Contracts to improve health services—quickly

Cambodia began experimenting with different forms of contracting to improve health services in 1998. The lesson—thanks to good evaluation—is that contracting can help increase the coverage of some key services in a short time.

More than 25 years of conflict left Cambodia with little health infrastructure. In the late 1990s its health indicators were among the worst in Southeast Asia. Average life expectancy at birth was less than 55 years. Infant mortality was 95 per 1,000 live births. And maternal mortality was 437 per 100,000 live births.109 The public health care system remained rudimentary: average facility use was 0.35 contacts per person per year, and patients complained of very low quality.

Then in 1998 the government contracted with nongovernmental entities to provide health services in several districts. The contracting increased access to health services—and not at the expense of equity.

Contracting primary health care services (in and out)

Intervention and control areas consisted of randomly selected rural districts, each with 100,000 to 200,000 people.109 Contractors were chosen through a competitive process based on the quality of their technical proposal and their price. Three approaches were used.

- **Contracting out.** Contractors had full responsibility for the delivery of specified services in the district, directly employed their staff, and had full management control (two districts).
- **Contracting in.** Contractors provided only management support to civil service health staff, and recurrent operating costs were provided by the government through normal government channels (three districts).
- **Control areas.** The usual government provision was retained (four districts).

A budget supplement was provided to contracted-in and control districts.

Performance indicators were measured for all the districts by household, and health facility surveys, which were conducted in 1997 before the experiment. No district had more than 20 percent of its planned health facilities functioning. All had very poor health service coverage. And all were comparable in their socioeconomic status.

Annual per capita recurrent spending by donors and government was higher in the contracted-out districts: $2.80 in the contracted-in districts, $4.50 in contracted-out districts, compared with $2.90 in control districts.311 These differences are large and represent slightly less than 20 percent of the health expenditures (including private and excluding capital investments from the government) in all of the districts.

Contracting for better results

All districts improved service coverage in a short time. After only 2.5 years of the four-year experiment, all districts had achieved their contractual obligations for most of the evaluation indicators.312 The use of health services among the poorest half of the populace increased by nearly 30 percentage points in the contracted-out district (figure 1). One possible explanation is that the contracted-out districts did not charge official user fees; they also discouraged health care workers from taking “unofficial” user fees by paying significantly higher salaries to providers than in the other types of districts.

The pattern of increases is similar across a variety of service and coverage indicators (figure 2). The contracted-out districts often outperformed contracted-in districts, which outperformed control districts. But not all indicators were as responsive. The share of deliveries assisted changed by only a small amount in all three districts. And there was no difference between contracted-in and contracted-out districts in the increase in vitamin A coverage. The level of immunization in contracted districts also remained quite modest, peaking at only 40 percent.

Out-of-pocket expenditures on health care services fell dramatically in the contracted-out districts also remained quite modest, peaking at only 40 percent. Even though the health ministry encouraged all districts to implement official user fees, only one contracted-in district established a formal user fee system and used the receipts from the system to reward health care workers with monthly performance and punctuality bonuses. That could account for slightly higher spending for this type of district.311

There are several possible reasons for these pro-poor outcomes in the contracted districts.

- The regular availability of drugs and qualified staff strengthened service provision at health centers in the villages, where most poor people are concentrated.
- The contracted nongovernmental organizations used a market-based wage and benefits package to attract and retain health care providers.
- A reduction in the private out-of-pocket cost of services and a more predictable and transparent fee structure increased the demand for health care services by the poor.

![Figure 1](https://example.com/figure1.png)

**Figure 1** Percentage of illnesses treated at a health facility for people in the poorest half of the populace

<table>
<thead>
<tr>
<th>Year</th>
<th>Control</th>
<th>Contracted in</th>
<th>Contracted out</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>2001</td>
<td>15</td>
<td>25</td>
<td>30</td>
</tr>
</tbody>
</table>

Spotlight on Cambodia

Hold surveys and spot checks by government staff. Payments were linked to achieving targets, with bonuses for better-than-agreed-on performance.

Improving health services for the poor requires that health workers be adequately compensated and effectively supervised and supported. The NGOs working in contracted-out districts revised the salaries of health care providers, bringing them in line with average salaries in the private sector. In return, the NGOs required the providers to work full time in health facilities and to have no private practice.

In the contracted-in districts, the NGOs supplemented provider salaries with their own funds and, in one district, allocated a larger share of user-fee income. The control districts, left to their own devices, allowed workers to pursue private income-maximizing behavior through unofficial fees and private practice, to the detriment of the public health care services for the poorest of the poor.

Transparent and predictable fee structures are important in improving access to health services. Official user charges were introduced in only one contracted-in district, in consultation with communities, to provide incentives to health workers. To remove ambiguity about charges, a schedule of user fees was prominently displayed in all health facilities. This discouraged private practice and helped bring “under-the-table” payments formally into the system. Out-of-pocket spending on health fell in that district. No user fees were introduced in the other two contracted-in districts, or in the control districts, where out-of-pocket spending did not come down.

Contracting health services to NGOs can be difficult for policymakers to accept. But the Cambodian experience shows that it can be effective and equitable. It helped convince policymakers that the model could be adopted on a larger scale. They are extending contracting to 11 poor and remote districts, where the public provision of services is dismal.

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**Figure 2** Coverage of selected health indicators between 1997 and 2001 in control and contracted districts of Cambodia

- The availability of health services in villages reduced travel expenditures to seek health care, and NGOs enforced rules against informal payments by patients.

**Agreements on deliverables—
and enforceable contracts**

Contracting health services to NGOs can expand the coverage for poor people. In Cambodia it took agreements on deliverables and an enforceable contract, which in turn required an independent performance verification system. Once targets for 13 key health indicators were agreed on—for poor people—progress toward achieving them was measured through independent household surveys and spot checks by government staff. Payments were linked to achieving targets, with bonuses for better-than-agreed-on performance.

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