CHAPTER V

DISCUSSION, CONCLUSIONS, & RECOMMENDATIONS

5.1 Discussion

Improving service delivery depends on having some key resources such as manpower, materials, time, money, and management skills (WHO, 2005). It also depends to a large degree on the ways those resources and services are managed. The lack of managerial capacity at all levels of the health system is increasingly cited as binding constraint to scaling up services and achieving set goals. Weak management support systems may compound the problem as well as the working environment (rules, procedures, reporting lines, which frame their freedom for maneuver). The purpose of this research was to investigate the appropriateness of CUP management performance by a cross-sectional study.

The performance of management is not easy to be determined. Management has several functions and aspects. Most of them are not easy to capture by indicators e.g. the quality of the planning process. To compare performance with regard to different functions of management and to describe the overall performance, a marking system with points and scores for points reached of totally achievable points was established. These grouped answers reduce differences of the information and this increases inaccuracy. The reliability of judgment is reduced by the fact that secondary

information by respondents on the management process is influenced by subjectivity and their degree of comprehension of management. Factors which reduce reliability and accuracy of the information as described are aggravated by the small number of respondents surveyed per CUP. Apart from this, representation of information is limited because only about 25% members of each CUP were surveyed. Still, the answers of 95 respondents with totally 3,161 points achievable for management performance allow a valuable description of management performance across all CUPs.

5.2 Overall Score for Management Performance

The overall mean score for CUP-management performance is 66%. Management with a mean score of ≥70% were seen as reflecting sufficient performance and this was reached by 5 of 16 CUPs (31%). The value of this finding is limited by the fact that the judgment for each CUP is based on the information of only 25% of CUP members which is on average 6 persons per CUP.

The range of the overall score was very wide (23% - 86%). This may also reflect the level of differences in knowledge by respondents about the CUP management structure and function. The quite high score could partly be influenced by a selection bias, which means that in some CUPs the better members in a CUP volunteered to answer the questionnaire because their knowledge on CUP management was higher.

5.3 CUP Management by Function

5.3.1 CUP-management structure

It is useful to look at the overall score for the 6 main management functions because it indicates areas of strengths and weakness in CUP management. There is no clear regulation by MOPH on how to structure the district health system. The existing administrative structure with a DHO under the Ministry of Interior being responsible for primary care facilities and of a district hospital, which is supposed to work closely with these primary care facilities under the MOPH poses some difficulties in managing the district health care system.

Also instructions for organizing a Contracting Unit for Primary Care were not very clear. For the district to manage the CUP the term "CUP-Board" was introduced but many CUPs use other terms and some CUPs give the task to a district health coordination committee. The composition of CUP members also varied as indicated by the in-depth interviews. This could also indicate inadequate guidance by policy on how to organize the management structure. In this environment of uncertainty the districts did relatively well in organizing themselves and 9 of 16 reached a score for sufficient structural arrangements.

5.3.2 Planning

Planning is probably the most important function of management. Seven (47%) CUPs had a score of "sufficient" and the average score was 64%. This means that more than half of the CUPs should think of how to improve planning. More attention should be paid to participation, which did not seem to be sufficient even with regard to members of the CUP-management itself. Only 64% of the respondents

had participated. Participation was even less sufficient with regard to staff in PCU/HCs and to communities, which seem to have been involved in only one third of the districts.

Almost all (90%) of the respondents stated that their CUP had a strategic plan for two years or more. In the in-depth interview, the impression was that the CUP directors were not very close to the development of indicators for measuring target achievements because indicators were mainly prescribed by MOPH or PHO. It seems that indicators are in general prescribed by the MOPH. This study shows that participation in development of indicators and using them improves the quality of indicators and the motivation for honest monitoring.

5.3.3 Delegation

Of the 16 CUPs 6 (38%) had a sufficient score and the average score was 72%. Only two questions were introduced to judge the level of delegation of tasks and responsibilities - the presence of job descriptions and the right for PCU/HCs to calculate and decide on their own drug demand. 68% of respondents said that they had a job description and 77% stated that the PCU/HCs could calculate own drug demand. These findings are relatively positive but it should be considered that they may not represent fully the reality. Apart from this it seemed that there were different perceptions of the term job description and it seemed that a positive answer related rather to a written description of the tasks generally performed under the respective professional position.

5.3.4 Human Resource management

Of the 16 CUPs 14 (88%) had a sufficient score and the average score was 79%. Manpower is the most valuable resource in any organization. Therefore the presence of continuing training programs as reported by more than 80% of respondents are obviously a positive finding. The findings of the study do not allow to judge the quality of the training but obviously attention is given to capacity building. Only 45% of the respondents stated that there was an incentive system in their CUPs.

5.3.5 Financial management

Only 2 CUPs (13%) had a sufficient score for financial management and the average score was 45%. Respondents seemed sufficiently informed about the annual budget, which arrives to the account of the CUP and less informed about the money forwarded in cash to PCU/HCs.

The information given by respondents was not verified through other sources of information. It seems that most CUPs received only about 20% of the total capitation budget. There are 3 modes of forwarding money to the PCU/HC level: per registered person, by visits, and by activities. Allocation by registered persons was seen as appropriate in calculating the score. These findings indicate that there is a need to improve transparency on financial management because most respondents did not seem to understand issues related to funds in the CUP.

5.3.6 Monitoring and evaluation

Five (31%) of CUPs had a sufficient score for M&E and the average score was 63%. Only half of the CUPs produce an annual report for the whole district. Reports

were mostly written in relation to projects or facilities. Only half of the respondents stated that support visits to the PCU/HC level were done three times or more often in the last six months. It is could be concluded that about half of the CUPs have these visits less frequently although they are also useful monitoring instruments. Planning and reporting with regard to monitoring visits seemed to be well done. 30% of the respondents said that there is no annual evaluation of the CUP performance and of those reporting an evaluation, only 30% said that pre-formulated indicators are used.

This finding was not a surprise because as shown by the planning process, monitoring and evaluation did not seem to be systematically done. Planning including setting targets and developing indicators should be done systematically.

5.4 Factors that Influence CUP Management Performance

5.4.1 Management training

Almost half (47%) of the respondents had never had a management training and only 14% had had a training of 3 weeks or more. The research instrument does not allow any statement on the quality of training. Management training is important to enhance the CUP members' knowledge and skills. The in-depth interview revealed that most CUP directors had not been trained and they said they relied on personal instincts in managing the CUP. Therefore systematic management training would equip all members with basic skills to manage and organize the complex district health care system. Planning and financial management were sited as main areas of training needed.

5.4.2 Management experience

Only 32% of respondents had no previous management experience. Having been a secretary of a committee was seen as a management position.

5.4.3 Availability of specific advice

There are obviously no written guidelines provided by MOPH or NHSO but 70% of the respondents reported that the CUP had produced its own management guideline. This reflects leadership, having a sense of direction and teamwork. Only at the start of the universal coverage scheme had the MOPH and NHSO provided some instructions and documents with regard to CUP management. Continuous advice for management seems to come from the PHO according to information in the in-depth interview. This information was not quantified.

5.4.4 Autonomy in decision-making

The mean score for autonomy was 50% and the answers of 30% of the respondents reflected dissatisfaction with the degree of autonomy. This reflects the degree of decentralization in decision making in the CUPs. Without clear guidance how to use the increased autonomy, decentralization may not always result in better performance.

5.4.5 Support by PHO, DHO, TAO, and community

Commenting on the level of support in three categories, the respondents gave the highest score (43%) to support by DHO, closely followed PHO (41%) and the lowest score to support by community (23%) and TAO (9%). In the case of community the support has to be seen as involvement and cooperation. The low score

of only 9% for support by TAO is surprising. It may partly be explained by the fact that CUP-management members do not know the tambon situation well enough or carry a bias in their judgment.

5.4.6 Socio-demographic data of respondents

For completion of the picture, socio-demographic data was collected. The majority (70%) of the respondents were female of whom only one was a district hospital/CUP Director. This reflects a fair composition of CUP members where most of them are nurses by profession. The top positions are dominated by male who are also physicians.

In this study gender and age were not treated as independent variables i.e. factors that influence CUP management performance, although they are known to have an influence on management performance, but rather as potential confounding factors. Therefore gender and age were controlled in a partial correlation coefficient in order to eliminate the potential influence on management performance.

5.5 Association between Factors Influencing Management and CUP-management Performance

5.5.1 Association between degree of autonomy and CUP management performance

Pearson correlation coefficient between degree of autonomy and management performance was positive (0.390) with strong statistic significant $p=<0.001$, after controlling for gender and age. This was not a surprising finding and it suggests that adequately decentralized administration can result in sufficient performance if

managers understand the use of autonomy and how to capitalize on opportunities created by the autonomy.

5.5.2 Association between management training and CUP management performance

There was positive correlation (0.136) between having management training and management performance even after controlling for gender and age, but it was not statistically significant p=0.194. This could be explained by the well-known fact that the quality of training and even high quality training does not lead to better performance if the trainees are not coached for applying their knowledge and if the environment does not allow to use new knowledge and skills.

5.5.3 Association between previous management related work experience and CUP management performance

There was a positive correlation (0.233) between previous management related work experience and CUP management performance with a fairly strong association p=0.023. However, after partial correlation controlling for gender and age, management work experience had a positive correlation (0.187) but not statistically significant p=0.072. This finding does not correspond to general experience as also reflected in the literatures. Explanations could be that the previous experience was not relevant enough and that there was no proper management guidance. The statistical limitations mentioned before maybe a contribution to these results.

5.5.4 Association between support by key actors and CUP management performance

There was a positive correlation (0.328) between support by key actors and performance with a strong association p=0.001, after controlling for gender and age. This finding is not surprising because support is very crucial and as discussed before. The operating environment created by support by all actors should allow the use of new knowledge and skills which also plays a role in rendering training effective.

5.5.5 Association availability of a written management guide and CUP management performance

After controlling for gender and age, the correlation between availability of written management guide and CUP-management performance was positive (0.206) with fairly strong association p=0.048. In this case, it may not only be the mere presence or use the management guide, which explains the association but reasons reflected by the presence of the guide. The guide was in all cases developed by the CUP-management themselves, which shows probably good leadership, sense of direction and teamwork.

5.6 Conclusions

The following can be concluded from the study finding:

1) In spite of facing uncertainties of how to organize a CUP and lacking clear instructions or a "management guide" districts have done relatively well in managing the contracting units for primary care.

2) There is a considerable difference between the scores for the performance with regard to six major management functions. The performance is best in human resource management (79%), followed by delegation (72%), and lowest in financial management (45%).

3) The existing administrative structure with a DHO under the Ministry of Interior being responsible for primary care facilities and of a district hospital under the MOPH which is supposed to work closely with these primary care facility poses some difficulties in managing the district health care system. A management command line which is also needed as a basis for a "not command-based" and rather participatory leadership style as appropriate for the health care system. This constraint is only partly overcome by cooperation and arrangements based on good relationship between individuals. Already before the administrative structure of the health care in a district will be changed officially, solutions must be found how to put the district health care system under one leadership. One option was followed by one CUP which rotated the leadership between the DHO and the hospital director.

4) In 14 of the 16 CUPs the hospital director was holding another directing position at the same time and in 10 of the CUPs he was head of CUP-management team and head of PCU in his hospital. All three functions are important and time consuming. They demand for a full-time leader quite apart from the fact that delegation of responsibility is an important factor of staff motivation.

5) Delegation is so important that even a situation of only 20% of PCU/HCs not calculating drug demand themselves and where only 30% of respondents do not have job descriptions should be revised and changed.

6) Appropriate attention seems to be paid to capacity building. However, about half of the CUPs do not have an incentive system.

7) The proportions of the capitation budget arriving as cash at CUP level and within the CUP at PCU/HC level, seem to reflect insufficient decentralization of the authority to incur expenditure. The situation needs to be revised and changed. Information of all members of CUP management on finances should be improved.

8) The instrument of a comprehensive, annual report on the development of services, management and health does not seem to be officially introduced.

9) It is known that in most districts the relationship between the district hospital director and the district health director is strained. It was therefore a surprise that the answers of the CUP-management members resulted in a score of near to 50% for good cooperation with district health office. Still, cooperation with and support by district health office has to be strengthened and even more so involvement of TAO and communities.

10) The positions in the CUP-management seem to be appropriately distributed among the different professional categories. However, the representation from different institutions/ facilities needs to be improved.

11) A higher degree of decentralization, decision making, and management in general is desirable, but it has to be supported by effective training in management and provision of more autonomy.

12) No matter whether previous management-related work experience exists among the members, the management capacity of a management team should be periodically assessed and tailored training should be provided according to needs.

13) The finding with regard to support underline the importance of support in technical aspects but also as factor of a conducive work environment. Recalling that support by TAO and community was found in this as not being sufficient, it is strongly recommended to strengthen the system of support by all actors.

14) A written guide for CUP management is surely needed. The meaning of guide as an instrument that gives direction in contrary to a manual which instructs how to do things should be maintained. A common guide for all CUPs would facilitate the strengthening of UC and monitoring of performance. The positive aspects of a self-produced guide should be

preserved by assuring sufficient participation of users in developing a common guide.

5.7 Recommendations

1) The administrative structure of the district health sector needs to be changed. The position of a District Health Director (under the district authorities or the MOPH for the time being) has to be created, which coordinates hospitals, primary care and public health services.

2) The positions of the district health director, hospital director, and head of primary care services, and district public health director should be allocated to different managers.

3) The planning process should be strengthened especially with regard to participation of actors at the service level and community members. The PHO and the MOPH should involve districts in developing the monitoring instruments and encourage the establishment of a "District Self-assessment Instrument".

4) There is a need to plan for management related capacity building training for all members of the CUPs but special attention should be paid in coaching for use of new knowledge and skills. CUPs should develop an appropriate incentive system as one of the motivating factors for the staff.

5) The information of CUP management members on finances should be improved including transparency in financial management within the CUP network and participatory annual action-based-costing should be introduced.

6) A comprehensive annual report on the development of services, management and health issues should be officially introduced.

7) Cooperation with and support by DHO has to be strengthened as well as the involvement of TAO and communities.

8) Decentralization should be supported by effective training in management and use of opportunities of more autonomy in order to enhance CUP management performance.

9) Coaching for application of newly acquired knowledge and skills should be part of capacity building plans at district level. Sufficient attention has to be paid to the administrative and political frame conditions for management and to attempts of modifying them.

10) CUP management should periodically review the capacity of the management team and tailor training according to needs.

11) It is strongly recommended to strengthen the system of vertical and horizontal support in order to create a conducive working environment.

12) There is a need to develop a written "Guide for CUP Management". This should be an instrument that gives direction in contrary to a manual, which instructs how to do things. The MOPH should assure sufficient participation of users when developing the guide.

13) The NHSO should review the budget disbursement mechanisms and increase the proportion of the capitation budget under authority of the CUP-management for incurring expenditures.