The Contracting approach- experiences from Cambodia

Health Net International

Project description

- Operational Health District of Pearang in Prey Veng province
- Start date: April 1999
- End date: December 2007.
- Target population: approx. 192,000 (2007) in 15 communes
- One Referral Hospital (71 beds) and 15 Health Centres (2 with beds)
- Total No. of MOH staff: 123
  5 doctors, 14 Medical Assistants, 2 secondary midwives, 26 primary midwives, 24 Secondary nurses, 52 primary nurses

  -26 temporary staff

Partners and financing

- Partners: Ministry of Health, Asian Development Bank, DFID, Provincial and District Health authorities in Prey Veng province

- One of the first contracting projects on this scale and form

- Financing:
  ADB as loan to GOC/Ministry of Health
  DFID as grant for some provinces
  Government budget for staff salaries and running costs
  Health equity funds
  National programs (Global Fund etc.)
  Community user fees
  NGO contributions

Contract management

'Contracting'

means handing-over health service delivery management to Contractors (private, independent entity) in one of two ways:

- Contracting In

Handing-over the management to a Contractor to work within the same MOH management system

- Contracting Out

Contracting the management to a Contractor out of the normal MOH management system.

Contract management (continued)

- requires change in mindset at all levels
- Contractor as third party Manager functioning as 'Fund Holder'
- 'contracting-in' approach
- 'client-employee' relationship with the MoH
- requires extra inputs:
  - external technical assistance
  - staff from private sector to fill-in shortfalls
  - extra subsidies/incentives to subsidize staff salaries and running costs
  - system for monitoring contractual agreements with health facilities to ensure compliance and correct reporting
  - funding for special training events and community health promotion campaigns
  - resources for mobilizing and organizing the communities
  - resources for subsidizing the poor
  - resources for control of disease outbreaks
  - Occasional stop-gap measures when MOH system does not respond adequately e.g. funds for running costs, broken equipment, damaged buildings, filling in drug shortfalls etc.

Achievement of targets

Indicator	Contract goals 2004 -2007	Year	Baseline 1998, Evaluations (2001 & 2003) & HIS /Monitoring reports (2006)	Change from baseline
ANC2	50%	1998	3.00%	-
		2001	25.20%	741.30%
		2003	65.10%	2070.00%
		2006	82.00%	2633.30%
Vit A Child	75%	1998	32.80%	-
		2001	63.20%	192.68%
		2003	80.10%	244.21%
		2006	72.30%	220.43%
Child Immunization	70%	1998	24.00%	-
		2001	51.90%	116.30%
		2003	95.80%	299.17%
		2006	74.00%	208.33%
Facility Safe Delivery	40%	1998	3.00%	-
		2001	19.50%	550.80%
		2003	33.50%	1016.67%
		2006	65.15%	2071.70%
Modern Birth Spacing	35%	1998	14.00%	-
		2001	30.40%	117.20%
		2003	31.10%	122.14%
		2006	34.60%	147.14%
Usage by the poor	25%	1998	1.10%	-
		2001	18.00%	1536.40%
		2003	28.30%	2472.73%
		2006	NA	-

Example of direct costs of a 'well performing' HC

Pop. 16,669 (2006)

Av. annual outpatient consultancies/capita: 0.98

Av. annual direct costs/capita: USD 2.00

Source	**Av. / month USD**	**%**
Performance based subsidies	544.22	20%
User fees	463.63	17%
Government budget for running costs	504.78	18%
MOH salaries (6 staff)	196.85	7%
CMS drugs	926.83	33%
Extra drugs from private market	146.34	5%
Total	**2,782.39**	100%

Constraints

1. coordination with provincial level; unclear TORs
2. efficiency and accountability
3. ethical behavior & discipline- unclear policy guidelines & enforcement
4. national budget (running costs): access problems and long delays
5. delays in provision of buildings and equipment
6. central drug supply system; not responsive to demand
7. low capacity & inappropriate staff distribution
8. issue of 24 hour health care delivery & quality of care
9. Contractor-staff agreements often misunderstood, not respected
10. conflict of interest: private practices & under-the-table payments
11. promoting public health facilities- competition with unregulated private sector
12. traditional beliefs and practices: motivating community volunteers for improved behavior change communication

Success factors

A. Management

1. reasonable operational support from central MOH/HSSP
2. authority to direct staff and other resources; decisive and flexible management
3. ‘private business’’ approach: decentralization- sub-contracting
4. subcontracting allows flexible recruitment procedures
5. performance-based incentive contracts dependent on output/quality of care
6. clear and achievable targets
7. facilitating environment with clear staff job descriptions
8. incentive structure with adequate reward- livable wage
9. conditions conducive to conflict of interests removed
10. functioning disciplinary committee at Operational District level
11. strict monitoring system/checks and low tolerance for irregularities.

Success factors (continued)

B. Behaviour change communication

1. changed perceptions of both health staff and communities regarding quality of care through ethical approach and IEC program
2. improved communication between health staff and community

C. Access

1. community links, feedback mechanisms & referral systems
2. adequate subsidies for services that save lives or serve a public health interest
3. user fees: transparent, clearly advertised, set in consultation with communities
4. health equity funds replace user-fee exemptions (used exceptionally)
5. trained staff with quality of care improvements*: both professional as well as consumer point of view*

Results…. improvement in:

1. health staff motivation
2. range of health services available 24 hours/7 days a week
3. community satisfaction with user fee tariffs and quality of care, including waiting time, staff attitudes/behavior and patient referral
4. health seeking behavior
5. identification and resolution of critical management issues/problems
6. drug availability and management
7. maintenance of infrastructure and equipment
8. logistic systems, financial accountability and transparency
9. communicable disease treatment and control
10. emergency obstetrical care
11. out-of-pocket expenditure on health

Challenges

1. understanding and acceptance by all actors- *changing mindsets*
2. efficiency and accountability
3. building capacity of government staff and improving ethical behavior
4. providing livable wages based on performance *(staff motivation)*
5. avoiding conflict of interest *(staff private practices, under-the-table payments etc.)*
6. collaboration between Contractor and MOH/Provincial Health authorities- *client-employee relationship*
7. improved behavior change communication
8. how to identify and target the poor *(exemption mechanisms, health equity funds)*?
9. how to smoothen health care costs and make them more predictable *(community health insurance schemes)?*
10. accessible and quality health services attractive to the community- *addressing community needs and aspirations*
11. promoting utilization of public health facilities

Opportunities for Regional Cooperation

1. identify issues common to public health systems and discuss policy & guidelines
2. setting minimum acceptable health care standards
3. document and disseminate best practices and lessons learned
4. sharing of human resources and experiences- backstopping, forums, exposure visits/exchange programs
5. develop regional strategy for addressing shared problems: *try to influence the public health system, not force the system*