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*Correspondence to: Keovathanak Khim; Email: kkvathanak@gmail.com
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INTRODUCTION

The slow pace of improvement in public health service delivery and a perceived lack of accountability to the population associated with traditional line-item budgeting approaches have in many cases driven the search for more effective health management practices in government health care delivery. Cambodia has experimented with pay-for-performance (P4P) measures by piloting different methods of contracting the delivery of government health services to state and nonstate actors. These contracting arrangements have replaced the usual input-based mode of health care management through the Ministry of Health (MOH) in several health districts and in some cases have provided financial incentives...
to facilities and staff against agreed performance targets. As a private-sector management model adapted to the public sector,1 contracting works through the purchasing function in the form of an agreement in which the provider commits to a predefined set of outputs or outcomes.2 These incentive payment methods within the contracting framework may be considered as part of the taxonomy of performance-based financing (PBF) in World Bank terminology.3 In this article, we review and analyze the experience of piloting different contracting approaches in health service delivery and developing national policy for a unique contracting process in Cambodia.

A Buddhist nation in Southeast Asia with an estimated population of 15 million in 2015 (80% of whom live in rural areas, where the need for more efficient health service delivery is greatest), Cambodia is a postconflict country now moving into lower-middle income status. After two decades of war, civil conflict, and international isolation, the health infrastructure was in complete ruin at the end of the 1980s. National reconstruction began in the 1990s with very limited national resources and an increasing level of foreign aid.4–6 Government services include three levels: the central MOH and subsidiary departments, with eight national disease centers and national hospitals in 2015; 25 provincial health departments (PHDs) of the MOH; and 94 MOH operational health districts (ODs), where front-line service delivery takes place at 99 referral hospitals (RHs) and 1,141 primary health centers (HCs).7 However, only one third of first contacts for health care nationally take place in public-sector facilities.8 Though the national health workforce and infrastructure (hospitals and health centers) are provided principally by the MOH, the largest part of total health expenditure is out-of-pocket and directed to private service providers (a disparate sector including private pharmacies, dual practice of public sector staff, and private clinics); this occurs mainly due to a lack of performance in the government sector.

In recent years, there has been increased investment in the government health infrastructure and human resources and significant progress in national health indicators. Nevertheless, there is considerable room for improvement in the quality of public health care delivery, and services remain underutilized.9 Among the many factors that contribute to low utilization levels at public facilities, one important factor is the underperformance of health workers due to low salaries, the lack of real incentives, low job motivation, and weak management;10,11 along with a lack of effective performance appraisal, feedback, supervision, and systems for communications and reporting.12 Weaknesses in health staff capacity and support and inadequate financial and physical resources (such as facilities, drugs, and medical equipment) have also affected provider performance. Selected national health indicators for the years 2000–2014 are summarized in Table 1.

To address these challenges, the MOH has piloted various contracting approaches and mechanisms in rural areas since 1997 together with the payment of performance incentives. (Though staff incentives have been paid in different ways in urban centers, no contracting model has been applied in an urban area.) This has involved an ongoing process of designing, piloting, and evaluating different models of contracting, decision making, and scale-up conducted by the MOH in collaboration with donor partners. Initially, government service delivery was contracted to nongovernment providers (that is, international nongovernmental organizations [NGOs]). Later, a system of contracting within the MOH included performance-based staff incentives. The purpose and intent of these schemes was to overcome the inefficiencies of central government administrative procedures; provide the managers of ODs, referral hospitals, and health centers with greater authority and the structures to make service delivery decisions locally; supplement health staff salaries; and provide a human resource monitoring and support structure.

The contracting pilots unfolded in three distinct phases. The dates below indicate the beginning and the end of each pilot program, which correspond to periods of time covered by donor-funded national projects for health system strengthening (including consecutive health sector support projects); our research focuses mainly on the special operating agencies (SOAs) experience in phase 3:

1. 1997–2002: An external contracting-in and contracting-out pilot implemented by donors through the MOH and

| Indicator | 2000 | 2005 | 2010 | 2015 |
|-----------|------|------|------|------|
| Neonatal mortality (both sexes, per 1000 live births) | 37 | 28 | 27 | 18 |
| Infant mortality (both sexes, per 1000 live births) | 95 | 66 | 45 | 28 |
| Under-five mortality (both sexes, per 1000 live births) | 124 | 83 | 54 | 35 |
| Maternal mortality ratio (per 100,000 live births) | 437 | 472 | 206 | 170 |
| % HIV among general population | 2.0 | 1.2 | 0.6 | 0.6 |
| Tuberculosis prevalence (per 100,000 population) | 1670 | n/a | 817 | 715 |

a/a: data not available; all data are from the Cambodia Demographic Health Survey except marked otherwise.

Ref. 61.

TABLE 1. Health Situations in Cambodia 2000–2015a
a so-called New Deal arrangement implemented by international NGOs at some MOH facilities.

2. 2003–2009: The MOH donor hybrid contracting pilot that combined features of contracting in and contracting out and a second New Deal (version 2) supported by the Belgian Technical Cooperation (BTC).

3. July 2009–present: A uniform model of internal contracting implemented within the MOH as one part of a broader public-sector administrative reform using MOH units as designated SOAs to manage and deliver health services

Published evidence suggests that under the initial contracting-in/out pilot, providing financial incentives improved the performance of providers and managers, who were more active in tackling service delivery problems, and the delivery of maternal and child health services improved, albeit with higher costs. The New Deal approach produced similar results, along with the increased utilization of public health services. The impact of these interventions varied between ODs as a function of organizational, demographic, and provider characteristics, including the volume of activity, local competition, acceptance of salary supplements, and trust in the rationale behind contracting.

The second phase of hybrid contracting contributed significantly to increased utilization of maternal and child health services, more efficient use of resources, and greater accountability on the part of providers. The New Deal 2 program contributed to improved provider performance and improved maternal and child health service delivery.

In the third phase, it has been shown that improvements in service delivery due to the previous contracting pilots were sustained, especially where performance incentives were adequate and performance management was strong. The SOA approach further improved performance where objective monitoring of contract outputs, clear and adequate rules, and greater provider autonomy were in place. Evidence suggests that providers in SOA districts were more motivated and had stronger clinical performance than those in non-SOA districts.

METHODS

In this article, we analyze the piloting process that led to the eventual adoption and expansion of the SOA internal contracting model. Our aim is both to inform the further development of the contracting approach in Cambodia and to provide an understanding of the issues involved in the design, management, and scale-up of similar schemes in other settings. We adopt a policy analysis method to identify the
collection was performed between April and September 2015. Most interviews were face-to-face and a number were conducted electronically using Skype. Interviews were conducted by the first author as the principal investigator and two coinvestigators in Khmer and English. Many of the interviews were electronically recorded and transcribed in Khmer. Notes were taken in cases where voice recording was not possible. Important findings in these interviews were extracted from the transcripts and translated into English. The study was approved by the National Ethics Committee of the MOH and by the World Health Organization (WHO) Ethics Review Committee.

Data from the documentary analysis and key informant interviews were used to address—with respect to each phase of contracting development—how and why specific changes took place. This was done by investigating who made the key decisions that led to change, what the balance of influence was between government and donor partners, what the circumstances were that provided the opportunity for change in a particular way, and the less-reported events that lay behind the apparent course leading to a policy outcome. Facts were judged as important to our analysis according to their apparent influence (based generally on testimony) on eventual outcomes, corroboration of evidence between documentary analysis and key informants, and through an informal process of peer review among experts most familiar with the field of study (the authors themselves have been involved in the process of health reform in Cambodia).

RESULTS

First, we describe the different designs of the various contracting models piloted in Cambodia since the 1990s. We then analyze the process by which the different models were designed and implemented and the major reasons for moving from one model to the next.

Differences in Design During the Three Contracting Phases

Between 1997 and 2002, three distinct contracting models were piloted: the first two were the contracting-in and contracting-out models promoted by the Asian Development Bank (ADB) as part of its support for national health system development; the third was a so-called New Deal approach first developed by the Swiss Red Cross and later adopted by Médecins Sans Frontières and UNICEF in collaboration with WHO and the MOH to address underutilization and low efficiency in the public health sector.

The contracting-in/out pilot program was implemented through the MOH with donor support in five ODs. In three contracting-in ODs, the autonomy awarded to international NGOs contracted by the MOH was more limited; these international NGOs could hire additional staff outside of the MOH staff quota but were otherwise required to follow established public-sector procedures in all matters, including with respect to personnel and procurement.

In two ODs, the contracting-out international NGOs were awarded full management autonomy within the OD, including with respect to personnel and procurement. As a completely separate initiative, the New Deal was implemented in four ODs; the model used government staff, procedures, and infrastructure but also institutionalized performance-based incentives for health managers and providers.

Between 2003 and 2009, two new contracting schemes were piloted. One was an MOH donor hybrid contracting scheme that combined features of contracting in and contracting out and was implemented in 11 ODs. In this scheme, contracted international NGOs managed human resources and were required to meet specified indicators for service delivery or risk financial penalties. The international NGOs had the right to hire and fire additional staff over and above the civil service quota provided through the MOH.

The second was called the New Deal version 2 and was supported by BTC. In this model, the PHD signed an internal contract with the OD management, which in turn developed performance contracts with service delivery units. With financial and technical support from BTC, PHDs were given authority to manage contracts with subsidiary health districts and facilities that were provided with funding linked to the achievement of service delivery and management indicators.

Since July 2009, a uniform model of internal contracting has been implemented within the MOH as one part of a broader public-sector administrative reform through the designation of selected ODs as SOAs in which facility and district directors were provided with increased management autonomy to hire staff additional to those on the MOH payroll and procure certain supplies.

A first cohort of 11 ODs that had formerly implemented hybrid contracting began SOA implementation in July 2009, followed in January 2010 by another ten ODs and provincial hospitals that formerly had implemented the New Deal 2 arrangement. Three additional ODs in Takeo province were added in January 2011, and by 2015 a total of 36 ODs and provincial hospitals had become SOAs. On behalf of the MOH, the secretariat of the donor- and government-funded Health Sector Support Project (HSSP) acted as principal to the head contract to sign performance agreements with
selected PHDs; in turn, the PHDs and each SOA signed performance agreements; SOA directors and the managers of facilities (referral hospitals and health centers) also signed performance agreements.

These internal contracting arrangements were consistent with the preferences of the government’s Council for Administrative Reform, which favored the delivery of government services through the MOH rather than NGOs and in the hands of local rather than international managers. In a separate but supporting initiative, the government and donor partners agreed to provide each SOA with additional funding paid directly from the central level to the OD on top of the routine MOH line-item budget allocations funneled through the MOH central provisional district facility hierarchy. These took the form of service delivery grants (SDGs), which were also funded through the HSSP secretariat and allocated to operational costs and staff incentives.35

Key informants (KIs 3, 9, 23, 28) suggested that all of these different contracting models focused on improving the management of health services and encouraged greater flexibility in the management of providers. The models differed in the level of autonomy given to the contracted OD managers and in the governance structure of health care delivery. Respondents generally agreed that many MOH officials had taken a position in opposition to the contracting-in/out approach promoted by the ADB because it appeared to them to be moving responsibility, and donor funding, for service delivery activities at the district level from the MOH to NGOs. This seemed to contrast with the approach taken under the New Deal arrangement, which maintained service delivery activities through the existing MOH structures (supported by donor partners and NGOs). A number of key issues emerged from our analysis of the policy process that underlay changes during the three phases.

1997–2002: Why Was Contracting Introduced and What Factors Influenced the Design and Implementation Arrangements?
The piloting of the different contractual arrangements in each phase reflected the convergence of three essential elements at a particular point in time: (1) the population health and health policy context of the country; (2) the availability of external financing and donor interests that favored performance-based initiatives; and (3) the receptiveness of MOH officials to piloting and experimentation. The key factors during this initial phase of contracting are summarized in Table 2.

Both the documentary review and key informants, local and foreign (KIs 11, 12, 2, 13, 15, 24, 25, 26), revealed a generally felt need to accelerate improvements in population health as the main consideration in implementing the initial trials to reform service delivering (the context). The foundation for implementing the innovative contracting arrangements was provided by earlier reforms in 1995 and 1996, including the Health Coverage Plan, which expanded the health infrastructure and created the health ODs, and the National Health Financing Charter, which enabled government health facilities to levy nominal user charges while retaining 99% of fee revenues for operational costs and staff

### TABLE 2. Policy Issues Affecting the Introduction of Contracting During 1997–2002

| Issue | Details |
|-------|---------|
| Context | National health reform process 1996–2002 |
|        | Poor health status of the population and inadequate health service delivery and quality |
|        | Low salaries for government workers and insufficient health providers in rural areas |
|        | National strategy defined by the Health Coverage Plan and National Health Financing Charter |
|        | Availability of considerable donor funding, an appetite internationally for piloting private-sector management models in the public sector, and willingness within the MOH to pilot new interventions |
| Actors | MOH, donor partners, and NGOs |
|        | All policies implemented through the Ministry of Health |
|        | Contracting-in/out pilot funded by the Asian Development Bank, with international NGOs contracted to provide services in five ODs, including Health Net International, Enfants et Développement, Save the Children Australia, and the Association of Medical Doctors of Asia |
|        | First New Deal pilot initiated by Swiss Red Cross at Takeo provincial hospital and replicated elsewhere by Médecins Sans Frontières and UNICEF in collaboration with the WHO and the MOH, covering four ODs |
| Process | Initiation, design, and implementation |
|        | The Asian Development Bank proposed to move service delivery from the MOH to contracted third parties; supported by the World Bank in a national project-funding partnership |
|        | MOH retained responsibility for oversight of contracting implementation through the Health Sector Support Project secretariat |
|        | With MOH support, the New Deal model was replicated in three additional ODs with donor partner and NGO funding and support |
|        | All pilot interventions were monitored and evaluated by the MOH in collaboration with donor partners |
incentives. These initiatives began a longer-term process of health reform and capacity enhancement (for implementation and policy) of the MOH.

Development partners were chiefly instrumental in the piloting of contracting methods in 1997 (the actors), influenced by a global move toward adopting private-sector methods in the public sector, particularly performance-based incentives. Within a nationwide program of health sector support, the ADB (30 million USD) and the World Bank (20 million USD) initiated loan programs, and technical advisors supported by the banks proposed that contracting methods should be piloted (KIs 17, 22). Working on a completely separate initiative with the MOH and WHO, the Swiss Red Cross devised the New Deal model that, it was argued, was more appropriate to Cambodian conditions in its use of performance incentives while maintaining support for the established government health delivery system (KIs 20, 27).

With a desire to be further integrated into the international and regional communities after decades of conflict, limited fiscal resources, and the need to speed up reconstruction of the health sector, MOH officials (as actors) were receptive to proposals for the piloting and evaluation of new service delivery approaches, including contracting (the process). The MOH was dependent on development assistance, and key informants (KIs 17 and 27) believed that very few of the officials then had higher level education or fully understood the implications of the proposed reforms.

It was the combination of these factors—the economic and health reform context, the donor partners and MOH who comprised the main actors, and the process of piloting new interventions as the basis for further decision making—that determined the introduction of the different contracting initiatives and the forms that they took (the process). The MOH was dependent on development assistance, and key informants (KIs 17 and 27) believed that very few of the officials then had higher level education or fully understood the implications of the proposed reforms.

It was the combination of these factors—the economic and health reform context, the donor partners and MOH who comprised the main actors, and the process of piloting new interventions as the basis for further decision making—that determined the introduction of the different contracting initiatives and the forms that they took (the process). The commitment to and acceptance of performance incentives (by donor partners and the MOH) reflected not just a desire to improve service delivery outcomes but also the generally low level of the official salary structure. The financial power of the donor partners together with their apparently superior technical capacity put the MOH in a position where it had little room to affect these policy outcomes. The interplay of these forces, the further development of the health system, and the increasing financial and human resources capacity of the MOH would, in subsequent years, lead to a different balance between government and donor influence in determining policy outcomes.

2003–2009: Why Was a New Contracting Design Introduced and What Was Its Character?

The move to hybrid contracting was seen as a compromise following a long and intense process of negotiation between the MOH and DPs. Crucial considerations were the fit between the contracting model and the wider political context, the higher service delivery unit costs under the first contracting pilot, and a longer-term vision for building a sense of local ownership for sustainable improvement in the sector. The major changes in this period and the factors driving these changes are summarized in Table 3.

Ultimately, the hybrid model proposed by the MOH gained support from DPs (the actors). Although the contracting-out approach had been identified by DPs as the most

| Issue | Details |
|-------|---------|
| Context | National economic growth and public-sector reform. National economic growth and increased government funding for the health sector. Population health as well as health service coverage and quality remained poor. Decentralization, public administrative reform, and public financial management reform initiated nationally. Health Strategic Plan 2003–2007 adopted by the MOH. Health Sector Support Program 2003–2010 funded jointly by MOH and donor partners. Global Health Initiatives (GAVI, Global Fund) commenced activities. |
| Actors | MOH, donor partners, and NGOs New hybrid contracting model proposed by the MOH and funded by the World Bank, Asian Development Bank, the UK Department for International Development, and UNICEF. International NGOs contracted by the MOH to provide technical support in 11 ODs (CARE Australia, Save the Children Australia, Health Net International, Enfant et Développement, The Association of Medical Doctors of Asia, and Health Unlimited). New Deal 2 funded by Belgian Technical Cooperation in collaboration with the MOH; internal contracting with PHDs to manage service delivery in seven ODs and three provincial hospitals. |
| Process | Negotiation and transition Agreement on the move from contracting-in/out to hybrid contracting achieved only after tough negotiations between the MOH and donor partners. Pressure on the government to contribute more funding to contracting activities. Consultation between MOH and Belgian Technical Cooperation to formulate New Deal 2. |

TABLE 3. Policy Issues Driving Change in Contracting Arrangements During 2003–2009
effective method, the MOH had its own concerns (listed below). The DPs ultimately agreed after consideration of the high fiduciary risks of the earlier forms (that is, the higher costs of the contracting-out model preferred by donor partners could not be sustained financially by the MOH if scaled up nationally), weaknesses in the government’s financial management system, limitations in local administrative capacity, and weaknesses in health system governance (KIs 11, 12).

Among the chief concerns with the earlier contracting-out approach expressed by the MOH, including provincial and district officials, were the following:

- The high service delivery costs of contracting out compared to routine government health service delivery.
- The administrative demands of contracting out, which meant that local government officials had been required to suspend their MOH post for four years to join the contracting pilot.
- The potential loss of staff from the government health system under an extended contracting-out model.
- The outsourcing of government health services to international NGOs.
- The wide pay differentials and divergent power relationships between NGO-employed health providers and government service providers.
- The sense that there was a lack of national ownership of schemes that had begun as purely donor-funded projects.

Key informants familiar with the MOH position said that the MOH recognized the value and the potential of contracting (KIs 9, 13), and the MOH moved further in this direction by explicitly supporting the contracting approach in the Health Strategic Plan 2003–2007 as a means to strengthen service delivery to achieve Cambodia’s health-related Millennium Development Goals. The hybrid contracting model was then considered a means of transition to a form of contracting more in line with MOH strategies while also allowing more time for local MOH officials to gain expertise and experience passed on from the contracted INGOs. At the same time, New Deal 2 used an internal contracting approach within the MOH provincial health system, led by the PHD, with the purpose of empowering and building the capacity of local officials in both clinical and management skills.

The international NGOs involved in hybrid contracting and New Deal 2 were contractually bound to introduce a P4P mechanism and to build the capacity of district and provincial health officials and in turn risked financial penalties if they failed to achieve performance indicators. Nevertheless, according to a government official, the hybrid contracting international NGOs fell short in their capacity building role; of the 11 ODs involved in hybrid contracting, only two were perceived to have some capacity in contract management by the end of the period and no contracted NGO had drafted an exit strategy (KI 12).

Under the New Deal 2 model, the PHDs were given the authority to lead and manage the internal contracts and were the focus of BTC capacity building efforts. This primary attention to the PHD (which consumed most of the time and resources of BTC) most likely meant that the needs and functions of OD offices received much less attention from BTC than required, according to local key informants. On many occasions, the limited capacity of the PHD meant that BTC often stepped in to manage contracts directly (KI 18).

Gaps remained, however, in the different contracting processes during this period. The New Deal 2 arrangement itself incurred high costs of service delivery from the payment of performance incentives and operational costs. Enforcement of the performance contracts was not easy and at times led to staff resentment (KIs 3, 7).

Changes in the political and fiscal environments during this period (the context) had created a situation in which the government moved to reclaim the initiative in national reconstruction from the DP community (the main actors), which had dominated policy making and development funding since the early 1990s. The MOH was particularly unwilling to accept the idea that donor loan funds for which the MOH was fully responsible (in particular, in contrast to grants) would be allocated to nongovernment agencies through the contracting process. The MOH was also fully committed to maintaining its role in service delivery and the funding that was associated with it and to strengthening the capacity of its own staff. Therefore, despite strong initial opposition from the DPs to removing the third-party provider NGOs from service delivery, the preference of the MOH and the government to move to the hybrid contracting model eventually held sway. But this model, too, gave way to a new form as the context changed.

**From 2009 Onwards: What Drove the Change Toward Internal Contracting?**

The introduction of the SOA model represented the culmination of a decade of contracting experience and accumulated national capacity in contracting methods. Both a stronger national fiscal situation—the health budget increased from 100 million USD in 2008 to 250 million USD in 2013—and the government’s desire to create a sense of national ownership of health service management and delivery were cited
by respondents as important factors in building support for
the SOA model (the context; KIs 14, 16). The SOA approach
was thought to complement other reforms, including the Pub-
lic Financial Management Reform launched in 2008 to
improve financial accountability, budget policy linkages and
performance accountability, and government decentraliza-
tion procedures (KIs 13, 15). At the same time, the gov-
ernment initiated the merit-based pay initiative and the
performance management and accountability system within
the civil service (and the MOH) to improve staff motivation
and job performance. The factors driving these changes are
summarized in Table 4.

The years of accumulated experience with contracting and
the increasing financial strength of the MOH meant that key
national policy makers (the actors) were confident in insisting
on a move to the new model of internal contracting
within an established program of public-sector reform (the
context). Though weaknesses in government administration
meant that DPs continued to lack trust in MOH management
and financial procedures, the greater capacity of MOH deci-
dion makers and service providers meant that agreement on
the way forward favored the MOH plan. The policy process
was influenced mainly by the commitment of the government
to what it saw as sustainability and local ownership, though
there was still general agreement that the move to SOA
arrangements was part of an ongoing transition in govern-
ment administration.

Despite the genuine commitment to move to the internal
contracting model, experience with SOA implementation in
these more recent years has revealed several gaps and weak-
nesses in administrative arrangements (though not the basic
design) that may threaten the ongoing implementation of the
model—and undermine the strong arguments based on
improving national ownership of the process—unless cor-
rected during the scaling-up process.

These underlying challenges include low job motivation
related to inadequate incomes and resource levels, insufficient
funding for staff hiring, gaps in the monitoring of
SOAs and staff performance, and the compromised integrity
of performance monitoring. These concerns have been con-
firmed by HSSP monitoring reports and include the following:

- The overlapping roles of the SOA principal (purchaser)
  and monitoring groups.
- A lack of clarity in contracting implementation guide-
  lines and inadequate provider autonomy.
- A generally poor understanding of the roles and respon-
  sibilities of the contracting parties.
- Inadequate funds and delays in receipt.

| Issue | Details |
|-------|---------|
| **Context** | Continued economic growth and public-sector reform |
| | Annual government health spending increased from 150 million USD in 2010 to 250 million USD in 2014. |
| | Despite gains, further improvements in population health were necessary. |
| | A new national public sector reform program created the category of special operating agency to improve performance of government service delivery units, including increased autonomy under the public financial management reform. |
| | Service delivery grants, the merit-based payment initiative and the performance management, and accountability system introduced alongside the SOAs. |
| | MOH selected as the first ministry to pilot the SOA arrangement at selected ODs and provincial hospitals. |
| | The Health Strategic Plan 2008–2015 required an increased focus on accountability of MOH units as well as improved quality, accountability, sustainability, and equity in service provision. |
| **Actors** | MOH, SOAs, donor partners, and NGOs |
| | Government financial contribution to the joint MOH donor Health Sector Support Project approached ~40% |
| | Donor partners included the World Bank, UNICEF, United Nations Population Fund, Australian Aid, Belgian Technical Cooperation, the UK Department for International Development, and Agence Française de Développement. |
| | Short-term capacity building support provided by NGOs (Reproductive Health Association of Cambodia, CARE Australia, Save the Children Australia, Swiss Red Cross, and Belgian Technical Cooperation). |
| | Monitoring of SOAs by SOA teams, PHD teams, central MOH teams; external agency contracted to audit program and financial management. |
| **Process** | Preparation, change, and implementation |
| | UK firm Oxford Policy Management assisted the MOH in the design and preparation of the SOA model and new incentive mechanisms. |
| | Protracted negotiations within the group of donor partners about the management pooled funds (government and donor partners). |
| | SOA architecture established by the MOH; PHD and OD management capacity assessed. |
| | Challenges emerged in SOA implementation and monitoring of results: slow fund flows, lack of objective management of performance, inadequate clear rules and procedures, and lack of autonomy. |

**TABLE 4. Policy Issues Driving Change in Contracting Arrangements During 2009–2015**
• A shortage of skilled staff; deficiencies in reporting skills.
• Inadequate monitoring and enforcement of contracts.

Development partners remain concerned there is a fiduciary risk that the government will be unable to sustain budget funding for the SOA model when scaled up to national coverage and continue to lack trust in government administrative and financial systems. One consequence of this was evident when the DPs showed their reluctance to put donor funding for SDGs into the national budget system (according to at least one foreign advisor: KI 29).

The process of scaling up the contracting model to national coverage appears to have been restricted by several policy-related factors:

• An extended time was required to implement and test the initial models of contracting and to build local capacity (KIs 1, 3, 5, 8).
• The lack of robust evidence on the impact of contracting on service delivery raised questions about its effectiveness (KI 13).
• As a supply-side intervention, the SOA process had to compete with a large number of other experimental interventions introduced mainly in response to different DP demands (KI 27).
• As a provider-focused model implemented within the district health system, the internal contracting method has not yet settled comfortably within the existing administrative system (KIs 4, 5, 6, 7, 10).

DISCUSSION AND CONCLUSIONS

The activities of the disparate private sector, the common occurrence of dual practice by government staff, and inadequate regulatory control have all provided a difficult context in which the SOA contracting reform has commenced.\textsuperscript{22,44} The SOA model now appears to be permanently in place, but further progress in scaling up the current SOA model will require improved regulation, improvement in the governance system, and increased levels of staff remuneration.

The evolution of contracting in Cambodia has been characterized by a shift from international assistance to national ownership, a gradual increase in domestic financial resources and capacity, and a commensurate movement of management from external to internal actors, a trend that is common in the evolution of many predominantly donor-funded programs in other regions of the world.\textsuperscript{45} Though the initial external contracting programs during 1997–2003 were almost entirely donor driven, the shift to hybrid contracting in 2003–2009 marked a successful bid by national actors to adopt a form of contracting that drew on the expertise of the international NGOs while largely retaining preexisting public-sector institutional arrangements. After 2009, the SOA experience represented a major change in the management structure of the government-controlled public health institutions as one part of a larger administrative reform, including a national process of decentralization and deconcentration of government services.\textsuperscript{46}

We have shown elsewhere that health service delivery improvements within rural ODs achieved during 2003–2009 were, generally, at least maintained under the SOA contracting arrangement.\textsuperscript{47} These improvements have occurred, in fact, despite shortcomings in SOA design and implementation.\textsuperscript{21} A separation of functions (that is, fund-holding, purchasing, service provision) is regarded internationally as one of the principles of a well-designed contractual arrangement.\textsuperscript{48,49} It is known that the successful application of the internal contracting design requires a clear delineation of roles (of purchaser and provider), robust mechanisms to ensure objectivity in contract management, and long-term fiscal support to ensure the efficiency and sustainability of the scheme.\textsuperscript{50,51} In Cambodia, the shift from a purchaser–provider split under earlier forms of contracting to a joint MOH purchaser and provider role under the internal contracting model confronts planners with the challenge of ensuring the integrity of the contract monitoring system.\textsuperscript{21}

Our research adds to the body of evidence on contracting and the processes by which policy decisions are made and implemented. From this experience we can draw several more general conclusions and argue convincingly that the road to national scaling-up of public sector reforms such as internal contracting differs greatly between countries, depending largely on context and circumstance. It is clear that an apparently linear path of reform is not always the best for long-term sustainability. Outcomes will generally be dependent on the influence of different players among the constellation of actors who influence policy, all working within a particular context that is constantly changing, to some extent as a result of successful reforms themselves. Different actors bring their own agendas and will have different levels of importance at different times; in the early periods of change and development it is likely that development partners will play a larger role than later on where domestic actors tend to become predominant. It is clear, too, that outcomes are greatly influenced by the content of the earlier stages of policy design and implementation, and these early initiatives also affect the context as well as the actors who may become increasingly important in later stages.
Over time, the extent of service delivery outcomes covered by the agreed SOA contracts has expanded. In the first pilots, ten performance indicators were included, all related to maternal and child health. Under the SOA scheme, the number of indicators has doubled and now include dengue fever prevention, HIV/AIDS care, malaria, diabetic care, and hypertension.\(^{52,53}\) Nevertheless, the geographic scaling-up of the supply-side SOA contracting arrangements was extended to only one third of health districts by 2015, which stands in contrast with the national Health Equity Fund, a demand-side financing scheme that provides financial access for the poor to government health facilities.\(^{54-56}\) Piloted in two ODs in 2000, the scheme has been scaled up to nationwide coverage with donor and government support.\(^{57}\)

Circumstances are changing quickly in Cambodia. The 2014 National Health Financing Policy confirms the right of health facilities, when fully accredited, to gain revenues from demand-side payments. At the time of our study, one proposition under discussion was to replace the supply-side SDG with a demand-side payment to providers (consistent with the Health Equity Fund mechanism). Though the details had not been determined, it was thought that this could take the form of a specified payment per patient visit paid to providers by a third party, semi-autonomous national agency—for example, under the MOH, Health Equity and Quality Improvement Project (H-EQUIP), or the social protection single operator—in the place of the current block grant. This would have the effect of reinstating the purchaser–provider split in the contracting mechanism.

The scaling up of the SOA arrangements to national coverage by 2020 is now under consideration by the Cambodian government and may possibly mean the expansion of SDGs to all health districts nationally. These issues are discussed in several policy documents that appeared in 2016, following our data collection. The National Social Protection Policy Framework 2016–2025 from the Royal Government of Cambodia (dated August 2016)\(^{58}\) identifies five main categories of benefit, of which one is health insurance (meaning all aspects of social health protection); it proposes the eventual establishment of a single operator (single payer) for all social insurance (including social health insurance and the expanded tax-financed Health Equity Fund). The framework is before the council of ministers awaiting approval.

The Health Equity Fund Operational Manual (dated November 4, 2016, and published by the MOH)\(^{59}\) defines the organizational arrangements for the national Health Equity Fund with operations in every health district and endorses the creation of a single operator to manage all social health insurance schemes. The Service Delivery Grants Operational Manual produced by the MOH for the national H-EQUIP, dated November 4, 2016),\(^{60}\) has put forth expanding the SDGs to national coverage as a central aim, with increased autonomy for lower levels of the health system and administered by a “Third Party Agency: . . . an independent agency appointed by H-EQUIP . . . ” to provide ex-post assessment of performance.

Like the Health Equity Fund, the SOA model appears to have emerged in Cambodia as an innovative and home-grown solution to recognized health system challenges. In both cases, the model developed, at different times in the face of opposition from development partners and international technical advisers. The experience underlines the importance of domestically determined solutions to the scaling up and sustainability of health system interventions. In this case, neither move to hybrid contracting or to internal contracting was favored by development partners, but each case represented a commitment by the MOH to implement procedures that fitted best with its own long-term strategies, capacities, needs, and resources. These are, in fact, the principal components of sustainability. Though the chosen models may not have appeared to be the best solution at the time, they were accepted as fit-for-purpose and fit-for-context.

A number of limitations are evident in our study. Because many key informants (particularly international advisors) are now located in a variety of other countries, the process of conducting in-depth interviews was constrained and had to be conducted electronically. Many respondents in senior positions faced the pressure of limited time to join an interview. Nevertheless, respondents were willing to share their views on the evolution of the different contracting schemes. Secondly, the recall of events from the past is often less than accurate and some respondents had difficulty remembering the details of the different initiatives. To address these constraints, we triangulated information from key informant interviews, documents, and other published sources. Thirdly, the gray literature focuses on the end product of discussions, debates, and meetings and provided little information about the dynamics of the process and stakeholders’ relationships; much of the content and character of these discussions therefore came from the key informant interviews.

The SOA model is not free from deficiencies or ongoing challenges, nor is the role and capacity of the MOH. Nevertheless, our study suggests that changes to contractual arrangements over time reflected a broader process of economic and social development in Cambodia that has strengthened the country’s capacity to develop independent solutions. The SOA contracting approach has been endorsed by the government as a means to improve the management
of service delivery within the government health system and will move to national coverage in the foreseeable future.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors state that there was no conflict of interest in undertaking this study.

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