Towards a 'new deal' for health staff in Cambodia

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Cambodia's recent history

Cambodia is still marked by the violent events of its recent history. After Cambodia gained independence from France in 1953, Prince Sihanouk, led the *Royaume du Cambodge* till 1970. He tried to keep Cambodia out of the Vietnam war, but it became progressively involved. Lon Nol overthrew Sihanouk in 1970 and installed a pro-American regime. The countryside was heavily bombarded by the American airforces, in an attempt to cut of the Vietcong's supply lines. The communist insurgents, the Khmer Rouge, gained popularity in the rural areas, and took the capital Phnom Penh in 1975.

During the four years of the Khmer Rouge regime, all urban population was evacuated to the countryside, and forced to engage exclusively in rice cultivation. Mass killings, especially of previous urban dwellers and educated Cambodians, took place. There was also a high death toll due to starvation, disease and lack of health care. In 1979, the Vietnamese toppled the Khmer Rouge. This is variably referred to as invasion or liberation; most Cambodians perceived it as a mixture of both. But the Western countries continued to support the anti-Vietnamese alliance, including the Khmer Rouge, who remained in control of large rural areas of Cambodia. The Vietnamese officially left Cambodia in 1989, leaving in place a Cambodian government led by Hun Sen.

The Paris Peace Accord between all Cambodians factions was concluded in 1991. It lead to the installation of a UN Transitional Authority for Cambodia (UNTAC), to disarm the fighting factions, and to prepare elections. Disarmament largely failed, but the elections were held in 1993, followed by a power-sharing agreement between the Royalist FUNCINPEC and the former communists, CPP, led by two co-prime ministers. In 1997, the agreement collapsed, resulting in the take-over of full power by Hun Sen, and renewed factional fighting and bloodshed. In 1998, new elections took place, leading again to a power-sharing agreement, between FUNCINPEC & CPP, this time firmly led by strong man Hun Sen. In the meantime, most Khmer Rouge commanders defected to the government, and after Pol Pot's death, the last remaining commander, Tamok; was arrested. Cambodia has now regained political stability.

Cambodia is still predominantly a poor agricultural country. Since the late 1980s, a free market economic system replaced the failing centrally planned economy. Till today the economy remains largely unregulated; leading to growing inequalities between rich and poor, and many excesses (e.g. trade in fake medicines and sex trade). The government administration remains inefficient and corrupt. Although there are many expatriate advisors at all levels of government. This is largely a heritage from the UNTAC period

A brief recent history of the health system in Cambodia

Before 1975, the government set up an infirmary in each commune (between 2,000 and 3,000 inhabitants), and a hospital in every district (between 15,000 and 100,000 inhabitants). By 1975 over 1,000 medical doctors were trained, most of them in Phnom Penh, but also in Europe, especially in France.

The Khmer Rouge abolished modern health care ("the peasants can care themselves for the sick, using herbs and traditional medicine"). They also killed most health workers, and abolished all schools. In 1979 the Vienamese-led administration renovated the previously existing health system. Less than 50 doctors had survived the Khmer Rouge regime. To staff the health facilities, the Vietnamese trained many health workers in accelerated training courses, especially for disease-specific activities (TB, malaria, EPI, &c). Drugs, medical equipment and technical assistance came from socialist countries, and all health services were free of charge.

After the withdrawal of all support from socialist countries in 1989, Western donors pushed for a reform of the health system. During the first phase, 1989-93, the central administration of the Ministry of Health (MOH) was reformed. The second phase, 1994-98, focused on the provincial and district levels, with a health coverage plan dividing the country in operational districts. During this period, many NGOs and international agencies came to support existing health facilities or to create new ones. This lead to highly unequal health system development in different provinces. Since 1998, the third phase of reform is focusing on human resource development and a sector-wide approach (SWAP).

The health sector in 1999

Since 1996 a health coverage plan exists for the whole country. Cambodia's 22 provinces are split in 69 operational districts (ODs), with between 100,000 and 200,000 inhabitants each. For each OD one referral hospital, a network of health centres – one for 10,000 inhabitants on average – and an OD office is planned. Health district development, as taught in ICHD in Antwerp, is thus the official national policy in Cambodia. A multitude of guidelines is developed, many workshops & seminars are organised to implement this policy.

The Central Medical Store is functioning well, and manages to supply all government health facilities with adequate quantities of essentials drugs. Budgets for running costs are relatively adequate, although they often fail to reach the

periphery. Health staff is nominated in all health facilities, and many efforts are made to upgrade their training. Buildings are renovated and equipment supplied. Official fees are very low, and affordable for the majority of the population, and there are exceptions for the poor. But, despite all these efforts, supported by many international agencies, and NGOs, there is not one operational district really functioning. In fact, there are very few health centres and hospitals functioning adequately. Very few patients are hospitalised in government hospitals, and most health centres treat only minor problems.

So, the official health policy looks good, at least on paper, but the results on the ground remain very weak. Why? There are many problems, but two seem overwhelming to us. The first concerns the staff and their motivation, the second the population and their demand for care.

Staff. Some staff officially on the payroll does not exist, others never show up at work, and the remainder usually work only one or two hours a day in the public service. The quality of the care they deliver is often poor. Most patients in public health facilities have to pay parallel fees, get prescriptions for the private pharmacy, or an invitation to consult at a private practise. Indeed, most government health staff have their own private practise. Why does staff have such attitude? Because their salary is grossly inadequate. They receive only $10 to $12 per month, while it is estimated that they need at least $100 per month to cover the minimal needs for living. Consequently, they develop the creative coping mechanisms mentioned above.

Population. The offer of care in the public services, especially the health centres, does not meet the population's demand for medical care. For instance, in the health centres, there are no injectable drugs or infusions available, while they are in high demand by the population. Most patients continue to search treatment through drug vendors, pharmacies, or private practitioners, many unqualified. In private practise medicine is considered much like any other business: a patient receives whatever he is ready to pay for (much like in a cigarette or alcohol shop).

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

Staff who is not paid, consider the drugs as their income, which they can sell or take home for their private practise. The population considers the health centres a cheap source of drugs for minor ailments, but continue to go to the private sector for anything more severe. Presently, there is a dual health system in Cambodia: (1) a public health system, with a very low utilisation; officially cheap, but probably expensive; with low quality of care; and (2) an unregulated private care system, where drug vendors are often the first choice, with private providers of unknown qualification, delivering very irrational treatment at a high cost. And the drugs delivered are often fake.

At this stage, the situation does not seem very vulnerable. (1) The public health system is under-funded. The official state budget for MOH is below $3 per inhabitant per year, is often not available (only around $1 per inhabitant per year was disbursed in 1998), and the amounts that are available are often misappropriated or misused. (2) There is no political willingness to regulate the private sector. And all attempts to do so, may further jeopardise access to health care in areas without a public health service, where private medicine is the only option available to most.

In this situation, MOH & MSF chose as first priority to develop a really functional operational district in a rural area of Cambodia. MOH & MSF want to show that it is possibly to implement on the ground the national health policy, and to make it acceptable to the population. The public service should be able to compete effectively with the private sector. They chose Sotnikum operational district as a pilot area.

Pilot experience in Sotnikum

Sotnikum is a poor rural area, with 218,000 inhabitants, at 40 kilometre from Siem Reap town, in the province where the historic temples of Angkor are located. In Sotnikum OD, there are already 14 health centres functional, out of the 17 foreseen in the health coverage plan. These health centres are considered to be among the best in Cambodia, with a user rate of between 0.5 and 1.2 new cases per inhabitant and per year. This relative success is due to the high community involvement in these health centres, where so-called 'feed-back committees' and 'co-management committees' are functioning in every health centre. Presently, Sotnikum has only a small 80-bed hospital, 40 of them are for TB patients. This hospital is currently being upgraded with surgery, X-ray, ultrasound, better lab facilities, and an extra ward. In the district, there are 30 staff for the hospital, 80 for the health centres and 11 for the operational district office.

"New deal" with staff

The cornerstone of the pilot experience is a "new deal" with the health staff: a better income for the staff in exchange for a better service for the population. As the first step, such "new deal" was negotiated with the hospital staff. They are ready to respect a strict internal regulation in exchange for a monthly bonus of $65 on average (range $130 -$25). The internal regulation stipulates that all staff have to respect the official working hours, including night and weekend duties, and their individual job descriptions. It further mentions that any illegal fees, any misappropriation of drugs, or any poaching of patients from the public system to the private practise will be sanctioned. To manage this system, the hospital gained semi-autonomous status, and the staff elected a hospital management committee. The hospital thus

became a kind of co-operative of the hospital staff. This system will start on 1 December 1999. Within three months a similar deal has to be developed for the staff of the health centres and the district office.

To fund the "new deal" three sources of income for the health system are needed: increased patient fees; increased & more reliable state budget; and complementary funding by MSF. For Sotnikum hospital, it was estimated that $8,000 per month are needed, and that approximately 20% can be raised through patient fees, 60% will be covered by government budget, and MSF will have to top up with an additional 20%. The MSF contribution will be replaced by increased government budget over 3 years. The provincial governor has a key role in the distribution and management of the state budget. To assure that each party lives up to its commitment, a contract is being established stipulating the contribution of each.

Management of the experiment

To manage the new district health system, not only a hospital management committee, and health centre committees are needed, but also a district management committee. MOH & MSF also decided to establish a steering committee, where provincial authorities, both health & administrative authorities, central MOH & Ministry of Finance, as well as WHO, UNICEF, National Institute of Public Health & MSF are represented. This steering committee has a double role: (1) to guide the experiment, and make sure it is done in the spirit of the health sector reform, & (2) to facilitate that the lessons learnt will be used as a source of inspiration for this same health sector reform.

Near future

Although fees are far below those commonly practised in the private sector, they are still not affordable for a considerable proportion of the population. Improve **access for the poor**, through an external committee that is not controlled by the hospital staff is one of the next steps on the agenda. This committee will pay the hospital a fee-for-service for the poor. This will entail the creation of a purchaser function within the operational district.

Once the "new deal" running, conditions to **improve the quality of care** will be better. Only in an environment where staff has a reasonable income from their work in the public sector, and where everybody contributes to the public goal of the health facility, can quality improvement be aimed at.

The clinical knowledge of many staff is still insufficient for correct rational diagnosis and treatment at the referral level. To improve this, MOH & MSF try to establish a "Thai connection": a collaboration with the Rural Doctor's Association in Thailand, to enable Cambodian staff to exchange knowledge and experience with Thai counterparts. This may entail exchange visits and practical training in Thai hospitals.

As a conclusion: Ideas for a more distant future

One of the ideas presently being discussed at central MOH, is to give some operational districts a **global budget** to be managed locally with a high degree of autonomy. Presently, the direct funding of the districts, excluding drugs (which are supplied in kind) is in a district like Sotnikum below $0.5 per inhabitant per year. The government wants to triple government spending for social services, such as health and education, and would be ready to make up to $2.0 per inhabitant per year available to the health districts. Such funding increase would considerably facilitate the introduction of new initiatives, and incentive schemes for the staff.

At the same time, the possible introduction of **a provider / purchaser split** is being discussed. This would entail that health centres and the hospital be considered as more autonomous management units (providers), with contracts being established between them and the district or province office (the purchaser). Such contracts would stipulate rights and obligations of each partner, attempting to improve responsibility and accountability. It would further allow for better targeting priorities, such as care for obstetric emergencies, or vaccinations, or care for the poor or chronically ill (e.g. AIDS).

Presently, MOH is also experimenting with **contracting out**, where the management of entire districts is delegated to international NGOs, or private firms, but funded with public funds. Some officials suggested to contract out the management of Sotnikum district to MSF.

All the above tackles mainly the problem of staff motivation, under-funding of the public health system, and the management of the health services. It does not tackle the low **acceptability of the service** offered in the health centres, the minimum package of activities (MPA). Improved quality of care, *as perceived by the population*, may entail offering more drugs, including injections and infusions, and more convenient opening hours (e.g. early morning consultations, evening consultations, permanent on-call service during nights and weekends, and possibly home visits).

The idea of a **pregnancy insurance** has also been raised. Pregnant women could take an insurance (e.g. for $10), covering all pregnancy related medical expenses, including delivery service by a qualified midwife, and referral by ambulance to a hospital with surgical facilities in case of obstetric emergency.

We intend to report back to you on the evolution in the Cambodian health system in the next INFI Newsletter.