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Strengthening district health service management and delivery through internal contracting: Lessons from pilot projects in Cambodia

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ABSTRACT

Following a decade of piloting different models of contracting, in mid-2009 the Cambodian Ministry of Health began to test a form of 'internal contracting' for health care delivery in selected health districts (including hospitals and health centers) contracted by the provincial health department as Special Operating Agencies (SOAs) and provided with greater management autonomy. This study assesses the internal contracting approach as a means for improving the management of district health services and strengthening service delivery. While the study may contribute to the emerging field now known as performance-based financing, the lessons deal more broadly with the impact of management reform and increased autonomy in contrast to traditional public sector line-management and budgeting. Carried out during 2011, the study was based on: (i) a review of the literature and of operational documents; (ii) primary data from semi-structured key informant interviews with 20 health officials in two provinces involved in four SOA pilot districts; and (iii) routine data from the 2011 SOA performance monitoring report. Five prerequisites were identified for effective contract management and improved service delivery: a clear understanding of roles and responsibilities by the contracting parties; implementation of clear rules and procedures; effective management of performance; effective monitoring of the contract; and adequate and timely provision of resources. Both the level and allocation of incentives and management bottlenecks at various levels continue to impede implementation. We conclude that, in contracted arrangements like these, the clear separation of contracting functions (purchasing, commissioning, monitoring and regulating), management autonomy where responsibilities are genuinely devolved and accepted, and the provision of resources adequate to meet contract demands are necessary conditions for success.

Introduction

Since the late 1990s, Cambodia has piloted different methods of contracting government health services to expand provision and improve efficiency. During the first phase from 1999 to 2003 both contracting-in methods were piloted in three health districts and contracting-out in two districts with support principally from the Asian Development Bank (Bhushan, Keller, & Schwartz, 2002). Under contracting-in, the contractor (an international non-government organisation/NGO) worked within the Ministry of Health (MOH) system to strengthen the existing district administrative structure, but without the right to hire or fire health workers. Under contracting-out, the contracted NGO had complete responsibility for service delivery, including hiring and firing, setting wages, procuring supplies and organizing health facilities. During a second phase in 2004–2008, a hybrid of these two approaches was implemented in 11 of a total of 77 health districts nationally under the donor-funded Health Sector Support Project (HSSP) (MOH, 2007). Under the hybrid approach, NGOs were contracted with the MOH to provide staff supervision and manage service delivery, applying civil service regulations but with the right to hire staff independently to fill shortages.

In 2009, a new pilot using an internal contracting approach was implemented, as part of a national public sector reform program, in the 11 health districts previously contracted to NGOs in the second phase. These districts have been converted to Special Operating Agencies (SOA) with semi-autonomous status within the MOH and are contracted to deliver services by their respective Provincial Health Department (PHD). This marks a return of management to the national staff of the MOH and a major policy shift in the management of district health service delivery.

This article assesses the performance of the SOAs as a means for improving the management of district health services and

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strengthening service delivery. It addresses the question: What is the impact of, and what are the success factors for, this type of internal contracting arrangement? We investigate the experience gained from the implementation of the SOA internal contracting pilot in Cambodia to identify the lessons learned for policy making designed to improve the management and delivery of public health services in similar developing country settings.

Contracting is one component of the New Public Management approach of the 1980's and 1990's (Dunleavy and Hood, 1994; Perrot, 2012). New Public Management is a set of management concepts that introduces market approaches to the public sector with the aim of improving the efficiency of public services (Craig and Porter, 2006). Contracting is based on principal-agent theory, likened to the purchaser–provider split, where the contract is a tool binding the relationship. The principal, or purchaser, is a party to the contract and pays for services or products delivered by the agent, or provider, in accordance with the conditions stated in the contract (Hood, 1991). The theory assumes that individual parties act on self-interest and try to gain as much profit as possible from the contract delivery. However, internal contracting arrangements rely on 'relational' contracts that are commonly based on trust and cooperation and may be less detailed than for external contracting (Perrot, 2006).

To prevent unfair advantages in the transaction, extra efforts on the part of principal are needed, such as collecting relevant information before contract negotiation and strict monitoring. These activities incur additional costs, commonly called transaction costs. To enforce compliance, contracts need to be formulated in detail to include conditions of payment based on outputs produced or sanctions against lack of or delay in delivering results (Duran et al., 2005). Contract monitoring then becomes essential to enforce delivery of outputs, provide an early warning on the implementation process and guard against gaming (e.g. faking numbers, misreporting). As the nature of the services or products becomes more complex, the contract becomes more detailed and the process for contract monitoring becomes more intensive, expensive and complicated (Forder, Robinson, & Hardy, 2005).

It is argued this form of contracting provides a greater focus on the achievement of results, overcomes the constraints that prevent governments from effectively using the resources made available to them (the absorptive capacity), takes advantages of private sector flexibility and efficiency for improving public services, introduces competition (bidding) to increase effectiveness and efficiency of services (Batley & Larbi, 2004, chap. 7; Loevinsohn & Harding, 2005a) and may help increase equity in accessing services (i.e. by including conditions of equity in the contract) (England, 2004). For example, evidence from the Democratic Republic of Congo indicates that a change from input budgeting to output-based contracting resulted in increased technical efficiency and was cost-effective (Soeters, Peerenboom, Mushagalusa, & Kimanuka, 2011).

Nevertheless, contracting has a number of shortcomings. In judging efficiency, transaction costs (which are sometimes hidden and can be very expensive) must be taken in to consideration (Guinness, 2011), and contracting may not improve efficiency in settings where only a few, often inefficient, contractors enter into competition (Loevinsohn & Harding, 2005a). Where hospitals are a natural monopoly, competition may be introduced by contracting-in private management, though patronage and corruption can make it difficult to replace under-performing staff and contractors (Batley & Larbi, 2004, chap. 7). Contracting requires sufficient capacity to design, manage and monitor contracts and a robust governance and administrative system (Abramson, 2009, chap. 1; Zaidi et al., 2011). As these areas are often weak in developing countries, some researchers argue it is risky to transfer such concepts to less-developed countries (Eldridge & Palmer, 2009). Even so, researchers argue that contracting using the performance-based financing (PBF) approach is more flexible and practical and may alleviate these systemic challenges (Macqa and Chiema, 2011). Setting detailed ground rules helps avoid conflicts and assure the success of contracting (Kadai, Sall, Andriantsara, & Perrot, 2006).

Within the contracting framework, agents or providers are granted flexibility in hiring and firing the staff or implementers who deliver services (Vujicic et al., 2009). Pay-for-performance incentives that are common to contracting approaches, including PBF, seem to be effective in developing countries where typically low official salaries erode motivation. The value of PBF approaches is a matter of discussion in the literature, with a number of authors interpreting the PBF concept narrowly as a contracting methodology (Eldridge & Palmer, 2009; Fretheim et al., 2012) while others consider it a more inclusive health financing reform (Soeters, Habineza, & Peerenboom, 2006; Soeters et al., 2011). Most studies of contracting schemes have focused on the outcomes in health service delivery (Basinga et al., 2011; Eichler, Levine, & Group, 2009). In Cambodia, Loevinsohn and Harding (2005a, 2005b) and Liu, Hotchkiss, and Bose (2008) indicated that contracting was relatively more robust than routine government health services in terms of access to and delivery of basic health services. Keller et al. (2008) showed that performance-based contracting implemented by NGOs with additional resources for hiring more staff and staff incentives led to an enhanced level of service delivery compared to non-contracted health districts without the intervention. Elsewhere, the impact of pay-for-performance schemes (including PBF) on health service delivery and health outcomes was found to vary, with some indicators improving more than others (Banerjee et al., 2010; Basinga et al., 2011; Basinga et al., 2010; Miller et al., 2012; Soeters et al., 2011). Some authors argue that impact evaluation – which does not take account of contextual factors and other system-wide effects – is not suitable for assessing PBF schemes and fails to reveal their real value (Fretheim et al., 2012).

There are few studies, however, of the design and process of contracting interventions (Ssengooba et al., 2012) and little is known about why and how contracting approaches contribute to the improvement (or lack of improvement) of health system performance (Basinga et al., 2011). Using empirical evidence collected during the first author's doctoral research, and building on extensive experience in health systems research in Cambodia, this paper aims to fill the gap by examining Cambodia's internal contracting arrangement. The preliminary results of this study were first presented to the Health System Reform in Asia Conference, Hong Kong, December 2010, sponsored by *Social Science & Medicine*.

Internal contracting in Cambodia

In Cambodia, internal contracting spans the three levels of the public health system: the central level comprises the MOH, its subsidiary departments, and national disease-control centers; a second level is administered by the PHD, including provincial hospitals; and the third level is the health Operational District (OD), which includes a referral hospital and health centers.

The MOH's Health Strategic Plan 2008–2015 identifies the SOA as an institutional design and contracting as a strategy for improving the accountability, efficiency, equity and quality of government health service administration (MOH, 2008; RGC, 2008, 2009). All the 11 ODs formerly contracted to NGOs became SOAs with semi-autonomous status in mid-2009. An additional funding package, called a Service Delivery Grant (SDG), was made available to SOAs for staff incentives and other activities, funded through the HSSP.

By the end of 2010, 22 ODs had become SOAs under relational contracts between the different levels of the MOH (see Fig. 1): PHDs