MSF Cambodia

Sotnikum New Deal, the first year.

Better income for health staff; better service to the population.

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Abbreviations used

ADD	Accelerated District Development
CFDS	Cambodian Family Development Services
CMS	Central Medical Store
CPA	Complementary Package of Activities
HC	Health Centre
HFS	Health Financing Scheme
IPD	in-patient department
MC	Management Committee (or Management Commission)
MD	Medical Doctor
MoEF	Ministry of Economy and Finance
MoH	Ministry of Health
MPA	Minimum Package of Activities
NGO	Non-governmental Organisation
OD	Operational District
ODO	Operational District Office
OPD	out-patient department
PAP	Priority Action Program
PHD	Provincial Health Department
RH	Referral Hospital
StCom	Steering Committee
TB	Tuberculosis

Note on currencies & exchanges rates

In Cambodia, both the national currency Riel and the US$ are widely used in all financial transactions. Over 1999-2000, the exchange rate between both currencies has been remarkably stable between 3,850 and 3,950 Riel per US$. For ease of calculation, in this report US$1 = 4,000 Riel has been used as approximation of the actual exchange rate.

INTRODUCTION & ACKNOWLEDGEMENTS

This document describes and analyses the Sotnikum New Deal experiment ("Better income for health staff, better service to the population") from its start in 1999, till early 2001. As usual, the writing of such document is a compromise between being comprehensive, and keeping it reasonably short. This version of the document is written as an MSF document by Bruno Meessen and Wim Van Damme; with contributions from the other authors. The document is thus clearly written from a 'MSF perspective'.

The authors thank all the field staff of MoH, MSF & UNICEF for their dedication. Someone observed: "the less time one has to tackle the day-to-day problems in Sotnikum, the more one seems enthusiastic about the New Deal". Indeed, the New Deal is an attractive idea, but not easy to implement. Only the day-to-day commitment of the field staff could keep it going. All comments are welcome; they will be used to update the document.

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EXECUTIVE SUMMARY

The New Deal is a local experiment launched in Sotnikum district, Siem Reap province, Cambodia by MoH, MSF & UNICEF, to break the vicious circle of under-payment of health staff and under-utilisation of the public health services. The New Deal tackles the low official income, and introduces the logic: "better income for the staff, in exchange for a better service to the population".

After one year, the New Deal project has shown that it is indeed possible to break this vicious circle. Since its inception, staff earn an increased official income (ranging on average between US$60 to US$100 per month compared to US$ 10 to US$15 previously); the commitment of the field staff to their job has increased substantially, and utilisation by the population increased in parallel.

Moreover, the New Deal has drawn a lot of attention from different actors involved in Health Sector Reform in Cambodia. It stimulated the debate on appropriate and sustainable ways to boost the public health sector, and helped shape new policy initiatives.

This document is divided in 4 chapters. **CHAPTER 1. BACKGROUND** (page 9) gives first a brief history of the health system in Cambodia. Then it explains two important bottlenecks in the health sector reform process: staff motivation, and the mismatch between the health care offered in the public health service and the population's demand for care. It further describes Sotnikum operational district, the setting where the New Deal takes place. Finally, it explains the objectives of the New Deal in Sotnikum: (1) improve access to quality health care for the population; (2) build a health system; & (3) advocacy: be a catalyst for changes in the national health policy in Cambodia.

CHAPTER 2. THE NEW DEAL: THE BASICS (page 15) explains first how the general dissatisfaction with the state of affairs in the public health system created a favourable environment to negotiate a New Deal. The New Deal uses better income for the staff as an entry point for obtaining a higher accountability of the staff. Transparency and negotiation are two corner stones of the New Deal. It borrowed from the experience in Takéo hospital, but attempts to palliate its weaknesses.

A health financing scheme is set up to fund the New Deal, using income from government budgets and from user fees, complemented with additional cash from external subsidies. A consolidated bookkeeping is designed to keep track of all income and expenses. A steering committee guides the project, and aims at obtaining wide involvement of key actors in the health sector in Cambodia. To get things moving early on, the project opted for short term contracting. There is one global contract between the steering committee and all the health facilities in the operational district. Each staff has an individual contract with the management committee of their respective health facility.

The project started with a 3-year time perspective. In 2000 the project concentrated on building up the system; in 2001, the project plans to concentrate on improving the system; and in 2002, an important focus should be on sustainability.

CHAPTER 3. THE NEW DEAL: THE PROCESS IN 2000 (page 23) contains an account of how the New Deal grew over 2000 in each of its five building blocks, and describes the results achieved during this first year. (1) In **Sotnikum hospital** the New Deal clearly worked: since its introduction the staff earns a better income, and they

give better care to more people. Together with the investments in, and the expansion of services, especially surgery, the year 2000 saw a profound transformation of the functioning of Sotnikum hospital, the service it renders to the community, and its perception by the community. However, management of human, financial and material resources, and quality of care remain problematic, and still need major improvements. Still, the New Deal created an environment in which these can be negotiated and tackled. (2) Also in **the health centres** the New Deal clearly worked, and is perceived as a major improvement by staff and patients. There are no major apparent difficulties in management. Real utilisation of the health centres increased, as did the number of deliveries and referrals to the hospital. The health centres faced great difficulties accessing the government budget. (3) In the **operational district office** (ODO), the New Deal was more difficult to develop, more difficult to follow-up, and is still unsatisfactory, both in terms of bonus generated for the ODO staff, and in terms of results obtained. (4) The **equity fund,** managed by a local NGO, identifies the poor who consult the hospital, and pays their fees. This seems to function in a satisfactory way. (5) The **steering committee** gathered a large group of actors every two months to monitor progress made in the New Deal, and to negotiate between the different stakeholders. Thanks to the steering committee, the project is well known by the key players in the Health Sector Reform in Cambodia. However, it did not manage to consolidate the commitment of all, especially the mid-level managers.

Many actors are involved in the New Deal. Those not involved in Sotnikum on a daily basis are generally more enthusiastic about the New Deal than the field staff. However, the large majority of MoH staff in Sotnikum consider the New Deal a good solution; but they complain over management weaknesses, especially a continued lack of transparency.

CHAPTER 4. THE NEW DEAL: THE IMPACT SO FAR, NEXT CHALLENGES (page 55) discusses the achievement of the objectives so far, and the main challenges ahead. (1) Access to health care has improved in Sotnikum; but the improvements in quality are still less satisfactory. (2) The New Deal contributed to building a health system. The different elements of the system are now in place; they are becoming more interdependent; and some progress has been made in making it sustainable. However, for each of the four dimensions of sustainability – technical, financial, managerial and socio-political sustainability – the results are still insufficient. (3) The New Deal certainly reached its objective of advocating changes in the national health policy. However, among the many challenges remaining, the authors selected three as particularly important: (i) the poor commitment of mid-level managers to the objectives of the New Deal; (ii) the need to develop further the human capacities; & (iii) the limits of an economic approach – which the New Deal by nature is – and thus the continuing need for ethics.

CHAPTER 1. BACKGROUND

A brief recent history of the health system in Cambodia

To say that the Khmers Rouge paid little attention to health care is an understatement. In the same shot, they abolished schools and modern medicine ("the peasants can take care of themselves using herbs and traditional medicine"), and murdered most health workers.

In 1979 the Vietnamese-led administration renovated the health system: an infirmary in each commune (between 2000 and 3000 inhabitants), and a hospital in every district (between 15,000 and 100,000 inhabitants). From the originally 1000 medical doctors (trained, most of them in Phnom Penh, but also in Europe, especially in France), less than 50 doctors had survived the Khmer Rouge regime. To staff the health facilities, the Vietnamese had to train many health workers in accelerated training courses, especially for disease-specific activities (TB, malaria, EPI, etc). At that time drugs, medical equipment and technical assistance came from Socialist countries and all health services were free of charge.

After the withdrawal of all support from socialist countries in 1989, Western donors faced a situation quite close to a brand new start for a whole country. This was a good opportunity to establish new bases. So they pushed for a reform of the health system along the public health paradigm developed for low-income countries. During the first phase, 1989-93, the central administration of the Ministry of Health (MoH) was reformed. The second phase, 1994-98, focused on the provincial and district levels. A health coverage plan dividing the country into operational districts was designed. Cambodia's 22 provinces were divided into 69 operational districts (ODs), with between 100,000 and 200,000 inhabitants in each district. For each OD one referral hospital and a network of health centres – one for 10 to 12,000 inhabitants on average – and an OD office (ODO) were planned. Health district development is thus the official national policy in Cambodia. A multitude of guidelines have been developed, and many workshops and seminars were organised to implement this policy. NGOs, international agencies and development banks help the government to turn the plan into reality: funds are made available to support existing facilities and to build and equip the newly planned ones. Many efforts are also made to upgrade the training of the staff.

Bottlenecks

By 2000, it is obvious that achievements are real. The Central Medical Store (CMS) is functioning well, and manages to supply all government health facilities with adequate quantities of essential drugs. Budgets for running costs are relatively adequate, although they often fail to reach the periphery. Many buildings are renovated and equipment supplied. Official fees, introduced in 1997, are very low and affordable for the majority of the population and there are exemptions for the poor. A "National Charter on Health Financing in Cambodia" is available to explore new ways to increase the financing of the health services.

Nevertheless, as all these usual constraints have been tackled, a more and more obviously disturbing fact can be set aside no more: despite all the efforts and support, not one operational district is really functioning – there are very few health centres

and hospitals functioning adequately. MoH and external actors must acknowledge this appalling reality. The brand new facilities are empty. Very few patients are hospitalised in government hospitals, and most health centres treat only minor problems.

So, while the official health policy looks good, at least on paper, the results on the ground are very weak. Why? There are many problems, but two seem overwhelming: (1) staff motivation, & (2) mismatch between health care offered and the population's demand for care.

Staff motivation. Some staff officially on the payroll do not exist, others never show up at work, and the remainder usually work only one or two hours a day in the public service. The quality of the care they deliver is often poor. Still, most patients in public health facilities have to pay informal fees, get prescriptions for the private pharmacy, or an "invitation" to consult at a private practice. Indeed, most government health staffs have their own private practice. Why is this? The main cause is certainly their grossly inadequate salary: government staff receive only US$10 to US$12 per month, while it is estimated that they need at least US$100 per month to cover the minimal needs for living. Consequently, they have developed creative coping mechanisms such as informal fees, drug embezzlement and private activity. It is difficult to get a hospital running with such a constraint.

Mismatch between health care offered and the population's demand for care. Due to standardisation,[1] the offer of care in the public services, especially in the health centres, does not meet the population's demand for health care. For instance, in the health centres there are no injectable drugs or infusions available, while they are in high demand. The population often considers the health centre merely a place to get free oral drugs for benign ailments. In fact, many patients go for self-treatment through drug vendors and pharmacies. Private practitioners are consulted for more severe illnesses, but at a cost, often only affordable for the better-off. The majority of the population can just afford treatment delivered at home by unqualified staff. All the population is maybe equal in one dimension: in private practice, medicine is considered much like any other commodity – patients receive whatever they are ready and able to pay for. And household surveys show that the 'average Cambodian' is indeed ready to pay a lot: over US$30 per inhabitant per year; the equivalent of 11% of total household expenditure.[2] Inefficient health care is definitely a thriving business in the country – some have pushed the lucre as far as selling fake drugs.

So, the health planners have conceived a health system – a policy, infrastructure, budgets, supplies, modes of functioning, and training to support it – but without due consideration for the human factor: staff & population. The health system was developed along technocratic lines with lack of sociological insight. The hardware was installed thinking that the software would adapt easily. Surprise… it did not.

The result is then a dual health system: (1) a public health system, with a very low utilisation – officially cheap, but probably expensive – with low quality of care; and (2) an unregulated private care sector where drug vendors are often the first choice and with private providers of unknown qualification delivering very irrational treatment at a high cost.

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[1] MPA = minimal package of activities in the health centres; & CPA = complementary package of activities in the hospitals.

[2] "Report on the Cambodian Socio-Economic Survey 1997", Ministry of Planning, Phnom Penh, Cambodia, 1998.

What to do then? In recent years this question has obsessed many actors involved in the development of the health sector in Cambodia. The private sector seems very difficult to handle. Paths for collaboration look difficult. Regulation is certainly needed, but the political willingness to enforce it is weak. Moreover, any attempt to do so may further jeopardise access to health care in areas without a public health service and where private medicine is the only option available to most.

Making the public health system functional and attractive for the population seems another reasonable option. Unfortunately, the financial constraint is very tight. The official state budget for MoH is below US$3 per inhabitant per year, is often not available (only around US$1 per inhabitant per year was disbursed in 1998), and what is available is often misappropriated or misused. Increasing the salaries of civil servants depends on the reform of administration and civil service, which is progressing very slowly. Tackling the reorganisation of the plethora of civil servants, especially in major cities, is difficult indeed . Donors cannot stretch their already massive support to the sector anymore. Moreover, they prefer to abide one of their major taboos: not getting involved in salary financing. Their way to tackle the income issue is through the classical perverse strategy: per diems.

In front of such a dead end some creativity is clearly wanted. MSF and MoH want to explore under which conditions it is possible to implement on the ground the national health policy, and to make it acceptable to the population. The public service should be able to compete effectively with the private sector. Sotnikum operational district is chosen as the place for such experimentation.

Sotnikum operational district

Sotnikum is a poor rural area, with 218,000 inhabitants, at 30 kilometres from Siem Reap town, in the province where the historic temples of Angkor are located. Sotnikum Operational District (OD) comprises 3 administrative districts: Sotnikum (approx. 100,000 inhabitants), Chikreng (approx. 100,000 inhabitants) & Svay Leu (approx. 13,000 inhabitants). In Sotnikum OD, there are already 16 health centres functional, out of the 17 foreseen in the health coverage plan. These health centres are considered to be among the best in Cambodia: attendance rate is between 0.5 and 1.2 new cases per inhabitant per year (national average for public services was 0.3 in 1998). This actual success is due to the high community involvement achieved in these health centres. So-called ‘feed-back committees’ and ‘co-management committees’ existing in every health centre nurture the relations between each community and its facility. Sotnikum had only a small 80-bed hospital, 40 of them were for TB patients. This hospital is currently being upgraded with surgery, X-ray, ultrasound, better lab facilities, and an extra ward. In the district, there are 30 staff for the hospital, 80 for the health centres and 11 for the operational district office. This understaffing is not the norm today in Cambodia.

The health services in Sotnikum OD are represented schematically in Figure 1. In Sotnikum OD, there are presently (1) one referral hospital in Dam Dek; (2) two “health centres with beds”, also called “former district hospitals”,[3] (3) 14 MPA health

[3] The basic idea behind the health coverage plan was to set up 69 operational districts, regrouping usually 2 or 3 administrative districts each, which had previously each one ‘district hospital’. In each OD, only one hospital would be developed to become a referral hospital; the other ‘former district hospitals’ becoming ‘health centres with beds’, with the intention to

centres, one of them in the hospital compound; (4) an unknown number of formal and informal private practises; (5) a great variety of formal and informal drug selling points.

Dam Dek is only 30 km from Siem Reap, with 3 hospitals: the large provincial hospital, with some 200 beds, and two private not-for-profit paediatric hospitals: a large one (Kantha Bopha) – free for all – and a smaller one (Angkor Children's hospital).

MSF has been present in Cambodia since 1989. A first generation of projects mainly targeted provincial hospitals. Then MSF decided to move to operational districts, an approach which MSF had strongly advocated for Cambodia. A first project was initiated in Sotnikum in 1993. Due to security reasons, the MSF team had to leave the zone in 1995 but came back to the district in 1997.

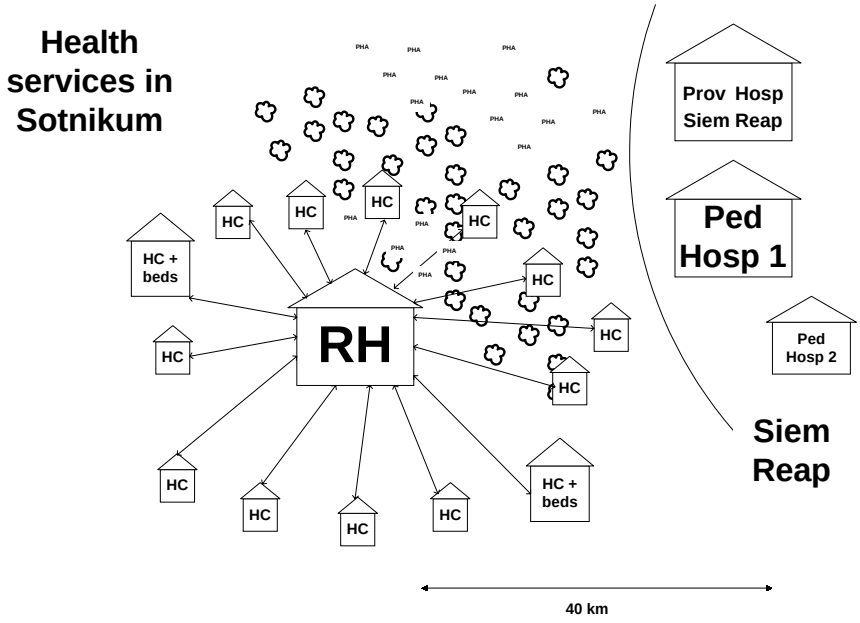

Figure 1: Health services in Sotnikum

HC = health centre; PHA = private pharmacy or drug seller, RH = referral hospital, Ped Hosp = paediatric hospital

progressively phase them out. In Sotnikum OD, the two former district hospitals are in Kampong Kdey and in Svay Leu. Before the introduction of the health coverage plan, the then district hospital in Kampong Kdey, with over 100,000 people in its district, had more activities than the one in Dam Dek. But because of its more strategic location, the latter was chosen to be developed as the district referral hospital. The district hospital in Svay Leu, with only some 13,000 inhabitants, has always been very small.

The objectives of the New Deal

The MSF project had initially objectives at two levels:

Objective 1: Access to care.

To give the population of Sotnikum district access to quality health care;

Objective 2: Building a health system.

To offer this good quality care to the population, the existing health system in Sotnikum should function optimally, with the building blocks: health centres, a referral hospital and an operational district office;

With the start of the New Deal, a third objective has been added:

Objective 3: Advocacy.

To be a catalyst for changes in the national health policy. The New Deal in Sotnikum is designed as a catalyst for changes in other parts of the health system, and to put key issues hampering its development on the national health policy agenda.

MSF's support to Sotnikum OD has been quite intensive. Operational district approach is indeed new for the country, and experience has shown that major progress is not that easy in Cambodia. For MSF, technical assistance is viewed as a way to upgrade service quality. However, besides MSF, UNICEF also had a strong involvement in Siem Reap province. UNICEF's provincial health adviser is, namely, a strong advocate for community participation hence the impressive results achieved in this area, especially in Sotnikum.

Beginning of 1998, MSF realised that all of its OD projects in Cambodia were facing the same dead end: if staff motivation constraints were not tackled, further progress would be very limited. Clearly, many things could still be improved, but MSF felt that no investment made sense if utilisation did not increase. A new dynamic was clearly to be initiated. Fortunately, by then MoH & Swiss Red Cross had launched a contracting experience in Takéo provincial hospital. This worked well, and was used as a basis for a new way of developing an operational district: a New Deal.

CHAPTER 2. THE NEW DEAL: THE BASICS

Rationale for a New Deal: general dissatisfaction

By 1999, there was a general dissatisfaction with the public health system; shared by all actors involved.

We have just sketched what could be the frustration for an **NGO.** While similar projects sometimes bring out quick and impressive benefits to populations in even poorer African countries, results in Cambodia remained desperately low. The field was especially frustrated with the unpredictable commitment of civil servants, the high level of misappropriation of resources, the lack of social accountability, and the prioritisation of personal objectives over collective ones.

On their side, **MoH field staff,** both care-givers and mid-level managers, were of course dissatisfied by their very low official income. They systematically prioritise unofficial or private activities, rather than their public duties (coping mechanisms).[4]

MoH policy makers at central level were more and more confused, as they discovered the huge gap between policy making and implementation. Despite a good follow-up of recommended and standard models results remained very limited in terms of service delivery and staff morale.

Donors and international organisations had been supporting Cambodia intensively for nearly ten years but had to acknowledge that their inputs (funds and intensive technical assistance) resulted in little improvement in service delivery. The Cambodian population is surely not the first winner of these years of efforts.

In fact by 1999 the **population** had already indicated for quite some time to other actors its dissatisfaction: because of low quality of care, unpredictable informal fees, unattractive services and treatments, long waiting times, etc. people do not seek care anymore to public facilities. Most of them rely on a thriving private sector. Irrational treatments lead to a very low efficiency, high prices to inequity and sometimes a definitive impoverishment of the household.

So, despite considerable inputs (drugs, equipment, buildings, training, technical assistance, etc.) the feeling of stagnation was widely shared. If the public health system pretends to be something more than an inherited channel to distribute income to civil servants, dramatic changes were needed.

It was thus thought that there was a fertile ground for a new consensus, a **New Deal**, in which most actors would agree to work towards a common general objective: a better service for the population in exchange for a more acceptable personal income.

> *New Deal is a broad consensus agreement, that redefines roles & responsibilities of all major actors, and which is perceived as fair by all involved. In practice, a New Deal in a health facility results in a health financing scheme detailing the sources of income of the facility, and the way the budget can be used, in particular to pay bonus to the staff.*

[4] Some gained an attractive income through private practise, or less legal coping mechanisms, but many did not.

Basic principles of the New Deal in Sotnikum

Better income as an entry point for higher accountability: The most obvious feature of the New Deal is certainly the fact that it promises a fair income to the staff. This living wage is used as an entry point for improving the health system. Practically, the better income is given in exchange for strict adherence to internal regulations that stipulate: (1) job descriptions and working hours, (2) no informal fees, (3) no misappropriation of drugs, material or money, & (4) no diversion of patients to private practice (poaching). So the higher income is the price paid for getting a renewed accountability from the personnel. The introduction of the New Deal is a one-step process. The results should be immediate, creating a transparent and more predictable working environment.

It was a basic assumption of the New Deal that such a new working environment would create a good basis to improve patient confidence in the health facility and to improve quality of care through additional inputs (training, technical assistance, supervision, etc). This is graphically represented in Figure 2.

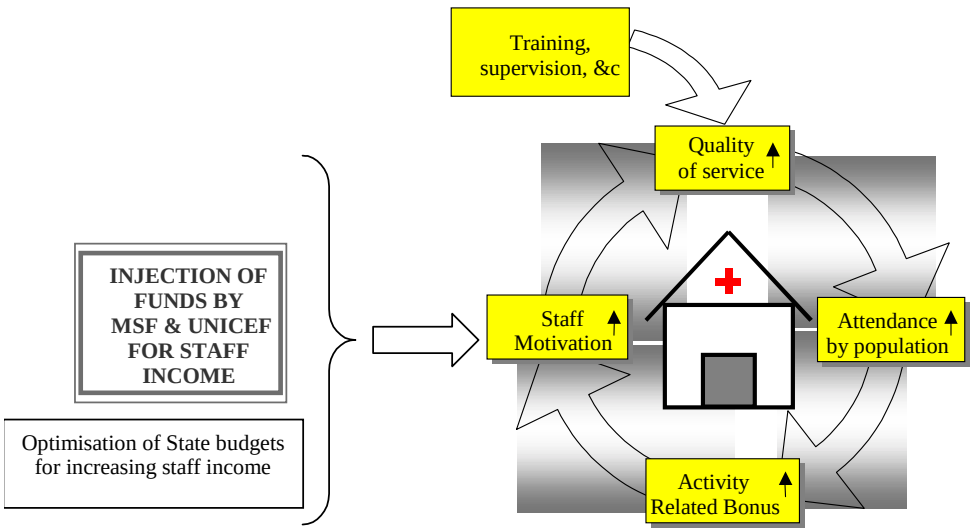

Figure 2: The virtuous circle of the New Deal (simplified model)

The ultimate objective of the New Deal is indeed not to have staff present in an empty health facility, but to provide quality health care to the many patients who need the service, especially the poor who cannot afford private health care.

Takéo+: In Cambodia, such a New Deal has existed since 1997 in Takéo hospital, started by MoH & Swiss Red Cross. Takéo was a source of inspiration for Sotnikum. However, MoH & MSF considered that five major modifications were needed (1) to be consistent with the national health policy the New Deal should not only involve the hospital, but the complete OD; (2) the system should be more flexible and adaptable to changing conditions; (3) access to the poor should be improved through an equity fund that is not managed by the hospital staff; (4) more stakeholders should be involved, not only in the preparation, but also during the implementation (MoH,

MoEF and administrative authorities; district, provincial and central level; NGOs, UNICEF & WHO);[5] & (5) the project should aim at a more "realistic" bonus level (US$60-90 per person per month on average was set as a benchmark).

To make the experience sustainable, and to enable its reproduction elsewhere in Cambodia, it was felt that special efforts were needed to avoid creating an "island of rational management in an ocean of coping mechanisms and mismanagement.." Therefore, the New Deal in Sotnikum has a clear role to play to catalyse changes in the whole health system (at the different levels of MoH, MoEF and the administrative system). Therefore, MSF & UNICEF believe that total **transparency** at all levels is an important principle.

To maintain a broad commitment and sense of ownership, the project uses **negotiation** and consensus building as important strategies. This leads somehow to bypass the strict hierarchical lines of authority, or more correctly, to establish new lines of accountability.

The "building blocks" of the health system in Sotnikum (hospital, health centres and ODO) are considered as **operational units** of the OD with some degree of management autonomy. In each of these building blocks a co-operative-like management style was developed. The staff are represented by a management committee they elect. Individual contracts were signed between the individual staff members and the management committee. These contracts stipulate that a bonus will be paid in exchange for strict adherence to the internal regulations. The management committee of the health facility is in charge of enforcing this new framework of accountability.

It was assumed that the population would accept to pay increased, but totally **transparent, official fees** in exchange for better service, including abolition of all informal payments. In fact, it was thought that these increased official fees would actually mean decreased real cash payments, thus cheaper health care for the population.

Funding of the New Deal: the health financing scheme

To turn the New Deal into reality, financial resources are of course necessary. From where to get them?

The sources of funding for the public health system in Cambodia can be grouped in (1) government budget, (2) user fees & (3) external subsidies. Many subsidies arrive in-kind in the provinces. This is the case for all the drugs from CMS, and most investments (training, equipment and buildings). Some subsidies arrive in cash and are spent at different levels in the health system. The origin of the cash available at OD level is basically:

(1) Several government budget lines: Chapter 10 for salaries; Chapter 11 for running costs; Chapter 13 (also called "Accelerated District Development",

[5] This broad participation was perceived as important to find the most appropriate system for the environment and to increase commitment and the sense of ownership, especially from the provincial level.

ADD-budget) for running costs or "Priority Action Program" PAP-budget (since late 2000);[6]

(2) User fees. They are regulated by the National Charter on Health Financing that stipulates that 49% of these fees can be used for staff incentives, 50% for running costs, & 1% for the treasury;

(3) External subsidies. Most health facilities receive external subsidies, from a variety of sources, such as subsidies from UNICEF for vaccination, subsidies from NGOs (sometimes salary support, more frequently per diems for training or outreach activities) or subsidies from World Bank for integrated supervision.

Most often, these different sources of income give the health facilities – on paper at least – enough budget for running costs, but very little for staff income. This imbalance is a problem in itself.

A kick for a start. Lack of budget to pay the government staff a decent income was the first problem the New Deal had to tackle. In 1999 it was hard to imagine any change in MoH policy, as regards the limited total budget and the lack of flexibility (to use the budgets for bonus). Clearly, decent income had to be found from other sources than the government ones. The National Charter on Health Financing restricted the possibilities also from the users' side. There was clearly no other solution than an injection of funds from foreign partners.

While advocating for increased and reliable government budget, specifically to pay for staff income, MSF & UNICEF accepted to inject additional cash on a 50/50 basis, as a temporary measure. In their eyes, this money would trigger a virtuous circle for the health facilities (Figure 2, page 16). As initial sources of funds and designers of the system, MSF & UNICEF were also able to enforce some major conditions: to make the best use of available resources, **total transparency and consolidated bookkeeping** would be corner stones of the reform.

So it is important to notice that, at this stage, the health financing schemes developed in the different health facilities are not cost-recovery schemes. It is estimated that patient fees can cover between 10% and 20% of the total cost. It is thus the objective that external subsidy presently paid by MSF & UNICEF will be later covered by increased government budget (possibly from external sources such as World Bank loans), not by increased patient fees. The project assumes that by end 2002, this could be reached and that there would be no need anymore for direct budget support from MSF & UNICEF.

Strategic & tactic choices

A steering committee to obtain wide involvement

To create a platform for discussions and create a broad basis of ownership, MSF & UNICEF wanted to involve many key actors in the decision-making process. It was also thought that this would increase chances to have an impact on national health

[6] ADD and PAP correspond to different donor attempts to increase funds to support the health sector reform process in Cambodia. As of today, some districts are financed through the ADD system; others are part of the more recent PAP system. More details and discussion are presented later in the document.

policy (such as human resource management and administrative reform, bookkeeping and procurement). Eventually this platform would be the place where commitment to the New Deal would be expressed and materialised.

To reach these aims, an external steering committee was set up. Such a steering committee had to include representatives of the different stakeholders: MoH (national, provincial, district levels and the National Institute of Public Health), several government administrations (provincial governor, district governor, MoEF), and representatives of UNICEF, WHO and MSF. Taking somehow the place of the hierarchical lines, the steering committee is the recognition of the fact that many actors are part of the process of the reform: space for debate must then be better organised and discussion more fluid. To reach this, it was decided that steering committee meetings would also be open to operational actors and guests (representatives of Sotnikum OD: staff from the hospital, the health centres and the ODO, and representatives of NGOs).

Formally the steering committee would be of course constrained by national health policy decisions, but it was expected that it could sometimes push their interpretation a little further. Since the beginning, it was decided that only the steering committee would be allowed to take decisions on patient fees, bonus systems and external budget support. Agreements would be formalised in a "global contract" between all actors, amended by the minutes of the steering committee meetings.

Early start with short-term contracting, to get things moving

It was decided to start early, initially only a New Deal for the hospital, while the deals for the other building blocks (ODO & health centres) were still being negotiated. At the start the basic principles were agreed, but the operational details of the New Deal were certainly unsatisfactory and unsophisticated. It was felt necessary "to get going," and to build the road while walking. It was hoped that this would bring more sense of reality in the discussions, involve more actors, and improve the sense of ownership. It was thought that this New Deal was such a fundamental change that it would induce several side-effects, impossible to foresee in advance. Also, the environment in Cambodia is changing fast and the system would have to adapt to these changes constantly. Thus, as the New Deal would have to be adjusted, MSF opted for short-term contracting (3 months), to increase flexibility and facilitate correction of undesirable system-adaptations.

Contracting at two levels to clarify roles

In the past the respective roles of the different building blocks of the OD system were not always clear to everybody, nor were the roles of the Provincial Health Department, the central MoH and the external actors, such as UNICEF and MSF. In the Sotnikum project contracting is chosen to clarify each other's roles and responsibilities. Moreover, for the different building blocks of the OD system, contracting attempts to set up relevant incentive mechanisms. As much as possible, incentives (for the whole facility and so for each of its members) enhance the pursuit of the system objectives (delivering a good service to the population).

To clarify the roles, two levels of management were introduced:

(1) Level A: management of health facilities: dividing the OD system in 19 management units (17 health centres, the hospital, & the ODO). These units got

more autonomy in managing their own affairs, and could then be held more accountable for the use of resources and the results obtained. Each of these units was organised on a co-operative-like basis (elections, individual contracts and self-control, encourage staff to pursue collective self-interest, etc). They establish individual contracts with their staff.

(2) Level B: management & steering of the health system.[7] As an interim strategy, the project steering committee is taking up this role. It used initially short term contracting between individual health facilities and the steering committee, to allow for an early start and a flexible and adaptable system. A global contract is established between all partners.

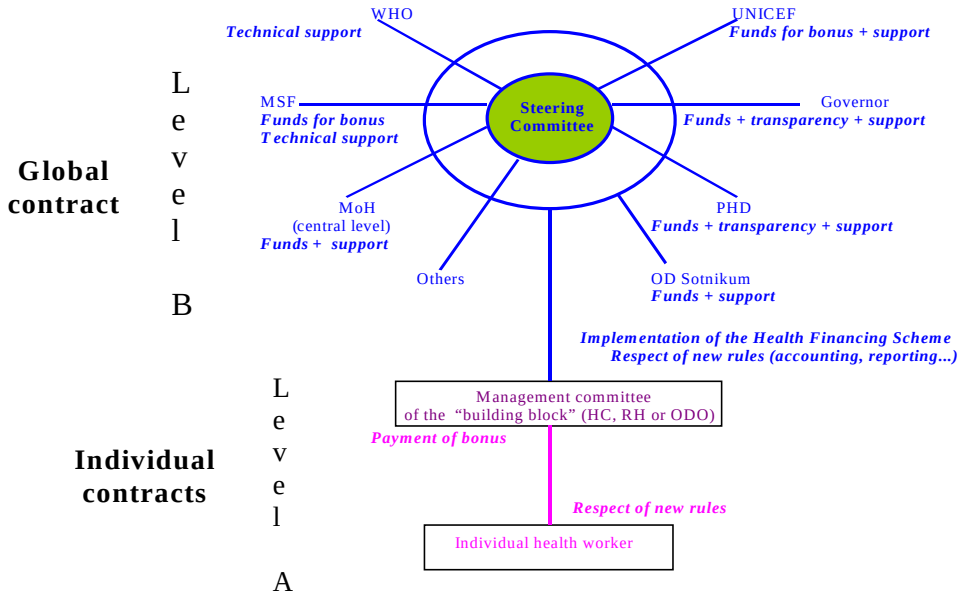

Figure 3: The scheme of contracts in Sotnikum

"Others" includes: the Ministry of Economics and Finance, the National Institute of Public Health, the Provincial Department of Economy and Finance and the Provincial Treasury.

To regulate this, two levels of contracting were introduced: (1) the "global contract" between the steering committee and the different health facilities; & (2) the "individual contract" between the management committees of the different health facilities and the individual staff members (Figure 3).

[7] In the operational district model the ODO should normally play this role. However, in the present state of affairs in Cambodia, the ODO is not able to play this role, itself being the weakest element of the system. Moreover, the role of the much stronger provincial health department (PHD) is not so clear.

For MSF & UNICEF staff, those two levels of management implied that the field staff gave technical assistance in the management of the health facilities (level A), and would refer to the steering committee (level B) certain decisions deemed difficult to solve locally, thus avoiding permanent local re-negotiations of money matters. Phnom Penh-based staff of MSF & UNICEF would take the lead in the steering committee, which has the final say in major issues.

Monitoring & evaluation

Indicators

The project aims, first of all, to improve the access to care for the population of Sotnikum OD (objective 1) and to build a health system (objective 2). Utilisation of the services by the population is used to measure the achievement of these objectives. Also, four tracer medical conditions have been proposed (1) TB; (2) malaria; (3) deliveries; & (4) EPI.

Selected indicators thus concern attendance rate to OPD and IPD, coverage of EPI and specific utilisation for the tracer conditions TB, malaria and deliveries. For these indicators, the evolution over time (before and after the project) will be analysed, as much as the absolute data.

1. Number of new cases per inhabitant per year in health centres (evolution per month per health centre)
2. Number of hospitalisations per 1000 inhabitants per year (evolution per month),
3. Number of major surgical interventions performed in Sotnikum hospital,
4. EPI coverage (measured per health centre),
5. Proportion of deliveries attended by professional health staff (measured per health centre),
6. Percentage of major obstetrical interventions per 100 deliveries performed on residents of Sotnikum OD,[8]
7. Number of new TB cases detected per 1000 inhabitants per year in Sotnikum OD (measured per health centre),
8. Proportion of TB cases cured after 8 months,
9. Number of malaria cases correctly treated in health centres (measured per health centre),
10. Number of severe malaria cases treated in the hospital.

The success for objective 3 (advocacy: be a catalyst for change in the national health policy) will be more difficult to quantify or even qualify. As the objective is nation-wide, the determining factors of a change are, of course, not limited to Sotnikum and the New Deal. Furthermore, there are other experiments ongoing that can converge or diverge with the Sotnikum New Deal in the lessons for the whole

[8] An unmet obstetrical needs survey covering the period 1998-1999 was performed for the entire Siem Reap province. The deficit in major obstetrical interventions for absolute maternal indications was found to be around 87 % (this means that around 59 pregnant women died because of unmet obstetrical needs). This survey established a baseline prior to introduction of the new health financing scheme and surgery in Sotnikum. “A Survey of essential obstetrical needs, Siem Reap Province, Cambodia”, Susanne von Schreeb, MSF, December 2000.

health sector reform. Eventually there is also a risk that the New Deal gets a lot of attention but for other than good reasons or with misunderstandings.

Monitoring tools

The process of monitoring will be achieved through different ways. The standard national monitoring tools are, of course, available: the supervision of health centres and hospital by ODO, the supervision of OD by PHD, the audits from national MoEF and MoH to PHD and OD and the health information system. As an innovative and particular process, the New Deal needs complementary monitoring tools. The steering committee and the different member stakeholders will monitor the process through meetings, and ODO evaluations, including audits of bookkeeping and evaluation by external consultants.

Time frame: 2000-2002

The project started with a 3-year time perspective. MSF agreed to support the New Deal 'in principle' during 3 years, till end 2002, but this support was conditional on progress being made, especially regarding the local availability of government budget. Implicitly, three phases were assumed: (1) the gradual build-up of the system, (2) improving the system, & (3) making it sustainable, independent from MSF & UNICEF.

These three phases run, of course, largely in parallel, but roughly one could say (1) that in 2000 the project concentrated on building up the system; (2) that in 2001 the project plans to concentrate on improving it; & (3) that for 2002 an important focus should be on sustainability.

CHAPTER 3. THE NEW DEAL: THE PROCESS IN 2000

General frame

Sotnikum OD consists of 3 types of building blocks: (1) the referral hospital, (2) the health centres, & (3) the operational district office (ODO). The project has also created an additional building block for enhancing access to the hospital: (4) the equity fund. Also, (5) the steering committee can be considered as a separate building block of the New Deal.

Role of health facilities: providing care

To improve the functioning of the hospital and the health centres, each health facility is considered a separate entity, and is directed along the following path:

(1) Introduction of a New Deal with the staff. A New Deal in a health facility – better income in exchange for a better service to the population – takes the form of a health financing scheme (HFS). The short-term aim of the New Deal is to obtain the presence and commitment of the staff, predictable fees, and transparent use of the resources. These effects should be obtained immediately after the introduction of the HFS.

(2) Improve quality of care. The project postulates that in this new environment where the behaviour of the staff is more predictable and negotiable, inputs to improve the quality of the work will indeed yield results. This effect will, of course, take time (how long?) and need extra inputs (supervision, training, guidelines, technical assistance, etc).

(3) Widen the range of activities. Especially in the hospital the range of activities had to be widened to develop a full CPA hospital (introduction of surgery and anaesthetics, X-ray and ultrasound, blood transfusion, etc). Also in the health centres the package of activities offered (MPA) may have to be widened (MPA+), but this is less urgent.

(4) System changes. The project postulates that once the different building blocks function under the New Deal, the relations between them can also be negotiated on a basis of mutual (financial) interest: referrals, supervisions, training, etc.

Role of the ODO: providing resources & support to the health facilities

Management and steering of the district health system remains quite problematic.

ODO. Presently, the role of the ODO is somehow limited to distribution of resources (drugs, vaccines, equipment, cash, and human resources) and getting reports (health information system and financial reports) to the PHD. Supervision is seen as a major role, but is poorly conceptualised and not productive (filling the check-list). Its role in the implementation of vertical programs (HIV/AIDS, TB, malaria, psychiatry, health education, etc) is also not clear.

For the ODO, the three elements foreseen in the New Deal were: (1) clarify its role: job descriptions and work plan, including teamwork; (2) total transparency in the management of resources; & (3) improve quality of support to health facilities, in particular supervision.

Implementation schedule: building the blocks first, the system later

An implementation plan was decided, starting with the referral hospital and then progressively including the rest, block by block, depending on the advancement of the negotiations with each element of the system (Figure 4).

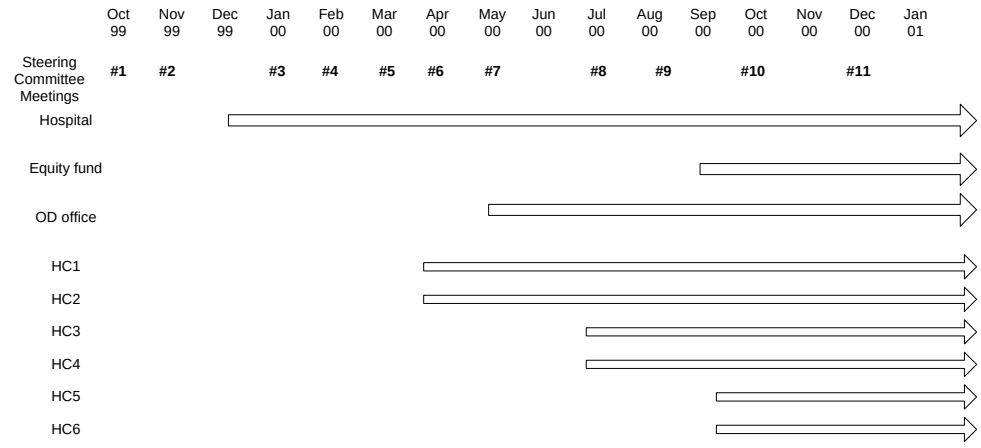

Figure 4: Building up of the New Deal in Sotnikum, 1999-2000

The New Deal was first introduced in the referral hospital in December 1999 for two reasons: (1) for the operational detail the hospital could heavily borrow from the Takéo experience; & (2) the hospital was considered both a core element and – at that time – the weakest point in the system. In April 2000, two health centres were included in the scheme. In May 2000, the ODO was included. In June 2000, two additional health centres were included. In August 2000, two more health centres were included. In September 2000 an equity fund, managed by the Cambodian NGO CFDS, was started (for more details, see page 48). A simultaneous start of the New Deal in all the different building blocks would surely have created less tension with the staff, but it was deemed operationally impossible. However, where possible the basis was laid for making the system work already.

During 2000, the main objective was to get all the building blocks functioning. How this evolved during 2000 is described systematically in this chapter: (1) the hospital, page 25; (2) the health centres, page 37; (3) the ODO, page 44; (4) the equity fund, page 48; & (5) the steering committee, page 50.

(1) Sotnikum hospital

The hospital in 1999

At the start of the New Deal in December 1999, Sotnikum hospital had some 80 beds (40 TB beds, and 40 general beds). There was no surgery, no X-ray, and no blood bank. The hospital had 34 staff, which is approximately half the staffing foreseen by MoH for referral hospitals. The hospital had no accountant, the OD accountant being in charge of both OD and hospital.

A New Deal for Sotnikum hospital in 2000

Objective: Having a well-functioning 120-bed referral hospital, offering the full complementary package of activities (CPA) to the entire population of Sotnikum OD.

Focus for 2000. In the short term, the focus was on (1) the introduction of the New Deal, to obtain (i) staff presence and commitment and (ii) improved management and financial transparency; & (2) development of new services (surgery & anaesthetics, X-ray, and blood bank).

In the medium term, the focus shifted to (1) improved quality of medical and nursing care; & (2) improved image of the hospital in the population and increased utilisation.

Aspects in follow-up in 2000 have been: (1) Management committee working (problems being solved, including disciplinary measures taken); (2) Presence of staff; (3) Number of new in-patients per month; (4) Number of major surgical operations per month; (5) Patient fees collected; (6) Transparent bookkeeping and procurement; & (7) Hospital hygiene.

Introduction of the New Deal for the hospital staff

Prior to the introduction of the New Deal, staff morale was low. Presence was sporadic and was often intended for 'poaching' patients (diverting them to the staff's private clinics). Medicines and material were regularly diverted for private use. Informal fees were frequent. Poor patients were often not cared for. The quality of the services rendered was poor. Utilisation of the hospital was low.

The New Deal was intended to change all this. Its preparation included the following steps:

° The rational of the New Deal was explained and approved during a general meeting of all hospital staff. The staff then elected a hospital management committee of 4 persons representing all staff categories, and delegated them the responsibility to elaborate the New Deal;

° This committee, with the support of a health economist consultant, elaborated a proposal consisting of:

  – job descriptions and a working schedule for the staff, covering 24h/7 days per week;

  – internal regulations stressing (1) respect of working hours & job description, (2) the unacceptability of misappropriation of medicines or materials, (3) no informal fees, and (4) no poaching. Breaking the rules would lead to loss of bonus, or other sanctions;

- an incentive system, a "maximum bonus" level for each staff category[9] and a system for overtime and duty payments; &
- an individual evaluation system: to evaluate the quality of performance of individual staff members. The result of the evaluation is the basis for the calculation of the individual bonus. The principle initially was: 70% of "maximum bonus" for presence and a proportion of 30% depending on the evaluation (Figure 5, page 29).

° All the above was subsequently explained to the entire staff, submitted to a secret vote, and approved by more than 80% of the staff.

° In the meantime, a 'global contract', was elaborated for discussion at the steering committee level.

° After the approval by the steering committee on 26 November 1999, individual contracts were drawn up between individual staff and the hospital management committee and signed by all but one of the staff.[10]

° The New Deal started on 1 December 1999, and overnight the staff had to change and adapt to the new rules.

° Staff health insurance. To facilitate access to the hospital services for the staff without endangering the financial equilibrium of the hospital, a staff health insurance fund was created. Each staff contributes monthly US$1, the hospital adds US$1. Staff and their first degree relatives pay 25% of hospital fees, and the insurance fund pays 75%.

Management of the hospital

THE HOSPITAL MANAGEMENT COMMITTEE (MC). As Takéo experience has shown, an important condition for the success of a New Deal is the development of a strong sense of ownership among the personnel. Indeed the improvement of the individual income is the result of the efforts by the whole group. The new equilibrium can thus be jeopardised by the behaviour of a few. By establishing a management committee, staffs have a body to enforce self-regulation and to operate the development of *their* hospital. This platform is also intended to enhance transparency in the management of resources.

Tasks and role of the MC: (1) staff management: evaluation of staff and bonus calculation, including sanctioning for disciplinary problems; (2) management of financial resources; & (3) general organisation of the hospital.

Membership: Initially, the management committee was composed of the director and 4 elected members: the vice-director, a medical assistant, a nurse, and the chief of administration. One or two MSF staff members would systematically attend all meetings. Later, the management committee was extended to include 2 more members.

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[9] After lengthy negotiations the staff agreed with US$65 per month on average (range from US$24 to US$130 per month) on the basis of a 48 hour working week.

[10] This doctor was moved out of the hospital to the ODO (and subsequently accepted the New Deal in the ODO).

Functioning: Throughout the year, the committee met 2 or 3 times per week for often-lengthy meetings. An offspring, the hygiene committee, has been formed addressing especially waste management.

TRANSPARENT BOOKKEEPING SYSTEM. PriceWaterhouseCoopers developed a bookkeeping system for the hospital, wrote an instruction manual and trained the hospital staff in its use. In June 2000, a health economist evaluated the financial management of the hospital after 6 months.

Development of full CPA

Progressively the hospital was upgraded to offer full CPA. This entailed starting surgery and anaesthetics,[11] including operating theatre management and sterilisation, starting X-ray and blood transfusion. Parallel to the introduction of new services, the improvement of the quality of existing medical and nursing services was attempted. Construction of an additional medicine ward was completed in 2000, and rehabilitation of the other hospital buildings is ongoing.

Technical assistance

The role of the MSF field staff is to give technical assistance and training. However, in some fields, especially in laboratory and bookkeeping, the weakness of the hospital staff has led MSF to be more involved operationally, and doing some substitution. MSF staff supporting the hospital totals approximately 3 full-time equivalent expatriate staff, and 4 full-time Cambodian staff.[12]

Design of the health financing scheme

A health economist made simulations about the financial inputs needed to run Sotnikum hospital under the New Deal regime.[13] He estimated the necessary monthly budget to be between US$8,000 and US$9,500, depending on utilisation and access to governmental budget. According to this calculation, the government budget would cover between 60 and 70%, while patient fees could contribute to not more than 20%. MSF & UNICEF would have to complement US$1,560 per month (less than 20% of the full cost).

The **GOVERNMENT BUDGET** supplies drugs and medical material in kind. This provision is quite reliable. Cash normally arrives for salaries (chapter 10) and for running costs (chapters 11 and 13). In 1999, the main source of government funding was "Accelerated District Development" money (ADD). ADD is disbursed by the MoH in Phnom Penh directly to the OD director (thus effectively bypassing the governor, provincial treasury and the PHD), in 8 steps covering 1.5 months each. However, a new system was planned for 2000: the Priority Action Program (PAP).

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[11] Previously, 2 MDs were trained in surgery and 2 nurses in anaesthesiology.

[12] Expatriate staff: (1) the project co-ordinator supports part-time the hospital, especially management and surgery; (2) one full-time MD supports quality improvement in the medical services, and management; (3) one full-time nurse set up the new services, and supports the management of the hospital; & (4) on a part-time basis, the MSF logistician also gives support for logistic issues (water, electricity, waste management, & maintenance). Cambodian staff: (1) one full-time MD following up on management; (2) one full-time lab assistant for on-the-job training; (3) one full-time accountant; & (4) a part-time logistician.

[13] Excluding all investments, such as buildings, vehicles, equipment and furniture.

This new approach was intended to solve different problems of public budget spending in Cambodia.[14] However, for the OD the change from ADD to PAP means handing back responsibility to the provincial level, but also an improvement in flexibility (post-control, instead of pre-control) and accountability.

USER FEES. MSF & UNICEF strongly insisted on the need for financial accessibility. They put relatively low patient fees as a condition for their budget support. This resulted in approx. US$8 for hospitalisation, and US$1.25 for OPD consultation for adults; half the amount for children. It was decided that hospitalisation should be a lump sum, whatever the length of hospitalisation, the consumption of drugs or technical services, such as X-ray. For OPD, lab and X-ray are charged separately. The OPD fee at the hospital is approximately ten times higher than in the health centre.[15]

EXTERNAL BUDGET SUPPORT BY MSF & UNICEF. Initially the budget support was conceived as a lump sum (see next point). However, after a short "honeymoon" of three months (December 1999 – February 2000), the number of patients decreased quite steeply over March – May 2000 (Figure 6, page 30). Therefore, MSF & UNICEF decided mid-2000 to strengthen incentive mechanisms and use their direct financial input as leverage to improve the functioning of the system. From now on, external funds to the hospital would be performance-related (a lump sum + doubling of 49% of patient fees). Conceptually and relationally, such a change was a move from being a donor to a commissioning body or a purchaser of services. It was anticipated that more powerful incentive mechanisms would create a stronger dynamic for the success of the project.

INCENTIVE SCHEME. Before the New Deal, the situation could be described as: (1) very low and undifferentiated official wages; (2) some consideration for work load in official extra-incomes (overtime, night duties and per diem); & (3) unequal access to unofficial payments and embezzlement (high amounts for a few, small amounts for most).

Along a more modern management, initiators of the New Deal were eager to take into account more individual efforts, skills and responsibilities in the new income scheme: performance-related incentives. So the bonus scale has introduced a distinction between the staffs according to qualification, responsibilities and workload. As mentioned earlier, individual performance-related pay (accounting for 30% for the individual bonus) was established (Figure 5).

[14] "Cambodia Public Expenditure Review, Enhancing the Effectiveness of Public Expenditures, Volume 1: Summary", The World Bank, Phnom Penh, January 1999.

[15] 5,000 Riel (US$1.25) for an outpatient consultation in the hospital; 500 Riel (US$0.125) in the health centres.

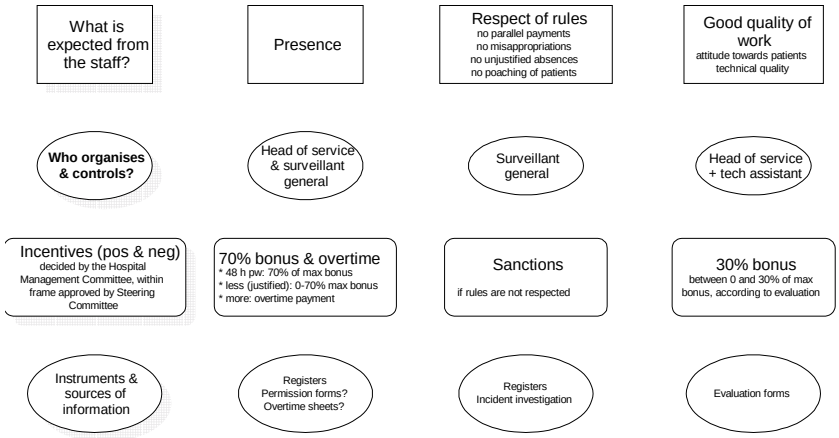

Figure 5: Bonus calculation for hospital staff

To finance a higher individual income, different sources were optimised. The re-organisation of the working schedule (the shift to "24 hours/7 days" services) gave an opportunity to increase official extra income (overtime paid with State running costs budgets). For the bonus itself, it was not authorised to be funded by any State budget. A first way to fund the bonuses was with money generated from user fees. The National Charter on Health Financing allows 49% of user fees to be used for staff incentives. As this source is directly linked to the activity of the hospital ("the more patients come, the bigger the cake is to share"), it establishes a strong incentive for the staff to improve quality of the service (Figure 2, page 16). MSF & UNICEF committed to "fill the gap" to reach a "fair bonus", estimated at US$1,560.[16]

However, because of decreasing hospital utilisation (March – May 2000, on Figure 6, page 30) MSF & UNICEF felt compelled mid-2000 to reinforce incentive mechanisms.[17] They decided to adopt an approach quite similar to the one in the health centres (see page 37), and to make part of MSF & UNICEF subsidy directly dependent on the quantity of activities delivered by the hospital. Concretely, this activity-related grant would be equal to the 49% of the monthly user fees (without setting any ceiling). The stimulus to higher activity is obvious. In accordance with this change, the unconditional lump sum was reduced from US$1,560 to US$800, another US$200 being conditioned on the results of a periodic assessment of hospital hygiene and maintenance. Along this new approach, MSF & UNICEF could in future contracts identify services and activities not well developed and pay a conditional amount for their development.

Results in 2000

GENERAL. For the level of the hospital staff (level B management, see Contracting at two levels to clarify roles, page 19 and Figure 3, page 20), **the New Deal basically worked**. All staff signed individual contracts, and formally respected the internal

[16] However, to "fill the gap" was perceived as difficult to manage. It would create a perverse incentive to widen the gap. Therefore, MSF & UNICEF decided to pay a monthly lump sum of US$1,560, equal to the estimated gap, whatever the actual gap would be.

[17] Such drop also occurred in March – May 1999.

regulations. This is a fundamental change: staff is present, fees are transparent, emergencies are attended at night, patients receive drugs and do not have to purchase any in private pharmacies, there are no more informal payments.[18] The number of documented violations of the internal regulations has been very limited[19] (but the Management Commission has found it difficult to sanction them). Most staff have worked between 50 and 60 hours per week. The staff have received a monthly bonus, steadily growing well above the negotiated "maximum bonus" negotiated initially.

FULL CPA. Surgery, blood bank and X-ray started in August– September 2000, thus completing the most important ingredients of a full CPA hospital with 120 beds. Surgery is quite attractive for the population and lucrative for the staff. It contributed very much to changes in the attendance and income for the hospital (Figure 8).

CONSTRUCTION WORKS. (1) the World Bank building, including operating theatre and technical wing, needed several "repairs" and was finally made operational in August 2000; (2) MSF constructed a new medicine building with 40 beds; & (3) a garage and workshop.

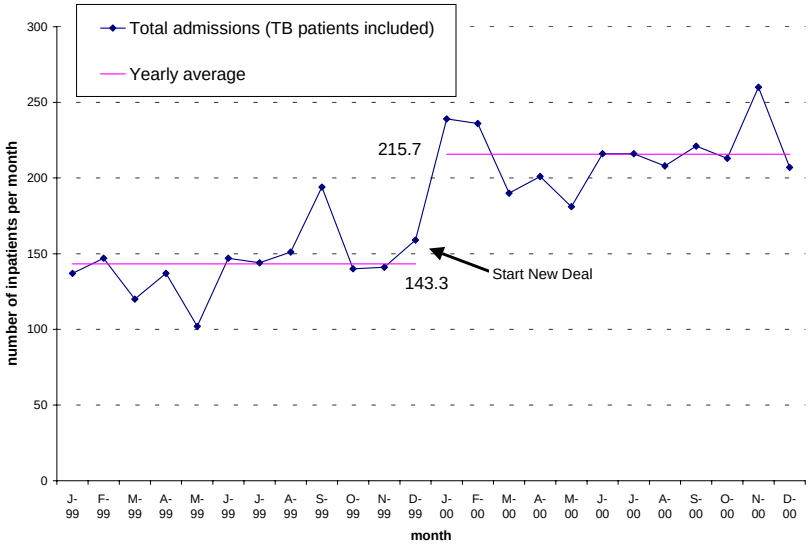

Figure 6: Inpatients at Sotnikum hospital, 1999-2000

THE NUMBER OF IN-PATIENTS rose fast in the beginning (Figure 6), but then experienced a drop (interpreted as the end of the "honeymoon" between the staff and the New Deal). Mid-2000 it rose again due to (1) the change in MSF/UNICEF purchasing policy,[20] (2) the start of the surgery, and (3) the introduction of the equity fund (see page 48). As compared to 1999, activities increased by 50% in 2000 (143

[18] These changes were confirmed in a "Patient satisfaction survey", performed by Dr Um Chai, MSF, Sotnikum, December 2000.

[19] There was one instance of informal fees in the laboratory and two cases of documented thefts (lab tests and patient rice).

[20] From [US$1,560 lump sum] to [US$800 lump sum + US$200 for hygiene + 49% of patient fees].

IPD per month in 1999 vs 216 in 2000).[21] However, in 2000 the number of outpatients and the number of deliveries remained very low. The bed occupancy rate was quite high, partly due to increased length of stay.

MC: MANAGEMENT COMMITTEE OR MANAGEMENT COMMISSION? During 2000, the management style in the hospital was an important discussion point. During several steering committee meetings, the relative power of the director of the hospital and the management committee were discussed. The MoH general director insisted that the hospital director had to assume full and final responsibility, being assisted in his task by the management commission, in an advisory role. On the ground, there was frequent friction between the director and MSF, and between the director and the other MC members on who decides what. Clearly the objective of creating a sense of ownership by the whole staff is not achieved: hospital staff complain about arbitrariness and a general lack of transparency in the bonus evaluation.[22]

Staff management, including the monthly evaluation and calculation of staff bonus, takes up a lot of time of the MC. During 2000, the hospital MC developed a new evaluation system. The effectiveness of this very time-consuming evaluation is sometimes questioned. MSF technical assistants find that the director and the other MC members lack strictness in applying the internal regulations. MSF decided to pull out of such a frustrating evaluation process.

STAFF BONUS. The original deal was calculated on a "maximum bonus" of US$65 per staff per month on average (ranging from US$25 to US$130). Mid-year there was a crisis, as the hospital did not generate enough income to pay the bonus. The director mobilised the funds anyhow (paid in fact with debts). Later, a second breach of the contract occurred: with the increase in patient fees, the individual staff bonus increased steeply, well beyond the "maximum bonus." This was possible, partly due to the limited number of staff in the hospital. Indeed, most staff work many hours overtime to make up for this.

THE HOSPITAL IS UNDERSTAFFED, BUT THE STAFF IS UNDEREMPLOYED. There is a consensus that the hospital is understaffed, especially in nurses (33 staff for a 120-bed hospital, while the official MoH staffing standards are at 69). There is quite some resistance against changes in work routines because the staff feels strongly overburdened (e.g. failure to introduce an improved drug distribution system to hospitalised patients). Paradoxically, during working time most of the staff are not very busy. Clearly new work practices have to be developed.

Staff organisation remains a problem. A clear identification of tasks and responsibilities is still needed. Delegation of power could be pushed farther. The imbalance among the qualification (lack of nurses and too many doctors) surely does not help.

Early in 2000, the hospital director requested 19 extra staff. The steering committee rejected this proposal and asked to prepare a "more realistic plan." Nothing happened for months. MSF & UNICEF insisted on increasing the number of nurses by four, as

[21] Moreover, it is likely that 1999 data, prior to the introduction of the New Deal, were inflated to justify drug quota. There is no doubt that in 2000 there were many more patients than in 1999.

[22] "Perception of the New Deal in Sotnikum by the different actors", Heng Thay Ly, NIPH, Phnom Penh, February 2001.

a lack of nurses is the universal excuse for resisting any moves towards quality improvement. However, the hospital management became very reluctant.[23] Even possible solutions were not investigated. At the December 2000 steering committee, MSF & UNICEF announced they would make further cash budget support partially dependent on finding a satisfactory solution to this problem.

TRAINING & QUALITY OF CARE. Quality of clinical care and nursing care remain low, and ways to improve it are not easy to imagine.[24] First, there is a problem of quality perception and accepted standards. Second, young Western doctors and nurses do not seem in the best position to convince Cambodian colleagues to accept new standards; even more so, if these young western doctors are involved in income-related evaluations. Other more autonomous processes, such as scientific medical meeting (e.g. review of cases), do not take root: the frequency is low and the MSF doctor has to push behind. Overwork seems as an easy excuse for managers and workers to be satisfied with the current state of affairs.

So we see that the hypothesis that fair income would generate a working environment conducive to improvement of quality of care obtained through additional inputs as training, technical assistance and supervision has not been fully realised. The impression among the MSF team is that the hospital director has not fully seized the opportunity given by the new accountability framework. Instead of empowering the management commission to get a stronger staff commitment, he lessened the role of this, indeed competing, body. He did not favour a clear division of responsibilities between the management commission and himself. The partition rule he practised was rather "popular decisions by the director, unpopular by the management commission".

HOSPITAL INCOME. CMS, through its in-kind provision of drugs, is with 31% the first source of income for the hospital (Figure 7). Other government funding (30%) consists mainly of the running cost budgets (ADD or PAP). External assistance by MSF & UNICEF constitute 20 % of the total income, while income from patients (user fees) constitutes 15%.

[23] The rationale behind this reluctance is not entirely clear. The obvious cause is the fear that more nurses mean less individual bonus for the current staff. For MSF & UNICEF, this refusal to tackle the problem is also a sign of a lack of commitment to the spirit of the New Deal. They judge that the hospital director should develop a dynamic in his hospital in favour of quality improvement, thought to be the best guarantee for increasing patients and income, and thus bonus, and dismantle any logic of short-term benefit opposing this progress.

[24] In November 1999, MSF organised an internal workshop in Phnom Penh on improving clinical care in the Cambodian context.

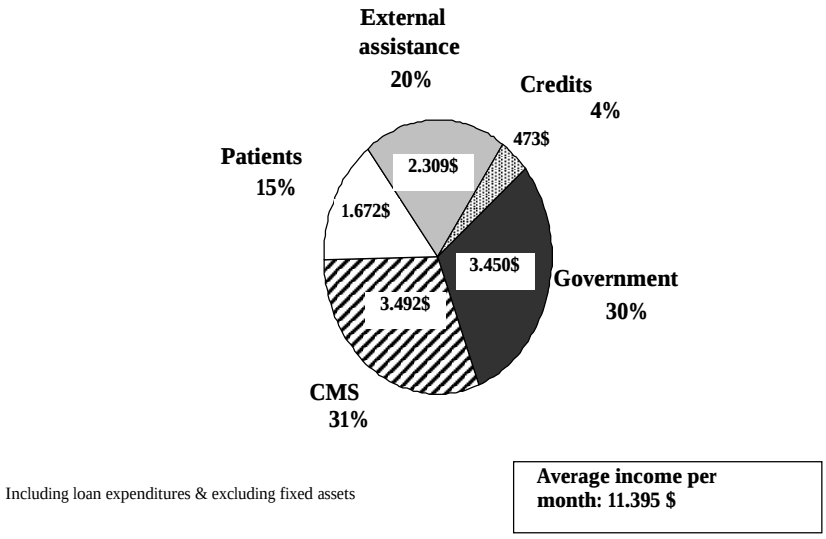

Figure 7: Sotnikum Hospital: average monthly income in 2000

User fees: Initially, the income from **patient fees** remained relatively low, and followed closely the number of in-patients. From September on, it increased fast, much faster than the number of patients (Figure 8). This can be explained mainly by (1) introduction of surgery[25] and the improved reputation of the hospital; (2) the change in purchasing policy of MSF & UNICEF; (3) the increase of the fees for hospitalisation,[26] & (4) the payment for poor patients by the equity fund since September 2000 (see page 48).[27] Hospital management is very eager on increasing income from patient fees. For some time, they charged an additional 5,000 Riel for X-ray and Ultrasound for hospitalised patients. This was disapproved by the steering committee, and consequently it stopped.

[25] Surgical patients pay 120,000 Riel (US$30) each.

[26] The fees for intensive care increased from 30,000 Riel (US$7.5) to 50,000 Riel (US$12.5).

[27] Before that the hospital exempted some patients from payment, but had to forego the corresponding income.

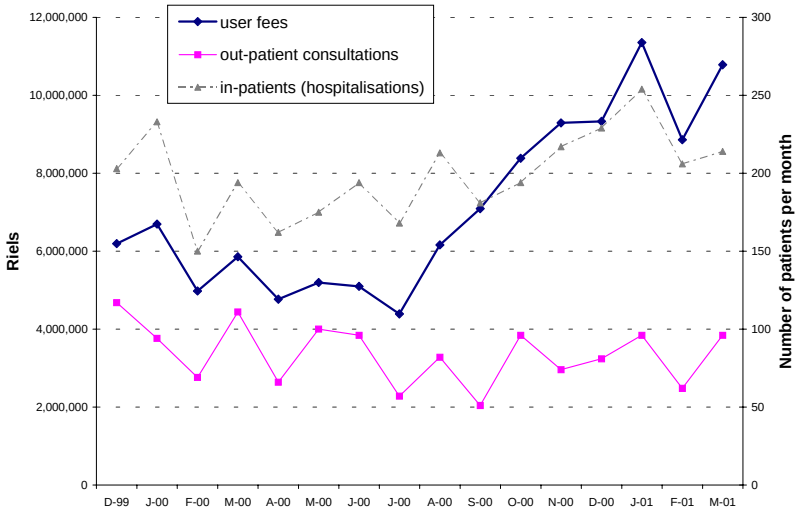

Figure 8: User fees and activities in Sotnikum hospital, December 1999- March 2001

External subsidy: as already explained, the MSF & UNICEF subsidy, initially a lump sum, was changed to a conditional funding in an attempt to boost the number of patients.

Government budget: one of the biggest problems throughout the year was access to the government budget. In 2000, one can distinguish 2 phases: (1) the ADD phase, till August, and (2) the PAP phase, since September.

> **Phase 1: ADD is available.** Between January and August 2000, 6 ADD steps arrived of approx. 40,000,000 Riel each (US$10,000), which gave the health system in Sotnikum an unprecedented 'wealth'. During that period, the main problem was that ODO remained reluctant to give the hospital its share of the ADD budget. When the ODO New Deal was introduced in May 2000, this improved considerably. Till August, the main discussions thus focussed on distribution of ADD money between health facilities in the district, and on transparency in bookkeeping and expenditure.
>
> **Phase 2: PAP is not available.** However, the transition from ADD to PAP in September caused serious problems. In fact, despite important amounts made available by MoEF to the provincial treasury[28], this money did not arrive at all in Sotnikum OD. As a consequence, the hospital was often out of cash, even for patient food, and it accumulated debts with suppliers (mainly for electricity and fuel). MSF advanced some money for patient food, but this became somehow counter-productive.[29] Eventually at the end of 2000, Sotnikum OD received less than one fourth of the budget scheduled for the last semester. But, this was definitely too late for anything else than reimbursing debts in 2001.

[28] 100,000,000 Riel (US$25,000) in September for quarter 3, and the same amount in December for quarter 4.

[29] The directors openly stated in the steering committee, that they didn't insist too much on getting government budget, as borrowing money from MSF was "more easy".

HOSPITAL EXPENDITURE. Drugs and medical supplies account for 32% of expenditure (Figure 9). This closely matches the in-kind donations by CMS. Thanks to the New Deal, human resource costs are 30 % of the hospital expenses (24% for staff bonus, 4% for overtime, but only 2% for government salary and allowances). Running costs make up 39% of the full cost of the hospital. This is quite excessive, if compared to other rationally run hospitals. It is mainly due to the imbalance of government funding (a lot for running costs, nearly nothing for salaries). Savings are surely possible.[30]

Allocation of resources: the hospital management continues to perceive different sources of income as "earmarked" for certain expenditure.

- Patient fees: 49% for staff bonus, and also as much as possible of the 50% for running costs for staff income, such as overtime (which MSF encouraged in a first stage, as they initially thought that the ADD money would continue to flow freely).
- MSF-UNICEF subsidy: entirely for staff bonus, although this was clearly not the purpose and this was repeated regularly.
- Government budget: for all running costs, small investment, etc.

The consequence of this earmarked thinking is a denial of proper adaptation in case of the drying up of a source of income. Once the State budget failed to arrive during the last quarters of 2000, the hospital management kept on using external funds and patient fees to maximise staff income (quite above the maximum bonus agreed) instead of satisfying also other priority needs, such as patient food. This focus limited to staff income can be alternatively interpreted as a poor commitment to the objectives of the New Deal, or as a very clear understanding of the objectives of the New Deal, depending on the point of view.

[30] However, this expenditure as registered in the bookkeeping does not represent the entire reality. It includes some investment costs (e.g. furniture & equipment), but also contains over-invoicing, false invoices and other "creative bookkeeping procedures".

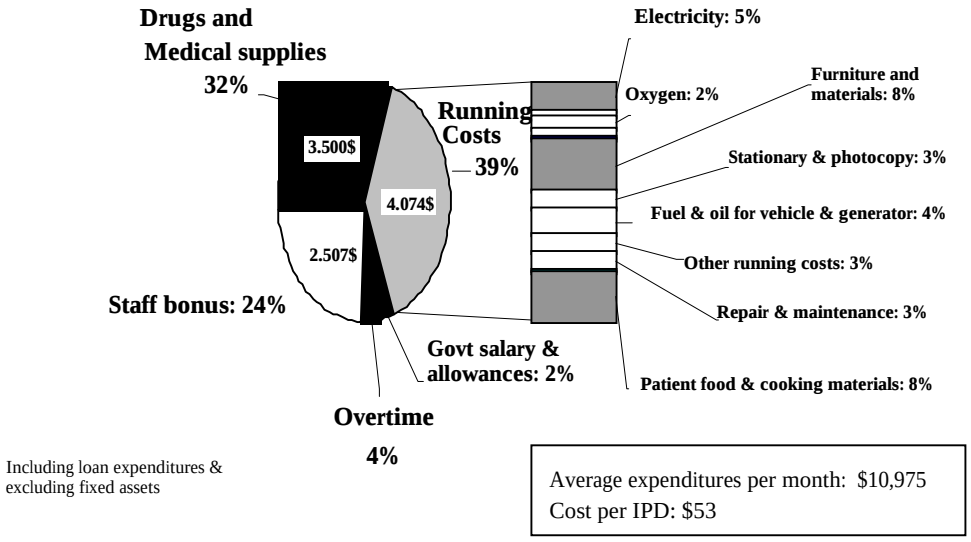

Figure 9: Sotnikum hospital: average monthly expenditure in 2000

BOOKKEEPING. PriceWaterhouseCoopers designed a bookkeeping system for the hospital, and started training the staff in performing it. Initially, the hospital and the ODO shared one bookkeeper. However, in mid-2000, the bookkeeper started working full-time for the ODO. In the hospital, bookkeeping remained a problem throughout 2000. Since the beginning of the New Deal, MSF paid a full-time accountant to train the hospital administration, in fact, largely doing substitution.

Transparency in expenditure remains an issue. Who decides on which expenses, and the relation between invoices and goods received in the hospital, is not always transparent. As mentioned above, the management commission has not been duly empowered. As far as rationalisation of expenditure is concerned, management of drugs has received relatively little attention up till now.

CONCLUSION ON THE HOSPITAL. The New Deal in Sotnikum hospital clearly works: since its introduction staff earn a better income, and they give better care to more people. Together with the investments and the expansion of services, especially surgery, the year 2000 saw a profound transformation of its functioning, the service it renders to the community, and its perception by the community. However, management of human, financial and material resources, and quality of care remain problematic and still need major improvements. Still, the New Deal created an environment in which these can be negotiated and tackled.

(2) The health centres

In 1999, before the New Deal

As already mentioned, the performance of the health centres in Sotnikum OD was, according to Cambodian standards, already fairly good before the New Deal. Sotnikum OD was in fact achieving among the highest user rates in the whole country (often between 0.5 and 1.0 new cases per inhabitant per year).[31] There is a consensus among actors that it was mainly due to the efforts put in community participation, especially by UNICEF. The continuous effort on training, introduction of full MPA and permanent attention paid to the health centres are probably also part of the explanation. Of course, the picture was uneven among the facilities: some health centres were performing quite well, others were still lagging behind. Poaching of patients to private practice was quite generalised, especially for cases who needed referral to the hospital. Actual opening time of the health centres was limited to the early morning, and any emergencies occurring outside these hours could not be attended. In fact, the health centres mainly dealt with minor health problems. While the New Deal for the health centres was less urgent than in the hospital, there was clearly also room for major improvements. Prior to the introduction of the New Deal, staff morale was low. Medicines and material were often diverted for private use, and patients recruited for private practise.

A New Deal for the health centres in 2000

Objective: Having the health centres offering quality services to the population living in their coverage area, including for severe cases, and improving referrals to the hospital.

Focus for 2000: Develop a good health centre New Deal model in a limited number of health centres, e.g. four. In the short term, attention was focussed on introduction of the New Deal to obtain (1) staff presence & commitment; (2) improved opening hours; & (3) transparent management of financial resources. After that, attention shifted to (1) improved malaria treatment (biological diagnosis and combination therapy); (2) improved obstetrical care by qualified midwives; (3) improved case-finding of TB suspects; & (4) improved transfer to the hospital.

As follow-up indicators were used: (1) number of new patients per month; (2) number of deliveries attended at the health centre per month; (3) patient fees collected; (4) number of referrals to the hospital; & (5) presence of staff.

Introduction of the New Deal for the health centre staff

The negotiation of a New Deal for the health centres has been a long process. It partly followed the same logic as in the hospital, but new elements were introduced to adapt the New Deal to the specificity of the health centres. One of the key questions was: How to make the health centres more accessible to the population? The staffs in the first two health centres have chosen to organise a permanent service: 24h / 7 days per week. They considered this to be an important factor to attract more patients.

[31] However, there are considerable doubts about those numbers. There is indeed an incentive to declare higher utilisation to justify higher drugs quota.

From the start, the bonus for the health centre staff was partly performance-related. It has two parts: a fixed part and a variable part. The fixed part is US$30 for health centre chiefs & US$20 for other staff. It is guaranteed if the health centre (i) is open 24 h/7 days per week, (ii) has a functioning feed-back committee, and (iii) if the internal regulations are followed. The variable part depends on the income generated by patient fees and referral of severe cases to the hospital, and on the per diem for outreach activities from the government budget. The health financing scheme in the health centres was designed to be "self-regulatory," meaning relatively independent from outside control.

It is one of the assumptions of this project that once a New Deal is functioning, inputs like better supervision from the OD office and training will yield more tangible results in terms of improved quality of care. So in the medium term, additional inputs such as training for the midwives to improve obstetrical care and regular supply of dipsticks and combination therapy to improve malaria treatment, were foreseen to boost the real and perceived quality of care in the health centres.

Management of the health centres

The New Deal in the hospital coincided with the introduction a new accountability framework: the idea being that each individual should be made accountable to the whole group of workers via the Management Commission (MC). The MC is also the platform for transparency and participation in decision-making. In the health centres, such a framework had been existing for some time prior to the introduction of the New Deal.[32] The health centre co-management committee, with half of the members from the staff and half from the population, is already a quite well-functioning unit for transparency, co-decision and accountability to the group. The feedback committee is a second platform to enhance the relations with the community. Such accountability to the population is perceived as important in primary health care.

We must notice that a health centre is a less hierarchical organisation than a hospital: the number of staffs is limited and they already work as a team. Achievements are more co-owned by the whole team. In accordance with this, it was decided to avoid making individual bonus dependent on individual evaluation. So the committees are not burdened with painful individual evaluation as the MC in the hospital. As in the hospital, to sustain transparency, PriceWaterhouseCoopers developed and introduced a simple consolidated bookkeeping system.

Technical assistance

The health financing scheme (HFS) for the health centres has been developed during direct negotiations between the health centre staff and MSF & UNICEF, in collaboration with the ODO. Initially MSF & UNICEF performed daily visits to the New Deal health centres. MSF & UNICEF employ one full-time medic each to follow up the New Deal health centres. Their visits involve control of income, and accuracy of registers. MSF & UNICEF staff trace a sample of patients back in their villages, and interview them on care received and fees paid.

[32] "The organization of the community participation in the health centers in Siem Reap Province", Rob Overtoom, UNICEF, Siem Reap, 1999.

Financial inputs

The **GOVERNMENT BUDGET** provides drugs and medical material in kind. Cash arrives for salaries through chapter 10. ADD money is intended to finance running costs, including 8,000 Riel for per diem per outreach session per person.

PATIENT FEES remain very low. The previous consultation fee of 500 Riel (US$0.125) for a booklet of five visits increased to 700 or 1000 Riel (US$0.175 or US$0.250) per visit, depending on the health centre. The fee for a delivery ranges from 10,000 to 15,000 Riel (US$2.50 to US$3.75), also depending on the health centre.

EXTERNAL INPUT: UNICEF & MSF budgeted roughly US$250 per health centre per month. (1) between US$130 and US$150 for fixed bonus; (2) between US$50 and US$120 for doubling 49% of patient fees; & (3) between US$5 and US$10 for 5,000 Riel per referral to the hospital (see further).

Starting to build the system

Treating different parts of the OD as independent management units can be disruptive for the systemic dimension. Contracts and incentive schemes must be designed as not to bring about perverse relations among the different units (e.g. excessive competition between the hospital and the health centres, retention of resources by the ODO, etc). On the contrary, incentive schemes could be used as a new way of improving the health system.

From the beginning MSF & UNICEF decided to pay to the health centre 5,000 Riel (US$1.25) for referrals (patients referred to and arrived in the hospital). This incentive is intended to counterbalance the numerous obstacles for a correct utilisation of the hospital. If there is indeed a risk of false positives (unjustified referred patients) with such a referral related incentive, the under-utilisation of the hospital by the rural population is perceived today as a more important problem.

After one month of functioning, the health centres agreed to pay 5% of their income from patient fees to the ODO, for good quality support: supervision, supplies, and in particular regular disbursement in cash of government funds to the health centres.

Results in 2000

General: the New Deal basically works. In all 6 New Deal health centres, the staff opted for 24h / 7 days per week service, although this is very demanding on staff time. Most health centres decided to increase patient fees, especially the fees for deliveries. The general perception by the population is highly positive: the certainty to find the facility open whatever the hour is especially perceived as a dramatic improvement and greatly enhances utilisation.[33]

The New Deal has been implemented in 6 health centres out of the 16 health centres existing (Figure 4, page 24). This was strongly UNICEF & MSF driven, with the ODO staff only marginally involved. From September – October onwards, there was considerable pressure from non-New Deal health centres and from ODO staff to

[33] "Comment le New Deal améliore la qualité des soins de santé et remplace les anciens arrangements à Sotnikum." Rein Antonissen. Antwerp, thesis RUCA, 2000. This positive perception by the population is also clear from the monthly community assessment done by field staff of MSF & UNICEF.

include other health centres rapidly, even in health centres where 'minimal' conditions were not fulfilled.[34] However, MSF & UNICEF feared this would be done in a hasty and un-prepared way and jeopardise the quality. They tried to use this as an opportunity to push ODO to take the lead; putting conditions and asking ODO to create them before launching extra health centres. Also in the former district hospital of Chikreng (Kampong Kdey), with its high number of staff, it was difficult to find an appropriate proposal.

The evolution of the **number of patients** seems positive in most of the health centres. But it is in fact difficult to interpret;[35] however, there isn't a steady increase in any of the health centres (Figure 10, Figure 11 & Figure 12). These figures show typical evolution in the utilisation of health centres after the introduction of the New Deal, which always coincides with the sudden increase in income from user fees.

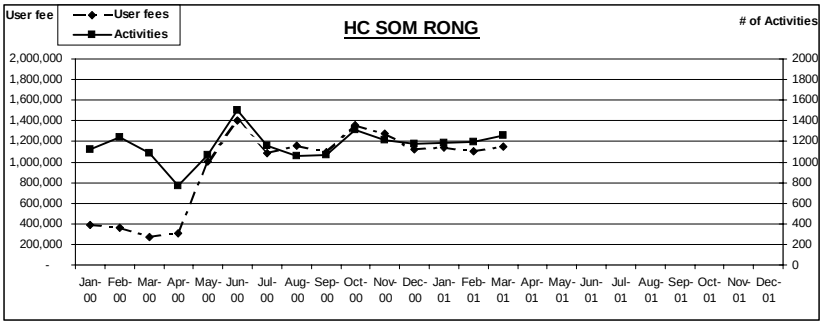

Figure 10: Utilisation in Samrong health centre (start New Deal in April 2000)

[34] Minimal conditions established by UNICEF & MSF: (1) enough and motivated staff, in particular a good health centre chief; (2) good community participation: feedback committees and co-management committees; & (3) capacity of ODO to give quality support, in particular supervision.

[35] Staff always mention that before the New Deal, it would be common practise for a person to consult the health centre with several booklets for different family members, thus counting several patients. In the New Deal, this practise was abolished. Also, before it was common practise to declare false patients – and exempt them from payment – to justify drug consumption. As a consequence, after the introduction of the New Deal some health centres officially notified a decrease in the number of patients, but they maintained to consult more "real patients"… However, they invariably declared a much higher income, which is now made transparent through the bookkeeping system.

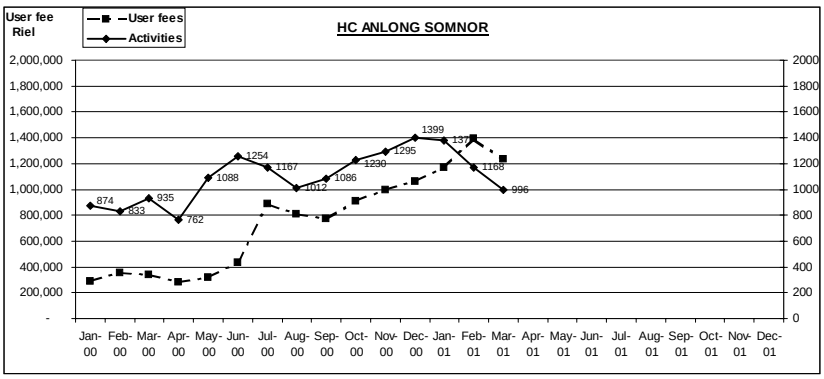

Figure 11: Utilisation in Anlong Somnor health centre (start New Deal in July 2000)

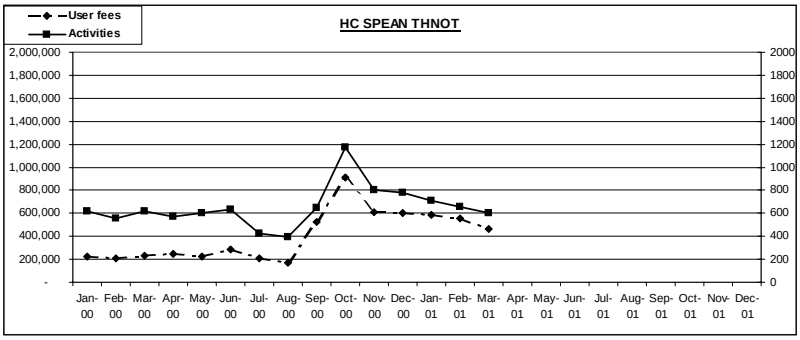

Figure 12: Utilisation in Spean Thnot health centre (start New Deal in September 2000)

The number of deliveries recorded in the health centre gives a variable picture, but mostly increased after the introduction of the New Deal (very high in Sang Veuil, temporarily 0 in Samrong, etc).[36] The number of referred patients increased significantly in all New Deal health centres (Figure 13, Figure 14 & Figure 15).

[36] The impression is that after the introduction of the New Deal, in certain health centres midwives accepted to attend deliveries in the health centre premises, which they would have otherwise attended in the homes of the patients, as private. Whether trained midwives now also attend deliveries that were previously attended by TBAs, or other untrained staff, should be further investigated.

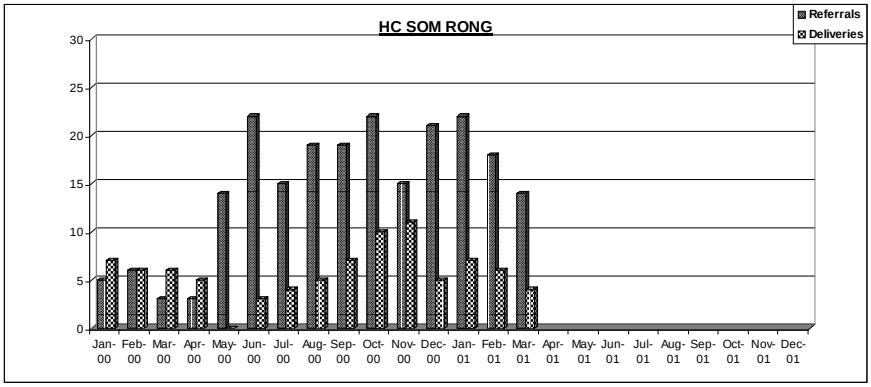

Figure 13: Deliveries & referrals in Somrong health centre

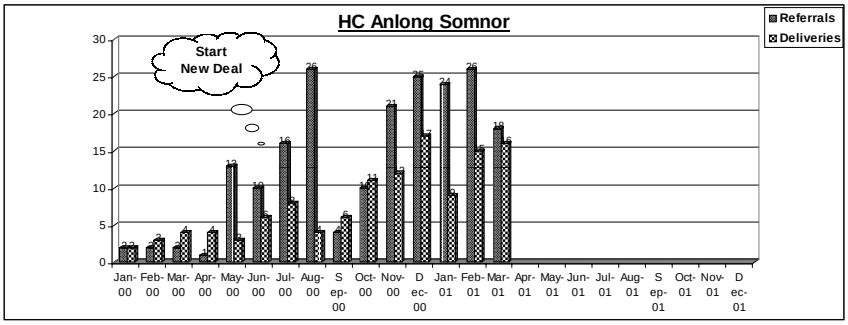

Figure 14: Deliveries & referrals in Anlong Somnor health centre

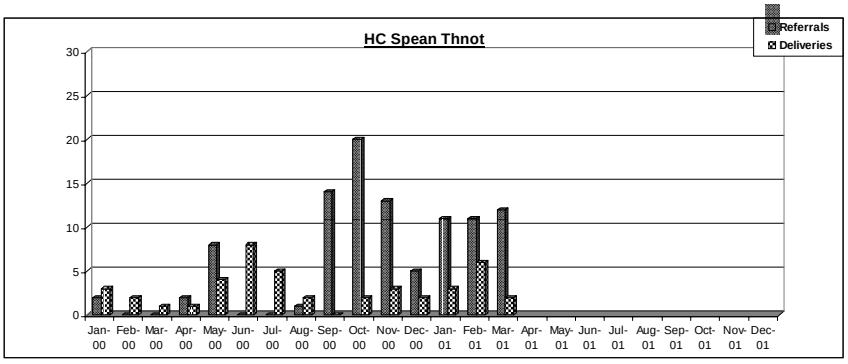

Figure 15: Deliveries & referrals in Spean Thnot health centre

In general, the **income of the health centres** is as expected (Figure 16): 49% of income are in-kind drug donations from CMS, 19% cash subsidy from MSF & UNICEF, 18% from user fees, only 3% from government for salaries, and 5% from government for running costs. As the hospital, health centres faced some difficulties to get from the ODO the ADD budget that was intended for them. Since the start of PAP, they did not receive any government budget anymore. The individual bonuses are in the range of what was forecast. In Sang Veuil health centre it is even up to US$100 per person per month.

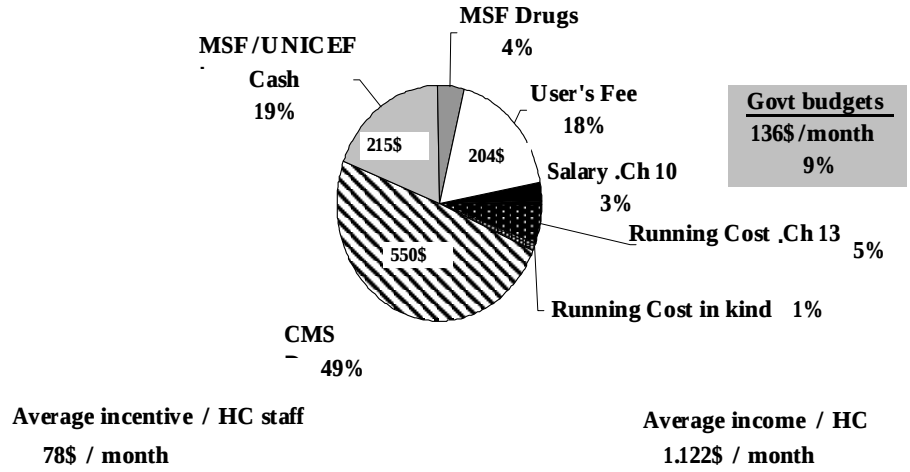

Figure 16: Monthly average income of New Deal health centres in 2000

There is, of course, a risk that the incentives introduced by the New Deal focus most attention is concentrated on fee-generating activities. These possible side-effects have not yet been analysed in depth.

Presently, the services offered are MPA (minimal package of activities), which are not very attractive to patients. Despite the space for initiatives, health centre staff did not dare to develop new strategies.[37] The project intends on an experimental basis to upgrade the package of activities offered (a so-called MPA+). As a first step care for malaria has been improved: systematic biological diagnosis (dipstick or microscopy) and combination therapy (artesunate + mefloquine) have been introduced, and higher fees charged for this service: 2,500 Riel (US$0.625).

Conclusion on the health centres

Also in the health centres the New Deal clearly works, and is perceived as a major improvement by staff and patients. There are no major apparent difficulties in management, although management has not been reviewed in depth. Real utilisation of the health centres increased, as did deliveries and referrals to the hospital. The health centres faced great difficulties accessing the government budget.

[37] MSF & UNICEF staff thought that once the New Deal logic well understood health centre staff would take initiatives to increase income (e.g. house calls), or formulate requests enabling them to attract more patients (e.g. more injections, treatment for chronic diseases, or consultations during outreach).

(3) The operational district office (ODO)

In 1999, prior to the introduction of the New Deal, staff morale among the 14 ODO staff was low, and their role not clear. ODO staffs were formally performing per diem-generating activities (seminars, workshops and administrative supervisions), and managed resources in a non-transparent way. Government funding was an especially big problem, with most expenditure reportedly being done by the ODO 'on behalf of' the health facilities, with little arriving in the health facilities, and very creative bookkeeping to justify expenses.

Introduction of the New Deal in 2000

Objective: having the ODO function as a support to and overall manager of the health centres and hospital.

In the short term, the focus was on (1) Consolidated accounts for the whole OD to have transparent financial management and accountability; (2) ADD money reaching the hospital and health centres in cash; (3) Clarify the role of the ODO; & (4) assure reliable supplies of drugs, vaccines and material to hospital & health centres.

In the medium term, it was planned to shift the focus to (1) improved and regular supervision of the health centres and the hospital; (2) ODO's role in receiving information from the hospital and health centres for the health information system, and the bookkeeping; processing of these data at ODO level and transfer to the PHD; & (3) improved internal management and team work, planning, meetings and delegation.

Aspects still being followed-up are: (1) presence of staff; (2) monthly work schedule prepared + monthly activity report; (3) number of supervisions to health centres; (4) ADD and PAP money arrived in cash to the health centres and the hospital; (5) transparent consolidated accounts for the whole OD; (6) teamwork in the ODO; (7) perception by the health centres and the hospital of the support they receive from the ODO; & (8) regular ODO meetings kept.

Introduction of the New Deal for ODO staff

The design of a New Deal for ODO staff was difficult. Discussions focused almost exclusively on the level of bonus, while what the "better work in exchange" meant was difficult to grasp.

For all involved (ODO staff, MSF & UNICEF), the activities to be performed by the ODO were more difficult to define, quantify and evaluate than those of the hospital or the health centres. Moreover, as ODO does not generate patient fees, it was not easy to establish a self-enforcing contract ("more patients come to you, more income you earn"). Performance had to be assessed by some evaluating agent, income had to be delivered by some purchasing body. Clearly this position is less easy for the staff than the one prevailing in the hospital and health centres.

The ODO is a budget management centre for MoEF, which is financially accountable for all the money used within all structures of the OD. MSF & UNICEF wanted to achieve in the short-term financial transparency in the ODO. Therefore, compiling the consolidated accounts for the whole OD, as designed by PriceWaterhouseCoopers, was an absolute condition. In a first stage, output was thus mostly defined in terms of financial management.

Finally, a New Deal was reached putting the "maximum bonus" for the ODO staff at 115% of the "maximum bonus" of the hospital staff with similar qualifications and responsibilities. However, the absolute amount was proportionally reduced to account for the 35-hour week applied in the ODO (as compared to the 48-hour week in the hospital).

MSF & UNICEF estimated that a gap of US$600 would exist to pay for bonus for ODO staff. MSF & UNICEF thus agreed with a monthly "maximum" subsidy of US$600, conditional upon evaluation by MSF & UNICEF staff from Phnom Penh, and a PHD representative (the "ODO evaluation").

The ODO evaluation analyses 4 criteria: (1) distribution of government budget to health facilities; (2) transparency in the utilisation of the budget; (3) adherence to consolidated bookkeeping, & (4) quality of teamwork. The results are translated in a score, which determines directly the subsidy.

The steering committee accepted the New Deal for the ODO, and it started on 21 May 2000 (Figure 4, page 24).

Management of the ODO

Between September 1999 and March 2000, the OD director, one vice-director, and the hospital director attended the 10 modules of the Health Services Management Training organised at NIPH in Phnom Penh. In order to create accountability of each individual to the group of colleagues, an ODO management committee has been established. Transparency is sustained through a budget management committee. One staff member of MSF & UNICEF is part of both committees.

Technical assistance

MSF & UNICEF judged that considerable input was needed to upgrade management and accounting skills, as well as the quality of supervision. Therefore, UNICEF appointed a full-time Cambodian MD to support the ODO staff in management and supervision, and a full-time medic for health centre support. MSF has appointed one full-time Cambodian medic to support the ODO; one Cambodian medic to support the health centres; one full-time accountant to support the ODO team for the consolidated accounts and the ADD budget; & a full-time expatriate nurse to supervise the whole thing.

Financial inputs

Government budget consists mainly of (1) ADD and PAP funds (for running costs and per diem for outreach activities, such as supervision) & (2) some World Bank budget for "integrated supervision". An ODO staff gets 8,000 Riel per supervision or outreach session. However, this does not concern the administrative staff. Therefore, as part of the New Deal, all ODO staff agreed to split the per diem in 3,000 Riel for direct expenses for the person going on supervision, and 5,000 Riel as bonus, to be shared among all staff.

"Indirect" user fees. To palliate the problem that ODO has no "own income," health centres and the hospital accepted to pay 5% of their patient fees to the ODO for "good quality support": access to government budget, quality supervision, supplies and co-ordination. This was perceived as a first step towards empowering the lower levels through a purchasing mechanism.

External subsidy. MSF & UNICEF agreed to inject cash to pay for staff bonus, but linked to clear deliverables. With the level of bonus negotiated, there is need for an estimated US$600 per month. ODO staff sometimes benefit from per diems from other sources such as seminars and missions outside the district. However, up until now, they have not been included in the New Deal. MSF & UNICEF strongly suggested the ODO to search for other sources of income, such as other NGOs (e.g. RACHA). However, ODO staff deny having any such income and did not undertake steps to obtain it.

Results in 2000

General: ODO staff formally complied with the New Deal. They were mostly present during the official working hours. However, they are said to be very unhappy about the New Deal, and complain about the high workload & the low bonus (US$53 per month on average, as compared to the hospital staff whose bonus increased steeply to over US$90 per month since September 2000).

Financial: the results in terms of transparency and distribution of available government budget in cash to the health facilities are considerable. In comparison with the pre-New Deal situation, improvements are real. Nevertheless, some problems remain: according to official accounting, health centres outside the New Deal would have got a relative higher share of the budget than health centres inside the New Deal (US$466 per month for non-New Deal health centres versus US$136 for New Deal health centres). The assumption to explain this discrepancy is that the ODO has still an incentive to allocate funds where transparency is the weakest.[38]

Overall management is more difficult to grasp. Distribution of drugs and vaccines is good and reliable. Meetings and supervisions are done and recorded. But MSF & UNICEF remain sceptical about the actual impact: the way they are conducted is more along the lines of formal compliance than a true quest of improvement. Solutions to the problems faced by the facilities, especially the health centres, are mainly brought by the parallel support delivered by UNICEF and MSF staff. The ODO has still a long way to go before switching from "administration" to "operation."

ODO EVALUATION. Initially, evaluations were monthly, later, every two months (before each steering committee meeting). For the 3 financial criteria, the results could be assessed in a relatively objective way. The results were quite appreciable. They concern, however, only a few of the ODO staff (director, vice-directors, and accountant). The other staff (OD pharmacist, EPI, statistics, MCH supervisor, TB and leprosy supervisor, malaria supervisor, cashier, secretary…) are not directly concerned. For them the term "teamwork" was coined, but it concerned in fact more overall management. For this fourth indicator, the ODO evaluation process was not very easy, nor "elegant." The staff perceives the evaluation by MSF & UNICEF as unfair and too strict (only 80 % of the external US$600 attributed).

INCOME: Government budget: ADD money arrived steadily till July 2000. However, income for per diems for supervisions and outreach was lower than initially estimated. The external budget support was on average US$428 per month, according to the ODO evaluation and constituted 30% of total income. The "indirect" patient fees amounted to US$170 per month or 12% of total income (Figure 17). However, since

[38] Whether this money really arrives in these health centres or is used to strengthen services in these health centres is highly unlikely.

the start, the ODO never had access to enough budgets for paying the bonus as calculated after the evaluation, creating frustration, especially as compared to the bonus of the hospital staff.

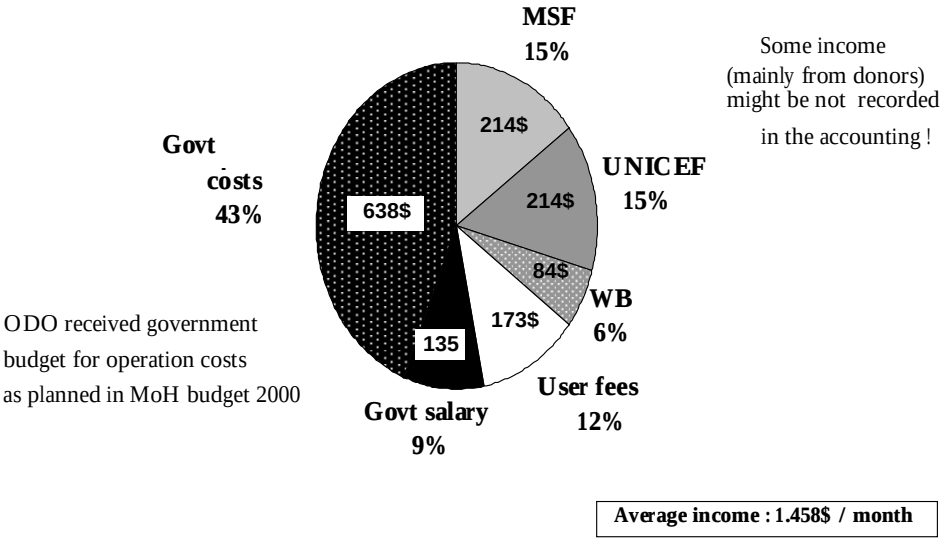

Figure 17: ODO income, 2000 (estimation for June – December 2000)

CONCLUSION ON ODO. The New Deal at the ODO was thus more difficult to develop, more difficult to follow-up, and is still unsatisfactory, both in terms of bonus generated for the ODO staff, and in terms of results obtained (as judged by MSF & UNICEF).

(4) The equity fund

Exemptions in Cambodia

The problem of financial access to health care has not waited for the official introduction of user fees to plague the Cambodian population: health expenditure is a heavy burden for most households. From unofficial payments in public services to fees in private facilities, some people go bankrupt in a desperate attempt to save their loved ones.

With the introduction of the National Charter on Health Financing the MoH attempted to improve the situation, especially for the poor. Each health facility had to identify and exempt the poor. However, exemptions managed by the staff of the facility itself has a straightforward limit: in the current funding pattern, each patient exempted is a financial loss for the staff. Some patients may be accepted for free, but just enough to comply with the official instructions and safeguard reputation. Moreover, it is not sure that an institution such as a hospital has the ability to identify correctly beneficiaries.

Situation in Sotnikum

Before the New Deal, official fees were very low in Sotnikum OD. Financial access was not perceived as being at the top of the agenda. The New Deal meant an increase in the user fees, especially at the hospital level – this is part of the price to pay to get staff motivation. External donors have initially brought most of the needed supplementary funds, but local revenues (population and state budget) are intended to take over later. In line with this, some powerful incentives have been introduced for enhancing collection of fees. Simultaneously imposing the facilities to accept poor patients for free would definitely be a contradictory message in such a set-up.

To avoid this pitfall, it has been decided that the hospital should be freed from the role of identifying and exempting poor patients. A purchaser-provider split should be introduced: an equity fund, entrusted to a local NGO, would be in charge of purchasing services for the benefit of the poor.

Set up of the equity fund

Objective: Develop a sustainable solution to improve financial access to hospital care for the poor. For 2000, the focus was on (1) design an exemption system not contradictory to the hospital's financial objectives; & (2) identify a local NGO to entrust the equity fund to, and have them develop selection criteria and other procedures.

As follow-up indicators are used: (1) the number of interviewed patients; (2) absolute and relative number of exempted patients; & (3) average financial assistance.

Implementation of the purchaser-provider split

MSF & UNICEF were ready to finance the care for the poor. They opted for a local actor with a good knowledge of the Khmer society and experience in this kind of intervention. As already tested in Thmar Pouk OD, MSF decided to sub-contract the operation of the so-called "equity fund" to a local NGO. The contract with CFDS

started in September 2000. MSF encouraged CFDS to look for other donors,[39] and develop other social activities.

Functioning

The principle of the equity fund is to take care of the poor patients who have arrived to the hospital. As soon as patients appear to need inpatient care, they (or one of their relatives) can apply for exemption. In practise it is the hospital staff who refer 'visibly poor' patients to CFDS. CFDS then verifies eligibility through an in-depth interview. CFDS is hiding the criteria used. They justify this as a way to prevent fake declarations, adapted to the criteria. This first meeting is also the opportunity for the social worker to determine the supplementary support the patient needs (cooking materials, food, reimbursement for transport…). Through daily visits, the social worker of CFDS will then make sure that the poor patient gets the attention needed.

Results in 2000

Exempted patients constitute 10% of total admissions (approx. 20 per month). This accounts for 11% of monthly user fees (US$232 per month). Main assistance is for hospital fees (71%) and transport (17%). The patients selected for exemption seem to constitute the real destitute. Hospital staff, MSF & UNICEF staff, all have the impression that selection is fair and unbiased. But, the equity fund is still little known among the population. CFDS has attended feedback committee meetings in all health centres to explain the functioning of the equity fund.

Conclusion

Clearly, the current logic of the equity fund is closer to "social assistance for poor patients" than a complete set of measures to remove obstacles for the poor population. Many of those needing hospital care, especially in remote areas, still do not know that there is an equity fund to enhance their use of the hospital. But as eligibility is decided by CFDS in a non-transparent way, those who know the existence of the fund could refrain from going to the hospital because of uncertainty.

Definitely, access to hospital care is not vulnerable to an isolated action. The equity fund is a step in a good direction: responsibilities have been clarified, assistance to poor is delivered and experience is being built up. At a later stage, some active information and, if possible, detection and identification ("poor card") could be implemented.

[39] We can expect that, as the donor community put poverty alleviation at the top of their agendas, some will be eager to "purchase" reliable local solutions for granting the poor access to quality health care.

(5) The steering committee

As mentioned before, Cambodia gets important support in the implementation of its health coverage plan. This assistance has come mainly through two ways: one centralised, the other decentralised. Major donors have allocated grants and loans for the construction and equipment of the planned facilities, and given technical assistance to central MoH. Their approach has been mainly through the MoH along a top-down planning from Phnom Penh. Simultaneously, field projects have been developing a piece of the health system locally. However, there was a real gap between both.

In the Cambodian health sector, MSF & UNICEF have been over the years, among the few actors with a simultaneously strong involvement in OD development on the ground, and credibility and influence at the central level. Experiencing every day constraints, they could feed this into the decision-making process at central level.

MSF & UNICEF used to transmit problems and request solutions mainly through their staff in Phnom Penh (direct contact with the MoH, and through networking with major agencies and NGOs). If this approach was clearly efficient for sharing the difficulties they faced in implementing the health sector reform, it was perceived as not the best solution for the New Deal. Such an innovative experiment requested a strong support from stakeholders and a closer follow-up. It was decided to establish a specific steering committee.

Objectives

- Negotiate with, and get commitment from, the different stakeholders in the New Deal.
- Monitor the progress of the New Deal and the OD in general.
- Solve the problems and the conflict in the implementation of the contracts.
- Establish a platform to share information related to the New Deal and more generally to bottlenecks in developing districts in rural Cambodia.
- Create a sense of ownership of the New Deal among all stakeholders.

Functioning of the steering committee

The Steering committee is established by the global contract described in Figure 3 (page 20). It has 16 members: (1) The Provincial Health Director, Siem Reap, Chair of the steering committee; (2) The Director of the Provincial Department of Finance, Siem Reap; (3) The Director of the Provincial Treasury, Siem Reap; (4) The Provincial Governor of Siem Reap; (5) The Provincial Health Advisor of Siem Reap; (6) The Governor of Sotnikum District; (7) The director general, MoH, Phnom Penh; (8) a member of the Health Economics Task Force, MoH, Phnom Penh; (9) a representative of the Financial Department, MoH, Phnom Penh; (10) the vice-director of the planning unit, MoH, Phnom Penh; (11) a representative of National Institute of Public Health, Phnom Penh; (12) Representative of MoEF; (13) WHO, team leader of Health Sector Reform; (14) UNICEF, senior health advisor; (15) head of mission, MSF, Phnom Penh; & (16) medical co-ordinator, MSF, Phnom Penh.

In this global contract each stakeholder signs his commitment to the New Deal: release of funds, technical support, etc. Some commitments, such as the ones by the funding sources (MSF & UNICEF), but also the one of those involved in the State

funds, are of paramount importance for the success of the New Deal. Within the same contract, the facility commits to improve its services in exchange for all these "promised" resources.

To achieve its monitoring role (of the New Deal and of the fulfilment of respective commitment), the steering committee gathers every two months, initially monthly, at Siem Reap (Figure 4, page 24). To achieve the objective of sharing experience, strategic visitors are welcomed to attend the meetings as observers. On average some 40 to 60 people attend the meetings, including many MoH, MSF & UNICEF field staff.

During the meetings, the OD and hospital directors give feedback about the activities and revenue of their facilities. Problems faced by the facilities, the staff or any stakeholder are raised, discussed, and a solution is searched. Minutes of the meeting are taken and approved at the beginning of the next meeting. These minutes serve to update the contracts if changes are minor. Major changes prompt a rewriting of the contract. Except for the opportunity cost of Cambodian resources (mainly time of the participants), the costs induced by the steering committee (transport, per diems, translation and minutes, rewriting of contracts…) are covered by MSF & UNICEF.

Results in 2000

The steering committee has definitely been a strength within the New Deal. The main output has been the important flow of information from the bottom (Sotnikum OD) to the top (MoH-Phnom Penh & UN agencies). Thanks to the regular meetings, key-persons in health sector reform in Cambodia are aware of the difficulties and possible solutions to implement the district approach in the field. This result seems to benefit the health sector reform process as a whole: some problems are getting higher on the national agenda, and some solutions are promoted for other places. Popularity of the New Deal leads to duplication or, at least, general acknowledgement that nothing is possible without incentive mechanisms for the staff. The success of the steering committee process is such that duplication is going farther than just the New Deal: many field experiments are (or planned to be) steered by such a stakeholder committee. Multiplication of the approach is of course impossible: major participants, as MoH top executives, have limited time. There is thus a risk that the Sotnikum experiment could suffer in the coming months from its own success.

In regard to the objective of "solving the problems faced by the New Deal in developing the district," the steering committee also seems a beneficial process. Points of disagreement are identified and expressed clearly. Transparency and participation in problem solving are played quite loudly, although essentially by the people high in the hierarchy, and by the foreigners. The representatives of the health centres, traditionally without voice in the top-down pyramid of MoH in Cambodia, can thus express their position and concerns.

To settle disputes, the key-participant is the general director of MoH: his influence is clearly an asset in regard to obstacles, especially those still existing within the MoH pyramid. His support has contributed to the overall dynamic of the New Deal. Probably problem-solving would have been even more satisfactory if the meetings had had a better technical support (quality of simultaneous and written translation, preparation of the agenda, closer attention to reach clear decision, etc). Local capacities and the transcultural context remain constraints.

In terms of consolidating the commitment of the different stakeholders, the achievements of the steering committee are disappointing. Despite attending all meetings, some signatories of the global contract are well short of their promises: state budgets are still difficult to access, transparency is still deficient, etc. Recent difficulties for health facilities to get their share of the government budget are raising suspicions about honest efforts by some actors for releasing the funds. Transparency is definitely a painful commitment for a few. The contractual approach (as an effort to fulfil respective obligations) is certainly in danger if some participants just start to pay lip-service to the process, read the contract and minutes in a restricted way, and forget what is the general aim of the New Deal.

Perception of the New Deal by different actors

As reflected in the composition of the steering committee, many actors are involved in the New Deal. The perception of its strengths and weaknesses differs between nursing staff & medical staff, between health centre staff & ODO staff, between health care providers and mid-level managers, between MoH staff and MSF & UNICEF staff, between field staff and 'outsiders'. Short-term visitors to Sotnikum are usually enthusiastic about the New Deal. People who work in Sotnikum on a daily basis – both the MoH staff, as well as staff from MSF & UNICEF – are less enthusiastic. There may be several reasons for this. (1) Everybody agrees that the New Deal is a good idea, and has positive effects, but field actors stress that its day-to-day implementation is far from straightforward. (2) Changing long-entrenched practises is a difficult process, and the New Deal changes many things: working hours, discipline, income-generating activities, etc. For most health staff, the New Deal is a profound change in their working environment. (3) The New Deal explicitly recognises staff income as one of the key incentives, and opens for the first time the way for negotiating it. As a consequence, it is openly discussed and becomes at times even the main subject of discussion, and apparently the main concern for the staff. Some actors, especially the field staff of MSF & UNICEF, perceive this as very unpleasant. (4) Outsiders see only the positive results: higher utilisation, more transparency, etc. But the New Deal is a new balance. Health staffs gain more official income, but lose possibilities for unofficial income. They have to respect a strict internal regulation, and have thus to work much harder than before. For outsiders, there are only gains. For insiders, there are gains and losses. For some the new gains-and-losses balance sheet is clearly beneficial, for most it is somehow in balance, for some it is clearly negative.

In February 2001, National Institute of Public Health carried out a survey among the MoH field staff in the hospital, the health centres and the ODO.[40] All the staff that returned the self-administered anonymous questionnaire answered "Yes" on two questions: (1) Is the New Deal a good solution? & (2) Would you like to continue with the New Deal? However, the ODO staffs were considerably less satisfied with the situation. A majority proposed to "continue, but with major changes." When asked during focus group discussions about the negative points of the New Deal, the staff voiced many complaints. But, it was remarkable that these concerned much more weaknesses in management (continued lack of transparency, lack of fairness in evaluations, and poor organisation) than complaints about their income.

The study did not include the district managers. But, it is obvious that they are far less committed to the New Deal than the field staff. The reasons why are further explored in Next challenges, page 60.

[40] "Perception of the New Deal in Sotnikum by the different actors", Heng Thay Ly, NIPH, Phnom Penh, February 2001.

CHAPTER 4. THE NEW DEAL: THE IMPACT SO FAR, NEXT CHALLENGES

Achievement of objectives

As explained on page 13, the New Deal has three objectives: (1) to give the population of Sotnikum access to quality health care; (2) to build a health system; & (3) advocacy: to be a catalyst for changes in the national health policy. So, what are the results after one year of New Deal?

Objective 1: Access to quality health care

The New Deal has clearly created a new working climate within the health facilities. Personnel come to their work, respect internal regulations and pay some attention to quality of services. Facilities are today open 24 hours a day, seven days a week. Users have clearly noticed these changes and they consider it as a real improvement in access. The higher empathy and kindness with users favours satisfaction, and hence future utilisation. Transparency in fees, reduction of uncertainty through lump sum payments and the equity fund are different mechanisms helping to reduce financial barriers for the population. Patients receive drugs without additional payment, and do not get prescriptions for private pharmacies anymore. The facilities are building a new reputation, which will be a major asset to go even further. Higher user rates are showing that access to care has improved in Sotnikum district.

Unfortunately, quality of care in the hospital is still unsatisfactory (in the health centres, it has not been analysed). MSF & UNICEF field staff still perceive, for example, that nursing care is of poor quality in the hospital. Of course, one must manage with the limited human capacity existing in a country that suffered profound destruction of its health care manpower. Nevertheless, limited skills and hasty education do not explain everything. The impression shared among MSF expatriates is that staff could perform better than they do today. The problem is perceived more as a lack of general management at the hospital and ODO levels. The New Deal was expected to set up a new environment more favourable for quality improvement. The feeling today is that positive changes are a long time coming. Managers do not seem to take the opportunity that fair income creates to obtain a higher accountability from the different workers. For MSF, it is more and more obvious that without a higher commitment from managers themselves, more training will not bring the necessary change. However, there is certainly also a different perception of quality of care among different actors (users, health care providers, MSF & UNICEF field staff, public health managers). Moreover, no explicit quality framework has been adopted.

Objective 2: Building a health system

Building a health system can be assessed using three dimensions: (1) establishment of the elements of the system; (2) existence of interdependent relationships among the elements; & (3) sustainability of the system as a whole.

(1) Establishment of the elements of the system: As far as the different "building blocks" are concerned, Sotnikum OD is going towards completion: the ODO is established, 16 of the 17 planned health centres are functional (6 of them in the New Deal), the referral hospital is delivering a full CPA and an equity fund is paying for the

poorest patients. So one may consider that the elements of the health system are there. Of course, the New Deal cannot take all the credit for these achievements. Building and equipment of facilities were a matter of investment by MSF and donors. But the New Deal has definitely contributed to turning facilities more functional. Extension of the New Deal to the remaining 10 health centres is the last step to have all units of the health system truly operational.

(2) Existence of interdependent relationships among the elements: How conducive has the New Deal been to turn the collection of elements into a real system? The systemic dimension of an operational district mainly exists in the establishment of a complementary and interdependent relationship among all the actors delivering promotional, preventive and clinical services to a population. Relations can be between the first level and second level of care (referral of patients, including evacuation of emergencies), between the ODO and both levels of care (supervision, drug supply, etc), between the facilities and actors outside the health sector (campaign of health education in schools, bars, etc).

The New Deal has clearly reinforced some of these links between the actors. Today, most patients who are identified in the health centres as needing hospital care arrive in the hospital (see Table 1). The situation prevailing before the New Deal (low qualified public nurses treating patients at home to make a living) has been reversed: as nurses earn a satisfactory income with the health centre activity, the patient going to the hospital is no more perceived as a lost business. This referral dynamic should certainly still be improved (cf. the unmet obstetrical needs, footnote 8 on page 21), but there are certainly improvements.

Health centres (period included)	Distance in minutes (by car or motorcycle)	Referred patients	Patients actually arrived	Proportion of patients referred who arrived
Kean Sangke (Jul 2000 – Feb 2001)	20’	83	74	89%
Sam Rong (Apr 2000 – Feb 2001)	35’	206	198	96%
Sanv Vueil (Apr 2000 – Feb 2001)	60’	119	103	86%
Kampong Khleang (Sep 2000 – Feb 2001)	60’	52	47	90%
Spean Thnot (Sep 2000 – Feb 2001)	90’	82	75	91%
Anlong Somnor (Jul 2000 – Feb 2001)	120’	153	101	66%
Total		**695**	**598**	**86%**

Table 1: Referrals to Sotnikum hospital by New Deal health centres

What about the ODO? In the traditional district model, the ODO has the role to take the lead in the promotion, co-ordination and development of strategies beneficial to the health of the population living in the district. The ODO is the actor in charge of developing the systemic dimension of the district. So it is up to the ODO team to organise the interconnections and relations among the different actors, whomever they are (public facilities, private practitioners, pharmacies, schools, factories…).

In Sotnikum, contributions by the ODO are numerous (reliable supplies in drugs and vaccines, collection of data, support for specific diseases…); they are so well established today that they appear organic to the system. Nevertheless, we must acknowledge that the ODO is still far from performing the full set of interventions it is supposed to perform. Many ODO functions are still assumed by MSF & UNICEF, mainly in management and problem solving. The district supervision team can not yet fulfil its mission. The model of the health district relies, in fact, on a pro-active approach by the ODO. Nowadays, the Cambodian health pyramid is still organised in a very top-down way: facilities are seen more as subordinates rather than as actors to support, or clients to care for.

Unfortunately, it seems to be not only a matter of work culture and history. In Cambodia today, the OD managers have too few incentives to give a real support to the facilities under their responsibility. Their performance to achieve this objective is not assessed and it does not enter into account for their current and future income. Controlling and retaining the budgets earmarked for the facilities are more lucrative strategies.

(3) Sustainability of the system as a whole: how sustainable is the current situation in Sotnikum OD? Sustainability in such a context can be analysed as having four dimensions: technical, financial, managerial and socio-political sustainability.

Technical sustainability means that the MoH staff have the technical knowledge and skills to maintain the system (medical knowledge, surgical abilities, nursing skills, etc). MSF is still doing substitution in several areas: bookkeeping, laboratory, health centre supervision, are but a few examples. There are still too many midwifes who have never attended deliveries, doctors whose knowledge is really too limited, and health centre nurses performing consultations but unable to recognise basic clinical signs. X-rays and ultrasound are still substandard. Much more quality training and supervision is certainly needed.

Financial sustainability means mainly that costs necessary to run the OD are covered by stable sources. If progress, as compared to the situation prevailing in the mid-90s, is gigantic (especially with State budgets), we have not yet reached this objective today. Even without considering the costs of MSF & UNICEF per se (technical assistance, national staff, vehicles, office…) and other investment costs (buildings, equipment, vehicles…), external contributions by MSF & UNICEF still accounts for some 15% of total costs of the OD (Table 2). Their contribution finances mainly staff bonus.

Source		US$	%
Government	for salaries	764	2%
	for operating costs	9,860	27%
	Drugs from CMS (in kind)	17,774	49%
Patients		2,187	6%
External (MSF & UNICEF)		5,353	15%
Total		36,227	

Table 2: Average monthly income, full Sotnikum OD, with 17 health centres, 2000

Table 2 shows that the State, mainly through "drugs" and "operating costs" is the major source of funding (79%). The financial statement clearly shows the imbalance between the different State contributions (2 % for salaries vs 49% for drugs & 27% for operating costs). Flexibility in use of funds is eagerly desired. Financial participation by the users (6%) is still low in comparison with many other developing countries … or in regard of what patients spend at private practitioners. The financial resources allocated to run Sotnikum OD corresponded to US$2 per inhabitant per year in 2000.

When considering financial sustainability, we must not only consider origin of the funds, but also their reliability. We have already described how difficult it is for the facilities to have access to their State budgets. This access issue is not only a matter of total amount and decentralisation of spending. It is also a question of predictability. Today it is quite difficult for any health facility to execute its planning (if it has any) or even routine activities, as budgets are released in too chaotic a way (no money coming for a while, then a lot coming with short term-end…).[41] This surely doesn't help for good management and rational spending. To summarise, we see that there are opportunities to increase the financial sustainability of the district. If the MoH budget would be more flexible and reliable and user fees a little bit increased, donor contribution could be quite drastically reduced in the near future.[42]

Managerial sustainability could be defined as having the management systems and management capabilities in place to manage the health facilities independently (management of financial resources, human resources, drugs, purchases, water and electricity, etc). As mentioned earlier, we are quite far from managerial sustainability today in Sotnikum OD. A lot of substitution is carried out by MSF in management of resources, accounting and logistics. The low capacity developed within the OD can be explained by an underestimation of the importance of sound and modern management, the very low level of skills and the reluctance of some leaders to share their responsibilities. Without a major effort in capacity building, results may be compromised with the reduction of the technical assistance.

By **socio-political sustainability** we mean the fact that local political leaders and stakeholders are committed to support the system and favour its development. It is no distortion of reality to say that the New Deal is mainly the baby of MSF & UNICEF. The steering committee has certainly helped to develop some ownership among some stakeholders. Nevertheless, survival and development of the New Deal is still relying mostly on MSF & UNICEF, their vigilance and mobilisation of support. Both organisations have serious doubts about the commitment of some key-actors. New ways have to be explored to favour this commitment. Empowering beneficiaries and creating alliances including community leaders and local politicians could be an option.

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[41] The central government is certainly the first responsible for the unpredictable disbursement process (mid-year U-turn in the government policy, reluctance of Ministry of Finance to release the budgets, new priorities because of natural disaster as in 2000…), but the intermediary levels do not really help either (confusion and contradiction in instructions, refusal to release budgets because of tenuous mistakes…). The general result is a difficulty to distinguish what is a real constraint from what is just a smoke screen created to hide mismanagement and embezzlement.

[42] "Consultancy on economic follow-up after one year of implementation of a "New Deal" in Sotnikum Operational District, Kingdom of Cambodia", Jean-Marc Thomé, AEDES, February 2001.

If they are interested, they could be good allies to defend the New Deal and its achievements.

Objective 3: Advocacy; be a catalyst for change in the national health policy

We have already mentioned the particular position of MSF & UNICEF in the "health political" scene in Cambodia. Both have (i) field projects with direct benefit for the population (implementation of OD, support to facility management and involvement in clinical care) & (ii) a good relationship with the central level (MoH, major agencies and donors). After years of support to the health sector, both are definitely perceived as actors with good credentials in Cambodia.

MSF has used this particular position in two ways: to use field experiences to inform and influence the health sector reform, and use their credibility and good contacts at central levels to help solve the bottlenecks faced by their field projects. MSF adapted its advocacy method with the New Deal: they shifted from a mainly bilateral[43] and *ad hoc* lobby process to a more multilateral and continuous sharing of information and decisions about the project. This move was seen as necessary, considering the complexity and innovation inherent to the New Deal. The steering committee is a major part of this new way to be a catalyst for change at the central level, based on a field experiment. But also other initiatives show that MSF has turned advocacy in a permanent policy.[44]

Along this unflagging willingness to influence policy by operations, MSF has also changed its way to manage projects. Old tools as budgeting and planning are, of course, not completely out of the picture, but the process is driven in a more responsive way than before: as new opportunities or constraints may pop up at any time, the NGO must be able to react quickly. Flexibility in operations is beneficial for the project itself but it is also perceived as a tool for better advocacy. MSF advocacy with the New Deal is clearly more than words and statements. MSF advocates through a demonstrative example. After explicit expression of the bottlenecks, the NGO is trying to find solutions. So an innovative health financing and incentive scheme is being tested: the New Deal. The results are extensively discussed in other parts of this report. Through the advocacy process, MSF has made sure that main stakeholders are aware of them.

Actors in the health sector know today that the solution initially developed in Takeo can be extended to districts as done in Sotnikum. Yes, the population is ready to use rural referral hospitals and health centres. Yes, staff are ready to dedicate to their work if fair income is paid. Yes, it is possible to pay fair income without compromising accessibility of care. Yes, some resources do exist locally, and additional subsidy is small compared to overall costs of technical assistance and investments.

Different actors are also informed that many obstacles still remain. Yes, such a micro-reform needs creativity, expertise and a vision of the future. Yes, there can be

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[43] MSF in Cambodia has always been networking actively. MSF was namely one of the founders of Medicam, the "membership organisation for NGOs active in the health sector in Cambodia." Medicam publishes each year a high quality position paper on health sector reform.

[44] Numerous study tours in Sotnikum, organisation of a workshop in Phnom Penh in February 2001, or the writing of this report, are other examples of this advocacy process.

local opposition to progress. Yes, access to State budget is a continuous struggle in Cambodia. Yes, quality of care will remain a major challenge for years to come.

The New Deal is one of several experiments in health service organisation developed today in Cambodia. Together with similar projects (struggling with other constraints, building on other opportunities), they constitute major assets to make the health sector progress in Cambodia. They are responsible for important political breakthroughs: after hearing about them, actors change their mind, revisit their agendas and start thinking in another way.

Of course, impressive results do not come all the time. Mistakes are made, some solutions are wrong and sometimes projects are stopped. Hence, the need for a cautious design and a close follow-up of all these experiments. Such new strategies also bring their share of conflicts: some individuals may lose, for example if transparency and management are improved. Definitely, bad practices will not be eradicated in one day. It is a matter of continuous effort and advocacy. Independent organisations as MSF must play their role of watchdog. Cautiously, but stubbornly.

The New Deal can be viewed as an example of how to use a project as a leverage for advocating about a problem afflicting the health system as a whole. In Sotnikum OD, the State budget is no longer only the business of a few persons. Today this red-hot issue is on the table. MSF & UNICEF, but also more and more other stakeholders, keep on questioning, claiming and contesting… The journey to full transparency and access to budget will be long, but it looks like a "two steps forward, one step backward" walk; progressing in the long run.

Next challenges

The New Deal helped greatly to solve some major bottlenecks of health services development in Sotnikum. Income of the staff delivering care is no more the main constraint. New Deal facilities are full of patients. We are going towards what a real OD should be. This does not mean that all problems vanished. What are the main obstacles to achieve quality of care and building of the health system? Without being exhaustive, we identified (1) commitment; (2) human capacities; & (3) ethics, as the three major challenges ahead.

(1) Commitment

For the large majority of staff working in the health facilities, the New Deal has noticeably raised their dedication to work. Nevertheless, it is more and more obvious that the commitment of a few key-actors is lagging. According to several observers, they constitute today the major threat to the New Deal.

This low commitment expresses itself in many different ways. The great difficulty to access to State budget, to establish transparency in its management, to recruit qualified nurses, to reorganise the hospital or to develop team-work are different instances of this situation. Most of the time, the reluctance to change anything hides behind the assertion, sincere or not, that "constraints are too heavy and out of reach."

Reasons for such a low commitment can be multiple. Conflict with self-interest is probably one of them. In comparison with other positions or pre-New Deal regime, some individuals are probably losing out. It is more lucrative today to be in charge of an OD out of the spotlight than manager of a district or a hospital that get high

attention and thorough scrutiny. Put in another way: the New Deal has succeeded to create right incentive mechanisms for all the staff but the managers.

Managers are of course key-persons to turn the experiment wholly successful. As developed in this report, we know that the hospital and the ODO greatly need major reorganisation, team building and clarification of roles. For such an important work, leaders at OD and PHD levels must be fully committed to change and reform. You cannot reform a hospital against the director's will.

The operational district and primary health care approaches definitely postulate that one gets a strong support from the higher levels of the health pyramid; not that one is stuck in continuous recriminations. If this issue of commitment is not settled in the near future, we can expect that the New Deal will fail to bring any further improvements. Then, the pilot project will have proven its current results and the fact that major obstacles to make the health sector reform successful are within the health pyramid itself. This will of course affect the whole process of the project. The steering committee will lose its credibility in the eyes of the stakeholders. Failure to get the commitment of the managers and subsequent closure of the project might then be the last thing that MSF will have to advocate about.

This commitment is probably linked to societal choices in Cambodia. Is there political willingness to create conditions for making a public health service working? And which type of service? For whom? As yet, this is not clear. Some MoH officials support fully the health coverage plan and the health sector reform; but many others are dragging their feet. Administrative and civil service reform are progressing very slowly, at best. Which societal choices are Cambodia's leaders making? Can we see where Cambodia is heading if we understand better the health sectors in some of the neighbouring countries? Thailand? Vietnam? China?

(2) Human capacities

For building a health system and improving quality of care, one needs the commitment of the health workers, a good organisation of the work, but also the right mix of qualified staff. For establishing this right mix, two options are possible, complementary and necessary: recruitment of missing qualifications and upgrading of existing staff.

As far as recruitment of qualified staff is concerned, the situation is definitely not easy in Cambodia. The medical faculty and nursing schools have suffered greatly from the extermination of intellectuals during the Khmer Rouge years. As with many institutions in the country, everything had to be rebuilt from scratch. Another problem is that few health workers are eager to get a job far from the main cities. We can also guess that potential candidates for working in Sotnikum are not aware of the current status of income in Sotnikum OD or, at least, are uncertain about the sustainability of this "golden age".

Nevertheless, fresh nurses graduate from schools each year. Idle qualified workers crowd many other levels of the health pyramid. Through one-way or another, Sotnikum OD could attract them to strengthen its facilities. As soon as the New Deal proved its efficacy in increasing activities in the facilities, MSF & UNICEF pledged at the steering committee meetings extra financial support for recruitment of qualified nurses for the hospital. Despite obvious needs, no measure was taken. It sounds quite like preaching in the wilderness. What is the future for an OD which in not eager to

strengthen its workforce? How will it solve understaffing in the health centres, the need for more professional accountants in the hospital and the ODO? Without radical change in the understanding and tackling of the problem, the picture is quite gloomy.

For sure, whatever the incentive one pays or the training one gives, each worker is limited by his own education: you don't turn a nurse into a surgeon. Nevertheless to upgrade every day practices, each staff should fit in a quality-improving process. So, regarding existing staff, solutions must be developed. Managerial, clinical and nursing skills have been identified by the technical assistance as needing major upgrading.

Recent experience has shown that the current set-up of relationship between health staff and MSF trainers is not very effective. The idea of the New Deal came after the observation that training sessions and bedside training were useless if the constraint of staff income was not tackled first. Thanks to the New Deal, the precondition of a satisfactory income is satisfied. So we could have expected that investment in training would get a higher efficacy. But unfortunately, the progress MSF expected did not materialise up till now. Yes, quality of services (relationship with patients) improved, but compliance with clinical guidelines and technical recommendations is still far from achieved.

It is generally known that it is not easy to make health staff change their habits. But in the case of MSF in Sotnikum, explanations are numerous and certainly shared: cultural mismatch, age or gender of the expatriates, poor training skills and practices, inter-individual conflicts, pride, trust in own education, reluctance to change, poor commitment to patient health, divergence with self-interest, etc.

Quality of the relationship between the trainer and the trainee is of course an important factor for the success of the training process. To explain the difficulty that MSF faces today, we can make the hypothesis that the New Deal has modified the human set-up between the MSF and MoH staff.

With the New Deal, MSF has introduced a new way to make health services better. Indeed improvements are no more only matters of support and training as usual, but from now on they are also purchased by the NGO. As any purchaser, MSF is concerned with the return on its investment; so they clearly check for results and if these are absent funding is reduced.

This new tool to raise quality of care and sustain development of the system has then an obvious side effect on relationships: MSF expatriates risk more and more to be perceived as policemen and judges. So, if relating income to performance incites the staff to behave in the correct way (the one defined as performance), it changes also the relationship that the NGO workers can establish with the staff in the facility. Clearly, we doubt that those who assess and sanction are in the best position for training and support.

Along this need to clarify roles, MSF expatriates have pulled out from the hospital Management Commission in charge of the bonus calculation for the hospital staff. This step has reduced a little bit expatriates' frustrations but has not yet favoured a higher achievement of quality of care. It has facilitated openness for training efforts. Purchasing of services by the partner NGO definitely creates a new environment of work and relations. This has to be taken more into account for the development of the solutions for upgrading capacities.

What the New Deal reveals is in fact a new way to apprehend our long-term intervention in favour of a health system. Instead of the monolithic project vision, we

can analyse our action as a collection of different functions: empowering, training, support, negotiation, purchasing, control, sanction, etc. If we look at results these last years in Sotnikum OD, it is interesting to notice that UNICEF, MSF and the MoH have been more successful with some functions than with others. Do we betray reality if we say that the empowerment of the community and the New Deal have made the difference? In comparison, one can remain sceptical about the results of years of efforts in training.

We can think two ways to draw lessons from such a diagnosis. The first is to recommend interventions focusing on empowering community and purchasing progress ("they are the only channels that work"). A more clever interpretation could be that what MSF & UNICEF needed is in fact a better combination of the different functions. Along this idea, we must identify where functions conflict and try to reinvent the way we combine them. A more explicit split might be part of the solution.

(3) Ethics

Purchasing and performance-related contracting of health services is something new for most of us. Humanitarian organisations such MSF & UNICEF believe mostly in human goodwill to make the world better. MoH of all countries around the world rely on medical ethics and some public ethos (concern for the poor, altruism, etc) from their personnel. The New Deal starts from the observation that these nice ideas do not stand anymore when workers miss income to cover basic needs of their families. But the New Deal is not just the acknowledgement that even saints must eat; it is really more than that: to get quick and sound results, which were clearly urgently needed, it establishes a strong link between financial rewards and deeds. The implicit model is clearly closer to the *Homo oeconomicus* pursuing his own interest than the altruistic practitioner concerned about the health of his patient.

This is probably less naïve than the previous more idealistic frame that MSF & UNICEF used. Moreover, practice of medicine in richer countries proves that self-interest is not necessarily contradictory to care and services of high quality and ethics. Clearly institutions matter. Nevertheless we must be aware that establishing a systematic link between performance and financial reward is not possible[45] and desirable. The pervasive implementation of such logic will harm human relationship between the different actors. We have just shown how the relations between the NGO and the health staffs were already changing. It is obvious that relationship between practitioners and patients could also be affected by the incentive schemes.

Definitely the situation is better today than the one prevailing before the New Deal. All the patients in the hospital are people who did not receive care before, or are taken out of the business of irrational treatments delivered in the secrecy of their home. Informal payments have disappeared in the hospital. Fair income clearly exempts the staff from developing coping mechanisms to the detriment of the patients.

All the harmful practices have not been abolished. In fact by turning the public facilities into trustworthy providers of health care, we succeed also to make these

[45] Many dimensions of quality care are very difficult to measure. Standards and benchmarks are sometimes also difficult to identify. Then the assessment determining the reward is easy to contest. This probably is part of the explanation for the relative failure of the performance-related bonus in Sotnikum hospital.

practices more observable. To improve quality of care, different levers have to be used. Financial incentives such as those developed within the New Deal are one such lever. With the New Deal, we have indeed removed the veil of hypocrisy: yes, health staff, as anyone else, are sensitive to financial reward. But we must be concerned also to establish a balance with other sources of satisfaction. Some are clearly under the responsibility of the government and the MoH (pay a higher salary, sustain fair expectations about career, etc). Others must come from Khmer society and professional groups (support and good reputation for good and ethical practitioners, trust, etc). In the meantime, donors and NGOs must resist the temptation to get quick results only through powerful financial incentives. Worker satisfaction is definitely a balance of many dimensions. Professional ethics, satisfaction of accomplishing correctly his work and serving the people are also good investment for the future of Cambodia.