



Reforming Remuneration and HR Practices for Cambodia's Health Professionals

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KEY MESSAGES:

Cambodia has faced daunting challenges in rebuilding its health workforce following the Khmer Rouge genocide of 1975-79, during which about 90 percent of health professionals perished, and the period of civil war that then continued until the 1990s. Today, government salaries for medical workers remain low and most public sector health professionals depend on a combination incentive payments financed by government or development partners, income from providing health services outside their public sector jobs in the private sector, or by seeking non-medical second jobs. Although public health services should be relatively low cost or free, evidence suggests that many public sector health workers request gifts or payments.

A variety of health financing and incentive schemes have been adopted over the years since the 1990s. With a view to improving service delivery in the health sector, the World Bank recently undertook a study¹ to inform policies on: the compensation of public health workers; the management, motivation and incentives for public health workers; how to manage the existence of dual practice; and key reforms to financial initiatives such as Health Equity Funds (HEFs) and Special Operating Agencies (SOAs), both of which have an important impact on health workers. The resulting findings are important in reforming Cambodia's human resources for health (HRH) policies and providing solutions to enable Cambodia's health sector to play its full role in helping Cambodian citizens to fulfill their potential.

Overview

The supply, distribution, skills, and motivation of the Cambodia health workforce are key determinants of health system performance. After primarily focusing on increasing the supply of public sector health workers, there is now a policy shift towards improving the distribution, skills, performance and quality of staff in both the public and private health sectors. This Policy Note outlines the findings from a recent review of these issues—which included a survey of over 1,000 health workers—drawing some conclusions and offering

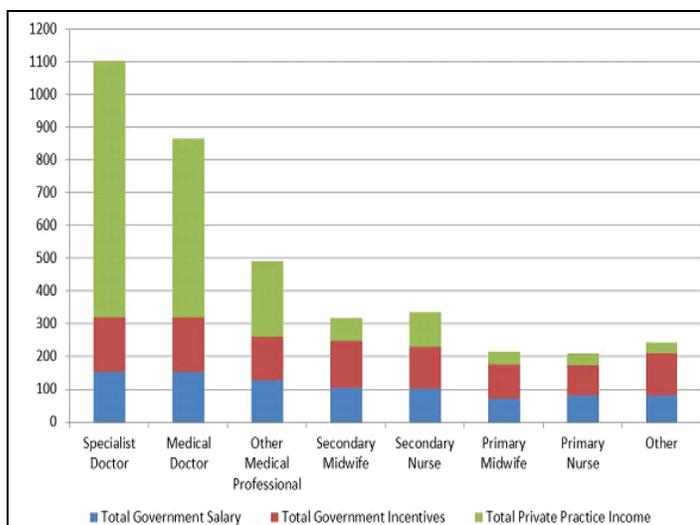
recommendations. The survey covered 1,168 health professionals, based on a representative sample of the total population of 5,404 health professionals in 19 operational districts in nine provinces and five national hospitals in Phnom Penh. Two primary questionnaires were used: (i) a Public Health Professional (HP) Questionnaire covering compensation or incomes and motivations and perceptions on HR tools among HPs working in the public sector; and (ii) a Facility Manager Questionnaire targeting the head of each facility and covering a census plus questions on facilities and facility needs, as well as motivation of staff.

Key Findings

Some of the key findings of the World Bank’s review are provided below:

- **Total health worker income has increased; dual practice income remains significant, but has declined as a percentage of total income since 2004.** Since 2004, public health worker compensation has more than doubled on average in nominal terms, including base salary and allowances, government incentives (financed by either the Government or development partners), and dual practice earnings. Government compensation (including incentives) as an average percentage of total income rose from one-third to about half, but dual practice remains the main income source for specialists/doctors (see Figure 1).
- **Salaries of public sector health workers remain low, with limited variation based on skills or experience.** The average base salary including allowances for public HPs is only about US\$100 per month, with doctors and specialists earning only 50 percent more than the average, making salaries highly compressed. Government incentives roughly double total government compensation across most categories of staff. In contrast, average dual practice income for specialists is over US\$800 per month, 2.5 times higher than total public sector earnings.

Figure 1. Specialists and doctors earn slightly higher government salary and incentives, but substantially higher dual practice earnings, compared with other skill classifications.



Source: HR Inc. Note: In this figure, dual practice earnings are averaged across all health professionals, regardless of whether or not they participate in dual practice. Subsequent figures show dual practice earnings only for those engaged in dual practice.

- **Various incentive schemes can double total incomes, but the schemes are fragmented and not consistently linked to performance.** Incentive payments come in several forms: (i) payments for health projects; (ii) user fees and Health Equity Funds (HEFs)¹; service delivery grants (SDGs) to Special Operating Agencies (SOAs)²; and midwifery incentive payments. Several findings emerge:
 - Incentive payments double public health worker income on average, but with high variations depending on the incentives available at a particular facility.
 - Staff are often unclear about the criteria for incentives, or perceive them to be unfair, or not based on their own performance.
 - Average incentives for doctors and specialists are only slightly higher than those for other staff, which means that incentives fail to remedy the compression of public sector compensation for doctors and specialists.
 - Delays in payment of incentives reduce linkages between performance and rewards.
 - Although incentives could be used to prioritize rural services, for example, most are not currently designed to do so.
- **Half public sector health workers work in dual practice, while about one-third have second non-medical jobs.** Seventy percent of doctors report doing dual practice work, while primary nurses and midwives are more likely to have non-medical second jobs than dual practice. Dual practice incomes average US\$50-US\$350 a month, with some specialists/doctors reporting US\$1,500 or more a month. Most health workers report that dual practice is becoming more difficult because of increased workloads and time-management conflicts in the public sector.
- **Satisfaction and accountability for performance appear to be highest at SOA health centers.** These are higher than for SOA hospitals, with the worst levels found in at national hospitals, even though these have the most autonomy (as Public Administrative

¹ Health Equity Funds (HEFs) pay user fees on behalf of the poor. They are financed by government and development partners, and usually operated by NGOs, and currently cover about one-third of the country geographically.

² Special Operating Agencies (SOAs) are granted increased autonomy (particularly with respect to paying staff incentives) in exchange for greater accountability. Currently, 22 of Cambodia’s 76 health districts are SOAs, along with eight referral hospitals. SDGs currently are financed by the Second Health Sector Support Program to provide performance-based financing to SOAs.

Enterprises). SOA health center staff earn more and report working longer hours than staff in non-SOA health centers.

- **Median public sector compensation diverges most from that of the private sector for experienced doctors and specialists.** Total public income for entry-level public sector health professionals is now on a par with the private sector. Experienced public sector nurses and midwives earn about one-third of their total income from dual practice, and their median total income is on par with the private sector. However, private sector earnings for experienced doctors and specialists (10 years plus experience) are several times higher than public earnings. For experienced doctors and specialists, when dual practice income is added to public sector income, this puts their earnings on a par with experienced private sector doctors and specialists.
- **Most public health workers do not want to lose their public sector jobs, but have unrealistic expectations of additional pay if they forgo dual practice.** Health workers generally prefer to retain their public sector jobs due to better access to training, job security and pensions, plus opportunities for dual practice. But, leaving aside specialists and some doctors, most other health workers would expect total incentives several times higher than current dual practice earnings before they would consider leaving dual practice entirely.
- **Job satisfaction and other motivators are also important for health workers,** including access to training, a supportive work environment, and adequate equipment. Staff and managers at SOAs rated their satisfaction and motivation higher than other health professionals.

Conclusions

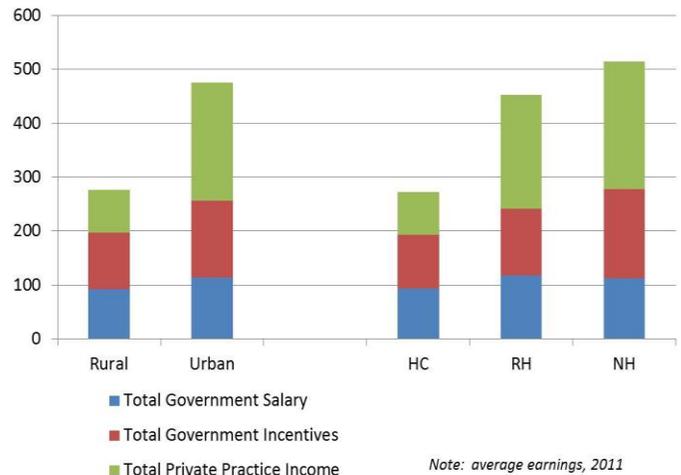
Several important conclusions emerge from the findings outlined above, as follows:

1. **Public sector salaries remain inadequate** relative to the private sector and dual practice earnings, and are highly compressed. As such, the Government's policy in recent years of 20 percent annual increases in all base salaries is insufficient to redress this imbalance, especially for doctors and specialists, who can earn far more in the private sector.
2. Various **incentive schemes are not equitably distributed**, adequately linked to performance, sustainably financed, or guided by a clear policy framework. This is likely to reduce the impact of incentives on staff motivation and distribution. Clarifying objectives would help to guide policy development to achieve specific goals, which could be to: top up salaries to levels closer to the

private sector; incentivize provision of priority services; encourage staff to serve in rural or remote areas; or reduce and better regulate dual practice.

3. **Different approaches will be needed to address compensation and motivation** for staff at health centers as opposed to hospitals; for nurses and midwives as opposed to specialists/doctors; and for staff in rural versus urban areas. Health workers in rural areas have less access to user-fee revenue and dual-practice income, but their salaries and incentive schemes fail to compensate them for these losses. This makes it harder to attract and retain staff in rural areas.

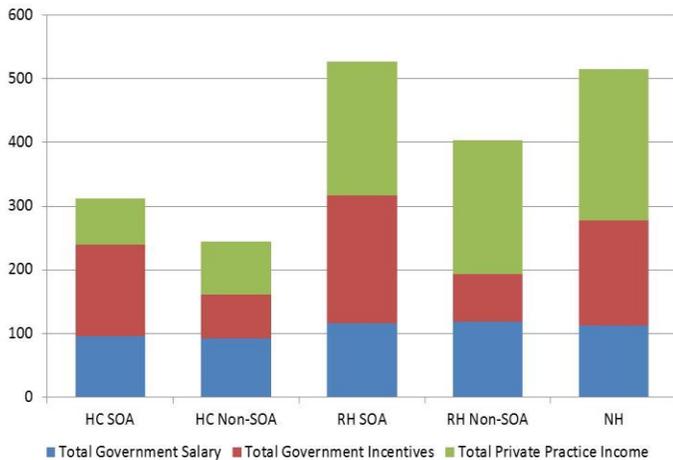
Figure 2. Urban HWs earn more incentives and far more dual practice income than rural health workers, and hospital workers earn more than health center workers (average)



4. Despite incentives, **dual practice remains widespread.** Experience from other countries suggests that banning it would be difficult and possibly counterproductive. Instead, dual practice needs to be better regulated and the negative effects mitigated by compensation reforms and strengthened accountability and oversight.
5. Salary increases or incentives alone are inadequate for improving motivation and performance, but need to be linked to **increased accountability.** Performance management has been improving but the performance management and appraisal system (PMAS) system could be further streamlined.
6. **Increased autonomy for health facilities, while promising, needs to be linked to stronger accountability.** The current SOA and SDG payment model appears to work better in health centers than in hospitals.

7. The current design of SDG grants works better for primary care than in hospitals, while payments
8. based on service outputs provided (HEFs) seem to work better in hospitals. This is consistent with global experience on **provider payment systems**.

Figure 3. SOA staff receive more incentive income, but only slightly less dual practice income (average)



Policy Recommendations

Establish a policy framework for payment of non-salary incentives. This should include a clear statement of objectives; transparent rules for the distribution of incentives (among facilities; within facilities; and among categories of staff); and accountability and oversight mechanisms. Establish appropriate maximum and minimum incentive allocations for various job categories.

Consolidate current incentive schemes. Two questions should be considered: How to pay health facilities for services (outputs and quality); and how to pay health workers within those facilities?

- Break the linkage between revenue-earning opportunities of health facilities and their ability to finance salaries and incentives.
- For referral and national hospitals, shift financing towards output-based payment systems, through a combination of HEFs, Social Health Insurance, and performance-based transfers.
- Establish a consolidated payment system for health centers, integrating output-based elements of HEFs and midwifery incentives with quality-based per capita payments (similar to SDGs).
- Establish guidelines for allocating incentive income to staff within facilities and introduce transparent information systems to monitor/report payments to managers and staff.
- Ensure criteria for incentives are clearly

understood by staff.

Strengthen policies for the use of non-financial incentives in order to improve the motivation and distribution of staff. For example, this could include priority access to training and promotions for those in rural areas.

Strengthen autonomy and accountability for public service providers. The SOA/SDG model seems to have improved accountability in health centers, but not in referral hospitals. National hospitals have the most autonomy, but also the greatest difficulty with HR management and performance accountability.

- For SOAs and non-SOAs, improve vertical accountability, as well as independent performance monitoring, with a greater role for citizens and local governments.
- Review PMAS for streamlining and increase effectiveness in management performance.
- Strengthen oversight mechanisms for national hospitals (PAEs), including specific performance contracts.
- Give greater flexibility to facility managers to influence staff deployment/assignment and performance management, with checks and balances.

Formalize and regulate dual-practice working arrangements. A sanction system alone would be ineffective while wide public/private wage gaps persist.

- For staff on full-time contracts, strengthen enforcement of public sector working hours, and establish guidelines for dual practice outside working hours.
- Establish part-time contracts for specialist staff, with clear criteria for hours worked, and performance standards and ethics (for example, no “poaching” of patients).
- Phase out dual practice for hospital managers in exchange for higher performance-based pay.
- Establish premiums for highly skilled staff and managers who eschew dual practice.

Strengthen systems and capacity for management and professional development.

- Provide training and mentoring of managers at all levels, including in HR and staff performance management.
- Build closer links through training for both public and private sector health professionals.
- Strengthen links between the HR and personnel management system, and the performance management information system.

Implement civil service pay reform. This needs to be done to ensure effective management and oversight of

service delivery in the health system.

- Implement a public sector compensation system, with competitive remuneration for health sector civil service managers, regulators and “back-office” staff.
- Look into transitional options for the sector, for example allowing a small percentage of incentive

revenue to be pooled and used for performance-based monitoring.

- Look into whether service delivery medical professionals and facility managers should continue as civil servants or shift to fixed-term contracts.

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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