in depth interviews

Interview	Number
KII	5
Managers	12 (3 in each district)
Health workers	12 (3 in each district)
Total	**29**

- Interviews recorded where consent given
- Interviews transcribed or noted in Khmer
- Translated into English
- Thematic analysis is currently underway

Incentives

- Absence of clear incentive structure for managers and health workers in contracted districts

- Various bonuses and incentives but they are not related to individual performance, are allocated differently in different districts, are generally small and are often paid late

"The main source is the money from midwifery scheme and the second one is the government salary. Salary from SOA is the least one" (Midwife, Memut district)

Staff involvement

Limited staff involvement in contract development

“I didn’t read the contract. They produce it for us and we just signed. So I didn’t really pay attention on the contract. I just signed a new contract yesterday or the day before yesterday” (Midwife, Memut district)

Staff behaviour

- Staff in some districts do private practice during government working hours

"For staff, it seems the current system is better. We can take some time during working hours to go home to look after our own patients. We can possibly make consultation with up to 10 patients per day. So it's good for those who run their clinic at home, but it's a bit difficult for those who do not have" (Midwife Memut district)

"If no contract with SOA, the motivation of our staff would not be the same, perhaps they will shift to work outside. If they work outside, it will have a bad effect - when people come here, they can't meet staff, staff don't stay full time" (Nurse, Oddar Meanchey district)

Staff behaviour

- Communication with patients is good – this was learned and encouraged during previous contracting schemes and maintained

“ Staff behaviour was better during Save the Children (Contracting in) period if compared to the time we switched to work under the government. However, now, there is a strong focus on our behaviour. During our meetings, the OD director always advises to soften staff behavior towards the patients. We have practiced it and there’s hardly any issue occurred in relation to our behavior. Staff behaviour has improved a lot so far.”
(Midwife, Memut district)

Preliminary findings from qualitative data

- Shift in contracting was driven primarily by the pressure for increased national ownership
- Progress towards increased coverage through contracting appears to have stalled with SOA

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Comparison: Sierra Leone

- First phase – understanding what is in place
- New system introduced for whole Sierra Leone 2011 and applied to:
  - All government Primary Health Units
  - All static clinics delivering PHC in district hospitals

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PBF in Sierra Leone

- Aims to change behaviour of HWs to deliver more quality services under the Free Health Care Policy:
  - Provide cash to facilities
  - Provide financial incentives
  - Facilities can hire workers and finance outreach activities

- Focuses on 6 key interventions
  - use of modern contraceptive methods
  - antenatal care
  - delivery by a skilled professional
  - postnatal care
  - immunisation of children under 1 year
  - outpatient care of children under 5 years

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Roles in system

- MoH is regulator
- Local government finance department is national fund-holder and purchaser
- District Health Management Team is local regulator
- Primary Health Unit is the service provider

Payment based on performance in the 6 dimensions

- Initial measurement of the 6 indicators from the HMIS
- Basic payment calculated
- Internal verification team
  - Check clinical register
  - Evaluate clinical indicators
  - Evaluate financial management and record keeping
- Additional and revised data entered into HMIS

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Use of PBF payment

- Maximum 60% incentives for PHU staff
- Minimum 40% operational costs and minor investments in the facility

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Study design

Document review

Key informant interviews

To understand the change process, implementation of the scheme and its consequences

In-depth interviews with health managers and workers

Analysis of secondary data

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Funded by UKaid from the British people

Thank you

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ReBUILD is a 6 year £6million research project funded by the UK Department for International Development (DFID)