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Fostering ownership of health services as a means to counter the workforce crisis

Contracting in Cambodia

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To overcome the workforce crisis in Cambodia, Swiss Red Cross implements a combination of measures aiming at increasing availability, competence, responsiveness and productivity of the health staff. While support systems such as materials, medicine, infrastructure are essential to build a basis, ownership of the health system by the staff needs to be fostered in order to hold the workforce to account for the task they have in serving the population. Swiss Red Cross is strengthening the ownership and accountability of staff through sub-contracts for health service delivery.

The world health report 2006 advocates that "at the heart of each and every health system, the workforce is central to advancing health" (1). Swiss Red Cross (SRC) has since long acknowledged that quality human resource management is one of the keys to successful health service delivery. While the provision of materials (including medicine), health financing and a functioning infrastructure are important, it is the people working in the health system who make a difference. In order to retain well trained and motivated staff within the system SRC is exploring innovative approaches. One of them is to create ownership among the staff of their health services. SRC in its project with the Ministry of Health in Cambodia tries to do this by sub-contracting responsibilities to the district health management offices and to health facilities. Unless staff at the district identify with their work, they will always find better paid options and migrate – with their gained knowledge – towards urban areas or elsewhere.

A sustainable district health system

Through a contract agreement (2), SRC is mandated by the Ministry of Health to carry out all public health activities in the two operational health districts of Ang Rokar and Kirivong in the Takeo Province of Cambodia – altogether 350'000 inhabitants. This includes service delivery at health centre and hospital level including referral, EPI, outreach, health education, health financing, human resource management and training.

SRC aims at developing a district health system that is sustainable managerially as well as financially. In line with SRC experience in the public health sector in Cambodia (3,4), the strategy is to foster a win-win situation in which the users benefit from a rational and competent health system where the health personnel reach a satisfactory level of life and professional development. SRC has set up an affordable operational basic health service in the two districts, delivering services, accessible to the majority of the population with a safety net for the poor while providing an adequate income for the health staff. For the project period (2004-2007 with possible extension until 2009) the Ministry of Health staff is seconded to the SRC management.

The WHR 2006 advocates that critical support systems must be in place for the workforce to be efficient and effective. In the two operational health districts where SRC is active these are guaranteed through the contract between Ministry of Health and SRC. Provision of infrastructure, equipment, materials and medicines are clearly regulated and reasonably well implemented.

Medicines are provided by the Ministry of Health central medical store with little delay and – except for some items – sufficient in quantity and quality. Running cost budget for the health facilities is provided through direct disbursement from the National Treasury to the districts. Most of the necessary infrastructure for a well functioning health system is in place according to the country's national health coverage plan. Referral between health centres and hospitals is organised and adequate transportation is in place. An important asset for the management of the district health system is the well developed national Health Sector Strategic Plan 2003-2007 with four detailed volumes (5).

Enhancing staff performance

SRC focuses its activities on existing staff and judges the following approaches as prerequisites in order to increase availability, competence, responsiveness and productivity of staff and to arrange for the present flaws in human resource allocation:

Quantity and quality of staff: Cambodia is among the countries which face a critical shortage of staff, especially of higher training (6). Of the 262 staff necessary to operate the health system in the two health districts, only 77% are officially employed by the Ministry of Health. The rest are contractual staff or are paid by the project (7). This is a threat to sustainability, foreseeing that at the end of the contract one fifth of the staff will leave the system and work privately. On few occasions new staff has been allocated to the health centres and hospitals by the Ministry of Health, as agreed in the contract. However, their qualifications did not comply with the requests forwarded to the Ministry of Health. For quality assurance, SRC has adapted the quality standards provided by Unger et al. (8) to the context of Takeo. This is followed up through SRC technical assistance.

Migration: The SRC project faces the problem of migration mostly with higher level staff (medical doctors) who either find jobs in urban areas or who are invited to year-long trainings. An important migration, however, is initiated by the pull factor the vertical programmes provide. Staff working (part-time) for vertical programmes for HIV/AIDS and TB are presently still paid better incentives than regular staff. This imbalance leads to a positive discrimination of certain illnesses that SRC would like to see managed in a more horizontal manner.

Fair and reliable compensation: Official payment is small. A government health staff may earn about 40-90 US$ per month from official public income (in Takeo a maximum of 60 US$). This can be topped up with per diems, allowances from aid organisations or from facility incomes and by private practice or other business. However, over 90% of the public health staff do not want to leave public services despite the poor official payment, as their position provides legitimacy and prestige for their private practice (9). SRC's approach is to provide adequate salaries and to limit private practice. These salaries are performance based and financed with government funds as well as with income of the facility (user fees) and with gradually reducing SRC subsidies.

Monitoring and supervision: For transparent and reliable incentives and in order to guarantee good quality services, SRC has put in place a monitoring team which follows up on patients. Through interviews at village level, SRC gathers information about treatment quality and staff behaviour. This information is fed back to the health managers and directly influences the performance based incentives provided to the health staff. Supervision of health centres is performed by district level health staff. For the hospitals this is guaranteed through staff of the provincial hospital while SRC technical advisors provide on-the-job training and supportive supervision.

Lifelong learning: In order to enhance staff quality and capacity, SRC has hired a Cambodian organisation specialised in the training of health staff. While quality of care is important, other aspects such as behavioural change are also emphasized in the trainings. SRC has acknowledged that the above mentioned approaches are important, but not sufficient for sustainability of the health services and human resources in health. Therefore it has implemented sub-contracting at district level in order to foster ownership and to guarantee sustainability and accountability.

Ownership

From the beginning, SRC planned to delegate responsibility to the districts. The Mid Term Evaluation 2006 confirmed the need for the planned sub-contracting in order to reach sustainability of management of the district health systems.

SRC has developed sub-contracts with the district health offices in the two districts. The district health office is now made responsible for the provision of health services in 10 health centres each, with which they have contracts as well. Later the additional health centres will follow.

The sub-contract has been developed among the same lines as SRC's contract with the Ministry of Health. It includes the quantitative Ministry of Health targets and is supplemented with targets developed by SRC aiming at sustainable management and quality of health care. (10)

The first results are promising and it has become clear that the approach has high potential to foster a situation where more ownership is created at district level. Patient numbers at the health centres have undergone drastic increases after a first slight reduction. Deliveries at health centres have in some cases more than doubled. And staff have realised that quality of management and health care delivery now depends fully on them.

Already now, staff who have previously expressed discontent with the new situation are exploring innovative ways of management and are thinking of initiatives for increasing and boosting health financing mechanisms at district level and improving quality of services.

The introduction of the sub-contracts has also been difficult, as it put additional burdens on the health management staff. It also meant that the district health office staff needed to monitor the quality and the reaching of targets and penalise non-performing health centres, unpopular tasks that were previously left to SRC. Subcontracting – with the initial slight decrease of contacts – was combined with a loss of performance based salary supplements at the beginning, a point that needed good preparation and explanation in order to prevent difficulties with the staff concerned.

Today, the SRC technical advisers remain responsible for the overall development. But their role has become much more a supportive one. Together with the managers and staff at the districts this led to new levels of discussion in order to develop further innovative approaches, intensifying the community participation, the involvement of local government in service delivery or to assist in the development of a health insurance and other mechanisms that lead to better access to health for the population.

Conclusion

There are no easy solutions to countering the health workforce crisis in Takeo province. However, sub-contracting to the district level may represent one of the many approaches to retain human resources. SRC strongly believes that the sub-contracting and the provision of responsibility at district level fosters ownership and leads to a situation where staff perform competently, provide services of good quality and are available for patients at the health facilities. SRC will intensify and extend sub-contracting and is hoping that more staff will be attracted to participate in this development. Ownership is necessary if quantity and quality of services are to be sustained.

Such approaches at micro level need to be streamlined and integrated into the realm of public health. Involvement at the macro level is therefore necessary and advocacy for sub-contracting needs to be further pursued vis-à-vis the Ministry of Health by SRC and the other contracting

partners.

Furthermore sub-contracting needs to be further analysed. It is well possible that not all of the positive aspects mentioned are due to sub-contracting alone but might be in relation to other approaches implemented simultaneously.

The decision on policies that foster better quality services at district level and which counter the workforce crisis – including the creation of ownership – require a strong political will. It is yet to be seen in how far such approaches will form part of the next strategic health plan and if important mechanisms such as sub-contracting or direct disbursement of running costs to district level will be part of it.

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10. The targets are: % of ANC visits, number of deliveries at health centre, increase of per capita contact rate, availability of staff at health centre, quality of care indicators, reporting indicators etc.

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