

## Promoting preventive health care

### Paying for performance in Haiti

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In Haiti nongovernmental organizations provide basic health services such as immunization and prenatal and maternal care. In an effort to improve the effectiveness of some of these organizations, the U.S. Agency for International Development introduced performance-based contracting in 1999. The providers had been operating under a payment system that reimbursed their expenses up to a ceiling. The new system set performance targets and withheld a portion of their historical budget, allowing them to earn back the withheld amount plus a bonus if they met the targets. A one-year pilot involving three of the providers showed some marked improvements in performance.

Those paying for health care services in developing countries typically have not required the providers to guarantee their performance. Public payers tend to fund public institutions to maintain capacity (paying salaries and recurrent costs) rather than to ensure that consumers receive high-quality services. Any contracts with private providers generally have not held them accountable for performance. Donors have tended to adopt similar practices, providing lump sum grants or reimbursing public providers and nongovernmental organizations (NGOs) for documented expenditures. As a result, providers tend to focus on securing funds rather than improving efficiency or the quality of care.

In this context, in 1995 the U.S. Agency for International Development (USAID) launched a 10-year project in Haiti aimed at strengthening the capacity of NGOs to deliver primary health care services. A key part of this effort was the introduction of a performance-based payment system. The challenge was to develop a system based on attainment of goals without imposing an excessive burden of monitoring and reporting requirements.

Following competitive tenders, USAID awarded funding for the two-phase, US\$92 million project to Management Sciences for Health (MSH), a U.S.-based NGO operating in developing countries. MSH manages and disburses the funds. During the first five-year phase, beginning in 1995, the project provided funding to 23 NGOs, an established group that had received USAID support in the past. For the second five-year phase, beginning in 2000, the number of NGOs increased to 33.

When the project began, the immediate need was to develop rapid mechanisms for funding NGOs so that they could provide critical basic health services, including maternal and child health and family planning services. Initially, and in line with general practice, NGOs were reimbursed for expenses up to a ceiling that was essentially a negotiated budget. Under this expenditure-based financing NGOs submit a proposed annual budget and a plan showing how they intend to ensure the delivery of a basic package of services. Then each month they submit cost reports with detailed documentation of their expenditures for reimbursement. NGOs are free to set their own fees for services. Most charge patients for drugs, and some for consultations.

### **Switching to performance-based contracts**

A 1997 population-based survey to review the existing system found that NGO performance was extremely uneven. In vaccinations a good performer reached 70 percent of the target population, while the worst performer

reached only 7 percent. One NGO made sure that 80 percent of women knew how to prepare an oral rehydration solution; another educated only 44 percent. Some NGOs provided the minimum two prenatal visits to 43 percent of pregnant women; others reached only 21 percent. These wide-ranging results were not correlated with costs (average costs per patient visit ranged from US\$1.35 to US\$51.93).

So in 1999 MSH decided to test a new approach—performance-based payment. The new payment system was expected to lead to efficient delivery of high-quality services in several ways:

- Because institutions receive a bonus if they achieve performance targets, they feel strong incentives to attain those targets.
- Because institutions assume financial risk for improving performance, they feel strong incentives to use resources efficiently and effectively.
- Because institutions are paid on the basis of results, they face strong incentives to improve management, motivate staff, and innovate.

Three NGOs, serving about 534,000 people, participated in a one-year pilot study. Under the performance-based system NGOs receive an up-front payment and then a quarterly sum rather than submitting their expenditures every month. At the end of a defined period—one year in this case—performance is measured and the size of the bonus determined.

To ensure that the NGOs viewed the change as advantageous, MSH used a collaborative approach in designing the new system. NGOs demonstrating the leadership and institutional capacity to respond to the system were invited to meetings to express their views about the pilot. Because these meetings occurred after NGOs had signed contracts for fiscal 1999 (October 1998–September 1999), they were willing to renegotiate only if the new contract could make them better off.

The meetings led to agreement on a new contract that would pay 95 percent of the budget under the expenditure-based contract—but would also pay a bonus of as much as 10 percent of that budget. The NGOs thus assumed a financial risk: if they failed to attain performance targets, they would lose 5 percent of the budget under the original contract. But they were willing to do so because they also had the possibility of earning 5 percent more than the budget.

Seven performance indicators were chosen, and a target was negotiated for each indicator and linked to a share of the bonus (table 1). (Negotiating with MSH, each NGO then translated the general targets into specific targets.) Five indicators related to improving health impact,

TABLE  
1

Performance indicators, targets, and weights in bonus

Indicator	Target	Share of bonus
Women using oral rehydration therapy to treat diarrhea in children	15% increase	10%
Children ages 12–23 months receiving full vaccination coverage	10% increase	20%
Pregnant women receiving at least 3 prenatal visits	20% increase	10%
Discontinuation rate for oral and injectable contraceptives	25% reduction	20%
Clinics with at least 4 modern methods of family planning; outreach points with at least 3	100% of clinics; 50% of outreach points	20%
Average waiting time for attention to a child	50% reduction	10%
Participation in local health organizing committee (UCS) and coordination with the Ministry of Health	UCS defined	10%

Source: Authors' compilation.

one to increasing consumer satisfaction by reducing waiting time, and one to improving community participation and coordination with the Ministry of Health.

Another goal of the project was to improve institutional sustainability. To facilitate learning and sharing, the project helped create a network of local NGOs. Regular meetings encouraged NGOs to share strategies that have succeeded or failed in the challenging Haitian environment. The project also provided technical assistance, to help NGOs review their pricing policies and develop a plan to generate revenue through sources unrelated to health services. CORE, a cost and revenue analysis tool, was used to help NGOs identify unit costs, revenues, and staff utilization (MSH 1998). The goal was to promote a culture of information-based decisionmaking to improve efficiency.

### Measuring performance

Since payment is tied to performance, the NGOs agreed that reporting on their own performance would create incentive problems. MSH contracted a neutral third party—l'Institut Haitien de l'Enfance (IHE), a local survey research firm—to measure baseline and end-of-pilot performance.

Using the standard cluster sampling methodology recommended by the World Health Organization (WHO 1991), IHE sampled households in each NGO's service area to measure immunization coverage, based on both immunization cards and reports from caretakers. IHE determined the percentage of women using oral rehydration solution to treat diarrhea through exit interviews at clinics with women who brought children in for other reasons. It reviewed a sample of medical records to find out what share of pregnant women had had three or more prenatal visits. Discontinuation rates for oral and injectable contraceptives were determined by reviewing family planning registers to identify women who had discontinued use, had not chosen another method, and had not expressed a desire to have a child. And average waiting time was determined through measures in a sample of institutions at different intervals.

This survey needs to be done annually, first to set up a baseline and then to check performance against this baseline. The annual cost is US\$40,000, less than US\$1 per person benefiting from the project.

### **The results one year later**

The most striking result was the increase in immunization coverage in all three NGO service areas (table 2). In two of the three areas the share of mothers who reported using oral rehydration therapy increased—and so did the share who reported using it correctly. Performance was relatively weak in meeting prenatal care and contraception targets, probably because of the need for ongoing counseling and behavioral change. The availability of modern contraceptive methods increased substantially.

Waiting time was judged to be an invalid indicator of quality because people who have to travel long distances to obtain lab tests might wait an entire day for results rather than come back. A new indicator of client satisfaction is being developed for the next phase. And because no easily measurable and verifiable indicator could be devised for community participation and collaboration with the Ministry of Health, the bonus linked to this performance indicator was given to all three NGOs.

All the NGOs in the pilot received more revenue than they would have under the expenditure-based scheme—and all supported continuing performance-based payment. The shift from justifying expenditures to focusing on results inspired them to question their model of service delivery and experiment with changes. The NGOs' possibility of earning bonuses sharpened staff's focus on achieving goals and led to innovation, including greater efforts to involve the community.

**TABLE 2** Results of performance-based payment pilot

Indicator	NGO 1		
	Base	Target	Results
Percentage of women using oral rehydration therapy	43	50	47
Percentage of women using oral rehydration therapy correctly	71	80	81
Immunization coverage (percentage of children ages 12–23 months)	40	44	79
Prenatal visits (percentage of pregnant women with at least 3)	32	38	36
Contraceptive discontinuation rate (percent)	32	24	43
Clinics with 4+ modern family planning methods	6	9	9

*Note:* Base data refer to September 1999, results to April 2000.  
*Source:* Authors' compilation.

To motivate staff to focus on results, two of the three NGOs introduced bonus schemes for staff. And one introduced a bonus scheme for community health agents, cutting their salary in half and reserving the rest for bonuses tied to performance. But when it found that transferring this much risk to relatively low-paid staff lessened their motivation, it increased the fixed share of payment and reduced the share from bonuses. Another NGO set up a bonus scheme for local organizations with which it works, and all considered allocating a share of any bonus they earn to clinics in their network on the basis of performance.

The performance-based payment also motivated NGOs to request assistance in strengthening their strategic planning, strategic pricing, cost and revenue analysis, human resource management, and measurement of client perceptions of quality.

### The future

The results of the pilot suggest that performance-based payment is a powerful way to hold NGOs accountable for results. The challenge is to define indicators that relate directly to health impact, client satisfaction, and institutional sustainability and to measure and monitor performance in a way that is not prohibitively expensive.

MSH staff and the NGOs in the pilot will work together to develop new indicators and improve processes for measuring and verifying performance.

	NGO 2			NGO 3		
	Base	Target	Results	Base	Target	Results
	56	64	50	56	64	86
	53	59	26	61	67	74
	49	54	69	35	38	73
	49	59	44	18	21	16
	43	32	30	26	20	12
	2	5	5	0	5	5

More NGOs will be incorporated into the performance-based payment system each year. And to increase performance incentives, a model being considered for fiscal 2002 would reduce the share of payment based on historical budgets and phase in a capitation (a fixed payment for providing defined services to an enrolled patient) combined with rewards for results.

#### Note

This chapter is based on a longer paper by the same authors, "Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti," available at <http://www.worldbank.org/wbi/>

[healthflagship/journal/index.htm](http://healthflagship/journal/index.htm).

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