ReBUILD Consortium

Research for stronger health systems post-conflict

Briefing

November 2015

Research to inform health systems development
An overview of the ReBUILD RPC in Cambodia

The ReBUILD RPC in Cambodia

The ReBUILD Research Programme Consortium has since 2012 been conducting research on the development of Cambodia's health system during its recovery from conflict. The research has focused on human resources for health, health systems financing, and contracting models, with an additional project on access to obstetric referral services.

With these research findings giving a long-term perspective on the development of Cambodia's health system, and the effects of a range of policies on access of the poor to health services, and on health worker incentives for an effective workforce, ReBUILD's work is very relevant for the ongoing health sector strategy development in Cambodia.

This brief gives a brief outline of the range of ReBUILD's research in Cambodia, and some of the emerging key findings. All the research will be made available in the form of full research reports and published articles, as well as a range of accessible briefing notes for those involved in decision-making and implementation in support of broad and equitable access to health care in Cambodia.

ReBUILD's research in Cambodia has been conducted in partnership with the Cambodia Development Research Institute (CDRI)

Research into policy and practice

ReBUILD's health systems research in Cambodia is relevant for both national and international policy processes.

Whilst a post-conflict perspective has been taken, the research has been designed to be highly relevant to the current processes and priorities for Cambodia's health system, including strategy and implementation of the new Health Strategic Plan (2016 – 2020).

And with Cambodia now being many years post conflict, and no longer recognised as a 'post-conflict' country by some development agencies, ReBUILD's 'long-lens' perspective on the effects of policies on the experience of households and health workers during Cambodia's post-conflict period provides learning opportunities for other countries recovering from conflict and for the national and international agencies supporting health systems development in these contexts.

ReBUILD's research projects in Cambodia

Health financing and impact on household spending (quantitative)

Aim: To measure the impact of health financing policies (user fees (UF), health equity funds (HEF), government health subsidy scheme, vouchers and various combination of these) on household health spending.

Approach: The study used national representative household survey data (Cambodia Socio-Economic Survey 2004 & 2009), using a difference-in-difference method and two part models to estimate effects of health financing policies on out-of-pocket spending.

Key findings: The study finds that health equity funds and vouchers help reduce household health spending, while UF and the government health subsidy schemes are unlikely to reduce this spending, as originally designed. Expansion of health equity funds and voucher schemes is advised, as is further policy-relevant research to improve the effectiveness of UF and government health subsidy scheme.

Health seeking behaviour and impact of health financing policy on household financial protection : A life history approach

Aim: (i) To explore the households' behaviour pathways in accessing healthcare from the 1950s to the present, and analyse the factors that influenced their decisions, and (ii) to identify whether pro-poor health financing policy such as community-based health insurance (CBHI) and HEF contributed to financial protection for poor and near-poor households since their introduction in 2000.

Approach: A life history approach was used to collect information on episodes of illnesses, deaths and births and on health spending history through in-depth interviews (IDIs) with 24 participants from Phnom Penh and Takeo provinces.

Key findings:

Behavior pathway: Cambodian people who used to rely mostly on traditional birth attendants and indigenous practitioners in the past, have increasingly shifted to modern healthcare methods and facilities provided through public and private healthcare services, especially since late 1990s and early 2000s.

Factors: The change in health seeking behavior were influenced by four factors: i) development of health care system both public and private healthcare services, ii) health financing schemes that either acted as barriers (user fees) or facilitators (CBHI/HEF) of access to health care; (iii) socio-political factors that improved security and accessibility of people to modern healthcare, and iv) individual factors such as awareness and household economic conditions.

Impact of health financing schemes on household financial protection: The impact of HEF & CBHI in illness treatment depended on the poverty level in each household, chronicity or severity of illness type and the implementation of the schemes

Key messages:

Health system development post-conflict takes time and must include a focus on improving socio-political and individual factors as well as developing health institutions. Prioritizing tasks is important for the government and donors to work on in this process

Health financing can be made more pro-poor by expanding coverage of HEF and CHBI, increasing the scope of HEF to cover chronic illnesses and expanding the benefit package of HEF and CBHI.

ReBUILD's research on human resources for health in Cambodia:

Aim: To analyse policies on human resources for health (HRH) from the post conflict period to the present, focusing on policy drivers relating to health workers' incentives and attracting/retaining health workers in underserved areas.

Approach: **Qualitative element:** Key informant interviews (KIIs) with health managers and senior MoH officials, and in-depth interviews (IDIs) with 18 health workers, using a 'life histories' approach, in 9 ODs in 6 provinces.

Quantitative element: Analysis of routine data on health worker supply, distribution and performance outputs.

Key findings: After many years of conflict, Cambodia focused on rapid production of health workforce for reconstructing and rebuilding health system in 1980s-1990s, and moves to focus on quality of health workers (HWs) trained, recruited, and distributed within public health system since 2002.

For HRH experiences, decentralized system of staff recruitment practiced in 1979-2001 was effective for HW deployment and retention in rural areas but uneven capacity of HWs trained and poor quality services. With the decentralised system of staff recruitment and distribution: 2002–present, the HWs have better theoretical knowledge, but hesitate to go and work in least developed rural areas. Deployment and

retention of HWs in rural areas become more problematic due to uneven social and economic development, low salary, change in basic needs and expectation of HWs, and limited capacity of local managers (PHD, OD and facility level) to deal with transparency and accountability of promotion and career advancement of HWs as being expected by individual HWs.

A number of strategic actions of HW incentives have been fragmentally implemented since mid-1990s and can be grouped into demand-and supply side schemes for increasing utility of health services and strengthening management capacity of local mangers. Fees collected from these finical incentives are largely used to increase the income of HWs at work. As the result, the remuneration of HWs from base pay and financial schemes increase over time. Nonetheless, it is not enough for attracting HWs to go and work in least developed areas, or to motivate the HWs to give up their informal practices because it is still much lower than expectation of HWs.

For attracting HWs to go and stay working in the most needed areas is to do with structural reform of recruitment, training and distribution system; and creating a more comprehensive incentive package, working and living environment for rural health workers by balancing the change in fulfillment of institutional needs for improving quality services and need for a decent-living of health workers.

ReBUILD's research on contracting health service in Cambodia

Research aims: To understand how contracting arrangements evolved since their introduction; to explore the perceived effects and challenges of current contracting arrangement- Special Operating Agency (SOA); and the implications for service delivery.

Approach: Four SOA operational districts were selected. IDIs were conducted with 27 managers and health workers and12 KIIS with donors and government officials. They were asked about drivers for the contracting change, process and challenges of SOA implementation, and perceptions on the utilization.

Key findings:

Reasons for change of contracting arrangement: wider health sector reform; costs of contracting with NGOs and the sustainability of this arrangement; limited ownership of health services by local managers in contracting schemes under contracting with NGOs; national and local capacity to manage contracting.

Perceived effects of SOA on service delivery:

***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.

***Behaviour of health managers and workers*:** Respondents perceived that SOA has a positive effect on behaviour of health managers and workers. Staff were more likely to wear full uniforms, be punctual, more responsible and committed to their role, be on standby 24 hours and be friendlier towards clients.

Perceived effects on service coverage and equity

Increases in service coverage: Respondents perceived increase in service utilization in districts where SOA was introduced for some reasons: improved public trust in health facilities; facilities open and staff available 24 hours; clear contracts and incentives encourage staff to be punctual for services.

Perceived increases in use of services by the poor: Three main reasons were highlighted respondents: all SOA districts are also equipped with Health Equity Funds (HEF) where the poor exempt from user fees; SOA has improved the attitudes of health workers towards all clients irrespective of socio-economic status; and facilities are open 24 hours.

Perceived Challenges of SOA Implementation

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) baseline data on utilisation (3) competition between facilities to achieve their own targets

Monitoring: There are infrequent visits by the central and provincial monitoring team due to lack of time, lack of monitoring budget, few incentives or lack of incentive for monitoring and limited capacity in conduct the assignment. SOA managers regularly

monitor the facilities and do spot checks within the community. However, SOA managers rarely sanction facility managers or staff when they find mistakes.

Key Messages

The SOA model enhances some aspects of performance health workers through adherence to work regulations stipulated in contracts and rewarded with incentives. Perceived improved quality of care has improved public trust in the health facilities, contributing to the perceived increase in service utilisation.

Managing contracts in SOA is a complex process requiring capacity in planning and monitoring at different levels in the health system.

Improvements in operation of SOA include: strengthening monitoring by the central and provincial levels; having reliable baseline data for specific performance indicators; and designing incentive schemes that address the issue of dual practice.

For further details on the research: .

All outputs will be available via the ReBUILD website **www.rebuildconsortium.com** as follows:

- **Health financing projects:** Full research reports available from December 2015.
- **Health worker incentives project:** Research reports available from December 2015.
- **Health contracting project:** More detailed policy brief available now. Full research report available from November 2015.
- **ReBUILD Affiliate research on obstetric referral services:** See separate brief available now via website, and upcoming journal articles.

What is the ReBUILD Consortium?

The ReBUILD Consortium is a 6-year research partnership, funded by the UK Department for International Development (2011-17), working with partners in Cambodia, Sierra Leone, Uganda, Zimbabwe and through 'affiliate' partners in other post-conflict countries. ReBUILD's aim is to improve access of the poor to effective health care and reduced health costs burdens, through the production and communication of robust, policy-relevant evidence on health financing and human resources for health.

Why focus on post-conflict contexts?

In countries affected by socio-economic crisis or conflict, health systems break down and external emergency assistance is often the main source of care. As recovery begins, so should the process of rebuilding health systems. But health systems research has neglected post-conflict contexts and not enough is known on the effectiveness of different approaches. ReBUILD has been created to address this challenge.

Find out more on ReBUILD's work in Cambodia and beyond

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Explore: ReBUILD's new resource on gender and post-conflict health systems **Building Back Better** www.buildingbackbetter.org and for more on our work to galvanise gender and ethics analysis in health systems, see http://resyst.lshtm.ac.uk/rings

Picture credits: 1. A trained health worker listens to the heartbeat of an infant in Preah Vihear, Cambodia. Photo: Chhor Sokunthea / World Bank. 2. A health provider at a clinic in Cambodia in a Maternal and Child Health Training Program. Reproductive and Child Health Alliance (RACHA). © 2001 Marcel Reyners, Courtesy of Photoshare

ReBUILD is funded by UK Aid from the Department for International Development

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