MSF Cambodia

The New Deal in Cambodia: The second year

Confirmed results, confirmed challenges

July 2002

The New Deals in Sotnikum and Thmar Pouk are joint ventures between the Cambodian Ministry of Health, MSF, UNICEF and the WHO,
in collaboration with the National Institute of Public Health (NIPH), Phnom Penh; AEDES, Brussels; and the Institute of Tropical Medicine, Antwerp.

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List of abbreviations

ADD	Accelerated District Development
ADB	Asian Development Bank
CAAFW	Cambodian Association for Assistance to Families and Widows
CFDS	Cambodian Family Development Services
DFID	Department For International Development
DOTS	Directly Observed Therapy, Short course
EPI	Expanded Programme of Immunisation
GDP	Gross Domestic Product
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit*
MoH	Ministry of Health
NGO	Non-governmental Organisation
OD	Operational District
ODO	Operational District Office
PAP	Priority Action Programme
PHD	Provincial Health Department
TB	Tuberculosis
WB	World Bank

Note on exchange rates

In Cambodia, both the national currency, the riel, and the US$ are widely used in all transactions. The exchange rate between both currencies was stable during 2001. According to OANDA.com, the average interbank rate was 3,887 Riel for 1 US dollar. For ease of calculation, all calculations in this report have been made with an exchange rate of 3,900 Riel per US$.

INTRODUCTION AND ACKNOWLEDGEMENTS

This document describes and analyses the New Deal experiments ("Better income for health staff, better service to the population") as they have been taking place in 2001. This report is thus the continuation of the report "Sotnikum New Deal: The first year", which was written in May 2001.[1]

If our first report focused on Sotnikum district, this one intends to be more general and to draw lessons from similar experiences elsewhere in Cambodia. References to Thmar Pouk district are particularly relevant for exploring the potential and the limits of the New Deal approach. The previous document aimed mainly at explaining the New Deal strategy (origin, concepts, implementation and results). The present document focuses on the prospects opened up by this approach. As the two documents are therefore complementary, for a fuller understanding of the stakes involved and of how the process has evolved in the various experiments, we recommend reading the previous report.

We thank Alison Marschner for editing the report. We are grateful to all the field staff of the Ministry of Health, MSF and UNICEF for their continuing dedication. We hope that this document is a fair tribute to their daily efforts to improve the health status of the Cambodian population.

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Antwerp and Phnom Penh, July 2002.

[1] "Sotnikum New Deal, Better income for health staff; better service to the population", W. Van Damme and B. Meessen, MSF Cambodia, May 2001. The report is available on request from the authors or from MSF-Cambodia (library@msf.org.kh). A pdf version is available at: http://www.msf.be/fr/pdf/cambodia.pdf

EXECUTIVE SUMMARY

The New Deal is a specific strategy adopted in Cambodia by the Ministry of Health (MoH), MSF, UNICEF and the WHO in order to find a way out for a public health system stuck in a crisis of under-utilisation and low efficiency. In a nutshell, the New Deal is a consensual approach to winning commitment from all the major actors to invest more resources in the rural health system. Real efforts are being made to understand institutional and individual constraints, but the respective obligations of those involved are clearly stated. The backbone of the New Deal is a set of contracts that free resources from donors and users to pay a bonus to the staff. These bonuses are performance-related.

Different projects in Cambodia are using this New Deal approach, although only Sotnikum and Thmar Pouk explicitly employ the New Deal name. There are also three New Deal-like experiences in provincial hospitals (Takeo, Svay Rieng and Kratie) and two in district hospitals (Mong Russey and Stung).

After more than four years in Takeo, two years in Sotnikum and Svay Rieng and one year in Thmar Pouk, there is enough evidence today to confirm the relevance of the approach. In all of these places, activities have significantly increased. Better rewarded for their efforts, health staffs are more committed to improving the services they deliver to the population. In Sotnikum and Thmar Pouk, the New Deal prompted the introduction of new institutional arrangements: a Steering Committee to pilot each experiment, management committees for the facilities concerned and a Health Equity Fund to enhance access to the hospital for the poor. Health Equity Funds have yielded quite impressive results.

This document is divided into five chapters.

Chapter 1. Background (page 11) explains the context of the New Deal. After evoking the opportunities and challenges arising out of Cambodia's current economic growth, we return briefly to the history of the New Deal approach in this country.

Chapter 2. The New Deal in Sotnikum (page 17) documents the strategies adopted in 2001 to boost the positive results already obtained in 2000. It reports a reorientation of the MSF approach: keeping a greater distance in regard to assessment, control and management, and developing a greater proximity in regard to clinical care. The outsourcing of clinical training seems particularly fruitful. The chapter also gives an overview of the results for 2001. The second year has confirmed that the New Deal is good for health, even if accountability and transparency remain sensitive points for the mid-level managers.

Chapter 3. The New Deal in Thmar Pouk covers the history of the New Deal in Thmar Pouk district (page 29) since the beginning in late 2000. After reviewing some of the specific characteristics of the district, such as a poorer population, overstaffing but more motivated staff, it summarises the implementation of this approach. This second experiment has obviously benefited from experience gained elsewhere. The New Deal has had a very impressive impact at the hospital level, despite the absence of surgical services there. The experience of 2001 is less conclusive in the health centres.

Chapter 4. The Health Equity Funds (page 39) develops the rationale behind the introduction of these funds and their sub-contracting to local non-governmental organisations (NGO). The superiority of a purchaser-provider split over a simple waiver is confirmed by the results in both hospitals. Today, the poor account for more than 20% of patients. Nevertheless, some further improvements are still desirable.

Chapter 5. Lessons Learned (page 47) discusses what we regard as three important lessons for the national health service in Cambodia. (1) The New Deal experiments show that major improvements in terms of coverage, utilisation and the responsiveness of health services will not be possible without a fundamental reshaping of incentives and accountability mechanisms in the public health service. Such reforms are particularly necessary for district and hospital managers, who also still need significant support in terms of capacity building. (2) The second major lesson concerns the place of the poor in the public health facilities in Cambodia. Our belief is that Health Equity Funds are indeed a step in the right direction, but a more general policy in favour of the poor has still to be elaborated. (3) The last lesson concerns the place of pilot projects in health sector reform. The New Deal shows that experimentation pays. We plead for a continuation of the very open-minded exploration prevailing in Cambodia today.

CHAPTER 1. BACKGROUND

General context

Cambodia is on the move. The political situation is stabilising and the economy is taking off. Tourists – and not only western backpackers – are flocking to the Angkor Wat temples. Traffic jams – and not only motorcycles or humanitarian four-wheel drives – are appearing in Phnom Penh. Cambodian society is clearly changing.

Statistics confirm what can easily be observed by a visitor. GDP grew by 5.3% in 2001, which was nearly as good as in 2000. The outlook for 2002-03 remains very positive: 4.5% in 2002 and 6.1% in 2003.[2]

This economic growth is a (deserved!) blessing, but new opportunities are always accompanied by new challenges. Further economic growth will depend on appropriate policies. Despite some evidence of expansion, agriculture (occupying around 75% of the population) is still lagging behind in terms of productivity gains. The secondary and tertiary sectors will thrive only if there is sufficient investment in infrastructure and human resources. Economic growth will mean human development, but only if the distribution of benefits is spread over the whole population.

Internally, the economic growth brought by the progressive integration of Cambodia into the world economy means that the social fabric will be totally reshaped. In industry, garment factories create new kinds of job opportunities.[3] Tourism may have a similarly powerful effect in the service sector. We can hope that this economic development will help to reduce poverty, which is still highly prevalent.[4] But there is reason to fear that it will be also a source of new tensions and injustices in Cambodian society.[5] The evidence is piling up: over recent years, many people, especially in the rural areas, have either experienced no change in their economic status, or even a deterioration.[6]

Meanwhile, external donors are observing that Cambodia is emerging from the post-conflict period. As far as aid is concerned, a new era is starting. The challenges will be quite different: with a greater need to focus on correcting the imbalances accompanying the economic growth rather than to provide general support to the whole country. Reconstruction of the country is giving way to the alleviation and reduction of poverty.

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[2] "Asian Development Outlook 2002", Asian Development Bank, Oxford University Press, April 2002.

[3] "A Study of the Cambodian Labour Market: Reference to Poverty Reduction, Growth and Adjustment to Crisis", M. Godfrey, S. Sovannarith, T. Saravy, P. Dorona, C. Katz, S. Acharya, S. Chanto and H. Thoraxy, Cambodia Development Resource Institute, Working Paper n° 18, August 2001.

[4] From 1994 to 1997, the incidence of poverty declined from 39% to 36% in Cambodia. Source: "A Poverty Profile of Cambodia – 1997", Ministry of Planning, Phnom Penh, Cambodia. Note: three different daily per capita poverty lines (rural, Phnom Penh and other urban areas) ranging from US$0.45 to US$0.68 (1997) are used in the study.

[5] From 1994 to 1997, the Gini coefficient of inequality increased from 0.38 to 0.42 for the whole country. Source: ibidem.

[6] "Participatory Poverty Assessment in Cambodia", ADB, Phnom Penh, December 2001.

Consequently, the major actors are reconsidering their involvement in the country. Some organisations have already pulled out or are in the process of doing so (e.g. ECHO, ICRC, UNHCR, MSF Holland) or are reducing drastically their activities (e.g. GTZ). Others are scaling up (e.g. the Belgian Cooperation) or organising their support in a different way (e.g. DFID-ADB-WB consortium). Although the period of massive assistance and external influence is not yet coming to an end, the rules of the game are changing.

Public services under pressure

The experience of other Asian countries in transition teaches us that dealing with the speed of economic change can become one of the major challenges for the government.

Indeed, from now on, macroeconomic policy mistakes will have a more obvious cost. The absence of progress within any sector will clearly stand out in comparison with the swift transformation of others. A region's backwardness will be apparent to travellers. Impoverishment within one group will become more unacceptable when other groups are getting richer.

Cambodia's citizens are taking initiatives to seize the new opportunities and improve their living conditions.[7] The crucial question is: will the government and the public services be able to stand the pace?

In fact, a transition from a socialist economy to a market economy can 'easily' lead to an impressive growth rate (at least in Asia). It is more difficult to avoid a collapse or an unfair redistribution of entitlements. Indeed, the development of a market economy leads to a fundamental transformation of the way people access the different resources necessary for survival. Once land can be sold and access to income is linked to the labour market, being without a job can mean starvation. The market creates opportunities, but also opens the way to new risks and tragedies.

The Cambodian state therefore has a major role to play in a market economy. Once traditional safety nets disappear, formal ones have to be organised. Once hierarchy and planning begin to give way to a free market and entrepreneurship, regulation becomes crucial. The social sectors, such as health and education, but also welfare, will thus be of major importance for protecting the more vulnerable, those less capable of profiting from the tough Asian capitalist system.

So, reshaping the role of the state should be on the government's agenda. The problem is that there is also a race against time. When designing policies for the coming decade, the speed of the continuing changes in society will itself have to be taken into consideration. And the population is not waiting: people are moving to cities, learning English and raising their expectations. If a solution is not available on the official market, it is certainly being demanded on the informal one. If English is not well taught in the public schools, if health care is not delivered at the public hospital, the informal sector will take over. However, it will do so in a very unregulated way, the quality will be poor and the services will only be available to those who have the means to pay. In economic terms, this is both inefficient and inequitable.

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[7] At least, those who are in a position to do so. What better indicator is there of the (naïve?) hope in the benefits of globalisation than the buoyant informal market for English tuition in the major cities?

No time to waste for health sector reform

As far as health care is concerned, policy makers – the government, but also donors – are already under strain. Public services are not achieving their targets. Most of the care is delivered in the informal sector. The poor have no access to services. The Cambodian state is already lagging behind the private sector in the health care market.

The public services urgently need reform. If this is delayed, there is a high risk that the Cambodia of tomorrow will be radically different from planners' expectations. If the country remains on the track of accelerated growth, the coming five years might be determinant. At this stage, the already dominant private health sector is still mainly in the hands of civil servants whose private practice represents a coping mechanism rather than a definitive desertion of the public service. But, in the midst of this informal public-private sector, more elaborate business plans are coming forward. Once the private sector has consolidated its position (through formal political representation and joint ventures with investors), it will be then considerably more difficult to establish the credibility of public health care provision. The first losers will be the poor for whom the private sector will be economically out of reach. Other losers may be the same civil servants.

Major challenges call for bold solutions. The MoH and the donor community are quite well aware of the health system crisis in Cambodia. They are deeply concerned about the low utilisation of public facilities despite the efforts and investments over several years. They are disappointed by the prospect of the health status of the population remaining poor; they are ready to take daring initiatives.

A variety of initiatives, a generation of New Deals

In recent years, a variety of strategies have been proposed to tackle the under-utilisation of Cambodia's health services. Some have quite well established methodologies. At the other end of the spectrum, others, such as the 'Boosting Strategy', have still to be introduced. Yet others, as the ADB-led contracting experience, have reached the implementation stage and their results have already been assessed.[8]

Among this set of experiments, there is also the New Deal approach. This strategy clearly has things in common with the Contracting Experience and the Boosting Strategy. Some of the mechanisms to boost activities in public facilities are the same: performance-related incentives, contracting, the creation of new bodies, etc. But there are also obvious differences. For example, unlike the Contracting-In and Contracting-Out, the New Deal is an attempt to find a solution within the MoH hierarchy.

Different experiments can be gathered under the New Deal label. The major ones are taking place in: Takeo Provincial Hospital (started in 1997 and supported till the end of 2001 by the Swiss Red Cross), Sotnikum health district (started late 1999 and supported by MSF and UNICEF), Thmar Pouk health district (started late 2000 and supported by MSF and WHO), Svay Rieng Provincial Hospital (started in 1999 and supported by UNICEF), Mong Russey District Hospital (started early 2000 and supported till end 2000 by Movimondo), Kratie Provincial Hospital (started in 2000

[8] For example, the large pilot test of contracting financed by a loan from the ADB. See "Final Evaluation Report: Contracting for Health Services Pilot Project", S. Keller and J.B. Schwartz, Phnom Penh, Cambodia, November 2001.

and supported till 2001 by HealthNet International) and Stung District Hospital (started in 2001 and supported until the end of that year by MSF-France).

Although all these projects share common features and are of special interest, it is clear that Sotnikum district in Siem Reap Province has been receiving most attention over the last two years. Despite the fact that the much of the credit for the New Deal strategy should go to the Takeo project, Sotnikum is today identified as the paragon of a New Deal.

This success in terms of visibility and recognition is not a matter of chance. Aware of the stakes for the public health system, the different partners involved have opted for the development of an experiment with clear objectives, strong commitment and high visibility. Sotnikum's reputation is thus the result of a strong political will, shared ownership and a constant effort of demonstration and documentation. But this fame should definitely not detract attention from the original options adopted elsewhere and their results.

In the 2001 report, we extensively documented the New Deal approach. We explained its origin and rationale, formulated the underlying principles, described its implementation, documented the first results and expressed our concerns for the future. The aim of this second report is: (1) to provide an update about an approach in continuous change, and (2) to further develop the prospects the New Deal opens up.

Here follows a short summary of the basic principles of the New Deal strategy. We refer to the first 2001 report for a full presentation.

New Deal in Sotnikum: a reminder

As with any qualitative process, the New Deal owes a lot to frustrations. Present in Cambodia since 1989, in 1998, MSF was facing what looked like a dead end in regard to its health district projects in the country. MSF was supporting five districts at that time, and utilisation of the public facilities remained very low, well below the results MSF was used to in similar projects in other countries, and far from achieving a level of activity that could bring about a real improvement in the population's health. It was agreed that the major reason for this poor result was the indecently low salaries, which led to staff demotivation, a loss of accountability, absenteeism, coping mechanisms and disrupted services.

The first victim of that situation was, of course, the population. Deprived of effective care in public facilities, people had to seek treatment in the informal, expensive and unregulated private sector. But the frustration experienced by the health staff and MSF was, in fact, also shared by MoH policy makers, other international organisations and the donors.

To overcome the barrier to motivation, only one option seemed to make sense: to provide the health staff with a fair income. It seemed both normal and possible to request improved results and performance from the staff in exchange. Indeed, ethical norms, internal regulations and codes of conduct had been undermined by years of demotivation. It seemed impossible to offer quality care to the population without a real clearing away of these accumulated bad habits. So, it was "yes" to better salaries, but only in exchange for better service to the population.

The Swiss Red Cross had been experimenting successfully with such a deal in Takeo Provincial Hospital since 1997. The MoH, WHO, UNICEF and MSF shared a willingness to test the idea in other settings. Extending it to entire health districts was of particular interest for health sector reform. Sotnikum, an operational district (OD)

supported by MSF and UNICEF, was identified as a good place to develop this approach.

The previous report detailed what the New Deal agreed in Sotnikum consists of. In a nutshell, a New Deal is a health financing scheme that determines the income a health facility will receive. It is explicit about the sources of the funding, the conditions for obtaining it and the way it can be used. This 'explicit expression' is contained within the terms of a contract bonding the health facility to the different stakeholders. The staff of a health facility commits itself to quantitative and qualitative improvements in the delivery of services. In order to encourage fulfilment of this commitment, a part of the new resources is performance linked. On their side, the stakeholders, organised in a Steering Committee, commit resources and pledge a strict compliance to certain rules (transparency, etc.).

The first Steering Committee meeting was held in October 1999 and the first New Deal agreement was launched in Sotnikum hospital in December of that year. Over the following months, similar deals were worked out for the other 'building blocks' in Sotnikum health district, some health centres and the Operational District Office (ODO). In September 2000, a Health Equity Fund was launched with the objective of improving access to the hospital for the poor, while protecting the hospital's income-generation capacity.

The first conclusions, in March 2001, about the effectiveness of the New Deal in Sotnikum were unambiguous: the New Deal is good for health! Results somehow varied between health facilities, but an increase in the utilisation of services could be observed everywhere. This increase in activities was undoubtedly a consequence of improved working conditions for the health staff. Their official income ranged between US$60 to US$100 per month compared with the previous US$10 to US$15. This clearly boosted staff performance.

This positive global picture did not mean that everything was perfect in Sotnikum. Some further improvements still seemed possible and necessary. And the report also expressed some concerns. As we will see, several challenges have still not been tackled.

New Deals elsewhere in Cambodia

In fact, the MoH, MSF and UNICEF took less than a year to appreciate the whole potential of the New Deal for Cambodia on the basis of the experiment already underway in Sotnikum. The MoH and UNICEF soon decided to implement a similar approach in Svay Rieng Provincial Hospital. In early 2000, the NGO Movimondo launched a New Deal in Mong Russey hospital, Battambang Province. In autumn 2000, MSF received agreement from Amsterdam to launch a New Deal in MSF-Holland's project in Thmar Pouk in Bantey Meanchey Province. In 2001, HealthNet International and MSF-France introduced similar agreements, in Kratie and Stung hospitals respectively.

All these experiments have their own individual ambitions and history. All of them are worth documenting. However, as the authors have been personally involved only in Sotnikum and Thmar Pouk districts, this document focuses mainly on these projects. It must be admitted that this is certainly a limitation of this report.

CHAPTER 2. THE NEW DEAL IN SOTNIKUM

Sotnikum operational district

Dam Dek, the small town in which the Sotnikum hospital and the operational district office are located, is 30 kilometres from Siem Reap town. Although Siem Reap is experiencing an explosive economic growth thanks to tourism, Sotnikum remains a poor rural area. Nevertheless, it is obvious that the countryside is starting to feel the impact of the changes. The district is also becoming less isolated. A new road has been built and transport opportunities are multiplying. Over the coming years, part of Sotnikum district will clearly be within the economic hinterland of Siem Reap. This trend will have an impact on the health system.

Partly thanks to MSF and UNICEF support, Sotnikum Operational District is today one of the few districts in Cambodia that can be regarded as truly operational.[9] All 17 health centres foreseen in the health coverage plan are now functional and offering the full Minimum Package of Activities. Some of these health centres are considered to be among the best in Cambodia. Part of the explanation lies in the high level of community involvement through the so-called 'feedback committees' and 'co-management committees'. One health centre is a former district hospital, and also provides in-patient care.

The referral hospital in Dam Dek has 120 beds. This hospital is providing the full Complementary Package of Activities: surgery, X-ray, ultrasound and lab facilities are all available. Because of the existence of two paediatric charity hospitals in Siem Reap, most of the in-patients are adults. The hospital suffers from chronic understaffing.

Sotnikum health district can today be regarded as a real health system. Most patients referred by the health centres do go on to attend the referral hospital and over 70% of hospital in-patients are referred by a health centre.

The situation at the beginning of 2001

In our first report, we tried to give a fair coverage of the experiment in its early stages. The general tone was something like: "The New Deal has a strong positive impact, but the commitment of some mid-level managers is still lagging behind."

On the positive side, it was clear that the New Deal had effectively broken the vicious circle of staff demotivation and the under-utilisation of services. Thanks to the sharp increase in official income, the health staff was more committed to its work. This better service was clearly acknowledged by the population: in most facilities, the rate of utilisation rose steeply. Regarding its primary objective to reconcile the population with its public facilities, the New Deal thus seemed to be on the right track. An important positive result was also the fact that MSF and UNICEF accounted for only 15% of the resources used. The New Deal was also successful as a strategy for enforcing a greater release of national budgets and facilitating revenue collection from the users.

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[9] UNICEF has been present in Siem Reap Province since 1993. Its support consists mainly of technical assistance to the Provincial Health Department (PHD). MSF started working in Sotnikum in 1997. Its main objectives are to provide quality health care to the population, to build a sustainable health system and to contribute to health policy in Cambodia.

However, in 2001, it was clear that more improvements were still needed.[10] For the MSF team, the main issue was that the quality of care remained too low in too many facilities. Consultant health economists were concerned with the difficulty in establishing management abilities at the hospital and district levels. Staff in the health facilities was unhappy with what was perceived as mismanagement by mid-level managers (hospital and OD directors).

At the hospital level, MSF staff members were still observing a low compliance with basic rules in nursing and medical practice. This state of affairs was regarded more as a lack of commitment than a lack of ability on the part of the workers; and as a lack of enforcement on the part of the management.

A major concern was that the health staff did not demonstrate an appropriate level of responsibility in the wards. Early in 2001, there was a consensus among MSF expatriates involved in the everyday functioning of the hospital that this was mainly due to: (1) the absence of a clear delegation of tasks; and (2) the low level of commitment by the director to reorganise the hospital in an appropriate manner. The insufficient number of nurses was also part of the problem, but this was regarded more as an alibi for the low level of responsibility acceptance than as the real cause. Moreover, the management did not really attempt to solve this problem.

In parallel to what was perceived as the director's lack of effort to improve the organisation of the hospital, he also seemed reluctant to empower the elected management committee. The difficulties experienced with the implementation of the quality-related individual bonuses were a symptom of that. MSF regarded this as a failure, which it attributed to a lack of will on the part of the management. Participatory management was not the model favoured by the hospital director, nor by his supervisors.

At the district level, visiting health economists were not particularly impressed by the achievement in terms of developing a management capacity. Except for drug and vaccine supplies, the Operational District Office seemed more like a bottleneck for the development of the facilities than a real support. Throughout 2000, the facilities had to struggle to get access to national budgets. When problems were identified at the level of a facility (insufficient staffing at the hospital, need for rehabilitation work or a small repair in a health centre, etc.), the ODO did not usually provide the support that was expected. Eventually, it became obvious that too many management functions, such as consolidated accounting, monitoring, problem solving or logistic support, were still being performed by MSF or UNICEF staff.

Several reasons could explain that situation. Part of the explanation was very structural. The tradition of autocracy and bureaucracy in Cambodia was, for example, seen as an obstacle to achieving the skills and attitudes needed in the OD model (empathic supervision, participatory decision-making and teamwork). Part of the problem was also that the ODO staff was not satisfied with the bonus offered under the New Deal. And a final explanation had more to do with some individuals. For example, several outside observers expressed scepticism about the capacity of the OD director to develop his district. According to them, his profile was not adequate for meeting the challenge. Moreover, as he did not have an impressive track record in

[10] Dr H. Thay Ly covered the frustrations well in his presentation at the National Workshop "The New Deal, one year on" on February 23, 2001.

terms of transparent management and problem solving, serious doubts were expressed about his commitment to the New Deal.

2001: the second year

Actions taken

Extension of the New Deal to other health centres

At the end of 2000, six health centres were included in the New Deal. The subsequent general improvement in their performance clearly called for an extension to more health centres.

While the MoH advocated a rapid extension, MSF and UNICEF preferred to go more slowly and keep the process under control. Some facilities were not yet ready. By setting conditions for entry (e.g. the presence of a minimal mix of qualifications at health centre level), the external actors had an instrument for motivating the ODO to resolve existing problems.

In 2001, six new health centres were included in the New Deal, leaving five still remaining outside at the end of 2001.

A slight revision in New Deal incentives

To counter certain problems identified at the beginning of 2001, some measures were taken within the New Deal itself.

As the first deal offered to the ODO staff was not satisfactory (on average, their bonus was 40% less than that offered to hospital staff), MSF agreed to double the 5% of funds the ODO received from the health centres (the 'commission' on the revenue collected from the users). Later in the year, the ODO started to collect more income through per diems from the World Bank. Today, their bonus is in line with those earned in the best performing facilities (Table 1).

		Individual Monthly Bonus		
Facility	# of months	Highest	Lowest	Average
Operational District Office	12	134	26	68
Hospital	12	156	35	78
Som Rong Health Centre	12	96	86	88
Sang Vui Health Centre	12	74	64	66
Kean Sangke Health Centre	12	70	60	63
Anlong Somnor Health Centre	12	88	78	80
Spean Thnot Health Centre	12	67	57	69
Kampong Khleang Health Centre	12	66	56	58
Lveang Russey Health Centre	9	61	51	49
Svay Lou Health Centre	8	57	47	49
Pongro Krom Health Centre	6	63	53	55
Dam Dek Health Centre	2	76	66	68
Kok Thlok Krom Health Centre	2	66	56	58
Kampong Kdei Health Centre with beds	1	118	98	101

Table 1: Spread of monthly average bonuses in 2001 (in US$)

Creation of a Monitoring Team

Since the New Deal was first launched in late 1999, regardless of investment and financial input, MSF field assistance to Sotnikum OD has been characterised by three components: (1) technical assistance (training); (2) substitution; and (3) monitoring and evaluation. The constant involvement in monitoring and evaluation in 2000 resulted in the MoH sometimes perceiving the MSF staff in the role of a 'policeman'. Unsurprisingly, this affected its training role. Mid-2001, it was decided to separate monitoring and evaluation from the technical assistance role. It was therefore proposed to set up a Monitoring Team, which would be separate and independent from the Sotnikum MSF and MoH field teams.

The main objective in setting up the Monitoring Team was to strengthen the implementation of the New Deal in Sotnikum. By doing so, lessons might also be learned about how to use monitoring to improve the public health services in Cambodia. Indeed, if the contractual approach is to be advocated as a solution for the country, ways must already be found of transferring responsibility to national bodies for monitoring whether contracts are correctly fulfilled.

In practical terms, the Monitoring Team is composed of three members: one representative from Siem Reap's PHD (full-time), one representative of MSF (full-time), and one representative of UNICEF (part-time), each respectively under the supervision of the PHD director, MSF and UNICEF supervisors in Phnom Penh.

The Monitoring Team conducts regular field visits to each health facility included in the New Deal, covering each facility at least every three months. The purpose of these visits is: (1) to observe activities, such as consultations and outreach, and carry out spot checks to detect any irregularities; (2) to interview some of the patients who have attended the health facilities in order to determine their satisfaction with the services provided and to check the reliability of data; and (3) to discuss with stakeholders, such as community representatives and local authorities, to get feedback. The Monitoring Team also discusses regularly with other key informants – such as MoH staff, field staff of MSF and UNICEF, and the staff of the NGO administering the Health Equity Fund – to collect information on the quality of services and on critical incidents. The team also gathers information by reviewing documents and registers of the health facilities themselves.

Monitoring focuses mainly on ensuring whether the conditions laid down in the contracts are being fulfilled (24-hour service, no unofficial payments, no poaching of patients, and no embezzlement of drugs or materials). The Monitoring Team reports regularly to its supervisors and also provides feedback on its findings to all stakeholders. The final results of the monitoring are presented every three months to the Steering Committee, where possible sanctions for breaches of the contract are discussed.

In order to avoid the possibility of the health facilities developing a negative perception of the Monitoring Team 'policemen' and to promote constructive competition among the health centres, rewards are given every three months to the best performing health centres, focusing on different aspects each time (e.g. user rate, proportion of deliveries attended in the health centre, TB case finding, etc.).

As it was only initiated late in 2001, it is still too early to assess the relevance and performance of this monitoring strategy. However, it is clearly something that is worth further documenting

Upgrading the district

During 2001, MSF continued its effort to upgrade the health district. A health centre was built in Kvav, a very poor and remote area. Since early July, the health coverage plan has thus been achieved. Some infrastructures have also been built or rehabilitated in the hospital compound: a new kitchen for TB patients, a sanitary block in the medicine ward, a new floor for the administration and a rehabilitated TB ward.

There also has been some upgrading in the activities offered. The most noteworthy is the introduction of DOTS in the health centres. This has led to a significant increase in the detection of TB patients and a major change in the composition of TB in-patients at the referral hospital. In general, TB has received more attention throughout 2001. There is a marked improvement in TB care at the hospital. This owes a lot to the good collaboration between the MSF doctor and his counterpart at the hospital.

Some other activities have also benefited from more attention in 2001. Although HIV/AIDS is still lagging behind, malaria, dengue and measles have received special support. Although the nationwide mass measles vaccination campaign considerably disrupted the overall functioning of the different services, the OD has strengthened its capacity to cope with future outbreaks of malaria or dengue.

A new strategy for clinical training

Training is an important part of MSF's assistance to improving the quality of care in the hospital and health centres. Early in 2001, it was clear that the traditional training approach, i.e. lectures or on-the-job training, provided only by MSF expatriate doctors or nurses on the spot, was not effective in terms of changing practices and behaviour. The main hypothesis was that this was the result of a cultural mismatch between the young western 'experts' and the supposedly 'unqualified' Khmer staff. This relationship model was rejected by the Khmer staff and proved frustrating for the MSF team.

Consequently, MSF has set up a new training strategy for hospital staff combining three different approaches: (1) on-the-job training by an expatriate doctor; (2) sending staff for training at national centres of excellence, and (3) hiring senior Khmer trainers from some good hospitals in Phnom Penh to provide training courses on the spot. In addition, a more in-depth assessment of training needs is made before any training is provided.

So far, several Sotnikum staff members have been sent to Takeo Provincial Hospital for practical general medicine and paediatric training and to the Centre of Hope for X-ray and ultrasound training. At the same time, senior doctors and nurses from the Centre of Hope and the National TB Centre (CENAT) provided training courses in Sotnikum hospital.

Since the introduction of the new strategy, the field staff has reported positive changes. According to a recent evaluation, the general impressions of both hospital and MSF field staff are extremely positive.

Reorientation of MSF support

To cope with persistent frustration among the expatriate team, MSF decided to review its day-to-day involvement in Sotnikum OD in 2001. Consequently, in mid-2001, the MSF expatriate team was reduced and it was decided that the team's role needed to be clarified. The New Deal had certainly blurred the picture. How can somebody be

regarded as a trustworthy trainer and everyday colleague, if, at the same time, s/he is expected to play a policing role and will also act as a judge in the future?

During 2001, the MSF field team pulled out from the micro-management of the New Deal. Monitoring and evaluation tasks have been entrusted to actors not involved in everyday relationships with the district staff (namely: the Monitoring Team and MSF and UNICEF co-ordinators in Phnom Penh). The general idea was to protect the MSF field team from conflicts with its MoH counterparts.

There was also a move in terms of the agenda. Rather than taking any new initiatives, the priorities have been to consolidate the existing results. A special focus on the quality of clinical care has been developed. The general trend has also been to withdraw from enforcing solutions on the Khmer partners. It is hoped that all these choices will reduce frustration among the MSF field team and will facilitate a greater feeling of ownership of the New Deal among MoH managers.

Results

The Health Financing Scheme

As far as the major bottleneck is concerned, in 2001, the New Deal has confirmed its ability to satisfy the basic needs of the health workers. Throughout the year, the different categories of personnel remained satisfied with their bonuses (Table 1, page 19). As a consequence, general morale remained positive. Except for a few individual incidents, staff members respected the internal rules and were present at their work. Breaches of contract, such as under-the-table payments or misappropriation of resources, were very rare and were sanctioned.

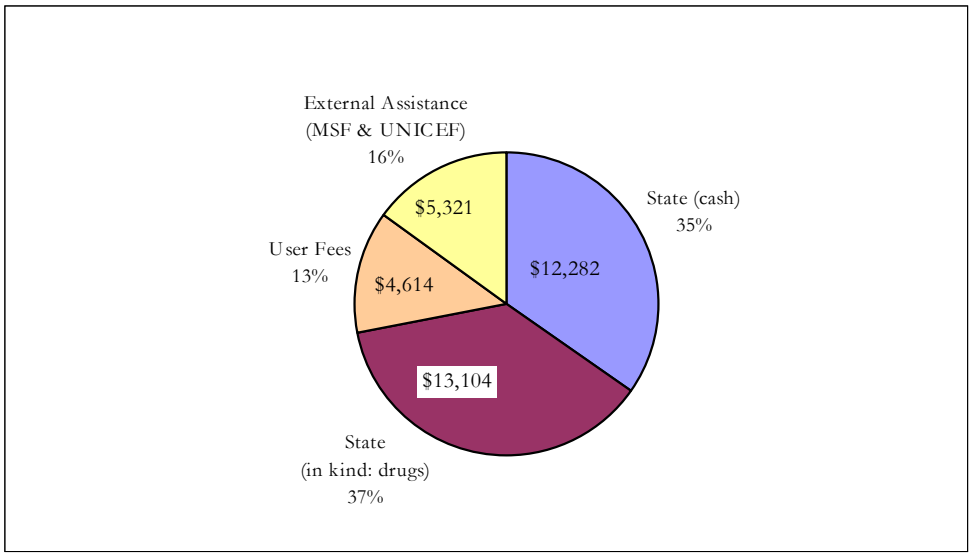

Figure 1: Sotnikum OD: breakdown of average monthly income in 2001

The total monthly average income of Sotnikum OD was US$35,321 in 2001.[11] The external contribution by MSF and UNICEF has been constant (US$5,321) as it mainly covers bonuses with a maximum ceiling. The contribution from users rose from a monthly average of US$2,187 in 2000 to US$4,614 in 2001.

The total amount of the financial resources utilised in Sotnikum OD comes to less than US$2 per capita per year. Even if we add the NGO operating costs (estimated at around US$1.5 per capita per year) and the investment costs (around US$0.7), the total cost is only around US$4 per capita per year. With an average household health expenditure estimated at US$33 per capita per year in Cambodia, this means that only 11% of total health care expenditure in the district reaches the public facilities,[12] with the major share (89%) going to the private sector (private practitioners, drugs and transportation). The positive conclusion is that there is clearly still room for tapping more resources in the public system.

Overall, access to the government budget for running costs was quite satisfactory in 2001: US$11,314 per month, which means an increase of 15% in comparison with the previous year. Moreover, this year, health centres have really been able to access the budgets they ought to have. This is a major improvement and has been acknowledged by the facilities.

But, these figures are also somehow misleading. First, the release of budget funds remained highly unreliable. Only a very small share of the budget was disbursed in the first quarter, while 37% arrived in the last fortnight of the year. Clearly, disbursement of the government budget in Cambodia follows the logic of the centre, not of the periphery. Moreover, the constraint of inflexible budget lines did not lessen in 2001. There is still no budget line for salary supplements. However, a large part of the budget has been spent, in a non-transparent way, on consumables and durable equipment.

Activities

2001 confirmed the general trend observed in 2000: the New Deal is good for producing a quantitative increase, but many opportunities are not seized because of the managers lack sufficient commitment.

At the level of the health centres, the general trend towards increased attendance is continuing.[13] Total consultations increased by 17% between 1999 and 2001 (Figure 2). Over the same period, deliveries assisted by a trained midwife by 80% (Figure 3). Moreover, data in 2001 are considerably more reliable than in 1999.

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[11] The operating costs (staff, vehicles, office, etc.) of MSF and UNICEF projects are not included in the OD's income. Also left out is the investment in buildings, durable equipment and training (except per diems declared by the staff).

[12] For a discussion about household expenditure on health care, see: "Joint Health Sector Review", Ministry of Health, Cambodia, 2001. There is a controversy about the exact amount and share of household income, not about the fact that out-of-pocket payments are unacceptably high given the poverty levels.

[13] We prefer to present only the activities for which the data available are reliable. E.g. according to the ODO, EPI coverage (fully vaccinated children) is close to 80%. However, critical incidents observed during field visits make us doubt about the reliability of these data.

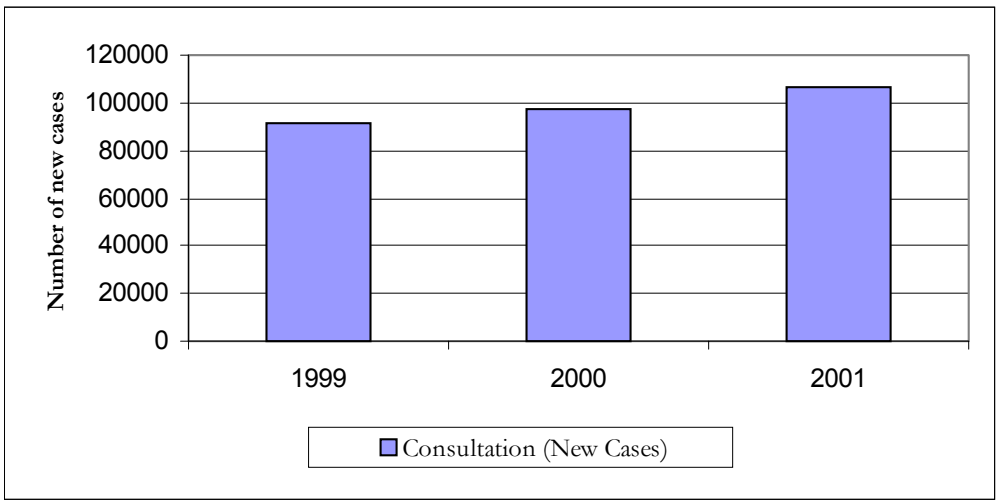

Figure 2: Consultations in Sotnikum Health Centres

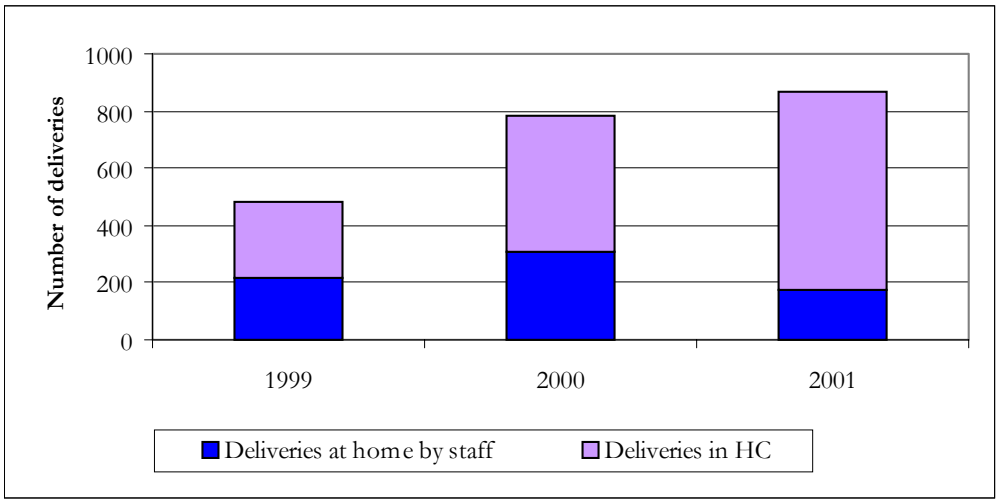

Figure 3: Deliveries assisted by Health Centre staff in Sotnikum OD

The effectiveness of the referral system is particularly impressive: 81% of patients referred by the health centres actually went on to visit the hospital. To our knowledge, this is an exceptional situation in a low-income country. In 2001, half of the in-patients had been referred from a health centre before coming to the hospital (up from 30% in 1999, Figure 4). The district, as an integrated health system, is no longer a fiction.

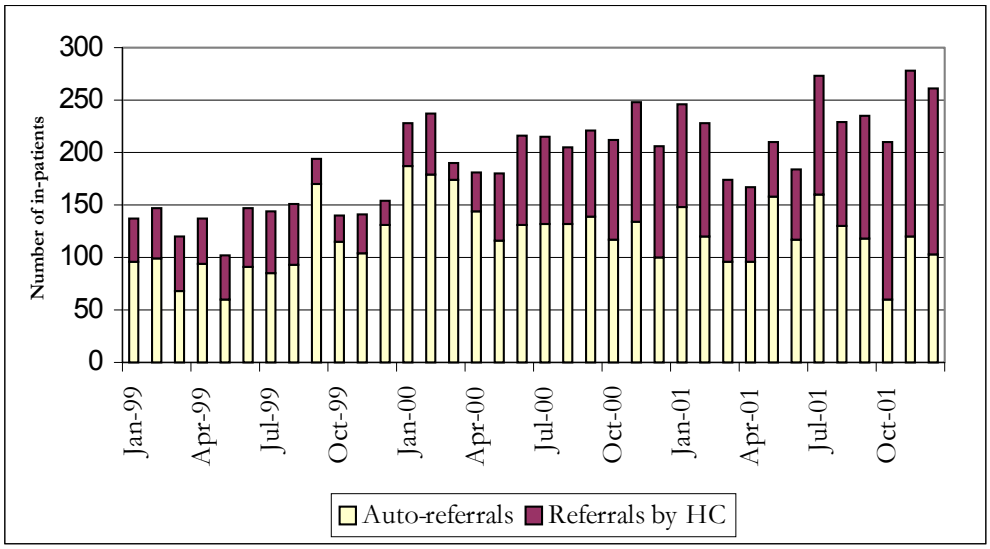

Figure 4: Referrals to Sotnikum hospital (1999-2001)

At the level of the hospital, there are some reasons to be enthusiastic, and some reasons for concern. On the positive side, there are two major trends to report: (1) activities kept on increasing, and (2) the case mix became continually more complex.

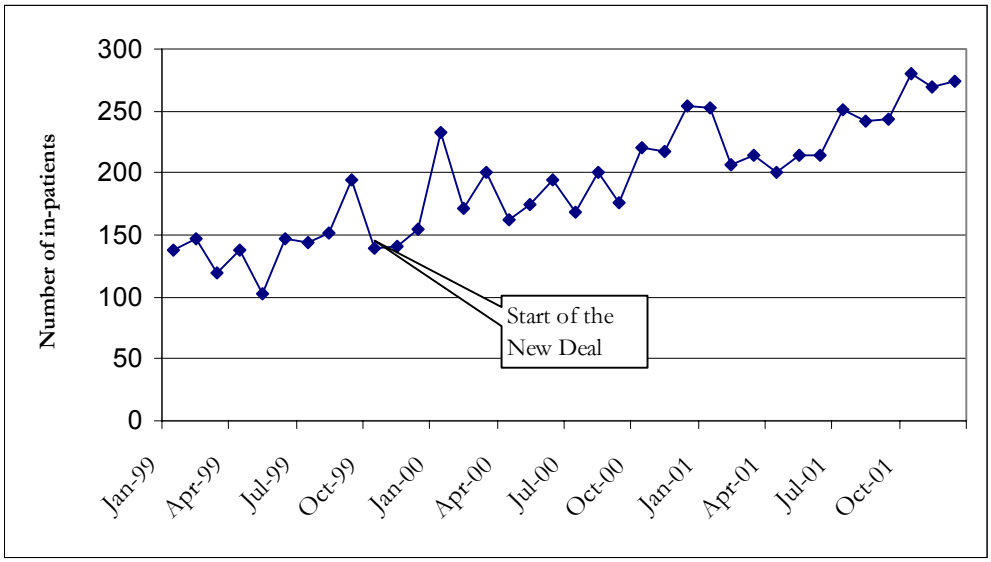

Figure 5: In-patients (TB included) at Sotnikum hospital (1999-2001)

The number of in-patients alone is not a good reflection of the increase in activities. Paraclinical activities, for instance, increased to a higher rate. In 2001, the number of complementary examinations increased steeply. During the last quarter of 2001, ultrasound examinations increased by 570%, X-rays by 280% and lab examinations by 130% compared with the last quarter of 2000. Over the same period, the number of in-patients increased by a 'mere' 40%. This increase testifies to the

change in the case mix and the subsequent change in medical practice, which is also influenced by the clinical training given.

In general, the hospital is taking care of a growing number of complex and advanced cases. There are, of course, an increasing number of surgical interventions (Figure 6). But, there is also a shift, maybe less spectacular but not necessarily less significant, in the severity of the cases in internal medicine. Malaria serves as a good example: while the total number of cases dropped dramatically (a result of the introduction of combination therapy in the health centres?), those arriving at the hospital were considerably more severe. TB is another example: thanks to the introduction of DOTS in the health centres, the hospital was able to free hospital beds for more severe or complicated cases (extrapulmonary and smear negative cases).

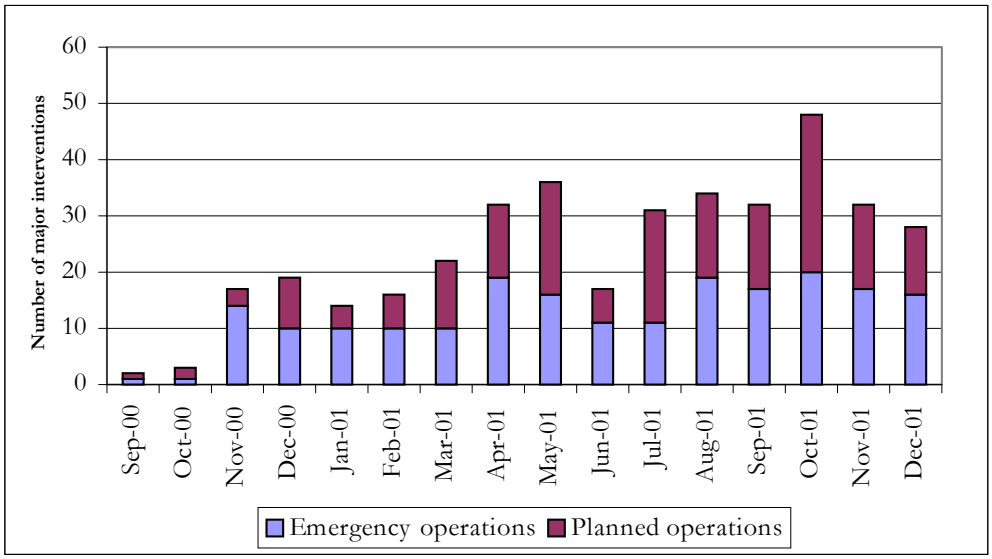

Figure 6: Major surgical interventions in Sotnikum hospital (2000-2001)

Partly because of the arrival of these more severe cases, the hospital mortality rate increased from 2.69% to 3.08% between 2000 and 2001.[14] Another way to interpret this rise in mortality is that the population regards dying at home as no longer inevitable: the hospital is starting to be seen as a life-saving possibility.

Unfortunately, we must also observe that the referral hospital remained the sensitive spot for the project throughout 2001. Indeed, from MSF's point of view, the year has been a painful struggle to get the hospital truly committed to patient wellbeing.

In certain periods of the year, a willingness to improve services prevailed among the hospital staff. MSF doctors reported a shift in attitudes and a greater openness to learning. This usually coincided with the director's presence and his own level of commitment. But both of these were sometimes irregular. Improvements might be achieved one month (better hygiene, better delegation of tasks, follow-up of vital

[14] Neither can we exclude the fact that the increased workload (the bed occupancy rate was 157% in 2001) hampers the possibility of providing a better quality of care and is another part of the explanation. The particularly long average length of stay (9.25 days in 2001) indicates that measures must be taken.

signs, etc.), but a setback would be observed two months later (some incidents involving under-the-table payments, absenteeism during the week-end, fluid balance sheets not filled, etc.). The end of 2001 was particularly difficult. The recurrent absences of the director for family reasons and the resultant lack of direction led to a general drop in staff morale.

Our analysis is that Sotnikum hospital's performance is determined to a great extent by the dominant management model. This model is very similar to that of small and medium-sized firms: it is personalised and autocratic. When the boss is present, dedicated and setting an example, wonders can result; when he is absent or is busy with other things, nobody can take responsibility or solve problems, and everything becomes bogged down.

To summarise: in the opinion of all observers (and probably that of staff members themselves) the referral hospital could do better than it did in 2001. Despite MSF's constant efforts to improve quality, it remained short of its real potential. Moreover, some improvements are still too much dependant on an MSF presence.[15]

A few words about the operational district office. 2001 can be considered a year of consolidation, but there are no major improvements to report. As far as the administrative side is concerned, the ODO has improved its skills. Today, it seems able to master the subtleties of state funding, especially the Priority Action Programme (PAP) procedures. We have already reported the improved access to government funds for the facilities. The ODO in 2001 proved less a bottleneck and more like a supportive institution. Planning, accounting, problem solving and general management have improved a little bit, but MSF still has to play a substitution role.

In brief, 2001 saw a consolidation of the New Deal in Sotnikum. More health centres were included and activities increased everywhere, especially in the hospital. The district is becoming a real system, and its finance and management have stabilised. A Monitoring Team was set up and more clinical training was provided. However, results in regard to the quality of care and management are still unsatisfactory and further improvements are needed.

[15] The absence of the MSF doctor for a short period in 2001 proved that the medical team is not anywhere near independent either clinically or managerially.

CHAPTER 3. THE NEW DEAL IN THMAR POUK

Thmar Pouk Operational District

The Takeo experience had already proved that the New Deal approach was an appropriate strategy for a provincial hospital. And a few months of the New Deal in Sotnikum proved that it also was a powerful way of enhancing the development of a health district in Cambodia. Unsurprisingly then, early in 2000, MSF considered launching a similar process in another health district in Cambodia.

Thmar Pouk district is situated in Bantey Meanchey Province, Northwest Cambodia, on the border with Thailand. The total population is around 106,000. Up until 1998, this zone was still on the frontline and plagued by insecurity and landmines, all of which partly explain the delayed economic recovery. Mine clearing is still underway.

Poverty, a low population density and a lack of basic transport infrastructure are clear constraints for the development of the health system in the region. The main characteristics of the health sector in Thmar Pouk district are:

(i) The district health coverage plan has been designed, but it is still not fully implemented. Only eight of the ten health centres planned actually exist.

(ii) The referral hospital is not providing the full package of activities and no surgery is available.[16]

(iii) The great majority of the staff is composed of returnees who were trained in the refugee camps in Thailand. Their diplomas are not yet recognised by the government. Most of the facilities have far too many staff members with a low level of skills, often eight or nine per health centre.

The MSF Project

MSF-Holland has been present in Thmar Pouk since 1992. At that time, the MSF project was mainly directed towards the populations in danger as the result of the conflict. As stability improved, MSF committed itself to helping the government to turn a collection of scattered health units into a real health district in line with the official health coverage plan (1996). For 2000-02, the MSF project set as its objectives: (1) to improve access to quality health care for the whole population; and (2) to build up the health system and try to make it sustainable.

In 2000, MSF-Holland decided to pull out of Cambodia, with the closure of the Thmar Pouk project fixed for end of 2002. Unlike Sotnikum, the New Deal in Thmar Pouk was perceived from its inception as a hand-over process aimed at future sustainability. The other difference in terms of objectives is the absence of any reference to pilot function. Thmar Pouk was an opportunity to test the New Deal in another setting, but it was not conceived as another 'showcase'. Consequently, Thmar

[16] There are valid reasons for that. On the demand side, the relatively small catchment area should be taken into account, particularly because of the lack of economic attraction by the small town of Thmar Pouk on an important part of the district. On the supply side, there is a Provincial Hospital with very developed surgical abilities within one hour's travel distance. Thmar Pouk hospital currently has neither the qualified staff nor the facility to deliver surgical interventions.

Pouk has remained outside the visiting circuit in Cambodia. This is not necessarily a disadvantage.

Implementation of the New Deal

Ownership from the start

In Thmar Pouk, the initial request for a New Deal came from the OD managers themselves. This request was expressed on recurrent occasions while the preparations for Sotnikum OD were still going on, and was couched in even stronger terms once the New Deal began operating there. The MSF field team was rather sceptical, but decided to put them to the test.

MSF first adopted a wait-and-see policy: the NGO would only consider holding discussions on a New Deal if some basic conditions were met (e.g. MoH doctors present in the hospital, improved financial transparency with a maximum limit on cuts of 9% in Accelerated District Development (ADD) instalment payments ('steps'), a Health Equity Fund up and running and managed by a local NGO, attendance registers for staff, no more under-the-table payments in the hospital, etc). In order to keep responsibility and initiative in the managers' hands from the start, a 'steering group' consisting of the key people from the OD and some MSF representatives was created to direct this process. The results were impressive; in less than six months, all the conditions had been met.

Duplication of the existing model

For the MSF team and the health economists, there was no reason to change a winning formula. The main strategy was very similar: to improve income for the staff in exchange for improved services for the population.

Unsurprisingly, the institutional arrangements for organising the New Deal in Thmar Pouk are the same as those we find in Sotnikum: (1) a Steering Committee to assess whether the contract is fulfilled, (2) a global contract to win the commitment of the different stakeholders, (3) a health financing scheme to tap resources and establish strong financial incentives, (4) the creation of a management committee in each facility, and (5) the introduction of internal regulations within the facilities.

The process of establishing these different elements was quite similar to what happened in Sotnikum: after the initial study by a health economist (using simulation techniques to calculate the possible level for the bonus), a few information sessions were held for the staff, there was a period of negotiation among the stakeholders, and the management committees were elected.

Nevertheless two important differences between Sotnikum and Thmar Pouk should be noted. (1) Because of MSF-H's willingness to pull out of Cambodia within two years from the start of the New Deal, sustainability was taken into account more explicitly and at an earlier stage than in Thmar Pouk. (2) The pilot project status of the New Deal in Sotnikum may have some advantages (greater visibility and greater willingness of high-level MoH staff to intervene directly to solve problems), but it also brings complications (frequent visits, the threat of 'hold-ups'[17], etc.). In general, Thmar Pouk has flourished, but away from the spotlights.

[17] In economics, a 'hold-up' is a situation where one party invested in a joint venture and later has no other choice in order to continue than to accept unfavourable changes in the

Overstaffing provides a less favourable environment

Another major difference between Sotnikum and Thmar Pouk was the staffing situation. While understaffing was stretching the human resource capacity in Sotnikum OD, Thmar Pouk's facilities were overstaffed. Eight or nine health workers for a health centre with very low activity was a standard situation in Thmar Pouk OD. In particular, there was an excessive number of nurses with very low qualifications.

As far as the health financing scheme was concerned, the overstaffing meant a problem in regard to bonus levels: with MSF providing a similar total cash subsidy for bonuses in Thmar Pouk to that in Sotnikum, the share per worker would actually be lower in Thmar Pouk. There was a real risk of not reaching the critical threshold of a minimally acceptable bonus level with incentives remaining too low to convince each worker to be fully committed to providing a better service.

The prevailing level of activities in the facilities further compounded the risk. In 1999, Thmar Pouk hospital was delivering very few services beyond health centre level, and in-patient numbers remained steady at around 100 per month. A similarly low level of activities could be observed in most health centres. There was no reason to expect a change. For instance, the community support existing in Sotnikum through the feedback committees did not exist in Thmar Pouk. This low level of activity, added to the population's poverty, meant that the health economists could not envisage a very high financial contribution from the users in order to fund the bonuses.

After consultations with the managers about what would be perceived as a fair and motivating income by the personnel, the health economists concluded that it was not possible to include all the staff within the New Deal. In fact, even with the proposed reduction in human resources, only 75% of the bonuses initially requested could be provided. Difficult choices had to be made.

Greater cohesion between the management team and the staff?

In terms of process, the introduction of the New Deal in Thmar Pouk therefore required a new preliminary and, not surprisingly, very unpopular step: staff members would have to be selected for inclusion in the scheme. On one side was the happy majority who would be included in the bonus system, and on the other side, the unlucky few who had to be left out. Without this triage, the economists believed that the New Deal would be overburdened and unable to take off.

Committed to acquiring the New Deal for their staff, the managers were now in a awkward position: they were under pressure from MSF to exclude some of their employees from what appeared to be the Promised Land (?). Even more awkward for them was the fact that they now had to identify who had the necessary qualifications and was committed to making the New Deal work.

Unsurprisingly, the managers opted for a less embarrassing solution. They found an official way out to cope with the limited budget granted by MSF for the bonus payments by turning some positions into part-time jobs. The absence of eight nurses

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contractual relationships as required by the other party. In Sotnikum, it is clear that several stakeholders have invested resources and reputations in order to turn the New Deal experience into a successful pilot for the country. Any individual stakeholder can then hold up the others by holding the whole dynamic hostage.

for two years of training also provided an opportunity for them to postpone difficult decisions at the hospital level.

With hindsight, this half measure was the first clue that the Thmar Pouk managers are quite close to their staff. It is still not clear if the greater cohesion is the result of a stronger sense of solidarity or a less favourable balance of power as regards the managers.[18] In any case, the following months confirmed the fact than the situation is different from Sotnikum.

Given the institutional and incentive set-up of the New Deal, this greater cohesion has, of course, an influence on the experiment's chances of success. Indeed, the logic of the New Deal is to set incentives that align the different interests as closely as possible: the interests of individual workers to be aligned with the interests of the group, which must be aligned with the interests of the facility, which are themselves to be aligned with the interests of the patient.

In this long chain, the group of individual workers has a central importance. The New Deal tries to empower this group. If the interests of the group coincide with the facility's development (through some ownership of revenue) and if the group has some decisional power (through a degree of participation in management), the patients may eventually benefit.

Accordingly, the contractual arrangements for the New Deal establish some kind of co-ownership of the facilities: the management committee is elected by the staff, is responsible for distributing the bonuses and hopefully takes decisions to boost the development of the facility. But as a member of the group, each individual worker can also have an influence outside the committee. Joint responsibility and mutual control are also important dimensions in the governance and management model of the New Deal.[19]

While participatory management has remained elusive in Sotnikum, it was quickly adopted by the managers in Thmar Pouk.[20] This was clearly a continuation of their previous efforts (their own lobbying, their acceptance of transparency, their good practice in regard to achieving the release of public budgets and their everyday partnership with the MSF team). We shall see that this improved fit between the theoretical model and what was really put into practice by the managers worked wonders at the level of the referral hospital.

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[18] It is of course difficult to formulate more than assumptions. A first explanation is that all the staff in Thmar Pouk share a common history (refugees in Thailand and training in the border camps) and possibly a common fate: so far, as their qualifications are not fully acknowledged by the MoH, they are enlisted at the lowest salary level on the pay roll. All of them are surely eager to prove that they are just as capable as those who received their training in Cambodia. Another explanation of the managers' attitude could be that they will be given credit for a successful development of their district. And finally, there is the possibility that the managers might feel some personal obligation towards some of the staff.

[19] This model was inspired by what we observed in Takeo hospital. With hindsight, we might nevertheless wonder today if 'self-management by the staff' is really the governance model prevailing in the provincial hospital. 'Self-management by the surgeons' would probably be a better description of what actually happens.

[20] The adoption was nevertheless not immediate. During the first few months, there was tension and frustration between the managers and the rest of the staff. The MSF lobby and the pressure imposed by the dengue outbreak have also had an influence.

Taking advantage of the lessons learned

Thmar Pouk, of course, took advantage of the experience accumulated in other provinces. First of all, thanks to Sotnikum and Takeo, it was very easy for the different stakeholders to grasp what the New Deal actually was. Several visits to Sotnikum were organised for MoH and MSF staff during 2000. Unlike Sotnikum in the previous year, this time the discussions were between well-informed partners who were well aware of where they were heading. By employing institutional solutions and management tools developed in Takeo and Sotnikum, Thmar Pouk was able to get off to a quick start. For example, all the documents that had been written up in Sotnikum (already largely inspired from Takeo) were used in Thmar Pouk.

Sotnikum was the first time a New Deal was put to the test in a non-favourable environment.[21] It was therefore only logical that this project had to face teething problems. As we said in the first report, MSF had to build the road while walking along it. In Thmar Pouk, it was possible to benefit from this experience.

The main difference with Sotnikum was the development of a stronger feeling of ownership of the approach among the health system managers in Thmar Pouk. MSF decided to direct less the content of the New Deal and its process of implementation, and to aim for a simple system that could be easily understood and implemented on a broad scale.

An example of this new approach is the criteria used to calculate the monthly individual bonuses in the hospital. From the experience in Sotnikum, MSF understood that a quality-related payment system was difficult to implement. In Sotnikum, the evaluation grids designed for the hospital were not really accepted and referred to by the managers.

Instead of enforcing a similar system, MSF let the Thmar Pouk managers adopt a simpler one based only on fundamental rules (respect for working time, no illegal payments, no misappropriation of drugs, and no 'poaching' of patients), but with a strict obligation of compliance. This option was also more in line with the specific constraints in Thmar Pouk: the obligation to get off to a quick start and on a broad scale, and the limited amount of the expected bonus.[22] Subsequent experience confirmed the wisdom of selecting this option.

A progressive process

In mid-December 2000, the New Deal started simultaneously in all the health facilities in Thmar Pouk town: the hospital, the urban health centre (Kum Ru) and the ODO. In return for its early commitment, the latter had to receive early compensation and, after the experience of Sotnikum, it was judged preferable to include all the MoH staff working in the same town in order to avoid jealousy.

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[21] The quality and content of the package of services were already well established when the Swiss Red Cross started its health-financing scheme in Takeo. The reputation of the hospital was good and it already had a large clientele.

[22] This is one lesson we draw from various experiences with incentive scheme in other developing countries: making a bonus conditional on quality when the amount is not even sufficient to cover a worker's basic needs is perceived as unfair and is therefore doomed to fail.

Subsequently, health centres have been included only if they fulfil certain criteria.[23] The first rural health centre was included in April, a second one in May, and a third one two months later. The other health centres had not yet fulfilled the criteria in late 2001.

A comprehensive project

It is important to remember that any New Deal run by MSF is part of a more general MSF project. In 2001, this was supported by a team of two or three expatriates and six national staff (excluding a support staff of guards and drivers).

In 2001, several investments were made in the district, including the construction of new obstetrics and medical wards in the hospital. Training has also been an important part of MSF's support to the district. As in Sotnikum, a combination of three strategies was adopted for hospital staff. The training partners were the National Paediatric Hospital, the Calmette Hospital and Takeo Provincial Hospital.

The results so far

The Health Financing Scheme

In Thmar Pouk, the New Deal had to deal with tight economic constraints. For reasons of sustainability, MSF decided that its financial contribution should not exceed 15-20% of the entire cost of the district health care system. At the same time, user fees were kept very low because the population is quite poor. Clearly, the financial means available were largely dependent on the release of government funds, to a considerably greater extent than in Sotnikum.

As regards national budgets, 2001 saw some mixed results. Certainly, in absolute terms, the OD had good access to ADD budgets. All eight 'steps' arrived and the 'cuts' were limited to 9%.[24] But, in fact, the 'steps' were all considerably delayed.[25] By September 2001, despite (thanks to?) constant lobbying by MSF and the ODO, and despite an outbreak of dengue, the OD had accessed only 33% of its ADD budget and hardly any chapter 11 funds. For the hospital, overwhelmed with dengue patients, there really was a problem.

As regards chapter 11 funds, access has been poorer. Only 31% of the total budget (US$38,718) was released (US$11,913). Because of 'cuts', the OD actually received

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[23] The criteria are: (1) good understanding and acceptance of the New Deal by the whole staff; (2) a track record of transparency in regard to services and finance; (3) the provision of the Minimal Package of Activities; (4) community acceptance and participation; (5) acceptance of control and sanctions; (6) reasonable staffing levels (five to seven people); and (7) a minimum user rate of 0.4 new consultations per inhabitant and per year calculated over the previous three months. Only when these criteria were fulfilled could the Steering Committee give the green light to start with a contract for an initial three months.

[24] ADD budgets are disbursed directly to the OD director by the MoH in Phnom Penh, thus bypassing the provincial level completely. This system was introduced a few years ago to guarantee the OD a greater effective share of their budgets by avoiding the high 'transaction costs' at the provincial level (Provincial Governor, PHD and Treasury). For more information about ADD, PAP and different budget chapters, refer to the 2001 report.

[25] The last two 'steps' (i.e. 25% of the budget) arrived in April 2002!

only US$7,744. This amount consisted of funding for patient food for 11 months and US$1,282 petty cash to help the OD to cope with the dengue epidemic. However, this is already an improvement compared to 2000 (only US$4,883 received, equivalent to the cost of nine months' food for patients).

Thmar Pouk OD thus suffers from similar evils to those facing Sotnikum: the national budget is difficult to access, its release is unpredictable and is organised not according to the regular needs at the lower levels, but to the objectives at the top (meaning the massive release of funds annually, but at the end of the budgetary year). This definitely does not facilitate the regular execution of activities.

Nevertheless, in Thmar Pouk, as in Sotnikum, access to the national budget keeps on improving. This is probably one of the great achievements of the New Deal dynamic and the pressure exerted by the Steering Committee. Therefore, despite the unfavourable environment, the Health Financing Scheme seems to be working out satisfactorily in Thmar Pouk (Figure 7).

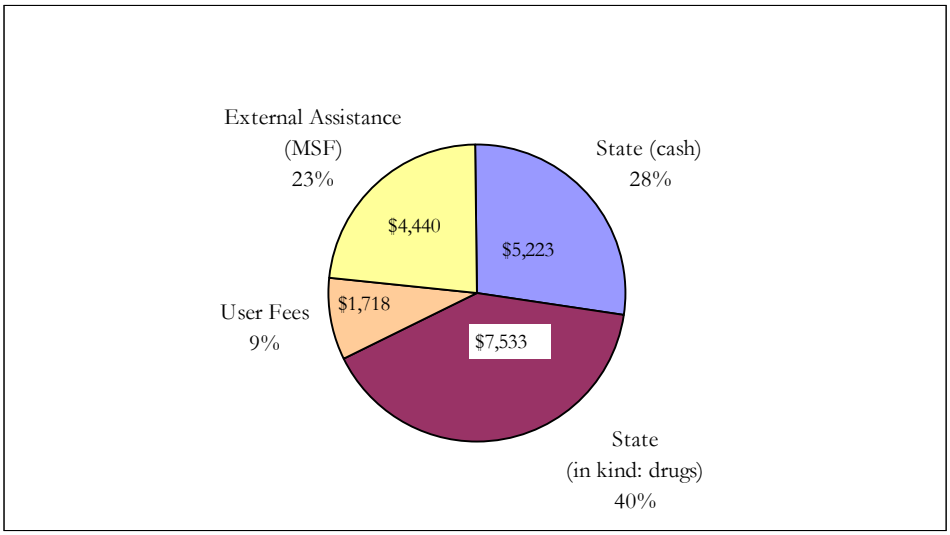

Figure 7: Thmar Pouk OD: breakdown of average monthly income (2001)

To guarantee a bonus high enough to really motivate the staff, the health economists advocated for a reduction in staff numbers in the facilities involved in the New Deal. MSF pushed for that to happen, but the managers resisted. Eventually, a compromise was agreed setting a maximum of seven staff per health centre.

		Individual Monthly Bonus		
Facility	# of months	Highest	Lowest	Average
Operational District Office	12	58	16	36
Hospital	12	61	14	40
Kum Ru Health Centre	12	47	19	33
Slor Kram Health Centre	9	43	24	32
Ban Trakouan Health Centre	8	47	37	39
Bantey Chmar Health Centre	6	29	21	24

Table 2: Spread of monthly average bonus in 2001 (in US$)

Because of lower user rates and lower fees, this staffing arrangement eventually led to average bonuses in Thmar Pouk that are roughly half those in Sotnikum (compare with Table 1 on page 19).[27]

Activities

Despite the severe constraints, the New Deal has undoubtedly had a positive impact on Thmar Pouk district. In Kum Ru health centre, the number of consultations increased by 42% in comparison with 2000. But in other health centres, the increase has been less spectacular (Slo Kram +24%, Ban Trakun, +30%, Bantey Chmar, 0%). This was clearly far below expectations.

Low individual bonuses may be part of the explanation. The limited success in reducing the number of staff included in the New Deal is surely not irrelevant. In fact, it is not surprising that in a co-operative type of governance model, where the staff is somehow co-owner of the health centre, staff members cannot solve the overstaffing problem by themselves; of course, as a co-owner, a worker will not vote for his/her own dismissal.[28] Solutions will have to come from the top or from increased activities. Consequently, in late 2001, the ODO and the Steering Committee decided that specific measures would have to be taken in 2002 to redress the dynamic of the New Deal at health centre level.

Although the health economists did not say so outright, while carrying out their consultancy, they were sceptical about the future of Thmar Pouk hospital. If MSF doctors had been unable to increase the number of patients after years of effort (Figure 8), why should the situation radically change with the New Deal? In June 2000, it was clear that only a few people considered the hospital as an appropriate place to seek care. The reasons for the economists' scepticism were obvious: the catchment area was small, there was no operating theatre and a Provincial Hospital was not very far away, most staff members were poorly trained and staff morale was low.

But a few months into the New Deal, the hospital staff had proved these pessimistic forecasts to be wrong. The level of activities rocketed well above the high assumptions of the financial projections. Today, we can consider that the New Deal has totally transformed the once 'unpromising hospital'.

The first proof is, of course, the explosion in activities. From 2000 to 2001, there has been an increase of 260% (Figure 8). Certainly, a part of the increase in attendance was due to a dengue epidemic between May and October 2001.[29] But this is only a partial explanation. It seems likely that the hospital staff would not have accepted such a high workload during the outbreak without an increased income, something that was

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[27] It is nevertheless important to note that these bonuses do not include income earned from overtime (national budget) and the per diems received from other international organisations. In fact, some staff received incentives that are really higher than these bonuses, especially during the dengue epidemic, or during training seminars.

[28] Another distribution of ownership rights would probably help to solve this issue. For example, in Pearang (a 'contracting-in' district), each health centre is sub-contracted as a concession to an individual manager and he decides how many employees are needed to run it.

[29] Dengue admissions accounted for 20% of total admissions in 2001. For more details, see: "Dengue Epidemic in Thmar Pouk Operational District", Van Leemput, Phoeurn and Van Damme, MSF Phnom Penh and Sisophon, 2002.

achieved with the New Deal. Nor would so many parents have brought their children to the hospital in the absence of a New Deal.

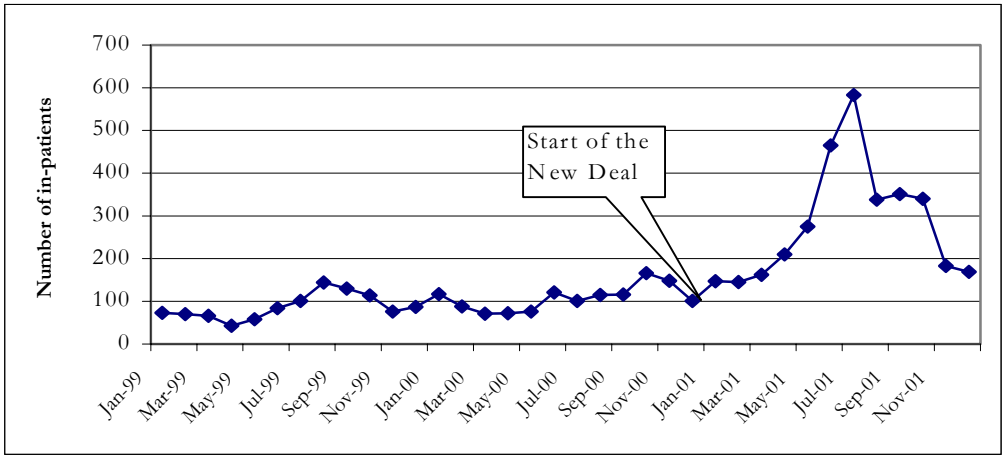

Figure 8: In-patients (TB included) at Thmar Pouk Referral Hospital (1999-2001)

But even more striking than the figures, is the work climate prevailing in Thmar Pouk hospital. Under the managers' leadership, the staff is really eager to improve service delivery. There are clearly still many things to improve (and the poor qualifications of some nurses is a constraint that looks likely to remain), but a general improvement can be felt in the dynamic of the effort expended. The improved hygiene in the wards and on the compound is a good indicator of that.

The success of the referral hospital in dealing with the dengue outbreak has clearly enhanced its reputation in the eyes of the surrounding population. In late 2001, attendance remained high. The hospital is now regarded as the place to go to for general medicine and paediatrics. Obstetrics remains the main concern. This is a problem that has been identified for some time. In order to tackle it, two primary midwives were sent to take part in an MoH upgrading course two years ago. Once graduated (in April 2002), they will come back to the hospital as secondary midwives. In the meantime, four midwives have been sent to Takeo Hospital for two months' practical training. The OD Mother-and-Child Health supervisor also provided training in the obstetric wards, and all midwives followed one week's practical Sexually Transmitted Infections training in the MSF clinic in Sisophon. With all this investment in training, it is hoped that activity in the obstetrical ward will increase in 2002.

In terms of sustainability, it can be considered that the hospital is also on the right track. Financial dependence on MSF is limited, as there is undoubtedly room for increasing the fees. Managerial abilities are also improving. The director of the referral hospital has continued to show initiative and independence in his decision-making, and willingness to sanction breaches of contracts (sales of blood and under-the-table payments) that occurred in 2001.

A few words about the ODO. As elsewhere in Cambodia, the exact mission of the ODO has not yet been totally grasped by the management team in Thmar Pouk (see chapter 5, page 48). The move from a top-down routine administration to proactive management, including development of a vision and forward planning, has not yet been fully achieved. But there are reasons for hope.

In March, a new body, the Operational District Management Committee was set up. Its main role is to discuss management and policy issues related to the New Deal. Meetings are held twice a month. They are chaired by the OD director and the members include key staff of the OD and the hospital, and gradually, as more health centres are included in the New Deal, the health centre chiefs as well. This committee has been quite active throughout the year: meetings are well attended and lively discussions precede the taking of decisions. An original model of district management seems under construction in Thmar Pouk.

The main reason for satisfaction and pride is certainly the capacity for reactivity demonstrated by the ODO during the dengue outbreak. Throughout the epidemic, the ODO continued to look for ways to find additional human and other resources (funding, equipment, drugs, etc.). The final success owes a lot to their constant support.

Other evidence (e.g. the capacity of the ODO to raise funding from donors and agencies to develop new activities) makes us believe that Thmar Pouk OD is definitely on the right track.

A last word about the Steering Committee. After one year of existence, we can conclude that the New Deal has benefited from the positive support of all the different stakeholders in Thmar Pouk. Steering Committee meetings are held in a good atmosphere, without the kind of confrontation that can sometimes be observed in Sotnikum.

CHAPTER 4. THE HEALTH EQUITY FUNDS

The background context

The New Deal: better services, but at a higher official costs

We have already reported the low utilisation of the public facilities before the New Deal was implemented. The main explanation for this low attendance was not really a question of exclusion by the facility, but more one of rejection by a population dissatisfied with the quality of care on offer.[30]

For MSF and UNICEF, there was hence no hesitation about the priorities: the first objective had to be the provision of better services to a greater number of users. This is clearly what the New Deal aimed to achieve. At that time, the official user fees were very low in the health facilities of both districts. Keeping fees low is the strategy adopted by the government to 'guarantee' access to health care.

For the designers of the New Deal, this option had to be challenged. In fact, the main result of generalised low fees is that facilities are forbidden to collect the funding they need for running their activities. Certainly, the result is good access, but an access to hospitals deprived of staff. Moreover, as proven by the average household expenditure in the private health sector, Cambodian families are prepared to pay a lot for health care. The strategy adopted by the New Deal in Takeo, then in Sotnikum and Thmar Pouk, is thus the reverse of the official approach: an increase in the level of fees (after consultation with representatives of the population) to allow the facilities to tap more resources in order to carry out their activities, especially to pay bonuses to their staff. In chapters 2 and 3, we have provided evidence of the relevance of this strategy. It is nevertheless obvious that because of this increase in fees, especially at the hospital, one problem was not solved: access for the poorer. A solution had to be found.

Health Equity Fund sub-contracted to a local NGO

Poor patients and the failure of fee waivers

User fees in health facilities can constitute a major barrier for the population in regard to its access to health care. The issue is particularly critical for hospital care as the technicality, intensity and duration of the care delivered to an in-patient often leads to significant costs. If the cost recovery rate is too ambitious, then this is synonymous with user fees that are unaffordable to the poor. Moreover, most of the population has no hospital in its immediate vicinity. Transportation and the 'opportunity costs' involved in accompanying the patient also constitute a heavy burden for the poorest.

The fact that access to hospital care is a major issue in developing countries, especially for the poor, is today widely acknowledged at both national and international level. Nevertheless, solutions are still lagging behind. In most countries,

[30] But it is clear that some coping mechanisms developed by the staff were a barrier to access, especially for the poorest.

waivers are formally in place, but evidence is accumulating that they most often do not achieve the objective of improving access for the poor.[31]

What is the situation in Cambodia? According to the National Charter on Health Financing, each health facility has to identify and exempt the poor. However, given the current funding pattern and the fact that a facility's staff is obliged to decide on who to exempt among its patients, there is a limit to the number of exemptions granted as each patient exempted represents a financial loss to the staff. Some patients (not necessarily poor patients) may be accepted free of charge, but just enough of them to comply with official instructions and safeguard the facility's reputation. Moreover, even if this solution were implemented, it would only be a half-solution. The poor have many more obstacles to overcome, and they also have specific needs. Without a good understanding of these, all solutions will remain just hasty and face-saving exercises. It is therefore not surprising that the poor are under-represented among hospital users in Cambodia today.[32]

An alternative to waivers: a purchaser fund entrusted to an independent institution

The New Deal established incentives for improving the collection of fees at the level of the health facilities. Simultaneously imposing a requirement on the hospitals to accept poor patients free of charge would have given a contradictory message. To avoid this pitfall, it was decided to split the functions and the roles.

The first thing to do was to create an incentive for the referral hospital to accept poor patients. The fact that, as the poor are unable to pay, and therefore cannot provide an incentive for the hospital, this does not mean that the hospital has to bear the costs of improved access. In fact, it is more logical that, as with any producer of goods or services, the hospital should receive compensation for each poor patient accepted. The straightforward idea would be a level of compensation equal to the amount paid by the better-off. However, if this option is retained, somebody else has to pay the user fees that the poor patients should have paid. A special fund therefore has to be set-up. In Thmar Pouk, MSF was prepared to finance such a fund. In Sotnikum, MSF's and UNICEF's 'joint venture' was extended to include the fund. From now on, poor patients would be a source of income for the hospital.

The second question concerned who should be entrusted with this fund. Indeed, somebody has to be accountable to the donor in regard to the correct utilisation of the money involved. By correct utilisation, we mean: good targeting and good management of the expenditures.

A first option would have been to entrust the fund to the hospital itself. But, again, we are then faced with a conflict of interests. As far as the hospital is concerned, the fundamental objective is to increase revenue, whatever the profile of the user. With this pattern of incentives, it would be in the hospital's interest to spend the money from the fund and disregard the requirements of correct targeting and real protection

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[31] For good reviews of experiences elsewhere: "Protecting the Poor Under Cost Recovery: The Role of Means Testing", C. Y. Willis and C. Leighton, Health Policy and Planning, 10, pp 241-256, 1995; "Indigence and Access to Health Care in Sub-Saharan Africa", F. Stierle, M. Kaddar, A. Tchicaya and B. Schmidt-Ehry, International Journal of Health Planning Management, 14, pp 81-105, 1999.

[32] "A Poverty Profile of Cambodia – 1997", Ministry of Planning, Cambodia.

of the poor. To maximise profit, the hospital would be tempted to forget about targeting and avoid allocating resources to social care and patient follow-up. In addition, there would be no interest in advocating for the rights of the poor inside the hospital.

If we really want the fund to serve the poor, we must chose an operator more independent of the hospital and with institutional interests that are more in line with those of the poor. The fund would then be entrusted to an agent who would purchase care for the poor. In the literature, such a set-up is referred as a "purchaser-provider split".

Theoretically, we could think of different bodies that could play this purchaser role: a welfare service attached to the Ministry of Social Affairs, an NGO, a community body or even a private profit-making institution.[33]

Indeed, the main criterion concerns the mechanisms for ensuring that the operator will be accountable to the donors and will really strive for an improvement in the situation of the poor. The best solution, of course, is to find an actor whose mission statement and values express a real commitment to the protection of the poor. But this is not enough; we must also ensure the presence of accountability mechanisms that will prevent the operator deviating from the objective assigned.

The actor chosen will vary according to the context. In Cambodia, local social welfare NGOs seem to be particularly appropriate. Their mission statement is to take care of the poor. Consequently, they have developed expertise and experience in providing appropriate services for them. Their workers could also be expected to have an education, a personal history, and values and interests that would help them in the execution of this work. These organisations are likely to be more independent of the authorities and political patronage than government bodies. They are also becoming more and more vocal and eager to prove that civil society has a role to play in Cambodia.

Moreover, the social welfare NGO market is quite competitive in Cambodia. Thanks to the support and the role model provided by international NGOs, there has been a blossoming of local NGOs over the last ten years. Quite a number of these were set up by returnees from the border camps in Thailand where they witnessed 'good will entrepreneurship' at close hand. This situation means that there are local NGOs ready to play some role in identifying the poor and taking care of them, even in quite remote hospitals. The existence of institutional alternatives is a major guarantee that local NGOs will take care to fulfil their role correctly. Indeed, the failure to do so would be sanctioned in a very straightforward manner: the donor would terminate the contract and entrust it to another NGO. Is there any better accountability mechanism?

Targeting and the package of services delivered

The main objective of a Health Equity Fund is clearly to exempt the poor from paying hospital fees. The first step is therefore to identify the poor among the patients arriving at the hospital. Good targeting is, of course, of paramount importance.

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[33] MSF was never interested in doing the job itself. Indeed, as an international medical organisation, MSF has no expertise in the identification of the poor and faces relatively high staff costs. A local body is not only more cost-effective, but also represents a step towards institutional sustainability.

Efforts should be made to avoid the denial of benefits to the poor ('exclusion error': not identifying a poor user as such), but also to avoid them being granted to the better off ('inclusion error': mistakenly identifying a non-poor user as poor). If the first error occurs, this can be regarded as a hole in the safety net mechanism. If the second error occurs, then there the fund has sprung a leak with some resources earmarked for the poor going to people who do not need them.

The second subject of concern is the package of services provided for those identified as poor. Although paying hospital fee is the fund's *raison d'être*, it can, however, also cover other costs faced by patients. Transportation costs are an important barrier to access, especially for those coming from remote areas. But a hospital stay entails other expenses, which can accumulate into a major burden for the poor, especially in regard to food for accompanying relatives, and cooking materials.

Once there is a social worker inside the hospital compound, it would be a pity to limit his/her function to paying fees and buying teapots. Many poor suffer from some kind of social exclusion and stigma. Coming to the hospital can be a really daunting experience for them. The social workers could therefore provide an empathic presence and ensure both social care and the protection of the rights and dignity of the poor during their hospital stay. Prejudices about poor people exist in every culture, including among hospital staff. A go-between can have a role to play.

Eventually, if a relationship of confidence is developed between the patient and the social worker, this provides a new opportunity to coach poor patients in regard to their future needs. Of course, it will not be possible to solve all their problems, but some support and advice can be given.

Implementation in Thmar Pouk and Sotnikum

Health Equity Funds in both hospitals

The first Health Equity Fund was created in Thmar Pouk hospital in May 2000 (hence seven months before the start of the New Deal in this district). The contracting NGO, the Cambodian Association for Assistance to Families and Widows (CAAFW), was already present in the Province and involved in welfare services. The Health Equity Fund in Sotnikum was initiated on September 2000. The contracting NGO there is Cambodian Family Development Services (CFDS), one of the biggest Cambodian social welfare NGOs.

The Health Equity Fund functions similarly in both districts. The basic principle is to take care of poor patients once they arrive at the hospital. This is clearly a limitation (see discussion below), but it has huge advantages in terms of operationality and cost-effectiveness.

Patients, or one of their relatives can apply for support from the Health Equity Fund. In practice, the hospital staff refers patients unable to pay to the local NGO, which has an office on the hospital compound. The social worker from the local NGO then verifies eligibility through an in-depth interview. The NGO does not reveal the criteria used. They justify this as a way to prevent fake declarations, deliberately adapted to meet the criteria. This first meeting is also the opportunity for the social worker to determine any additional support required by the patient, such as cooking materials, food or reimbursement for the transport costs incurred.

Through daily visits, the social worker of the local NGO then makes sure that the poor patient gets the attention needed. These visits to the wards are also an opportunity to 'retroactivate' the targeting: the social worker tries to identify poor patients who paid the fee, but should have benefited from the exemption mechanism. Initially, both Health Equity Funds were managed by one social worker. Later a second one was hired to guarantee a service seven days a week, to do some patient follow-up in their home villages (including better assessments of further health needs for particular beneficiaries) and to improve community awareness.

Results

A major improvement for the poor

The number of patients assisted by the Health Equity Fund has increased progressively over the year (see Sotnikum data in Figure 9). In December 2001, respectively 26% and 25% of all in-patients in Thmar Pouk and Sotnikum were exempted. For the whole of 2001, they accounted for some 15% of hospital user fees. The poor are beginning to be a really lucrative source of activity for the hospitals and their staff.

A survey gave some evidence of the quality of the targeting.[34] Inclusion errors looked to be close to nil and exclusion errors seemed to be rare. The identification is in fact very precise. Thanks to the presence of the social NGO in the wards, it is even possible to deliver progressive support: the extremely poor get more support than the moderately poor.

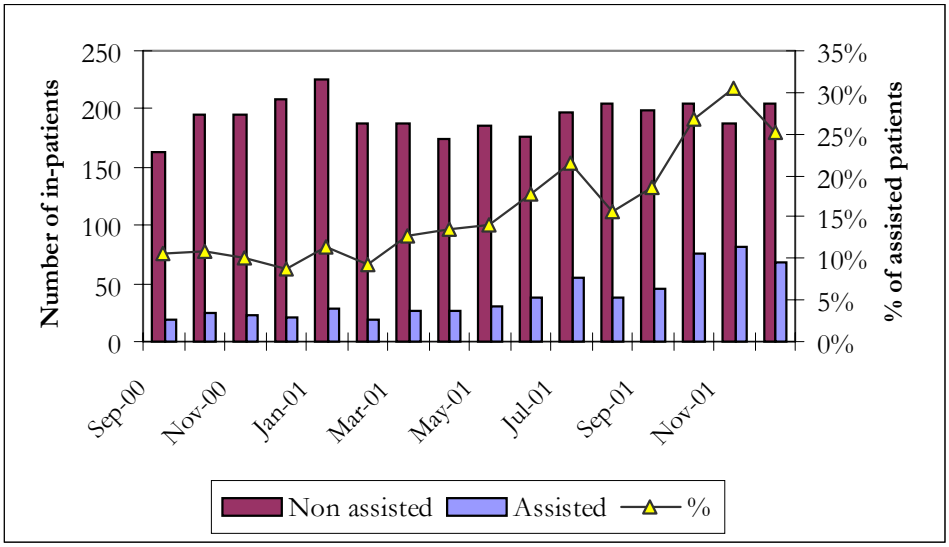

Figure 9: In-patients assisted by the Health Equity Fund in Sotnikum hospital

In terms of benefits, it is also important to note that by getting support from the social NGO, the poor are admitted to the hospital without paying, and thus have access to the other sources of hospital funding (the state and the international NGO).

[34] "Considering Equity in Health Sector Reform, Case study of a New Deal in Sotnikum, Cambodia", W. Hardeman, Working Paper Series No. 361, Institute of Social Studies, The Hague, February 2002. The reader is referred to this document for an extensive assessment of the Health Equity Fund in Sotnikum.

A payment by the Health Equity Fund of US$10 in Sotnikum (US$6 in Thmar Pouk) gives the patient access to hospitalisation, which has a real cost of US$48 (US$28 in Thmar Pouk). This multiplier effect, combined with near absence of leakage to the non-poor and the very low operational costs, (Figure 10) leads to a greater transfer of resources to the poor than the total cost of the Health Equity Fund.

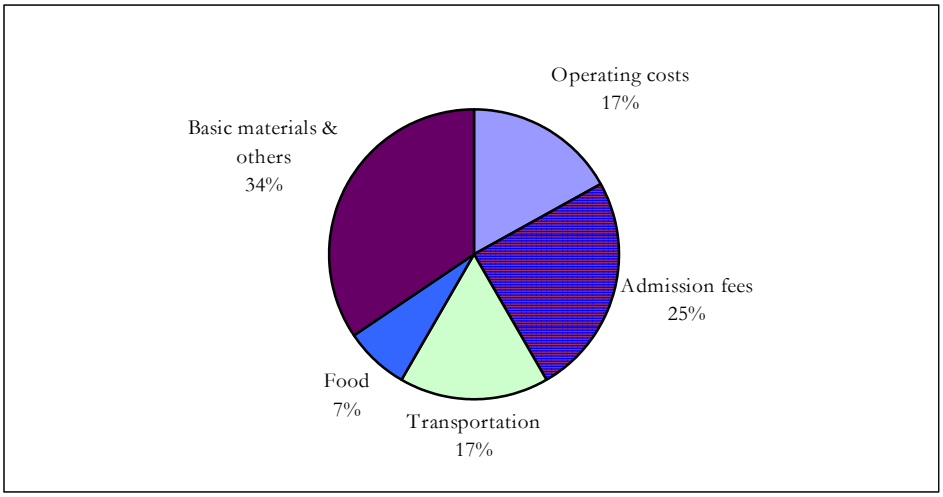

Figure 10: Health Equity Fund in Thmar Pouk: breakdown of expenditure (2001)

Shortcomings in terms of coverage

Although the Health Equity Funds in Sotnikum and Thmar Pouk have improved financial access for poor in-patients, many potential beneficiaries are still not coming to the hospital. While 20-25% of in-patients are supported by the Health Equity Fund, the proportion of people under the poverty line is probably closer to 40% in Sotnikum and even higher in Thmar Pouk.[35]

A significant number of poor people continue to delay seeking hospital care. There are several reasons for this, such as:

1. A preference for being cared for at home by informal private health practitioners;
2. A lack of information about public health care and the Health Equity Fund;
3. Uncertainty about their eligibility for support from the Health Equity Fund;
4. A lack of money to pay for transport;
5. Lost income due to lost time at work (opportunity cost);
6. No-one to accompany the patient to the hospital or to take care of dependents at home; and
7. A lack of physical access (i.e. remote areas).

For too many of them, the Health Equity Fund also comes too late in terms of welfare: the initial resort to ineffective and expensive treatments in the informal sector

[35] The figure given by "A Poverty Profile of Cambodia – 1997" is 43% for rural areas.

has already considerably reduced their assets. As a result, they are already financially ruined when they arrive at the hospital.[36]

As the Health Equity Funds function at present, most of these remaining obstacles to hospital care are not being tackled. Some additional measures clearly have to be taken. An initial one could be to organise an information campaign about the Health Equity Fund and the general improvement of services at the hospitals. It would also be interesting to test some active identifications and the distribution of exemption cards at the community level. So, improvements in the Health Equity Fund are still needed. This is part of the MSF programme for 2002.

We discuss the more general prospects for the poor in the next chapter.

[36] During the dengue outbreak in Thmar Pouk district in 2001, many people paid over US$100 to the private sector (thereby becoming indebted and having to sell off assets), while treatment was available at the hospital for US$6.

CHAPTER 5. LESSONS LEARNED

After two years of the New Deal experience (and even five if Takeo is taken into account), it is certainly valid to draw more general lessons. In this report, we have identified three topics. The first one covers the insights provided by the New Deal experience for the development of health districts in Cambodia. The second topic is a plea based on the emerging conviction that poverty and illness are intrinsically interlinked in Cambodia and deserve simultaneous attention. The last one tries to defend the idea that there should be room for experiment and innovation within health sector reform.

The future of Cambodia's health districts: insights from the New Deal

In the early nineties, Cambodia decided to reconstruct its health sector along the systemic model of health districts. A health coverage plan was drawn up dividing the country into 69 operational districts. Each OD (covering a population of between 100,000 and 200,000 inhabitants) was allotted one referral hospital, a network of health centres (one for every 10-12,000 inhabitants on average) and an OD office (ODO).

Over the following years, donors, development banks, international agencies and NGOs have supported the government in its effort to develop the public health system. Alongside the health coverage plan, there have been significant investments in infrastructure and equipment. A great deal of effort has been made to upgrade the skills of health staff at different levels of the MoH pyramid through training, workshops and the preparation of guidelines.

There is no doubt that these efforts have been valuable and have set Cambodia's health system on the right track. It cannot be denied that major improvements have been made over ten years. In comparison with other Cambodian government departments, the MoH can be proud of how it now functions and what is has achieved. Nevertheless, it is also clear that the health sector reform is not yet delivering the dramatic improvement the population has the right to expect. The general health status remains low, illness is increasingly a cause of poverty and the public facilities are under-utilised and not sufficiently responsive to the demands of the population.

Health sector reform requires a permanent process of questioning achievements, identifying challenges and solving bottlenecks. We think that the New Deal experience, together with other field projects, can provide interesting insights into the challenges and possible solutions for health districts in Cambodia.

In this report, we have decided to focus on three issues: (1) incentives, (2) management capacity and (3) accountability. In our opinion, these are three of the major challenges presently facing the public health system in Cambodia. Our concern is that, if these issues are not tackled, the health sector reform will fall short of its ambitions and fail to deliver the services needed by the Cambodian population, and especially the poor.

(1) The importance of performance incentives

If there is only one lesson to be drawn from the New Deal and similar experiments, such as 'contracting-in' in Pearang, it is that: there is a need for a fundamental revision of the incentive framework within the Cambodian public health services. Without it, there is a risk that an effective national health system will remain a dream.

By 'incentive framework', we do not only refer to equitable incomes for health staff. We point to the whole set of mechanisms that motivate the different health agents to fulfil their missions and perform their functions correctly.

Today, the existing incentive set-up does not support good performance. For instance, the government budgets are hardly linked to activities.[37] Why would an OD director develop his district when the budget for the ODO is the same no matter what activities are delivered or what coverage is achieved? His own future and present income is not linked to his achievements. Can we really expect an OD director to provide a vision and creative initiatives, and take risks? And perhaps even more significantly, as embezzlement is presently hardly ever sanctioned, it is probably more interesting not to be supported by an international and demanding organisation. "*Pour vivre heureux, vivons cachés*". The picture is just the same for the hospital. Today, the number of patients hardly has any influence on the national budget. Hospital directors are not personally encouraged to develop their hospital: neither their careers nor their incomes are related to their performance.

As long as this perverse incentive framework remains unchanged, the performance of the national health system will remain disappointing. Managers have no incentive to strive to improve their districts and facilities. The impressive results of Sotnikum, Thmar Pouk, Takeo or Pearang are all clearly the consequence of performance-related incentives: the facilities and the individual workers have to earn their income. The rule that "the more you do and the better you do, the more you get" should be applied to the whole national health system.

Performance must become a greater determinant of income than it is at present. However, we do not ignore the fact that performance-related pay has limitations, especially at the individual level. In Cambodia, we also believe that some aspects, such as performance indicators, monitoring costs and the feeling of ownership, still have to be worked out or improved. Nevertheless, we make a strong plea for continuing, deepening and extending the current experiments. Without this reshaping of incentives, there is a risk that the health coverage plan will indeed remain only a plan, with limited impact on the population.

(2) Further strengthening managerial abilities in the health system

Incentives alone will not be enough: whatever the prize, victory is not won in a day. In the previous report, we already stressed the importance of investing in human capital to get an effective health system. The MoH and the different stakeholders are quite aware of this need.

At this stage of implementing the health district model in Cambodia, our main concern is about the capacity of the district management teams. Referring to manuals and successful experiments in other countries, it is clear that the Cambodian OD

[37] An example from the 2002 national budget for Siem Reap Province: Sotnikum district will receive a budget only 50% greater than that of Kralanh district, despite a level of activity that was three times higher in 2001.

offices are still far from being what could be expected from a district management team.

In fact, if the basic functions (drug supplies, administration, public finance, etc.) have been quite well assimilated by many ODOs, they are still lagging behind in regard to the more complex roles, process and functions, such as effective problem-solving and planning.

An example of role: leadership

In its reference document for Asia, the WHO stresses the importance of good leadership from the district director.[38]

> "This leadership role involves:
>
> 1. setting the direction: challenging the status quo, viewing things broadly, making choices, being flexible, creating a vision and strategies;
> 2. aligning people: communicating with staff, community, other agencies, keeping messages simple, allowing constructive questioning, maximising credibility, recognizing the size of the task;
> 3. motivating and inspiring: appealing to the values of staff and the community, providing autonomy, encouraging, recognizing and rewarding."

Nobody will contest that too few district managers practice this kind of leadership today in Cambodia. In particular, the dimension of 'setting the direction' is missing. Too many managers take refuge in routine administrative tasks.

An example of process: teamwork

Teamwork is at the core of the district model. Teams are everywhere: in general management (e.g. district office), short-term interventions (e.g. dengue outbreak), specific issues or projects (e.g. quality assurance) and of course within the facilities themselves (e.g. health centre or hospital ward).

Our assessment is that teamwork is still not fully practised in the Cambodian health system. Responsibilities are not clearly stated, managers are reluctant to delegate tasks, exchanges and communications are too rare, meetings are usually very much 'top-down' sessions, etc. This is particularly damaging at ODO level.

An example in regard to function: quality management

Quality in regard to health care and services is not only a matter of initial qualifications and appropriate equipment. Quality can only be sustained by permanent vigilance and a continuous process of improvement, taking into consideration not only managerial logic, but also including the views of providers and their patients.

It is clearly one of the functions of the district management team to set up mechanisms to sustain and improve the quality of the services delivered. The planning and organisation of continuous training, problem solving, field supervision and quality assurance should be included among the different tasks of the district management team.

These tasks call for specific profiles and skills: seniority, personal experience in the field taught or supervised, clinical knowledge, communication abilities and empathy, an analytical mind, commitment to improvement, an aptitude for problem solving, etc.

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[38] "District Health Facilities: Guidelines for Development and Operations", WHO, Western Pacific Series No. 22, part V, pp 241-280, 1998.

Most ODO team members in Cambodia do not really correspond to this profile at the moment. Maybe because of the lack of standards of excellence that can be referred to locally, quality is too often a concern only for the supporting NGO (whose staff may indeed be more aware of the limitations in the Cambodian system as the result of experience in other countries).

Local constraints must be acknowledged. Dramatic changes should not be expected overnight. But we sometimes feel quite alone in defending the right of patients to receive effective care.

The move forward

The improvements made over recent years cannot be denied. Because of the wholesale slaughter of the Pol Pot years, Cambodia had to start again, nearly from scratch. And management is certainly improving in the country's health system; at least in the two districts we know best.

But, the MoH and aid agencies should not overestimate the present level of managerial ability in Cambodia's health districts. This is particularly worrying at this stage of the health system's development when the responsibilities of the co-ordinating body, the ODO, are of major importance. Today most of the ODOs fall short of their mission.

The effort to develop their abilities has to be maintained. Management training, such as that delivered by the National Institute of Public Health (NIPH), must be supported and expanded. New tools should probably also be introduced.[39] And, as mentioned before, managers have to be assessed and rewarded according to their achievements.

Managers should become more accountable

Although we agree (1) to link the incomes of individuals and institutions to their performance, and (2) to help them to improve performance through capacity building, we are not sure yet that results will follow.

Indeed, before granting the supplementary income to the agents, there must be certainty that their performance has really improved. The 'purchaser' must be able to assess the results, be sure that the contract has been fulfilled and enforce sanctions if necessary. To ensure such accountability, we need two major mechanisms: (1) a full disclosure of information (transparency, reporting, accounting, auditing, meetings, feedback to the population, a free press, etc.), and (2) the ability to impose sanctions on the agent (a contractual capacity to financial sanctions, a contract interruption clause, the possibility of an appeal to justice, the opportunity of making a contract with another agent in the 'market', etc.). The first aspect, the full disclosure of information, guarantees that the purchaser has a full capacity to assess whether a contract has been fulfilled. The second aspect, gives the purchaser the ability to sanction an agent who does not fulfil his/her commitment.

Outside observers of the New Deal sometimes tend to overlook this dimension of the experiment. In our opinion, it is clearly the reverse side of the coin: incentives can work only if the agent is accountable to the purchaser. If the rules are not enforced, improvements may remain limited.

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[39] See, for example: "Health Sector Decentralization and Management: Developing a District General Policy on Management", C. Collins and C. Barker, Tropical Doctor, 31, pp 11-15, 2001.

Referral hospitals as case studies

In this report, we have described the situation prevailing in both district hospitals in 2001. This can be described in a nutshell: (1) in Sotnikum, the referral hospital received little support from its ODO, the hospital director was reluctant to embrace participatory management, the director's decisions and behaviour were regularly in contradiction to the founding principles of the New Deal approach; and (2) in Thmar Pouk, there was a positive complicity between the ODO and the referral hospital, the management was somehow more participatory, and the director strove to stay in line with the New Deal philosophy.

In the face of a situation such as that in Sotnikum, the temptation – especially for a powerful NGO – is, of course, to point to individuals and their personalities. The solution then comes easily (at least in theory; politically it can be considerably more difficult): remove the obstacle and appoint other managers who will do better. Rather than this being a problem of individuals, we think that the chronic frustration in Sotnikum hospital illustrates the limits of the *governance model* that is in place today in the referral hospitals in Cambodia.

Of course, we are not inside the MoH, so it is not easy for us to understand all the ins and outs. Nevertheless, what we observe in general in the country is that managers are not very accountable, neither to their hierarchy, nor to the population (users, local community, civil authority, etc.).

Why do managers seem not to be very accountable to their hierarchical superiors? We can risk a speculative explanation. First, the term 'hierarchy' is misleading in the Cambodian context. In Cambodia, a hierarchy is not really a constituted body to which individuals are accountable (in line with a national policy, pre-declared objectives, internal rules, regular reporting, auditing mechanisms, disciplinary measures, etc.). The hierarchy is more likely to be represented by an individual boss with whom there is a personal relationship. From an external viewpoint, the interaction between one level and its subordinate levels seems to develop alongside a continuous process of personal transactions and obligations. Of course, there are rules, but some seem to be enforced mainly when they provide the 'hierarchy' with additional power in the game of interpersonal transactions. The way that budget and accounting procedures are used in the recurrent bargaining over national budgets is a good example of that mechanism.

Second, the classical system of rewards and sanctions available to the public administration does not seem to be operating. To our knowledge, sanctions are not being applied within the Cambodian public health system. Maybe because of the very low salaries, major failures or errors are not punished. The opportunities for progressing in a career also seem quite limited. The dynamic turnover in management positions that exists in many other developing countries is not seen in Cambodia. This absence of career prospects within the MoH certainly does not encourage managers to develop the facilities they are responsible for, whereas taking care of their own business affairs (private practice, manipulating their positions in order to extract additional income, etc.) is certainly more beneficial.

Why do the managers of public facilities not seem to be very accountable to the population or its representatives? In this aspect, it cannot be said that Cambodia is radically different from the majority of developing countries. The immediate consequence is nevertheless the same lack of responsiveness to the users that we observe elsewhere. As a consequence of this lack of accountability, which is further

compounded by the low incomes for staff, absenteeism and coping mechanisms are widespread.

To return to our 'case study' of Sotnikum, if our analysis is correct, replacing the individual with someone else will not bring about a definitive solution. It is structural reform that is needed: it is the *governance model* itself that must be changed for the hospital.[40]

At this stage, it is of course impossible to provide a blueprint of the institutional changes that should be introduced. Our basic recommendations would be:

(1) To get the policy makers to recognise the reality of the problem: hospital directors, and managers in general, have to be accountable;

(2) To study the different governance models existing in Cambodia today;[41]

(3) To accumulate knowledge about different governance models in other countries; and

(4) To develop pilot experiences in a few districts in Cambodia.

In terms of innovations, our suggestions would be (1) to give more autonomy to the hospitals, (2) to set up a performance-related pay scheme for hospital managers, (3) to offer them more career prospects, (4) to introduce clear and strict accountability mechanisms (e.g. allowing dismissal of poor performers), and (5) to establish boards of directors for the hospitals.

These suggestions are not a luxury inspired by the frustrations of a few expatriates in a remote district of Cambodia. Our belief is that the situation is probably worse in many other places. If hospital and OD managers are not more accountable, any training or increase in budget will yield only limited benefit for the populations. The 69 operational districts and referral hospitals may well remain the dream of the planners.

A 'poor-friendly' health system

Poverty and illness: a plea for a global strategy

Another major lesson from the New Deal experience is that giving the poor real access to health care calls for a specific strategy and specific resources. In fact, what the poor need is a policy tailored to their requirements: a real pro-poor policy. And a policy means: (1) political will, (2) a good understanding of the issue, (3) specific resources, (4) good strategies, and (5) regular appraisals of the achievements.

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[40] By governance, we mean the relationships between, on one side, the managers of an institution and, on the other side, its owners and the stakeholders. The nature of these relationships is mainly defined by the incentive and accountability mechanisms that must guarantee that management decisions are in line with the interests of the owners and stakeholders.

[41] For instance, there are currently different models for the health centres: in Pearang, health centres are under a concession model; in Sotnikum, we have a staff-community model; the dominant model overall in Cambodia remains the model of a public hierarchy. The results in terms of performance are clearly not similar! Takeo Provincial Hospital is another example of a very innovative governance model (most decision-making power lies in the hands of the staff, particularly the surgeons).

Political will guarantees that the decision-makers and stakeholders will strive relentlessly to find a solution to the problem. Poverty alleviation, poverty reduction or poverty prevention are indeed highly political. These terms have recently entered the discourse of the Cambodian authorities, and aid agencies have started to pay more attention to poverty. But the issue of the relationship between poverty and illness deserves a more prominent place at the top of the national agenda. The fight against poverty calls for clear objectives, a long-term commitment and a global alliance. With the Poverty Reduction Strategy Paper process, things will hopefully improve over the coming years. But the commitment must be transformed into realistic objectives for the different levels of the state pyramid, its health system included. It is important to note that the strategy must also win support from the local communities. In that sense, establishing an effective health district in a region without adequate health coverage is a prerequisite to implementing a specific solution for the poor as a sub-group. When targeting is too specific, it can sometimes be politically counterproductive.

A good understanding is necessary for the design of relevant, quality and comprehensive solutions. The barriers to health facility utilisation are indeed numerous. Besides the fees, there is the lack of knowledge, the distance, the opportunity cost of in-patients' time or that of accompanying relatives, the shame and social stigma, etc. Tackling one barrier is not enough. The solutions must be flexible enough to bring answers to problems of very different natures. Ideally, the interventions should also help us to accumulate knowledge.

Specific resources ensure commitment to the effort. For instance, if funds are clearly earmarked for facilitating the access of the poor to the hospital, it will be easier to measure their correct utilisation. The more specific an intervention's objective, the easier it is to measure its effectiveness. So, among the solutions, we may need some sort of 'National Fund for the Poor'. At the start, this fund can be financed by donors, but the government will soon have to participate financially.

Good strategies: a 'good' public intervention mainly means spreading equitably appropriate benefits to the target group in a cost-effective way. In practical terms, it means that we must have good targeting (good coverage and minimised leakage) and deliver services that are really of value to the poor. Evidence for effective strategies can be collected from the growing literature on the relationship between poverty and illness.

Measurable achievements: the impact of the policy must be measured. Methods such as *incidence analysis* (are the beneficiaries really the poor?) will be useful. The different interventions have to be assessed. Operators must be accountable, including to the poor. Local committees, councils, yearly report, working groups, benchmarking and the disclosure of information to the press will all have to be developed.

The extension of Health Equity Funds throughout the country

The Health Equity Fund is a good example of a solution that should easily find its place in such a policy. Presented in different fora, the model has gained popularity and support in Cambodia, especially among donors concerned with poverty reduction. As we are at the origin of this enthusiasm, we do not want to temper it. But before this model is scaled up to cover the whole country, we think important to express a few caveats.

A good understanding of the theoretical underpinnings

Our first recommendation to any organisation interested in setting up a Health Equity Fund is to be aware of the exact nature of the institutional model in place in Sotnikum and Thmar Pouk. Certainly, the Health Equity Funds are sources of numerous benefits (box). But these are obtained only because of a very specific institutional arrangement.

First, a Health Equity Fund brings a real health benefit to the poor only if the hospital is providing effective health care. For it to be extended over the whole country in the future, this must be the main prerequisite: implement it only in places where it can be considered that the hospital is already delivering quality health care. For other hospitals, the first intervention (or at least concomitant) must remain the upgrading of services to ensure they are of a minimal quality.

Second, the Health Equity Fund must be entrusted to a body independent of the hospital. If the fund is entrusted to hospital staff, conflicts of interests will arise and benefits will be limited for the poor and for Cambodian society in general. As an institution, the hospital has no interest in being specific in its targeting. For governance reasons, we think that local NGOs presently represent the best solution in Cambodia. However, the local NGOs are not all of the same standing. Some have more expertise than others in targeting, 'social care' and welfare assistance. Some coaching might be necessary.

The Equity Fund sub-contracted to a local NGO: A cornucopia of possible advantages?

For the poor: (1) better health through higher utilisation of hospital services; (2) prevention of poverty (by directly orienting the poor towards cheap and efficient hospitals and reducing the total costs of treatment); (3) a support responsive to specific needs; (4) social support and dignity during the hospital stay; (5) guidance, representation and protection of rights inside the hospital.
For the hospital: (6) higher government funding (in Cambodia, higher utilisation leads, through donations of drugs and a budget for running costs, to higher state budgets for the facility); (7) higher revenue from poor patients (no loss of income through exemptions); (8) higher revenue from 'rich' patients (opportunity to increase the fees for non-poor users).
For the health system: (9) an incentive for better services in the public hospitals, which enables a global efficiency mechanism ('allocation by the feet'): money goes only to the hospitals attended by poor patients; (10) another opportunity to support the public hospitals.
For Cambodian society as a whole: (11) an efficient way to exempt the poor (the poor identification 'market' has a low entry cost, the competition among local social welfare NGOs will guarantee a good identification practice for a low price); (12) development of a private not-for-profit social sector, (13) institutional purchasing lever to defend patient rights and to promote a higher quality of care (accountability to the users).
For the donor community: (14) an efficient way to achieve the objectives of poverty prevention and health improvement; (15) financial support to the local NGO sector.

Third, the service that must be delivered to the poor by the Health Equity Fund is not limited to paying the hospital fees. As demonstrated by experience in Thmar Pouk and Sotnikum, the poor really need more than that.

Scaling up calls for new measures

As we are heading for an extension to the whole country, we can expect that a market of Health Equity Fund operators will quickly appear. There is a risk that hastily established operators might ruin the idea. Today, we should already be thinking of mechanisms that will guarantee good services at low cost. The first one is certainly a careful selection of operators. CFDS and CAAFW are now doing their job correctly because they have previous experience in poverty reduction and social services. Their hospital involvement is clearly in line with their mission statements. Nevertheless, good partners will not be enough. The best strategy will probably be to find the right balance between some competition among the actors (e.g. bidding for contracts) and some co-operation (e.g. networking to exchange ideas for better strategies).

If the scaling up can be highly decentralised (e.g. different international agencies or NGOs implementing a Health Equity Fund in the hospitals they support), it would be appropriate to quickly set up a national platform for exchanging experiences and steering the whole dynamic. Indeed, too much enthusiasm sometimes kills good ideas. There is presently a clear danger that the solution will be ruined by overspending. Our proposal is to progressively develop national expertise and capacity in analysis and coaching in relation of Health Equity Funds. As a first step, something along the lines of a national steering committee gathering together the different actors (MoH, funding agencies, international NGOs, local NGOs, etc.) would have to be established.

Eventually, we would need a standard method for assessing the performance of the different funds, especially if different institutional models are developed. Indeed, the local NGOs operating the funds have to be accountable to their funders. We must be sure that the resources are really going to the poor. Tools for assessing the performance of the operators still have to be designed (disclosure of information). A monitoring process has also to be set up. As mentioned before, accountability also means the existence of the possibility of applying sanctions ('sanctionability'). Poorly-performing local NGOs will have to be replaced by new ones.

A formula for improvement

In chapter 4, we have evoked the limitations to the current functioning of Health Equity Funds. There is a clear need to improve the coverage: too many poor still do not know of or do not use the possibilities offered by the Health Equity Fund.

In 2002, as a pilot experiment, MSF will try to improve the current system in Sotnikum. The idea is to test the feasibility of a decentralised system of information, identification and support, possibly by making use of existing community-based volunteer structures. The pilot will be extended to one or two communes, with the aim of developing and gradually expanding to the entire district, thus further improving access, especially to the hospital.

A better documentation of the results

The experiences in Thmar Pouk and Sotnikum are still very recent. More documentation is needed. For example, the first survey to assess the performance of the Health Equity Fund used only a small sample. MSF will improve the monitoring methodology in the near future. Indeed, the solution could be relevant for contexts other than Cambodia. But first, we need more evidence. Other similar experiences should be included in this documentation process.

Still a role for innovation in Cambodia

As a conclusion, we would like to say a few words about the New Deal as an experiment taking place within a general process of change and reform. If a final lesson can be drawn from this experience, we think it would be that experimentation is valuable for Cambodia.

There is no magic bullet

This second report on the New Deal is unambiguous about the willingness of the MSF team to document their projects in Cambodia. Our ambition is certainly not to convince readers that the New Deal is THE solution for Cambodia. On the contrary, we think it is imperfect and has some limits. Many bottlenecks remain and it is not at all certain that it will be possible to resolve them within the institutional set up we have developed.

Our strong belief is that it is still too early to have a clear vision of the exact reforms that the health system needs in Cambodia. There is nothing to serve as a blueprint. Local constraints matter, local opportunities have to be seized. At this stage, the New Deal shows that experiments must go on and lessons should be learned out of the experience gained from them. And indeed, many lessons can already be learned, not only from Sotnikum and Thmar Pouk, but certainly also from Pearang, Ang Roka, Memot, Takeo, Mong Russey, Kratie, Svay Rieng, Pursat, Kirivong and other projects.

All these different projects are bringing new ideas and leading to the development of new solutions. Cross-fertilisation and the exploration of new paths are the best strategies at this stage.

Patience, creativity and pragmatism

The other lesson of the New Deal is that progress is never linear. A major step forward one day might well be followed by a step backward the next day. The example of Sotnikum OD is a clear demonstration of that.

Sometimes progress is even accidental. The Health Equity Fund story is exemplary. Initially, it was designed as a minor experimental solution to sustain what was the major innovation: a global contract committing resources to finance performance-linked bonuses for the staff. Today, close observers of health sector innovations in Cambodia believe that the Health Equity Fund could be the really major break-through in the MSF project. So, experimentation pays!

It may be relevant to note the approach used for solving the problem of access for the poor: identify a problem, have a clear analysis of the incentives' issue, test a simple idea, pilot the solution, monitor it closely (and correct it if necessary) and quickly draw the lessons to be learned from it. There were no long initial studies. MSF had no real experience in designing specific solutions with regard to the poor. The contracted NGOs were quite unknown to MSF or UNICEF; trust and a calculated risk-taking were part of the experience. Knowledge about the complex relationship between poverty and health has been gathered mainly through a 'hands on' learning process.

We feel that this kind of pragmatic experimental approach is particularly effective in Cambodia. The MoH is very open-minded and international organisations, such as UNICEF and WHO, are very supportive. Except for some strict regulations, which present an obstacle for everybody, there are no major taboos.

This global commitment and the relentless effort to progress on the part of all concerned make us think that eventually we shall achieve what we are struggling for: the establishment of a real health system for the people of Cambodia, especially the poor.