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REACHING THE POOR WITH HEALTH SERVICES

Cambodia

Contracting Health Care Services for the Rural Poor

Contracting NGOs to manage the primary health care system was found to be an effective means to increase service coverage and achieve a more pro-poor distribution of services in rural areas of Cambodia. In the mid-1990s, war and political upheaval had left Cambodia with limited health care infrastructure, especially in rural areas. There were sufficient paramedical and management staff, but training and quality of care were inconsistent and morale was low. The primary health care system was not able to deliver an adequate level of services. Basic services like immunization were not being provided and the child mortality rate remained at very high levels.

The "Coverage Plan"

To address these issues, the Ministry of Health (MOH) proposed contracting NGOs to manage the public health care system at the district level using a results-based contract to monitor progress. The contract required the NGOs to provide management and technical support to help the public health system perform efficiently, and provide equitable primary health care services to rural populations. Because of the innovativeness of the approach, this was originally done on a pilot basis.

The MOH devised a "coverage plan" which defined a minimum package of activities comprising preventive and curative services, such as immunization, family planning, antenatal care, and provision of micronutrients. With financing provided by the Asian Development Bank, MOH conducted a large-scale experiment of contracting with NGOs for the delivery of these primary health care services as part of the overall coverage plan. In 1997, prior to health facility construction and procurement of equipment, a pre-contract baseline household survey was taken in twelve rural operational health districts. The five-year contracting experiment started at the beginning of 1999 and a final evaluation survey was taken at the end of 2003.

The districts included in the experiment were randomly assigned to one of three health care delivery models:

i) *contract-out,* in which the contractors had complete management responsibility for service delivery, including hiring, firing and setting wages, procuring and distributing essential drugs and supplies, and organizing and staffing public health facilities;

ii) *contract-in,* where the contractors worked within the MOH system to strengthen the existing district administrative structure and health care personnel with government supplied drugs and consumables, and a nominal budget supplement for staff incentives and operating expenses; and

iii) *government,* in which the management of services remained with the government District Health Management Team (DHMT), government supplied drugs and consumables and the same nominal budget supplement for staff incentives and operating expenses provided to the contract-in districts.

The three remaining candidate districts were not contracted and formally included in the experiment. These districts continued under government management, but did not receive a budget supplement. As such, these three districts serve as a comparison group for the other nine contracted and government-managed districts.

MOH used a competitive bidding process to select NGOs based on the quality of the technical proposals, and cost. Objectively verifiable health care service indicators were measured for all twelve districts using data from the baseline survey, and well-defined goals for improvement in service

coverage and coverage of the poor were specified for all districts. Health service indicators included child immunization and vitamin A, antenatal care, delivery by a trained birth attendant, delivery in a health facility, knowledge and use of birth spacing, and use of health facilities for illness. An equity goal to target services to the poorest one-half of the population also was mandated for all districts. New health care centers were built and old ones renovated. Each center served 10,000 people.

The nine districts formally included in the contracting experiment were made up of two contracted-out, three contracted-in, and four government districts. Including the three districts not formally in the experiment, the twelve districts were spatially separated in three different provinces, and each had a population of 100,000 to 200,000. At the beginning of the experiment in 1999, the twelve districts had a combined total of more than 1.5 million people.

The Contractors

The contractors, selected through international bidding, were awarded four-year contracts at a fixed annual price per capita for delivering specific primary health care services. All the winning bidders were international NGOs with previous experience in Cambodia.

Contracted out districts had to purchase their own supplies and pay labor costs. These items were included in the MOH budget for contracted-in and government districts. In all nine test districts, construction, renovation, furniture, and equipment were provided by the MOH and not counted against the contract budgets.

Table 1 shows the average annual recurrent expenditure per capita over the two-and-a-half-year period for the three different arrangements. The higher expenditure for contracted-out districts is largely attributable to NGO technical assistance provided by district managers and higher staff salaries.

District managers had different budget constraints, different baseline values for coverage and distribution of services, and possible differences in population demographics, all of which may have influenced resource allocation decisions.

The Health Care Indicators

The indicators used to gauge service coverage were consistent with the priorities set in the United Nations' Millennium Development Goals (MDGs) and in World Bank's Poverty Reduction Strategy Papers (PRSPs). They target preventive child and maternal health care (Table 2). The equity goal of targeting services to the poorest half of the population was mandated for all districts.

Results

There were large increases in the coverage rates of health services in all twelve districts, contracted and government managed, however the contracted districts achieved much higher coverage rates than the government districts. The immunization coverage rate in the contracted-out districts, for example, increased from 25.3 percent in 1997 to 82 percent in 2003, an improvement of 56.7 percentage points (Figure 1). With only one exception (births with a trained attendant in contracted-out districts), the contracted districts achieved larger increases in coverage rates than the government districts. Government districts increased coverage rates for all health services, but these increases were smaller than in contracted districts and failed to achieve the coverage targets for vitamin A, antenatal care, trained birth attendant,

Table 1. Average Annual Recurrent Expenditure per Capita

Expenditure category	Contracted-out	Contracted-in	Government provision
NGO technical assistance	1.28	0.77	0.0
Staff salaries	1.32	0.55	0.53
Drugs, supplies, and operating expenses	1.28	1.08	1.12
Total	3.88	2.40	1.65

Source: Schwartz and Bhushan 2005, table 8.2.

Table 2. Health Service Indicators: Definitions and Coverage Goals

Indicator	Definition and coverage	Goal (percent)
Fully immunized child (FIC)	Children age 12–23 months fully immunized.	70
Vitamin A (VITA)	High-dose vitamin A received twice in the past 12 months by children age 6–59 months.	70
Antenatal care (ANC)	At least two antenatal care visits, with blood pressure measurement at least once, for women who gave birth in the prior year.	50
Delivery by trained professional (TDEL)	Birth attendant was a qualified nurse, midwife, doctor, or medical assistant for women with a delivery in the past year	50
Delivery in a health facility (FDEL)	Birth was in a private or public health facility for women with a delivery in the past year	10
Use of modern birth-spacing method (MBS)	Women with a live child age 6–23 months currently using a modern method of birth spacing	30
Knowledge of modern birth spacing (KBS)	Women who gave birth in the prior 24 months and know four or more modern birth-spacing methods and where to obtain them.	70
Use of public health care facilities (USE)	Use of district public health care facilities (district hospital or primary health care center) for illness in the prior four weeks	Increase

Source: Schwartz and Bhushan 2005, table 8.4.

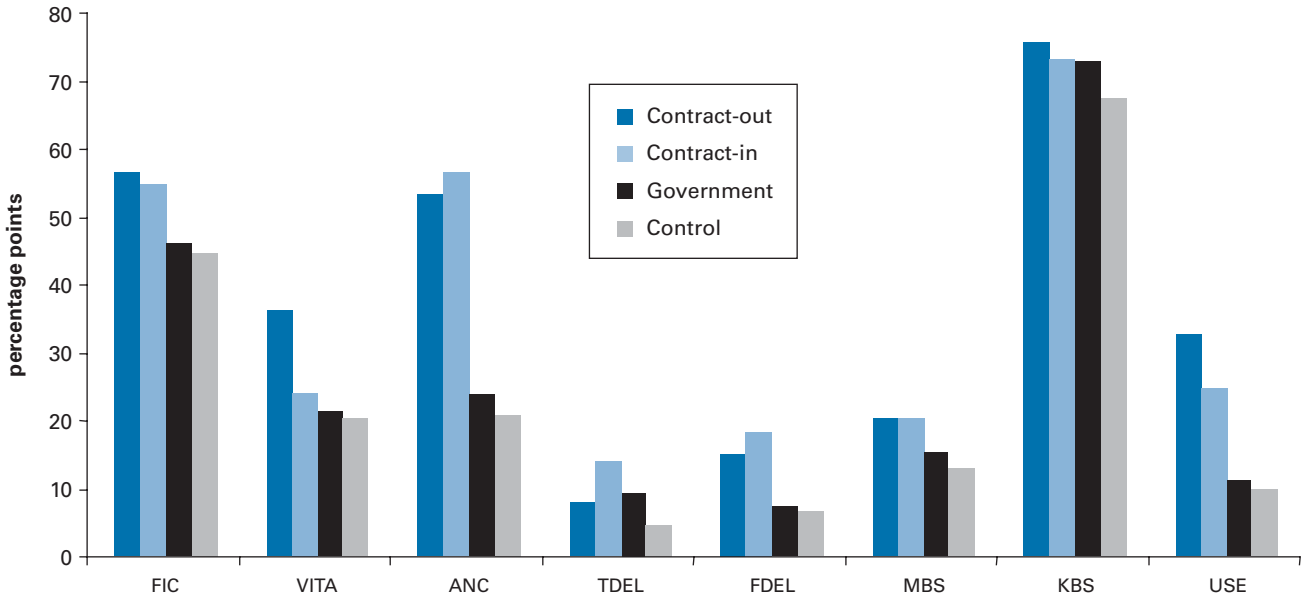
and modern birth spacing. In general, the difference in the higher coverage rates achieved by contracted districts compared with lower coverage in government districts, was largest for facility-based services (antenatal care, trained birth attendant, births in a facility, and use of public facilities for illness) than vertical public health programs (immunization, vitamin A, and use of modern contraceptive methods). Independent assessments of the quality of care also indicated that the contractors improved the quality of services provided at health facilities more than the government over the same period.

Benefits to the Poor

Contracted districts generally outperformed the government districts with changes in the distribution of health care services toward a more equitable or pro-poor distribution. Before the experiment, the non-poor were more likely to use public health care services in all twelve districts. Concentration indices indicate the provision of health care services in the contracted districts became more equitable or more pro-poor by the end of the five year experiment than in the government districts (Figure 2). There was a change toward a more pro-poor distribution in contracted districts for health services with only two exceptions (vitamin A for contract-out and facility birth delivery for contract-in). Government districts, on the other hand, changed toward a more pro-poor distribution only for vertical programs (immunization, vitamin A, and modern birth spacing), and these changes were smaller than the improvements made by the contracted districts. Government districts moved toward an even less pro-poor distribution for facility-based services, including antenatal care, trained birth delivery, birth in a facility, and use of public facilities for illness.

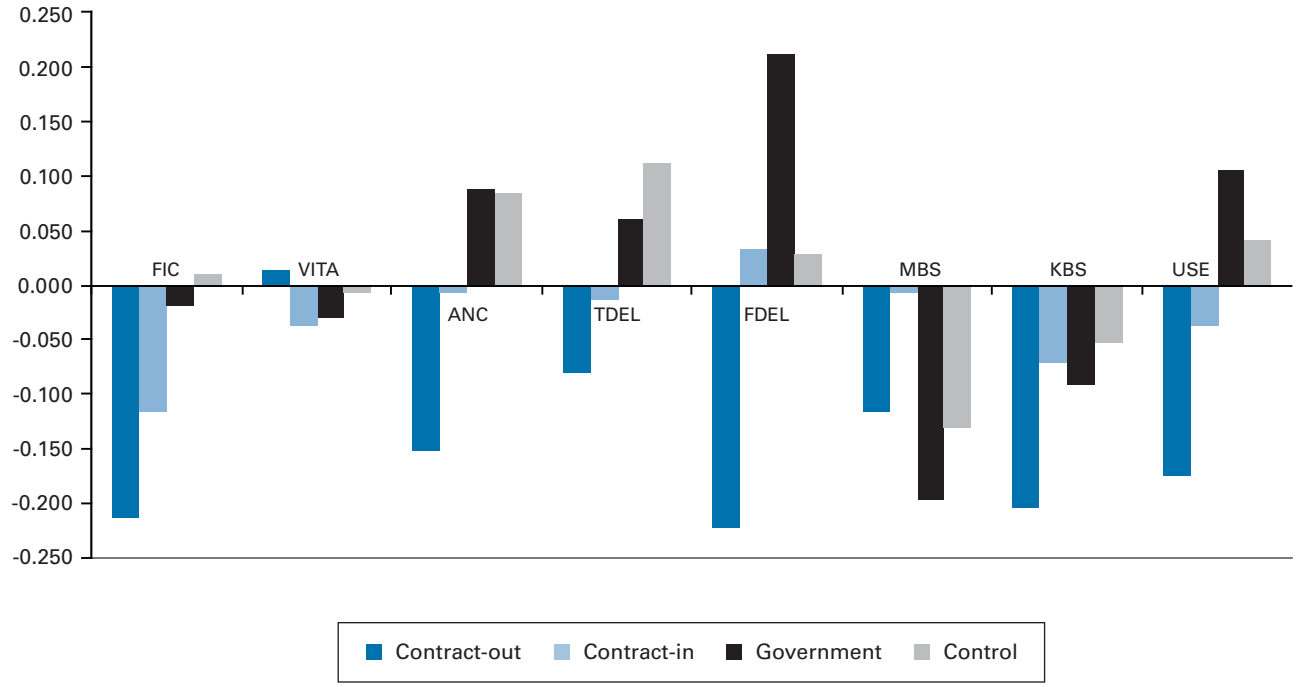
Not surprisingly, the annual public recurrent expenditure per capita on NGO-contracted districts was considerably higher than the public expenditure for government districts (Table 3). Technical assistance for district management provided by NGOs and salaries paid to health care workers largely account for these differences. It appears that public expenditures, however, substituted for private out-of-pocket expenditures to a greater degree in contracted districts than in government districts. At the end of the experiment, private out-of-pocket expenditures in the contracted districts were significantly lower than those in the government districts. Public expenditures in contracted-out districts, for example, were US$3.09 per capita higher than in government districts, but this higher public expenditure is associated with a

Figure 1. **Increases in Health Care Coverage Rates (percentage points), 1997–2003**



Notes: FIC = fully immunized children; VITA = vitamin A; ANC = antenatal care; TDEL = trained birth attendant; FDEL = delivery in a health facility; MBS = modern birth spacing; KBS = knowledge of modern birth spacing; USE = use of health facility for illness.

Figure 2. **Changes in Concentration Indices, 1997–2003**



Notes: Negative values indicate a change toward a pro-poor distribution of services. FIC = fully immunized children; VITA = vitamin A; ANC = antenatal care; TDEL = trained birth attendant; FDEL = delivery in a health facility; MBS = modern birth spacing; KBS = knowledge of modern birth spacing; USE = use of health facility for illness.

US$5.57 per capita lower level of private out-of-pocket expenditure compared with government districts. For all contracted districts, on average, a higher public expenditure of about US$2.50 per capita led to about a US$4.50 per capita lower private out-of-pocket expenditure. Moreover, total public plus private out-of-pocket expenditures in contracted districts were lower than in the government districts. The larger substitution of public for private expenditures in contracted districts benefited those with a lower ability to pay for health care services more than in government districts, and the overall efficiency of the health care system in contracted districts was better than in the government districts.

Conclusion

In summary, the results of this experiment of NGO contracting in rural Cambodia indicate that while all districts increased health service coverage rates, the contracted districts outperformed the government districts in achieving higher coverage rates and providing a more pro-poor distribution of services. In addition, private out-of-pocket health care expenditures in contracted districts were lower than government districts, which clearly benefited those who can least afford to pay. NGOs appear to be more responsive to contractual obligations to effectively and equitably provide health care services than standard government provision of services given the same goals. Overall, the results suggest contracting primary health care may be an efficient and effective means to increase health care coverage rates and better target primary health care services to the poor.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It was adapted from J. Brad Schwartz, Indu Bhushan, Erick Bloom and Benjamin Loevinsohn, "Contracting Health Care Services for the Rural Poor—the Case of Cambodia" in the World Bank's Development Outreach, May 2005 and Chapter 8 in *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why,"* Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck, eds. (Washington, DC: World Bank, 2005);The views expressed in this note do not necessarily reflect those of the World Bank.