

# THE MANAGER

MANAGEMENT STRATEGIES FOR IMPROVING HEALTH SERVICES

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## Using Performance-Based Payments to Improve Health Programs

### Editors' Note

LINKING THE PAYMENT OF FUNDS with the results of service activities is a powerful strategy that funding organizations can use to make the service-providing organizations accountable for achieving program goals. This new strategy offers financial incentives and holds great promise for improving performance of health services. It can be applied in both the public and the private sectors and at different levels of a national health system.

The use of performance-based payments for funding health services is a relatively new concept. Though much remains to be learned about the design and implementation of performance-based payment systems, experience shows that collaborative partnerships between payers and service-providing organizations can contribute to success. In such partnerships, the payers and service providers jointly determine the key performance areas, define performance targets, and assess performance.

THIS ISSUE OF *THE MANAGER* presents a system for funding programs that is tied to program performance to help providers improve their services and the impact of those services in the client population. This issue explains how different payment mechanisms encourage different types of organizational behavior, and why performance-based payment schemes are more likely to help achieve the desired goals than traditional payment schemes. ■

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## Improving Health Services by Paying for Performance

In many parts of the world, organizations that fund health services (the “payers”) have not required the institutions that provide the services (the “providers”) to guarantee their performance, in terms of impact on the health status of their clients. As a result, providers tend to focus on securing the funding to sustain their programs, rather than improving efficiency or quality of care.

Public-sector payers usually fund public institutions to maintain their capacity to provide services (for instance, by paying salaries and recurrent costs) without establishing a means to ensure that clients receive high-quality services. Payers’ contracts with private health care institutions have also not held service providers accountable for performance. Donors that support health services have tended to adopt similar practices of providing lump-sum grants or reimbursing public providers and nongovernmental organizations (NGOs) for documented expenditures.

In this environment, where providers are sustaining their programs through a focus on service delivery, how can health program managers be encouraged to focus instead on achieving results? Payers want providers to use increasingly scarce financial resources in the most productive ways to achieve program goals.

Payers are responding to the problem by experimenting with financial incentives as a condition of their agreements to disburse funds. The aim is to stimulate providers to reform inefficient practices and improve performance, yielding measurable gains in public health. The concept is to provide project funding on an incentives basis. An agreement between the payer and the service provider spells out the goals and objectives that the provider is expected to meet. The performance of the provider in meeting the agreed goals and objectives becomes the basis for releasing the next portion of funds in the project cycle. Performance is measured in terms of agreed targets in such areas as health improvement, institutional development, and increased responsiveness to clients.

The new performance-based approach of payers, in utilizing incentives for funding institutions that provide health care services, has been borrowed from the principal-agent theory of economics. According to this adaptation of the theory, the payer is the principal that, in the health care setting, may be a government, a donor, or an insurance company. The principal purchases services from an agent, an entity that provides health services. The principal and the agent together design a contract that rewards the agent for achieving agreed-on targets.

These arrangements focus on organizations and institutions that provide health services (for example, primary health care clinics, hospitals, or NGOs), not on individual health service providers (such as doctors or nurses).

This issue of *The Manager* describes how payers can form a partnership, or contractual relationship, with provider institutions to fund health services in accordance with a system of financial incentives for achieving defined measures of performance. This issue is written for managers in organizations that fund health services, such as ministries of health and pri-

vate foundations, as well as for managers in hospitals, health centers, and various types of programs that provide health services. In addition, this issue will be of interest to those concerned with the technical aspects of policy and planning of health programs.

This issue of *The Manager* was written by Rena Eichler, Principal Program Associate and health econo-

mist at MSH in Washington, DC; and Riitta-Liisa Kolehmainen-Aitken, Senior Program Associate and evaluation specialist at MSH in Boston. Dr. Eichler has worked extensively in several countries, including Haiti and Kenya, to develop and implement performance-based payment systems.

## Key Terms Used in This Issue

PAYER	an organization or program that provides funds to support delivery of health services (for example, a government health department that funds health units at local levels, a donor of international development aid, or an insurance company)
PERFORMANCE	the results achieved by the provider of health services, in terms of actions performed or impact on the health status of the client population
PERFORMANCE-BASED PAYMENT	a system of program funding whereby the payer supports the service provider's program according to that provider's performance (that is, if the provider achieves agreed-on results or health goals for the client population)
PROVIDER	an organization or program that provides health services directly to clients (such as a national program of public health services, a hospital, or a local health unit)

## Identifying Benefits of Performance-Based Payment Systems

In a performance-based payment system, service-providing institutions are encouraged to examine their institutional culture—their ways of organizing and delivering care, motivating and supervising staff, and using resources. The institution is rewarded for finding ways to improve effectiveness in delivering services and achieving targets (for example, in improving quality of or access to services).

The focus of the payment system is the results of program operations. The provider institution concentrates on achieving specific results in order to receive the next portion of funds. Another benefit is that monitoring and evaluation data are generated in the process. They can be used for planning strategy and operations of the health services.

The concept of using performance-based payment to improve the impact of health services and the performance of the institution providing the services is still new in many countries. No single model for a performance-based payment system exists. The payment system must be designed and implemented with

consideration of the goals, capacities, and constraints of health service providers.

If you work in an institution that funds health services, performance-based payment schemes can help you to

- sharpen the focus of the program you fund by working with providers to set targets that clearly define program objectives and by offering financial incentives to providers to achieve them;
- seek improvements in the internal management of provider institutions by setting targets linked to management improvements.

If you work in a provider institution, performance-based schemes can help you to

- improve the performance of your program, as well as your organization, by linking funding to defined performance outcomes;
- improve your institutional culture by focusing on performance and promoting innovation in program operations.

Financial rewards to individual health workers for work performance can help improve the impact of health services, especially if the rewards are aimed at improving the quality of those services. If they are not carefully designed, however, they may produce undesired results. One danger is that financial incentives may motivate health workers to pressure clients to accept services that they might not want, if they were fully informed and free to make their own choices.

### US POLICY GOALS

American policy upholds the principles of voluntary participation and informed choice for family planning acceptors, in providing them with a high quality of health services. The standards of voluntarism, informed choice, and provision of quality services can work for successful strategies of performance-based rewards, as long as the rewards are applied in improving the **quality** of the services, not acceptance of them.

To protect the beneficiaries of US-funded health and family planning services from such influences in making their own choices, in 1998 the US government passed the law known as the "Tiahrt Amendment." Applied to projects that receive US public funding, that law prohibits the use of financial rewards to individual health workers or clients that might pressure clients to accept family planning.

### PROTECTING CLIENTS FROM PRESSURE

The Tiahrt Amendment applies to all organizations that receive official development aid in the form of funds, goods, and services, and involve delivery of family planning services. Specifically, the law requires that:

- Projects may not pay incentives or other financial rewards to individual acceptors or to program personnel for achieving numerical targets.
- Individual providers of services may not implement or be subject to quotas or other targets involving numbers of births or family planning acceptors.
- Clients of services may not be denied program access or benefits if they choose not to accept family planning services.
- Family planning acceptors must receive full and clear information about the health benefits and risks of methods they choose.
- Studies of experimental family planning methods must advise participants of the potential benefits and risks they may experience.

(These restrictions do not, however, prohibit projects from using quantitative estimates or indicators for budgeting and planning purposes.)

### USAID PROTECTION

The policies of the US Agency for International Development (USAID) have protected against pressure or coercion in sterilization programs since 1982, long before the Tiahrt Amendment became law. To ensure that service providers do not feel pressure to apply numerical indicators as targets for recruiting acceptors, USAID-funded programs review their performance-based agreements and results regularly, as described in this issue of *The Manager*. Another USAID policy that protects programs against violation of the Tiahrt Amendment is that they not share their planning and budgeting targets for family planning activities with the individual service providers.

## Developing and Applying Performance-Based Payments

This section takes you through the features of payment schemes that are based on performance goals. You will learn how you can apply performance-based payments in your program by

- influencing performance through different payment methods;
- establishing performance measures;
- defining performance goals and incentives;
- designing the contract between payer and provider institution;
- encouraging an active partnership between payer and provider institutions.

By linking funding with health care objectives, you can provide a good environment for improving the performance of health services and their funding organizations.

### Defining the Payment Systems

Health reforms in recent years have increasingly sought to separate two functions: that of spending public money to pay for health services, and that of delivering such services. This is called a payer/provider split. The two functions of paying for services and delivering them have thus become the responsibility of separate institutions. *In Colombia, for example, social insurance funds were set up to be the payers that would then purchase services for their clients from public- or private-sector providers.*

Even in traditional health systems, there are organizations (the payers) that provide the funding for health services, and others that actually deliver the services (the provider institutions). A government agency is a payer when it holds the purse strings for funding the

operation of public hospitals and health centers. A private insurance company that pays for care by private provider institutions, such as private hospitals, is a payer. A donor is a payer when it funds health services that are provided by a government or NGO.

The payer can use four types of criteria to determine the amount of funding that it gives to the institution that provides services. Performance criteria can be based on inputs, outputs, capitation, and/or performance.

**Input-based payment.** Input-based funding has traditionally been the most common way for governments to support public hospitals and health centers. For example, inputs such as the number of hospital beds and staff members in a hospital, or the expected expenditures of an NGO, can be the basis for deciding the funding amount. Donors also commonly use an input-based payment mechanism when they provide a grant or reimburse public providers and NGOs for expenditures.

**Output-based payment.** The payer can use an output-based payment mechanism that ties the amount of funding to such measurable outputs as the number of outpatient procedures or inpatient days in a hospital, or the number of prenatal or family planning visits delivered by a health center.

**Capitation-based payment.** Capitation payment systems are based on the number of people to be served by the provider. Here, the payer pays a monthly per-capita payment to the provider institution to deliver a package of services to consumers who subscribe to that plan. Capitation payment differs from **input**-based payment because outputs (the services to be provided) are defined. Capitation payment differs from **output**-based payment because the amounts are based on the population of subscribers to the plan, rather than on specific health services. Examples include premiums paid to US-style health maintenance organizations (HMOs), or funding of district health programs based on total population.

**Performance-based payment.** A payment system that is based on performance links the amount of funding with the results that the provider achieves. An organization that performs well is one that sets clear objectives for its services, based on clear health goals, ensures good quality in the services it delivers, and uses its resources efficiently and effectively. The results can be defined in a number of ways, such as institutional development of the provider, growing client satisfaction, or increased impact on the health of the client population. Payer and provider agree on specific performance indicators and targets, and on the linkage of funding with reaching targets.

Performance-based payment can be combined with input-, output-, or capitation-based schemes. One part of the payment can be based on performance and the rest can be based on inputs, outputs, or subscribers (per capita).

The four bases for payment mechanisms (inputs, outputs, capitation, and performance) influence providers differently in service delivery and impact. The payer needs to understand how to use such influences to achieve the desired performance improvement results.

## Influencing Performance through Different Payment Systems

Using an **input-based payment mechanism** to fund the recurrent costs of a provider ensures that the health programs or facilities continue to function. However, the money that the service provider receives from the payer is not necessarily linked with either the type of services it delivers nor the quantity or quality of those services. Thus, funding based on inputs does not ensure that services meet priority health needs or are of high quality. Nor does such funding ensure that the money is used efficiently. For example, a district hospital whose staff and operating costs are paid by the ministry of health has no financial incentive to improve its clinical quality or the efficiency of its operations, or to provide an adequate volume of services.

An **output-based payment mechanism**, on the other hand, does offer incentives to the provider institution to deliver more of the types of services that the payment is based on. That can, however, produce undesirable results. One type of payment scheme pays providers for each service they perform. The effect is to encourage those institutions to perform more services than may be clinically warranted or safe. Moreover, they may be tempted to inflate the number of their outputs or to “re-label” them, since they know that funding depends on certain kinds of outputs. *Early in the 1990s, for example, authorities in the United Kingdom became concerned that some National Health Service Trusts were overstating their output. The trusts were paid on the basis of volume of activities. Because different activities carried distinct financial values, Trusts responded by inflating the numbers of highly compensated procedures such as day surgeries.*

An output-based payment system can also give provider institutions an incentive to overproduce those services for payment, while they may neglect other important services that are not rewarded.

Finally, a payment that is linked only to the **quantity** of services does not necessarily encourage providers to improve the **quality** of those services.

With the introduction of the purchaser/provider split, and the trend of contracting private and NGO providers in some areas, payers in many countries have searched for new ways to link the expenditure of funds with the effective delivery of the right kinds of services. The result is a growing interest in the possibilities of performance-based payment. *In the United States, for example, employers who pay premiums to HMOs for services to their employees are using performance-based payment to ensure that HMO services meet employees' health needs, are of good clinical quality, and are delivered in a way that satisfies clients.* The working solution on “Tying Payments to Performance Targets” describes how the HMO Pacific Business Group on Health operates.

## TYING PAYMENTS TO PERFORMANCE TARGETS: A MEANS OF GUARANTEEING PERFORMANCE

**Background.** Health maintenance organizations (HMOs) provide a significant proportion of health care in the United States. In 1997, HMOs provided health care to more than one quarter of the total population in 22 of the 50 states. Employers, who purchase health care for their employees from HMOs, form a large part of this market. However, dissatisfaction with the quality of some aspects of HMO services has led employers to seek ways to make HMOs accountable for their performance. A performance-based payment mechanism enables them to impose strong financial penalties if performance is judged unsatisfactory.

The Pacific Business Group on Health is an alliance of over 30 large employers that provide coverage for health care costs to nearly 3 million employees, dependents, and retirees in California. It spends more than \$3 billion on health care each year. Some of those employers participate in the group's Negotiating Alliance, which negotiates premiums, standard plan designs, and annual performance targets with HMOs that provide health services to employees and their families.

### **Targeting areas for performance guarantees.**

In 1996, the alliance negotiated an agreement with 13 HMOs that placed at risk a percentage of the annual premium that the employers paid to each HMO. If an HMO did not achieve jointly

selected and uniformly defined performance measures, it could lose 2 percent of its premium. Three areas of HMO performance were targeted: customer service, member satisfaction, and quality of care. Quality-of-care targets focused on childhood immunizations, Caesarean sections, mammography, cervical cancer screening, and prenatal care. An outside contractor collected and reviewed all data and medical records using uniform procedures.

A majority of the HMOs met or exceeded their satisfaction and quality-of-care performance targets. However, missed targets resulted in refunds to the group of almost \$2 million, of the total of more than \$8 million at risk. The group's experience shows that HMOs can be held accountable for meeting negotiated performance targets, and that their accountability can be rooted in economic incentives that are tied to unmet targets.

The alliance acknowledges that performance guarantees are still more of an art than a science. In its negotiations each year, the alliance continues to refine the performance measures that it uses with the HMOs. The current trend is toward fewer but more complex measures that more accurately reflect HMO performance in quality of care, customer service, and patient satisfaction.

**Source:** Adapted from Schauffler, Brown, and Milstein 1999.

Ministries of health in many countries are also realizing that they can use their purchasing power to achieve socially desirable results, such as improvements in immunization rates, coverage, and targeting of disadvantaged populations. Donors and other payers are also focusing increasingly on achieving the results that they desire.

In the adapted principal-agent concept of payer and provider roles, incentives encourage the agent to ensure that the funds are spent in ways that the principal believes to be important. Intensive monitoring is not an attractive way to assure good performance because it is too costly. Instead of spending resources to monitor the agent's operations, the principal and agent can jointly set appropriate performance objectives and financial incentives that reward the agent for successful fulfillment. The "right" incentives ought to be the most effective means of producing the desired results, because they are also aligned with the agent's best interest.

Correct incentives that link funding with results can be very powerful. A ministry of health, for example, that ties its funding to the performance of a provincial health office in improving immunization coverage, or increasing parents' knowledge of oral rehydration therapy, serves the interest of both the payer and the provider. The ministry can see how its resources were used to improve key areas of health service delivery. At the same time, provincial health offices that perform well can ensure continued funding of their program.

## Establishing Performance Measures

The primary aim in using performance-based payment is the **efficient** delivery of **high-quality** services that are **effective** in meeting health system goals. Using performance-based payment, you can to achieve performance improvements in a number of ways. You can encourage results that yield greater health impact. You can aim to increase customer satisfaction. You can target better coordination between different management levels or different sectors. You can seek improvements in the management of the provider organization.

How you define "good" performance will depend on the goals of your health system, the role of the provider

institution in reaching these goals, the services it provides, and the efficiency of its operations. In defining your goals and specific objectives, you should consider the following areas for improvement. The incentives system that you establish should support your performance areas for improvement, such as the following (adapted from Hurst and Jee-Hughes 2001).

### Efficiency

- more efficient use of financial and human resources

### Equity

- more equitable access to services
- more equitable resource allocation

### Responsiveness of the service-providing organization

- increased client participation
- increased satisfaction of patients and clients
- better continuity of care
- increased coverage

### Sustainability

- greater cost recovery
- better cross-subsidization
- lower staff turnover

### Health service outcomes

- more effective treatment regimes
- more appropriate health services
- greater staff competence

If you are the payer, you will need to decide which of the many aspects of a provider's performance you should target through performance-based payment. To do this, you must determine what your own strategic priorities are for improving organizational performance and health impact. You cannot encourage results unless you know what results you are aiming for. For example, you might work in a ministry of health at the central level and want to link the ministry's funding of provincial institutions with their performance. Before you choose the critical performance areas with your colleagues at the provincial level, you should know, for example, whether improved control of infectious diseases or greater access to prenatal care is more likely to improve health status.



Second, you as the payer must determine whether the best way to set targets for performance is by collaborating with the provider organizations or by imposing targets on them. If you decide to collaborate with the managers of the providers, you would jointly identify and agree on the most important areas of results where improvements are feasible. Or, you might decide to impose performance targets on the providers—if you believe that performance improvements are feasible, are key to achieving health objectives, but are unlikely to happen without financial incentives.

Before completing the list of key performance areas that are tied to payment, the payer and the provider institution must examine the following issues and agree on the answers. Which services or management areas in the institution need improving? Of all the areas where improvements could be made, which of them are critical for increased impact, higher quality of care, or more efficient operations? Do the managers of the provider institution have the authority they need to make changes, if they receive the financial resources? How many performance areas can they realistically address at one time?

Tying payment to performance can be a powerful incentive for improving management, using resources more efficiently and effectively, improving service delivery, or enhancing service quality. You should select which performance areas to target for the greatest impact, considering your resources and the particular goals and challenges of your situation.

**How can you measure performance?** Determination of the areas for improvement is not enough. You must be able to measure whether performance in those areas actually improves as a result of performance-based payment. To do so, you need to establish clear performance goals that must be reached before an incentive payment is released. Next, you must define indicators that you can use for measuring progress.

An indicator is a specific condition, capability, or numerical measure that simplifies description of complex concepts and allows managers to compare actual with expected results. You need to specify an indicator for each critical performance area. Indicators may be “process” oriented, such as improved immunization coverage of the target population; or they may be “outcome” oriented, such as increased child survival.

While improved outcomes are the ultimate goals, process measures are often good proxies for eventual outcomes and are more practical to measure in short periods of time. The indicators you choose for assessing performance should be:

- **linked directly with the impact** you want to achieve (if you aim to improve client satisfaction, you could design an exit interview survey and tie payment to improvements in survey results);
- **measurable** (if you aim to improve immunization coverage, you could develop an indicator that measures the percentage of children under one year who are fully immunized);
- **feasible** (an indicator is feasible if data that allow its measurement are already routinely collected or can easily be collected);
- **verifiable** (an indicator is verifiable if the same result can be obtained by different entities doing the measurement. An example of an indicator that is not verifiable is a report about customer satisfaction with a health facility that is based on anecdotal evidence).

You should select the strongest measures of the impact you seek, and make sure that you can actually measure the desired change in those indicators. At the same time, you should avoid choosing indicators that create for the provider an undue and costly burden of data collection.

Finally, remember that performance-based payment is still new. The first indicators you choose may not be the best measures of the performance change you seek. If you are willing to make informed and reasonable guesses, however, you may continually improve the match between the indicators you select and the performance you want to measure.

**Establishing the baseline and verifying the performance.** You will want to verify whether performance has really improved as a result of performance-based payment. You cannot measure change if you do not know the current performance level of the service-providing institution. It is essential to measure the baseline performance in each critical performance area before you institute a performance-based payment system.

Both partners, the payer and the provider, must agree on measures of baseline and performance change. If the provider is asked to report on its own performance, it may be tempted to “doctor” the data, since payment is tied to increases in performance measures.

To avoid such biases, or perceived biases, the payer should contract an independent, neutral party to determine baseline measures and verify performance whenever possible. A local survey research firm, for example, can be contracted to measure baseline and final performance, and to analyze and report the results. Sometimes there may not be sufficient resources to contract an external organization. Alternatively, representatives of the payer and the provider could conduct the performance measurement studies jointly.

## Defining Performance Goals and Incentives

A performance-based payment system will succeed only if it includes incentives that are designed to encourage both parties to cooperate effectively. One successful model builds on a spirit of partnership between the paying and providing organizations. Other models may be imposed by the payer, but must always include rewards that ensure that the provider’s best interest is to achieve the agreed-on target.

What can the payer and the provider do to enhance the potential for success? A payer that seeks ways to strengthen the provider’s motivation to improve performance can make a strong partner.

The payer should be able to guarantee that the promised funding will indeed be available when promised, and ensure the continuing credibility of the scheme by adhering to the terms of the agreement: rewarding good performance and withholding payments for poor performance. The agreement must have sufficient integrity to withstand political interference.

A provider should have a clear management structure and systems, and be able to make decisions that would improve its responsiveness to the performance-based incentives.

The provider institution may need to improve its internal management structures and systems to become a more successful partner. Performance gains may require that it strengthen such areas as its internal strategic and operational planning capacity, financial and human resource management systems, drug and commodities management systems, monitoring and evaluation processes, and quality assurance.

At the same time, a payer may decide to use a performance-based payment system to motivate a number of different providers. In such a case, the payer might find it useful to establish a network with or among the institutions. Meetings and information exchanges between institutions in such a network would allow managers and clinical staff to learn from each other by sharing their successes, challenges, and lessons in improving organizational performance.

## Working Solutions—The Philippines

### IMPROVING CHILD SURVIVAL THROUGH A PAYER/PROVIDER PARTNERSHIP

**Background.** Using “performance-based disbursement” as the funding mechanism, a partnership in the Philippines between the US Agency for International Development (USAID) and the Philippine Department of Health (DoH) successfully implemented the Child Survival Program. The partnership exemplifies what can be achieved when the goals of payer and provider institutions are strongly aligned, the project objectives and benchmarks are clearly defined and measurable, and a technical

review process is in place for effectively measuring performance and, if necessary, remedying shortfalls.

The Child Survival Program was launched in September 1989 to develop public health services, and related policy and institutional reforms, for improving survival of children in the Philippines. The US government earmarked grant aid amounting to \$45 million to the Philippine government over a 4½-year period, to March 1994. A team from Management Sciences for Health assisted the program from 1990 through 1993.

USAID disbursed the earmarked funds for program performance according to achievement of annual benchmarks and service-delivery benchmarks. Every November, the program had to document that it had achieved the annual benchmarked outcomes (for example, issuing an information, education, and communication plan for child survival), in order to receive funding for the following year's activities. For the service-delivery benchmarks, the program had to document achievement of nine targets (such as having fully immunized 85 percent of all children by their first birthday) throughout the country by the end of 1993.

**Paying for performance.** The system of performance benchmarks put USAID in the position of paying DoH for performance, instead of the usual donor's position of monitoring the recipient's use of funds. USAID was interested in determining whether its funding was having an impact in terms of the agreed performance indicators, but not in deciding how DoH should spend the money.

For its part, DoH preferred to control its own expenditures, thereby gaining flexibility and leverage in developing its own priorities. With the sizeable grant at stake, DoH could use the need to achieve benchmarks as a tool to expedite critical changes in policy and internal management systems. The reforms included a new approach to health planning at the local level that was implemented within a single year in all 75 provinces, 60 chartered cities, and 1,526 municipalities of the Philippines. Among other innovations, DoH adopted a program to train field epidemiologists in improved disease surveillance, outbreak investigations, and rapid response to disasters.

The chief advantages of performance-based disbursement for both payer and provider in this

Philippine case can be summed up as:

- efficiency in processing large amounts of official aid without bureaucratic delay in fund allocation and expenditure;
- alignment of important goals of both parties, resulting in shared priorities in the form of program results;
- a payer-provider relationship that is based on equality and trust, rather than on dependency and suspicion, with empowerment of the provider to determine how it will achieve the agreed benchmarks and targets.

The Philippine experience suggests that disbursement schemes are likely to succeed where all the following circumstances are present:

- payer and provider share a clear idea of what policy reforms or institutional changes are needed;
- policy reforms or institutional changes are important enough to justify large-scale funding;
- the provider can contribute local funds for program implementation voluntarily, but is not required to do so;
- both parties agree on annual performance benchmarks;
- a technical review process ensures that project impact is reliably measured in terms of the agreed benchmarks, and that the benchmarks or targets can be adjusted according to changing circumstances;
- personnel of both parties have good working relationships.

Source: Adapted from Solter 1993.

## Designing the Contract

A contract can be defined as an agreement between two parties that binds them in a framework for action to attain agreed goals and objectives, within a specified budget and period of time. It is also an essential basis for performance monitoring and evaluation. Two legal entities, such as a ministry of health and a private hospital, may sign a contract that legally binds the two organizations in an agreement to provide health services to the public.

Such a contract clearly defines what the payer expects for its money and what the provider institution will try to provide in return for that money. A contract with performance-based payments pays for defined results.

Another type of contract could perhaps better be called a service agreement or a “performance-management agreement.” Such a document is signed by two institutions that are part of the same legal entity and thus cannot enter into a legal arrangement with each other. An example is an agreement between a provincial health office that controls a health budget and the district health system that delivers services; or an agreement between a provincial government and local health departments to provide services.

The importance of the contract lies in the clear definition of the expectations of both parties that have created it through active and voluntary collaboration. It is also important as a written document that holds both parties accountable for adhering to their agreement. An “agreement” that is imposed by a supervisory organization rarely leads to desired changes.

The payer’s primary goal should be to specify its performance expectations as clearly as possible. The payer should not seek to micromanage the provider’s performance in executing the contract. The purpose of the contract is to state **what** should be done, not **how** it should be done.

The provider is responsible for determining the best ways of reaching the performance goals that the two

parties have agreed to. If the performance measures include improvements in institutional capacity, a measure is needed to show that the capacity improvement occurred. For example, if the payer would like the provider to know unit costs, then the performance measure can be a list of unit costs. The process that the provider follows to determine the unit costs is not the measure of performance. The outcome—a list of unit costs—is the valued performance measure.

What essential features should your contract include? At a minimum, it should include the following items (adapted from England 2000):

- types of health services to be delivered;
- target groups for those services;
- service goals to be achieved (such as quality, coverage, utilization);
- how performance will be measured and by whom;
- amount of financing to be made available;
- how payments will be made and when;
- time period covered by the contract;
- data to be collected and reporting format;
- names of individuals and their titles in the paying and providing organizations who will be responsible for the fulfillment of the contract;
- procedures for modifying the contract, if necessary;
- mechanisms for arbitration, in case of a dispute.

Reproduced here are sample provisions from an agreement between MSH and NGOs that are providing health services in a national program. The agreement specifies the terms of one example of a performance-based payments mechanism. Different types of payment plans and/or contracts may be appropriate for different situations.

## Sample Contract Provisions for Performance-Based Payment

The following provisions from a subcontract with a health services organization show how performance-based payment can be used as an incentive to achieve defined results. (The document is a subcontract because it implements provisions of an existing contract between MSH and the donor agency US Agency for International Development.)

THE CONTRACT	This subcontract is made and entered into by and between Management Sciences for Health (“MSH” or the “Contractor”), a nonprofit corporation organized and existing under the laws of Massachusetts with a principal place of business at 165 Allandale Road, Boston, Massachusetts, 02130, USA and Organization X (the “Subcontractor”).
ARTICLE I: PURPOSE	The purpose of this subcontract is to introduce performance-based contracting through issuance of a fixed-price, award-fee type of contract. This pilot project is being implemented as a transition from the general, input-based, grant type of agreement to an output-based, fixed-price type of subcontract. After issuing an input-based grant in year one of Project Y, the project awarded two progressively results-oriented, cost-reimbursement type of subcontracts to the Subcontractor. The final phase of the output-based strategy is to arrive at a fixed-price, performance-based type of subcontract that motivates the Subcontractor to increase its impact in the communes of A, B, C, and D in the areas of reproductive health, nutrition, childhood immunization, and child health. The Contractor shall pay the Subcontractor an incentive (award fee) in accordance with the award-fee plan, the objective of which is to increase impact through the Subcontractor’s technical performance, increase its quality of services (user satisfaction), and improve capacity-building in an effort to increase sustainability.
ARTICLE II: PERIOD OF PERFORMANCE	The period of performance of this subcontract is June 1, 1999 through March 31, 2000.
ARTICLE III: SUBCONTRACT TYPE AND AMOUNT OF SUBCONTRACT	This is a fixed-price type of subcontract with award fees. The fixed price is XX US dollars and is payable for satisfactory contract performance, defined as providing the minimum package of services as further described in Article V: Deliverables. The award fee is YY US dollars and will be paid in addition to the fixed price, provided that the Subcontractor’s performance accords with the award-fee plan in Article VI.
ARTICLE IV: PAYMENT SCHEDULE	<p>Each of the first three payments under this subcontract shall represent 20 percent of the fixed price and are scheduled for June 1, August 1, and October 1, 1999. Each of the next two payments shall represent 15 percent of the fixed price and are scheduled for December 1, 1999 and February 1, 2000. The final payment shall represent 10 percent of the fixed price and is scheduled for April 1, 2000. The payment schedule applies only to the fixed price of XX US dollars.</p> <p>An award-fee board shall be established to determine the award amount that the Subcontractor may earn in whole or in part at the end of the period of performance. The award-fee board shall be comprised of at least three members of the Contractor’s staff. The Contractor shall evaluate the Subcontractor’s technical performance against the performance indicators specified in the award-fee plan in Article VI. The amount</p>

of the award fee to be paid to the Subcontractor shall be a determination unilaterally made by the award-fee board and is not subject to the disputes clause. Payment of the award fee shall be made after the expiration date of this subcontract and as soon as results of local impact surveys are received.

ARTICLE V:  
DELIVERABLES

Under the project, the Subcontractor shall provide to a population of approximately 160,560 residents in the communes of A, B, C, and D the minimal package of services as described in the strategy document for 1998–2000. The Subcontractor agrees to provide the staff necessary to prepare and conduct biannual, joint assessments of service delivery with the Contractor. The Subcontractor's staff shall participate in discussions with the Contractor regarding the results of the assessments, programmatic changes, plans for sustainability of revenue generation, and related management issues during the pilot project of this performance-based contract.

As this is a pilot phase, the Subcontractor agrees to participate in the performance-based cluster group to review strategies and document the experience.

If the volume of services at any time during this period falls below 80 percent of the expected trend (based on historical data), the Subcontractor agrees to meet with the Contractor to discuss the situation and define corrective measures. If the downward trend continues, the Contractor reserves the right to reverse this subcontract to the previous cost-reimbursement type of contract. In any case, the total amount of this subcontract for the period February 1999–March 2000 will be no more than the total approved in January 1999.

The Subcontractor agrees to participate in the technical assistance activities organized under the project for this pilot phase.

ARTICLE VI:  
AWARD-FEE PLAN

At the end of period (March 31, 2000), the achievement of indicators described in the following table will be assessed. A yes/no decision will be made for each indicator of the table. The total award fee will be calculated based on the relative weight of indicators for which the Subcontractor has met the agreed targets.

SELECTED  
INDICATORS AND  
TARGETS FOR  
PERFORMANCE-  
BASED FINANCING

The following listing includes selected indicators, expected results, and their relative weights that form the basis for assessing the performance of the Subcontractors (nongovernmental organizations) under this subcontract. Although estimated levels of those indicators exist, it is considered convenient to validate the actual baseline measurement of each of the indicators during the first month of execution of this contract. The project is directly responsible for financing that validation activity.

**1. Percentage of women using oral rehydration solution (ORS) for children with diarrhea.**

Expected result = 15% increase in use of ORS.

Full achievement of the target will earn 10% of the total additional award in this contract.

Current baseline value for this indicator is estimated at 65% in the area being covered.

**2. Full vaccination coverage for children 12–23 months.**

Expected result = 10% increase.

Full achievement of the target will earn 20% of the total additional award in this contract.

Current baseline value for this indicator is estimated at 63% in the area being covered.

**3. Coverage of pregnant women with 3 or more prenatal visits; includes home visits in cases of women missing visits (if indicated service is provided during visit).**

Expected result = 20% increase.

Full achievement of the target will earn 10% of the total additional award in this contract.

Current baseline value for this indicator is estimated at 45% in the area being covered.

**4. Number of institutional service-delivery points (ISDPs) that provide 4 or more modern methods of contraception, and number of outreach points that provide 3 or more modern methods, at a significant level (5% or more of method mix).**

Expected result = all ISDPs providing 4 or more methods and 50% of outreach points with at least 3 modern methods.

Full achievement of the target will earn 20% of the total additional award in this contract.

Current baseline values for this indicator is estimated in two of five ISDPs that are already providing expected family planning services; 10 of 65 outreach points for delivering services are already providing the expected program performance in the area covered.

**5. Level of discontinuation rate for injectable and oral contraceptives.**

Expected result = 25% reduction.

Full achievement of the target will earn 20% of the total additional award in this contract.

Current baseline value for this indicator is estimated at 35% in the area being covered.

**6. Average duration of waiting time before providing appropriate attention to a child (in hours and minutes from arrival to beginning of attention).**

Expected result = 50% reduction.

Full achievement of this target will represent 10% of the total additional award in this contract.

Current baseline value for this indicator is estimated at 40 minutes (as an average) in the area covered.

At the beginning of the pilot program, a baseline measurement will be conducted by Agency Z in collaboration with the Subcontractor to validate the baseline estimates. Should the study indicate significant difference with the initial baseline value estimated, the Contractor and the Subcontractor agree to immediately revise these targets. Once the Contractor and the Subcontractor agree on the actual baseline measurement, any change in those indicators must be made by issuance of an amendment under this subcontract.

ARTICLE VII:  
TECHNICAL  
DIRECTION

Performance of the work herein shall be subject to the technical directions of the Chief of Party or his delegate. As used herein, "Technical Directions" are directions to the Subcontractor that amplify project descriptions, inputs, activities, and objectives; suggest project directions; or otherwise inform and complete the general scope of work. "Technical Directions" must be within the terms of this subcontract, and shall not change or modify them in any way.

ARTICLE VIII:  
TECHNICAL  
REPORTS

Monthly statistical reports are to be submitted to the project offices within 15 days after the end of the month and shall follow the standardized format set forth by the Contractor.

Three quarterly management reports and one final report shall be submitted within 15 days of the end of the quarter. The reports shall focus on management decisions made to address cost efficiency, strategies in program sustainability, and an indication of the amount of program income generated and the activities supported by the program income. The quarterly management reports should also illustrate how the overall project budget has been utilized by the Subcontractor to incorporate efficiency in management performance.

## Encouraging an Active Partnership between Payer and Provider Organizations

An active partnership between payer and provider can help to improve the delivery of services and their impact on the health status of the client population. When payments are linked with performance, the new basis of the payer-provider relationship encourages such an active partnership, in the ways suggested below.

**The provider organization.** The organizational culture of a passive service-provider rewards "business-as-usual" more than innovation. Managers in such institutions may be used to executing orders from above, more than thinking creatively about ways to improve their institution's performance. The staff may focus only on day-to-day clinical care of individual patients. They may neglect preventive and health-promoting services that, combined with curative care, could yield a bigger health impact. With a focus on day-to-day activities and not on long-term results, the institution's planning, monitoring, and evaluation systems and skills may be very weak.

Performance-based payment rewards results. To equip their institution to be an active partner in seeking results, managers in a service-providing institution must examine its internal management structure and systems, and the way it organizes care, uses financial and physical resources, and allocates, supervises, and motivates staff.

In addition to the key management actions that the institution should take in order to achieve the performance targets, it also should define the internal improvements that are necessary to support those actions. For example, the institution may need to develop a new internal monitoring system to support an increased focus on internal performance assessment. Perhaps new incentive plans for staff are necessary to support more effective performance in key areas.

The incentives for achieving results have the potential to transform managers and staff into strategic problem-solvers who are jointly focused on improving their institution's performance. That is more likely to happen, however, if the staff feel ownership of the strate-



gic plan and the results of planned activities. For example, a plan that is developed and imposed on an institution by its top managers has a much greater chance of being resented by the ordinary staff. A jointly and openly developed strategic plan can inspire the staff to work hard to reach the results of contracted activities.

A performance-based payment system has the potential to bring about a transformation in management roles, staff motivation, and management structures and skills. All of them directly contribute to improved quality and efficiency in the provider institution's work, as well as an increase in its own sustainability.

**The paying organization.** The paying organization may also need to change in order to make the performance contract work. Payers often perform a passive role, disbursing funds periodically, or functioning as auditors by checking vouchers that are submitted for reimbursement. Performance-based payment implies, however, that payers must be able to establish and measure performance indicators and to negotiate and manage new contracting processes. The payer may also choose to assist the provider in making the changes necessary to achieve performance improvements.

Those new functions imply a transformation from a passive to an active payer. For a payer organization that is used to following procedures passively, such transformations may present substantial challenges. The changes are crucial, however, if performance-based payment is to succeed in improving results.

To be effective, therefore, payers need to develop new capacities and new systems to implement the new contracting processes. Health information and accounting systems may need strengthening. Negotiating skills may need enhancing. Many payers, such as ministries of health, may be very weak in those capacities or not have them at all.

To succeed in transformation, therefore, the payer should strengthen its own staff skills and management structures, systems, and processes. For example, the payer will probably need to establish a new unit to be in charge of contracting, train its staff in the design of performance indicators, or develop new management systems for monitoring payments against performance.

Finally, if the payer intends to take an active role in helping the provider attain performance targets, the payer should develop the capacity to mobilize appropriate and timely technical assistance for the provider.

## Strengthening the Application of Performance-Based Payment Systems

Governments and organizations that consider developing health services programs with performance-based payments should not overlook the changes that will be required of both types of organizations: those that pay for and those that provide the services. Changes in systems will accompany changes in organizational culture, in both payer and provider institutions. While such changes can yield positive results in the long term, the costs of making the adjustment should not be underestimated.

Operations research should be a part of a performance-based payment system. Operations research can identify the causes of implementation problems and help adjust the payment system in response. It can inform the payers and the providers about the range of available actions to take in order to improve performance. It can show which interventions might be effective, and why. It can guide the selection of the most telling performance indicators. The lessons from operations research are important in improving the design of payment systems and minimizing implementation problems.

### A COLLABORATIVE PARTNERSHIP YIELDS PERFORMANCE IMPROVEMENTS

**Background.** Since 1995, Haitian nongovernmental organizations (NGOs) have provided basic health services that emphasize maternal and child health, reproductive health, and family planning, among others, in a project funded by the United States Agency for International Development (USAID). Dubbed “Haiti Santé 2004,” the project is being implemented by MSH, the Johns Hopkins University Center for Communication Programs, and Pathfinder International.

The NGOs were initially reimbursed for expenditures up to a negotiated ceiling. They were expected to submit a proposed annual budget and plan, and regular and detailed documentation of their expenditures. As the payer, Haiti Santé 2004 verified reported activities and expenditures and made reimbursements based on the NGOs’ monthly submissions.

A population-based survey in 1997 confirmed wide variability in NGO performance that did not correlate with the costs incurred per visit. Since the NGOs were reimbursed for all their reported expenditures, they faced weak incentives to increase their efficiency by improving their management and operations. They were also not motivated to expand the coverage or increase the quality of their services, because payment was not directly related to the results that they achieved.

#### **Designing incentives to improve performance.**

By 1999, Haiti Santé 2004 had become responsible for providing technical assistance to and funding the activities of 33 NGOs. It decided to design and test, with three NGOs, an innovative approach that based payment on results. Together, the implementing partners designed the pilot project, negotiated with the other NGOs, and launched the system. The payment model that was agreed to by the NGOs imposed some financial risk on them, but also offered the possibility of earning a performance bonus. The NGOs were to receive 95 percent of the budget that had been established under the existing expenditure-based financing contract. If they reached their performance goals, they were eligible for a bonus of up to an additional 10 percent of the original budget. The three NGOs in the pilot served an area with more than 500,000 inhabitants.

Haiti Santé 2004 and the three NGOs jointly determined seven performance indicators, and agreed on the conditions of the bonus award, which was related to increases in each indicator. Five indicators were related to improving health impact, one to increasing client satisfaction, and one to improving coordination with the Ministry of Health. (See Table 1.) Each NGO separately negotiated its performance targets for each indicator. Both the baseline and end-of-pilot performance of the NGOs were measured by an independent research firm.

## Performance Indicators, Targets and Relative Weights

Indicator	Target	Relative weight
Percentage of women using ORT to treat cases of children with diarrhea	15% increase	10% of bonus
Full vaccination coverage for children 12–23 months old	10% increase	20% of bonus
At least 3 prenatal visits	20% increase	10% of bonus
Reduction in the level of discontinuation rate for injectable and oral contraceptives	25% reduction	20% of bonus
Number of institutional service delivery points with at least 4 or more modern methods of family planning; and number of outreach points with 3 or more modern methods	Institutional service delivery points with 4+; 50% of outreach points with 3+	20% of bonus
Reduction in average waiting time before providing attention to a child (in hours and minutes from arrival to beginning of attention)	50% reduction	10% of bonus
UCS participation; coordination with Ministry of Health	UCS defined	10% of bonus

**Note:** FP = family planning; ORT = oral rehydration therapy; UCS = local health organization committee

The pilot achieved very promising results. Every NGO achieved a striking improvement in immunization coverage and availability of modern family planning methods. These achievements proved easier to achieve than

reducing the contraceptive discontinuation rate or ensuring adequate prenatal care. (The indicators of waiting time and community participation and collaboration with the ministry of health were judged either as invalid or difficult to measure and verify.)

## Results from Pilot Project on Performance-Based Payment in Haiti

Indicator	NGO 1			NGO 2			NGO 3		
	Base	Target	Result	Base	Target	Result	Base	Target	Result
ORT utilization	43	50	47	56	64	50	56	64	86
Immunization coverage	40	44	79	49	54	69	35	38	73
3+ prenatal visits	32	38	36	49	59	44	18	21	16
FP discontinuation	32	24	43	43	32	30	26	20	12
Institutions with 4+modern FP methods	6	9	9	2	5	5	0	5	5

**Note:** FP = family planning; ORT = oral rehydration therapy

All participating NGOs received more revenue on the basis of their performance than they would have received under the previous system, even though none of them achieved all of their performance targets. The shift from justifying expenditures to focusing on results inspired the NGOs to examine their models of service delivery and utilization of resources, and to explore new

options to improve quality, cut costs, and increase revenues. The managers endorsed this expanded managerial and budgeting flexibility. They noted the increased motivation of their staff and the spirit of innovation that had been created, and enthusiastically supported the continuation of the performance-based payment scheme.

**On rewarding staff as well as the client population...**

*An administrator describes the experience of one group of health and community organizations, "Our payment system of economic incentives recognizes the contribution of each employee to institutional productivity. It provides a deserved income for staff of the organization. (Currently the incentives represent from 60 to 130 percent of their salary levels.)*

The payment system ties the quantity of services to the quality of care and is supervised by an ethics committee. Our system requires quantitative changes in health indicators for the population (for example, early initiation of prenatal care and increase in the average number of prenatal visits). It continually evaluates use of installed capacity, productivity standards, and standards for quality of care. It ensures increases in service volume and quality of care, as well as improvements in management."

**On whether incentives could "backfire" and actually lead to "underperformance"...**

*A professor contemplates "...the possibility of a 'ratchet effect.' In the longer run, payment schemes linked with improvements to boost performance (instead of maintenance of certain minimal performance levels) may lead to rising target levels that become ever more difficult to achieve. That might induce providers/payees to 'underperform' and thus keep the performance target lower than they actually are capable of."*

**On keys to success in improving performance...**

*A field manager explains how judicious inputs help projects to succeed: "Performance-based contracting is often combined with technical assistance that prepares the subcontractor to operate under the new system. The technical assistance is tailored for each subcontractor's operational needs. The contracts go to nongovernmental organizations that meet certain capacity criteria. These inputs are key elements in a capacity-building strategy."*

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## Checklist for Using Performance-Based Payments to Improve Health Programs

- Familiarize yourself with payment systems that provide incentives for improving health services.
- Understand your options for applying performance-based payments.
- Set your strategic priorities for improving organizational performance and health impact.
- Choose critical performance areas and define performance goals.
- Determine the appropriate payment systems for improving performance according to your goals.
- Establish performance measures.
- Design an appropriate contract between payers (funding organizations) and service providers, specifying your performance-based payment system
- Encourage an active partnership between payer and provider organizations.
- Strengthen your application of performance-based payment systems by considering operations research.

### THE MANAGER

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