ReBUILD Consortium

Research summary: Annexe 1c

Project 3 – Contracting

Contracting of healthcare: processes and effects in Sierra Leone and Cambodia

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Background

Contracting is a process by which one party often termed the principal, contracts with another party, the agent, for the latter to deliver certain goods and services (Perrot 2004). The agent may be an external provider or, in the case of internal contracting, part of the same legal entity as the principal. The control of resources, including human resources, given to the agent varies considerably under different contracting models.

A number of advantages are claimed for contracting which explains its increasing popularity within public services, including healthcare provision. Contracting may increase the efficiency with which resources are used, leading to a reduction in the costs of providing services (Mills et al. 1997). Contractors may have greater managerial flexibility, be able to bring specialist expertise to bear and if they retain any surplus from the provision of services, have a clear incentive to keep costs down.

Contracting may encourage better planning of health service provision as a result of the information collected in the negotiation and enforcement of the contract, particularly if the principal is forced to define more clearly than before what the key objectives are (Leovinsohn and Harding 2005). The equitable provision of services can be pursued if contracts specify conditions or rewards for the provision of services to remote areas or marginalised populations (Harding and Preker 2003).

Among the potential disadvantages of contracting are high transaction costs, the neglect of services not included in the contract, the need for considerable administrative capacity to specify and manage the contract, and the cost of monitoring the contract (Ashton 1998; Mills and Broomberg 1998; Eldridge and Palmer 2009). The latter may be significant if there is information asymmetry where one party, usually the agent, has more knowledge of the true costs or quality of provision and is able to manipulate this information to their advantage.

As a consequence, many contracting arrangements use some type of performance based financing, in which how the agent is paid is linked to define outputs, alongside monitoring arrangements.

In any contracting arrangement, success depends on how coherent the objectives of the contract are, the regulatory mechanisms employed, how the contract is enforced and how well aligned are the interests of the different parties to the contract.

Sierra Leone

Decentralisation of the health system in Sierra Leone followed the Local Government Act of 2004 which established 19 Local Councils that are responsible for managing primary healthcare services. These local councils are made up of 13 district and six city councils. Each of the 13 districts namely: Bo, Bonthe, Moyamba, and Pujehun (Southern Region), Kailahun, Kenema, and Kono (Eastern Region), Bombali, Kambia, Koinadugu, Port Loko, Tonkolili (Northern Region) and Western area, has one district council. In addition, Bo, Bonthe, Kenema, Koidu and Makeni towns, and Freetown city each has one city council.

There are 13 District Health Management Teams (DHMTs), seven covering one district council each and six covering one city and one district council each.

The DHMTs in collaboration with other key stakeholders are in charge of service delivery. They plan, organise, manage, implement, monitor and supervise health programmes in their districts. The DHMTs make yearly plans which are presented to the Ministry of Health and Sanitation (MoHS) for funding. DHMTs are in charge of primary healthcare. Tertiary and secondary healthcare are being devolved to the councils.

A District Medical Officer (DMO) heads the DHMT and oversees healthcare delivery at district level. Each Local Council together with the DHMT signs an agreement - 'Tripartite Performance Based Financing (PBF) Agreement' - with each service provider (health facility) for provision of the PBF interventions. This agreement specifies the quantity and quality indicators, the formula on which PBF payments will be based and procedures for supervision, verification and dispute resolution.

The decentralisation of provision of primary care services to DHMTs in Sierra Leone is primarily an example of internal contracting. However, in areas with no government facilities or those with insufficient capacity to serve the local population, there is provision for NGO, FBO or private providers to join the scheme. Any such case would be an example of external contracting.

All Local Councils have a Health and Finance Committee(s) and they work in collaboration with the Local Government Finance Department (LGFD) at the Ministry of Finance and Economic Development (MoFED). They are responsible for developing a health plan and budgets that are reviewed by the DHMTs and then approved by the Local Councils. The plans are submitted to MoFED through MoHS for funding.

MoHS has an overall leadership and co-ordination role among donors and other key stakeholders. It is responsible for the formulation of health sector plans and policies, setting

and monitoring sector performance standards and mobilisation of resources. All aspects of the employment of healthcare workers are centrally controlled: recruitment is organised by MoHS, absorption into the civil service is controlled by the Directorate of Human Resources Management Office (HRMO) and the payroll is administered by the MoFED.

Resources transferred to the Local Councils are derived from a variety of sources including the World Bank District Services Development Programme (DSDP), GAVI for the Reproductive and Child Health programme (RCHP) and funds from Government of Sierra Leone (GoSL).

Districts receive payments based on the number of Peripheral Health Units (PHUs) they have and District Adjustment Factor to reflect the size of the district and the difficulty of the terrain. The Factor ranges from 1.0 (Koinadugu) to 0.6 (Western Area). PHUs receive funding based on the number of key interventions (Family Planning, Antenatal Care, deliveries, Postnatal Care, immunization of children under one year, outpatient visits of children under five) which they perform with adjustments for clinical quality and cross cutting quality factors. The resultant PBF funds can be divided into incentives for PHU health workers (up to 60% of funds) and 'investment' funding (the remainder or 40%).

There is another important system of contracting, the Performance Tracker: these are formal contracts between the President and Minister of Health and Sanitation (and other Ministers) on the one hand, and between the Minister of Health and Sanitation and each of the Directors (of the 11 Directorates) on the other. The contracts between the Minister and the Directors are quite specific, tracking tasks that are supposed to be carried to achieve every objective of the ministry.

Demand for the research in Sierra Leone

A World Bank evaluation of the contracting of primary healthcare services is planned for 2012 but it is understood that this study will be quite specific, focusing primarily on the impact of contracting on the PBF indicators. It will not involve any fieldwork or consultation with health workers. Consequently, there will remain important questions to which the Ministry of Health and Sanitation and other stakeholders would like answers, such as an understanding of the change process, of how implementation has worked in practice and of the implications of contracting on health worker incentives and performance. Certainly, in preparing the country situation analysis, contracting issues were given high priority by stakeholders in Sierra Leone. Moreover, while there has already been decentralisation of primary care to the councils, secondary and tertiary care are also being devolved and there is the opportunity to learn from recent experience with primary care lessons for best

practice in the flow of funds and the health worker incentives inherent in PBF for the operation of secondary and tertiary services.

Cambodia

Since the late 1990's Cambodia has seen several different contracting schemes in the health sector. Contracting in Cambodia has evolved significantly over the past decade and different terminologies have been used. Both contracting out and contracting in are external contracting and in all of them, Non-Governmental Organisations (NGOs) were contracting parties and involved in the management of services delivery with varying degrees of autonomy. This happened in the early days of pilot contracting (1999-2002).

A new term "hybrid contracting" was coined in the next phase of contracting (2004-2008) to denote mixed versions of contracting out and contracting in based on the accumulated experiences. Again, in all of these districts NGOs were involved. Since 2009, Cambodia has adopted an internal contracting model using performance incentives and monitoring mechanisms as the centre piece of the intervention along with a greater level of autonomy for health district management.

There has been no study on the new contracting arrangements. Past studies focused on the external contracting interventions and their impacts, but very little on the process of the contracting. The current arrangement is new and employs the principles of contracting. However, as it is an internal arrangement it is anticipated that it must conform to the bureaucratic environments, capacity and management framework of the government. Therefore, it is essential that the basic elements of the contracting are well understood setting the stage for further in depth investigation.

The purposes of the study broadly are three fold. First, it examines the process of change that resulted in the current model, providing an understanding of how the new arrangements were made, who and what institutions were involved in influencing the configuration, the actors' perceptions of new arrangements in relation to the bureaucratic environment and existing management and regulation of health districts.

Previous analysis of the change in contracting in Cambodia points to three major reasons: the high cost associated with the external contracting, including transaction costs, the limited national ownership acquired from the external contracting and the need for hands-on experience for improving capacity (Khim and Annear, 2010).

This study will examine the validity of this analysis and investigate how the new arrangement addresses the underlying reasons.

Secondly, the study will look at the constraints and challenges in the implementation of the contracting arrangements, whether or not they have been and have not been anticipated and how they were addressed. An example is the coping strategies employed by health districts to address fund delays and staff shortages and the capacity constraints.

Thirdly, it will look at the consequences of the new arrangements to see how and if the new arrangements result in better outcomes in terms of service provision and equity, including gender equity.

Demand for the research in Cambodia

The country situation analysis in Cambodia highlighted that there have been few attempts to date, to document the issues which the research will focus upon. The World Bank has commissioned studies to look at the management, human resources and the quality of health services in contracting districts in comparison with non-contracting districts. These studies are still in the inception phase.

There is an unmet demand for an understanding of the drivers of change in Cambodia, particularly the movement from one contracting regime to another, the adaptation of health districts to different contracting systems, and the consequences of contracting for service quality and equity.

Specifically, it is important to disentangle the relative importance of issues of ownership, capacity, costs and sustainability which have been widely cited as persistent problems of the external contracting period and the reasons for the switch to internal contracting.

Demand for the research in other post conflict countries

The research, particularly that in Cambodia will provide insights applicable to a variety of post conflict settings. Perrot (2004 and 2006) notes that contracting to external non-government providers are common in immediate post conflict situations because of the public sector's limited capacity for health service delivery. However, post conflict states will also commonly have limited capacity to effectively manage the process of specification, award, monitoring and evaluation of contracts.

This may be the greater constraint. Over time, the potential problems of external contracting in terms of ownership, accountability and sustainability may become more apparent. Cambodia's switch from external contracting back to internal contracting, within the public healthcare system, which is also the route undertaken by Sierra Leone, may generate wider lessons for other post conflict countries.

Aim and objectives of the research

Aim

To understand the change process and consequences of contracting within the health systems in Sierra Leone and Cambodia during the post conflict period.

Objectives

- To identify how the contracting arrangements have changed over time, the drivers for these changes, the reasons for these changes including the contextual factors influencing these changes
- To document the processes of implementation of contracting, including the contextual and health system factors which facilitate or constrain the implementation and how these factors have been addressed
- To assess the implications of the contracting arrangements on coverage of services and equity in terms of availability and utilisation of services
- To identify lessons learned for future development of contracting policies in post conflict situations.

Study design

By selecting districts with different experiences of contracting and looking at the evolution of contracting arrangements over time, detailed case studies will be developed.

Primary and secondary data will be collected using both qualitative and quantitative research methods in order to meet the research objectives. These will include: document review, key informant interviews, in depth interviews with healthcare providers, focus group discussions with service users and analysis of secondary data on health service utilisation and coverage.

Study site

In Cambodia, four districts with different experiences of contracting are selected for this study. Their selection is based on a number of considerations: current involvement in contracting; timing of introduction of contracting, level of services covered by contracting arrangements, geographical spread across the country and support from different NGOs and development partners. Each district contains one referral hospital, which will be visited. In addition, we will sample two health centres (HCs) per district, one of which will be close to the district centre and one far from the centre.

In Sierra Leone, the contracting schemes have been introduced nationwide. Therefore, the rationale for the selection of districts has focused on ensuring a range of different types of districts using the criteria of rural and urban populations, hard to reach areas and poverty. Six districts are selected from the four regions of Sierra Leone. In each district, the district hospital and two HCs will be selected. The HCs will be selected on the basis of their distance from the district centre.

Timeframe for period studied and justification

In Cambodia, the timeframe for the period of study is from 1999 to the present day. Contracting was introduced into Cambodia health sector in 1999 and significant changes in the arrangements and modalities have been implemented since then.

In Sierra Leone, the timeframe for the period of study is from 2004 to the present day. Performance Based Financing and Performance Tracker contracting arrangements were introduced during this period.

Methods

Method 1: Document Review

Objective:
To describe the contracting arrangements, the reasons for their introduction, how they have been implemented and any effects of the policy changes during the period of introduction to present time.

Some key documents are already known to the research teams. Others will be identified through discussion within the research teams, searching websites of organisations, key informant interviews and reference lists or bibliographies of documents reviewed.

There is a range of documents which the research teams will review which include:

- National Health Strategic Plans
- National Health Financing Reports
- Documents of organisations working in contracting
- Academic studies or commentaries
- Discussion documents on equity and poverty.

Data collection and analysis:
The research teams will access the documents from the government departments and their websites and other organisations such as WHO and World Bank. The documents will be reviewed by the research teams to answer the key questions: what are the policies related

to contracting during the post conflict period, how have they changed over time, what were the reasons for the changes, how were the policies implemented, and what were the effects of the implementation?

Constraints:
No significant constraints since almost all the principal documents have already been identified and sourced in both countries.

Method 2: Key informant interviews

Objective:
To explore key informants' perceptions of the process to prepare and deliver contracts.

Sampling methodology and size:
The key informants for both studies will be purposefully selected for inclusion based on their current or previous involvement in the contracting schemes. They will therefore have a detailed knowledge of the different schemes and be able to provide their unique perceptions of the schemes.

Other participants may be identified through the key informants already interviewed. The number of key informant interviews is estimated to be 20-30 in both countries. However this number may vary as a result of the document review and the initial key informant interviews.

The key informants at national, provincial or regional, and district levels will include:

- Policy makers in the relevant government ministries e.g. Ministry of Health, Ministry of Health and Sanitation, Ministry of Economics and Finance, Strategic Policy Unit, and relevant ministries with responsibility for gender issues.
- Representatives of Development Partners
- Representatives of NGOs
- Representatives of the Provincial Health Management Teams
- Representatives of the District Health Management Teams
- Representatives of Local Councils.

Key informant interviews will be the principal method employed in understanding the rationale, operation and effectiveness of the Performance Tracker system in Sierra Leone.

Data collection:
The research team will conduct the key informant interviews. The team leader will facilitate the interview using a topic guide. The research assistant will take notes and observe the

process. The interviews will be tape recorded after gaining permission from the participants. The interviews will take place in a private location acceptable to the interviewee, for example, in their office.

Data analysis:
In Cambodia and where appropriate, in Sierra Leone, the recordings will be transcribed in the local language then translated into English. Back translation from English into the local language will be conducted in a small sample of transcripts to assure accuracy of the translation. Participants' responses will be coded and grouped by themes related to the research questions. Qualitative analysis software, NVIVO, will be used to help manage and analyse the data.

Constraints:
Although many efforts will be made to ensure the quality of the translation and transcription, it is inevitable that some data will be lost.

Method 3: In depth interviews with healthcare managers and providers

Objective:
To explore health workers' and health managers' perceptions and experiences of the implementation of contracting, to identify any facilitators, constraints and challenges as well as coping mechanisms

This will include exploring if, and to what extent, equity (including gender equity) was considered in the ways contracts were developed and challenges and experiences of implementation.

Sampling methodology and size:
In each of the selected healthcare facilities, the manager will be selected for interview. Two health workers will be selected from each facility: one doctor and one midwife. In selecting the doctors and midwives, gender and length of service will be considered to ensure we capture a range of responses.

In Cambodia the sample size will be: 12 interviews with managers; 24 interviews with healthcare providers.

In Sierra Leone, the sample size will be: 18 interviews with managers; 36 interviews with healthcare providers. It is planned that the questions put to health workers about the contracting process will be added on to the interviews being conducted as part of ReBUILD project 2 on health worker incentives so that there is no need to carry out separate

interviews. There may also be the opportunity to do this for some or all of the interviews with health workers in Cambodia.

Data collection:
The research team will conduct the in depth interviews. The team leader will facilitate the interview using a topic guide whilst the research assistant takes notes and observes the process. The interviews will be tape recorded after gaining permission from the participants. The interviews will take place in a private room in the health facility or in their home if acceptable to the participant.

Data analysis:
In Cambodia and where appropriate, Sierra Leone, the recordings will be transcribed in the local language then translated into English. Back translation from English into the local language will be conducted in a small sample of transcripts to assure accuracy of the translation. Participants' responses will be coded and grouped by themes related to the research questions. Qualitative analysis software NVIVO will be used to help manage and analyse the data.

Constraints:
Although many efforts will be made to ensure the quality of the translation and transcription, it is inevitable that some data will be lost.

Method 4: Focus group discussions with health service users

Objective:
To explore health service users' perceptions of contracting and its effects on their access, utilisation and quality of care

Sampling methodology and size:
A Focus Group Discussion (FGD) will be conducted at the selected health centres and referral / district hospital. Each FGD will consist of 10 community members.

It is proposed that a total of 12 FGDs will be conducted in Cambodia and 18 FGDs in Sierra Leone. However, if it looks as if it will not be possible to conduct FGDs at all selected health facilities, the number could be reduced by identifying representative health centres by size, remoteness, the socio-economic characteristics of their catchment population or other variables.

Attention to gender and hierarchy will be carefully considered in the sampling for FGDs.

Data collection:
The research team will conduct the focus group discussions. The team leader will facilitate the discussion using a topic guide whilst the research assistant takes notes and observes the process. The discussion will be tape recorded after gaining permission from the participants. The discussions will take place in a private area which is acceptable to the participants.

Data analysis:
In Cambodia and where appropriate, Sierra Leone, the recordings will be transcribed in the local language then translated into English. Back translation from English into the local language will be conducted in a small sample of transcripts to assure accuracy of the translation. Participants' responses will be coded and grouped by themes related to the research questions. Qualitative analysis software, NVIVO, will be used to help manage and analyse the data.

Constraints:
Although many efforts will be made to ensure the quality of the translation and transcription, it is inevitable that some data will be lost.

Method 5: Analysis of secondary data

Objective:
To analyse the trends in health service coverage and equity during the study period.

Data collection:
Data will be collected using data collection forms from several sources including the Health Information System databases, national health statistics reports and annual health financing reports. Data will be collected from 1999 in Cambodia and from 2004 in Sierra Leone.

The indicators will include service outputs at province, district and facility level such as: childhood immunization, administration of vitamin A to children, antenatal care, deliveries by a skilled birth attendant, deliveries in health facilities, use of family planning methods, discharged patients, surgery, delivery by caesarean sections and bed occupancy rates.

To assess equity the service outputs will be disaggregated by gender, poverty levels, distance from health facility wherever possible. In addition, the number and percentage of eligible poor who received health services and were exempted from user charges will be collected.

Data analysis:
The data will be analysed to describe the trends in service coverage and equity during the study period.

Constraints:
While the relevant data should be available in Sierra Leone, since they are the indicators employed by the Performance Based Financing systems, it may be that they will not be readily available in disaggregated form in Cambodia.

Gender

In the sampling frames for the focus group discussions and in depth interviews with health service users and providers, gender, geography, poverty levels, disability and ethnicity will be considered.

In the secondary data analysis, breakdown by sex, age, level of poverty, disability and ethnicity will be presented where the original data set permits.

The intended research teams in both countries already have a gender mix.

Ethics

Applications for ethical approval will be made to the Sierra Leone Scientific and Ethics Committee and the National Ethical Committee for Health Research of the Ministry of Health in Cambodia prior to the commencement of the studies.

Research uptake

During the timeframes for the period of study, several different contracting arrangements have been in place. These changes in contracting, the reasons for their changes and the effects of the contracting schemes on service coverage and equity of use should inform future policy directions. To ensure that the results of this study will be used by the policy makers and key influential stakeholders, a broad plan for research uptake will be implemented.

At the start of the studies, meetings will be held with key stakeholders in the Ministries of Health and Finance, Donor organisations and NGOs to raise awareness of the study including the concept, purpose and approaches to be used.

In Cambodia, a focal point in the Ministry of Health will be identified and involved in the design and implementation of the study. S/he will assist in the coordination and facilitation

of meetings. S/he will liaise between the research team and the Ministry of Health on the issues relevant to the study in order to facilitate communication throughout the study period. This direct link between policy makers and researchers will help to ensure that the evidence from the study will be used to develop policies.

Towards the end of the studies, the preliminary results will be discussed with selected stakeholders, before they are shared with the wider community of stakeholders. Policy briefs and other documents will be developed.

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