



Results Based Financing

Program Financing and Implementation Approach

Service de Santé de Qualité pour Haïti – Central South

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Overview and objective of the concept note

To strengthen the delivery of health services, the Ministère de Santé Publique et de la Population (MSPP), in partnership with the World Bank and USAID designed a National Results-Based Financing (RBF) program in 2011. The national scheme builds on the pilot program implemented by the USAID-funded Santé pour le Développement et la Stabilité d’Haïti (SDSH II) project and is modeled after the Burundi and Rwanda RBF schemes. Under the Service de Santé de Qualité pour Haïti (SSQH) project, USAID will implement the MSPP-designed national scheme throughout the country. There are, however, several important contextual and design factors that need to be considered before the national roll-out begins.

The purpose of the concept note is to outline key design and implementation issues particular to the Haïti context and service delivery structure, and to provide financing and implementation options for MSPP and USAID to consider.

RBF Design: Operation cost vs. RBF Incentive

Results based financing is a broad term that covers a number of approaches to reward the provision of more and better health care services. However, the design, scope, and types of incentives vary broadly, from country to country. On one end of the spectrum, RBF financing represents a complete shift in purchasing – from a more traditional budget system where hospitals and clinics are given block grants regardless of performance, to a ‘fee-for-service’ payment structure with very little to no additional funding given to support the operation of the clinics. Revenue collected from the ‘fee-for-service’ design is intended to cover all operation costs and the health facility is financially self-sufficient. In this arrangement, health facilities bear the majority of the risks of poor performance and the payer is protected from potential ineffective and inefficient use of funds. On the other end of the spectrum, RBF incentives are bonus payments made on top of operation budgets designed to motivate improvements in service delivery. In this model, health facilities continue to receive public funding that finances day-to-day operations and are eligible to receive additional incentive payments when targets are reached. In this structure, the health facilities are exposed to less financial risk, as performance does not affect coverage of operation costs but influences incentive eligibility only. This model requires full financing of health services – both operational costs and RBF incentives – by parties external to the health facility.

While the ‘fee-for-service’ or some form of capitation payment model is common in middle and higher income countries, a majority of developing countries, including Burundi, Rwanda, Zambia and Afghanistan, employ the later type of incentive structure as the health facilities do not have the ability to fully cover operating costs from RBF incentives.

It should be noted that there is no ‘right’ model for a country. Rather, the design is dependent on a number of factors including the overall objective of the scheme, the country context, and the structure of health financing in the country. For instance, in Rwanda and Burundi, a majority of the operating costs are borne by the government, and RBF incentives are financed by implementing partners including USAID, the World Bank, and the Global Fund.

Table 1 provides an overview of the different models and example of countries that have adopted these models.

Table 1: RBF models in Rwanda, Burundi and Haiti (MSH)

	Model	Operation Cost	RBF Incentive
Rwanda	Scheme provides incentive payments on 22 quantity indicators. Final payment is dependent on score on the quality index	~ 100% paid for by government	RBF incentives, financed by development partners are provided in addition to operating cost
Burundi	Scheme covers 40 primary healthcare facilities. Facilities received a fixed amount per targeted action plus a bonus of up to 15 per cent for quality	~ 100% paid for by government	RBF incentives, financed by development partners are provided in addition to operating cost
Haiti (MSH Pilot)	5 – 6 quantity and quality indicators selected at random (out of a list of 14 indicators) Facility eligible to earn up to 10% additional financing if targets are met	95% paid for by USAID	Up to 10% additional payment financed by USAID

Evolution of the RBF system in Haiti and Key Issues to Consider

In 1999, Management Sciences for Health (MSH) introduced features of RBF scheme in three NGO-managed health facilities. Preliminary assessment showed substantial improvements in service utilization among the intervention sites, and the pilot scheme was scaled to all NGO facilities in 2005. At the end of the project SDSH included the both ZC and NGO supported facilities. Key elements of the pilot scheme include:

Implementing partner disbursed 95% of budgeted funding to health facilities on a quarterly basis, and health facilities are eligible to receive up to 10% of additional funding through RBF.

- MSH randomly selects 5 – 6 indicators (out of a list of 14 indicators) to assess on a quarterly basis. Payments are made based on ‘targets’ reached, rather than unit price.

In 2011, MSPP re-designed the RBF program and changed several important features including:

- RBF financial incentives will be largely driven by unit-price per indicator. In addition, health facilities are eligible to make up to an additional 25% of the total incentive amount based on quality of services.

- A list of 17 quantity indicators are pre-defined for dispensaries, CSLs and CALs plus 5 more indicators for referral hospitals (HCR); quality is assessed via scores from a quality grid of around 200 indicators.

The SSQH-CS team in consultation with MSPP team has developed a two tier program.
The first tier

- No clear guidelines on payment of operating cost. The MSPP RBF manual does not provide guidance on how health facility operation costs should be covered and by whom; nor does it specify for implementing partners already financing service delivery how they should balance the cost of operations with incentive payments at the facility level. This leaves open options to either continue fully funding operating costs or reduce operating cost subsidies and shift some of the risk to facilities by making RBF incentives necessary to fully cover the cost of operation. It should be noted that the World Bank RBF payments are only for RBF incentives and does not include operating costs.

Implications to SSQH program roll-out and sustainability of the program

Based on preliminary analysis, proportion of the overall budget represented by RBF incentive payment (should the health facility achieve coverage as predicted in the model) ranges from 1% of operating cost for HCR to as high as 38% of operating cost for health facilities.

Table 2: Annual Operations versus RBF Incentive Budget Totals

Department	Operation Costs in USD for 12-month Period (all SSQH-CS facilities)	RBF Incentive Costs in USD for 12-month Period (all SSQH-CS facilities)*
Grand Anse	\$1,449,122	\$221,668
Nippes	\$1,316,668	\$88,477
Centre	\$849,557	\$184,029
Ouest	\$3,608,992	\$1,861,494
Sud	\$855,955	\$99,666
Sud-est	\$320,190	\$88,604
Total	\$8,400,484	\$2,543,938

* RBF incentive budget are based on coverage estimates provided by MSPP in the RBF Budget Template.

Given current funding, SSQH cannot support the addition of RBF payments and continue to fully fund operation costs at the current level of funding.

The scenarios below detail options for shifting costs in order to make funds available for RBF.

Scenarios for Introducing RBF at Project-supported Sites

Given the stark funding gap between the operational costs of service delivery and the potential incentive-earning under the RBF model, SSQH-CS presents three scenarios for consideration for how the project could feasibly roll-out RBF in its catchment area.

The variables we considered to help balance cost constraints while still proposing a reasonable roll-out plan included a review of:

- 1) Coverage of RBF within each department (i.e., implementing RBF in all SSQH-CS facilities within the Department vs. selecting facilities within each Department to participate in the RBF scheme), and
- 2) The timing of scale-up efforts. All scenarios start with introducing RBF in Nippes and Grand Anse departments, per MSPP request (made during meeting on July 14, 2014), and expand next to Sud and Centre departments (following completion of the World Bank Impact Evaluation study), and finally to Ouest and Sud-Est departments. The speed at which this scale up happens will depend upon the coverage of RBF within each department and the funds available for RBF based on how the project shifts costs.

For all three scenarios outlined below, the general orientation to scale-up is consistent: RBF implementation will focus exclusively on Nippes and Grand Anse October 2014 – March 2015. During this time, the project will provide RBF-readiness support and trainings in selected facilities (exact number TBD, depending on financing scenario selected) in Sud and Centre. RBF scale up to these departments will follow the completion of the World Bank Impact Evaluation study in April 2015. Starting in October 2015 the project will provide RBF-readiness support and trainings in selected facilities (exact number TBD, depending on scenario selected) in Ouest, and Sud-Est departments with the aim for qualified facilities in these two departments to start RBF implementation by December 2015.

The exact number of facilities to implement RBF in Sud, Centre, Ouest, and Sud-Est will depend upon the scenario selected and cost analyses.

Table 3: Scenario Timeline for RBF Scale-up Per Department

Department	Oct. 2014 – Mar. 2015	April – Sept. 2014	Oct. 2015 – Mar. 2016	April – Sept. 2016
Nippes	X	X	X	X
Grand Anse	X	X	X	X
Sud		X	X	X
Centre		X	X	X
Ouest			X	X
Sud-Est			X	X

Scenario 1

Scenario 1 focuses on employing the full list of RBF quantitative and qualitative indicators at each service delivery tier¹. Scenario 1 strives to bring all SSQH facilities within Nippes & Grand Anse (15) onto the RBF model by end of December 2014. RBF preparations and trainings in these departments will begin in August 2014.

¹ SSQH-CS will implement 16 of the 17 indicators as the 17th indicator would contravene Tiaht regulations

In order to support the funding for RBF incentives scenario one would require a reduction to each facility's operational budget. In an effort to standardize budget cuts fairly across facilities (while not being overly prescriptive and burdensome), this scenario establishes two budget "floors" per level of service tier. On the other end of the scale, budget "ceilings" (operational + total RBF costs) help cap potential RBF payments across service tiers so as to incentivize at a consistent rate among similar facilities. Table 4 illustrates the two tier payment structure for Grand Anse and Nippes for the first year of RBF implementation based upon a cost analysis. RBF implementation October 2015 – September 2016 will have different payment spreads, further decreasing the operations budget while raising the potential for RBF incentives.

Scenario 1: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at full unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure:
 For Disp, CSL & CAL:
 • SSQH provides 90% operational cost
 • Facilities have opportunity to earn up to 15% additional funding from RBF incentives (total 105%)
 For Referrals and Hospitals:
 • SSQH provides 100% of operational cost
 • HCRs have opportunity to earn up to 1% additional funding from RBF incentives (total 101%)

Scenario 1 RBF Year 1 (October 2014 – September 2015) for Nippes & Grand Anse

- Tier 1 (Dispensary, CSL & CAL): 90% operational budget / up to 105% operational budget + RBF
- Tier 2 (Referral Hospitals/HCRs): 100% operational budget / up to 101% operational budget + RBF

Table 4: Scenario 1 - Minimum and Maximum Budgets per Facility in Grande Anse and Nippes

Facility	ZC/NGO	Primary Service Tier	1 Year's Operating expenses (in USD)	Minimum - Year 1*	Maximum - Year 1**
Grande Anse					
DDS Operating Cost			357,131.15	357,131.15	357,131.15
CS Abricots	Abricots	CSL	109,226.45	98,303.80	114,687.77
CS de Corail	Corail	CSL	83,997.34	75,597.60	88,197.20
Klinik Pèp Bondye	HHF	Dispensaire	396,631.26	356,968.14	416,462.83
Klinik St. Joseph	HHF	Dispensaire	72,965.12	65,668.60	76,613.37
CSSH	CSSH	CAL	105,825.34	95,242.81	111,116.61
CS Léon Coicou	CSLC	CAL	53,065.13	47,758.61	55,718.38
AEADMA, Dame Marie	AEADMA	HCR	270,280.61	270,280.61	272,983.42
Sub-total			1,449,122.40	1,366,951.33	1,492,910.73
Nippes					
DDS Operating			510,246.58	510,246.58	510,246.58
CS de L'Azile	L'Azile	CAL			

Disp. Changieux	L'Azile	Dispensaire			
Disp Morisseau	L'Azile	Dispensaire			
L'Azile Total			281,579.45	253,421.51	295,658.42
CS Petit Trou de Nippes	Petit Trou de Nippes	CAL			
Disp Grand Boucan	Petit Trou de Nippes	Dispensaire			
Petit Trou de Nippes Total			281,579.45	253,421.51	295,658.42
CS Jules Fleury	Anse Veau a	CAL			
Disp. Arnaud	Anse Veau a	Dispensaire			
Disp St. Yves	Anse Veau a	Dispensaire			
Total Anse a Veau			243,262.42	218,936.17	255,425.54
Sub-total			1,316,667.90	1,236,025.77	1,356,988.97

* Assumes 90% operating cost and 0% RBF incentive for Tier 1 facilities, and 100% operating cost and 0% RBF incentive for Tier 2 facilities

* Assumes 90% operating cost, and up to 15% additional payments as RBF incentives (total 105%) for Tier 1 facilities and 100% operating cost and up to 1% additional payments as RBF incentive (total 101%) for Tier 2 facilities.

The number of facilities to roll out RBF in the other four departments will be based upon further cost analyses. To the extent possible, payment structure will be consistent across six departments. However, the number of health facilities to be included in the RBF scheme within each Department will vary.

Contractual Arrangements: Agreements with NGO and publically-managed facilities will run for six months each with an option to renew. By October 2015, veteran facilities with these mechanisms will run for a full 12 months, while new facilities will start on a 6-month mechanism with an option to renew. Agreements will begin with a six month period to allow the project to evaluate facility performance and adjust budget floors and ceilings if appropriate. Technical assistance and CQI plans for facilities implementing RBF will emphasize strengthening quality and use of RBF management tools (Periodic Action Plans, monthly statistical reports [SIS], audit minutes and findings, and evaluation reports).

Scenario 1 Issues:

- Lower performing health facilities may not be able to earn enough from RBF incentive to cover operating costs; and
- Larger financial cost of RBF implementation will result in fewer facilities in Sud, Centre, Ouest, and Sud-Est implementing RBF.

Scenario 2

In scenario 2, salaries for the public facilities would be assumed by the MSPP. If the MSPP can support salaries for the public sites, reductions in the operation budgets for each facility to free funds for RBF payments will be smaller. The purpose in transferring salaries for the staff to MSPP is 1) to reduce the potential impact of the operational budget reductions on each facility, and 2) to enable the project to roll out RBF in a faster and more comprehensive manner.

Similar to the phased approach described in Scenario 1, SSQH –CS will begin RBF implementation in Nippes and Grand Anse, and expand to Sud, Center, Quest, and Sud-Est in subsequent years. The exact number of health facilities to be included in Sud, Center, Quest, and Sud-Est will depend on cost analysis.

Scenario 2: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at full unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure

- Transition salary payment for public facilities to MSPP
- SSQH continues to provide 1) full operational cost for NGOs and 2) operational cost minus salary for ZC facilities
- Facilities eligible for up to 10% in RBF incentives (110% total operation cost)

Table 5: Total Operating Expenses versus Total Salary Line Items in Zone Cibles

Departments	1 Year's Operating Expenses (ZCs Only) in USD	1 Year's Salary Expenses (ZCs Only) in USD	RBF Funding in USD *
Grand Anse	\$550,355	\$113,735	\$221,668
Nippes	\$574,987	\$315,780	\$88,477
Centre	\$651,458	\$432,866	\$184,029
Ouest	\$704,640	\$496,294	\$1,861,494
Sud	\$368,830	\$193,007	\$99,666
Sud-est	\$255,172	\$126,635	\$88,604
TOTAL	3,105,442	\$1,678,318	\$2,543,938

* RBF funding based on estimated coverage provided in the RBF budget template

The project will also work with NGO run facilities to reduce operating costs to allow for RBF incentives.

Scenario 2 Pros: Smaller reduction in operation budgets results in less risk for facilities in the event that they do not earn back 100% of the RBF budget.

Scenario 2 Issues: Additional funding will be needed to finance RBF incentive as salary expenses only account for around \$1.6 million in budget reductions, a further \$865,000 in budget reductions will be necessary in order to SSQH-CS to fuller cover RBF incentives. Depending on MSPP's budget and budget cycle, the Ministry may not be able to reallocate funds to cover salary expenses or may not be able to request for additional funds to absorb ZC staff during the first few months of RBF implementation.

Scenario 3

In scenario 3 SSQH- CS would implement the full set of RBF indicators (minus the FP indicators) at a reduced unit price per indicator. The rationale for this scenario is that a proportion of the current unit cost per indicator includes estimated operational cost to provide the service. Since operational cost is borne by SSQH-CS, a suggested solution is to reduce the unit price per indicator by 50 percent. Final percentage reduction to the unit cost will be determined after further discussion with MSPP, WB, LMG and MSPP.

Implementation will follow a phased approach as described in Scenario 1. The exact number of facilities to be included in Sud, Center, Quest, and Sud-Est will depend on cost analysis.

The following table presents illustrative cost analysis of reduced unit price per indicator (as suggested by MSPP/LMG). With the reduced price per indicator, facility operational budgets would only be cut by 5 percent.

Scenario 3: Key Design Element

Package: 16 quantitative indicators (excluding FP indicator per discussion with USAID) at 50% of unit price and list of qualitative indicators, adjusted for services offered at level of care.

Incentive Payment Structure:

For Disp, CSL & CAL:

- SSQH provides 95% operational cost
- Facilities have opportunity to earn up to 15% additional funding from RBF incentives (total 105%)

For Referrals and Hospitals:

- SSQH provides 100% of operational cost
- HCRs have opportunity to earn up to 1% additional funding from RBF incentives (total 101%)

Table 6: Scenario 3 - Minimum and Maximum Budgets per Facility in Grande Anse and Nippes

Facility	ZC/NGO	Primary Service Tier	1 Year's Operating expenses in USD	Minimum - Year 1	Maximum - Year 1
Grande Anse					
DDS Operating Cost			357,131.15	357,131.15	357,131.15
CS Abricots	Abricots	CSL	109,226.45	103,765.13	114,687.77
CS de Corail	Corail	CSL	83,997.34	79,797.47	88,197.20
Klinik Pèp Bondye	HHF	Dispensaire	396,631.26	376,799.70	416,462.83
Klinik St. Joseph	HHF	Dispensaire	72,965.12	69,316.86	76,613.37
CSSH	CSSH	CAL	105,825.34	100,534.08	111,116.61
CS Léon Coicou	CSLC	CAL	53,065.13	50,411.87	55,718.38
AEADMA, Dame Marie	AEADMA	HCR	270,280.61	270,280.61	272,983.42
Sub-total			1,449,122.40	1,408,036.86	1,492,910.73
Nippes					
DDS Operating Cost			510,246.58	510,246.58	510,246.58
CS de L'Azile	L'Azile	CAL			
Disp. Changieux	L'Azile	Dispensaire			
Disp Morisseau	L'Azile	Dispensaire			
L'Azile Total			281,579.45	267,500.48	295,658.42

CS Petit Trou de Nippes	Petit Trou de Nippes	CAL			
Disp Grand Boucan	Petit Trou de Nippes	Dispensaire			
Petit Trou de Nippes Total			281,579.45	267,500.48	295,658.42
CS Jules Fleury	Anse Veau a	CAL			
Disp. Arnaud	Anse Veau a	Dispensaire			
Disp St. Yves	Anse Veau a	Dispensaire			
Total Anse a Veau			243,262.42	231,099.29	255,425.54
Sub-total			1,316,667.90	1,276,346.84	1,356,988.97

Scenario 3 RBF Year 1 (October 2014 – September 2015) for Nippes & Grand Anse

- Tier 1 (Dispensary, CSL & CAL): 95% operational budget / up to 105% operational budget + RBF
- Tier 2 (Referral Hospitals/HCRs): 100% operational budget / up to 101% operational budget + RBF

Scenario 3 Pros: Smaller reduction in operation budgets results in less risk for facilities in the event that they do not earn back 100% of the RBF budget.

Scenario 3 Issues: With a reduction in financial incentive, RBF may have less anticipated impact on overall quality and quantity of services.

Summary of Scenarios

Table 7 presents a summary of the three financing scenarios and potential impact to health facilities, MSPP, and USAID. It should be noted that the following scenarios are based on the assumption that SSQH maintains the same level of funding for service delivery in Years 2 and 3. Any reduction in level of funding in service delivery will have a significant impact on RBF payment structure.

Table 7: Summary of Scenarios

	Design	Potential financial burden to Health Facilities	Potential financial burden to MSPP/DDS	Potential financial burden to USAID/SSQH
Scenario 1	16 indicators at full unit price Full list of quality indicators	Disp/CSL/CAL: 90% operational cost Up to 15% additional revenue from RBF HCR: No impact to operational cost. Up to 1% additional revenue from	Limited financial burden	<ul style="list-style-type: none"> • Up to 5% in additional payment if all health facilities earn full RBF incentive • Potential impact in other services with a reduction in operational cost

		RBF		
Scenario 2	16 indicators at full unit price. Full list of quality indicators Transition ZC salary payments to MSPP/DDS	Limited financial burden	Absorb \$1.6 million in salaries	<ul style="list-style-type: none"> • \$865,000 in financing gap • Potential impact in service delivery if ZC cannot absorb additional salary
Scenario 3	16 indicators at 50% unit price Full list of quality indicators	Disp/CSL/CAL: 95% operational cost Up to 10% additional revenue from RBF HCR: No impact to operational cost. Up to 1% additional revenue from RBF	Limited financial burden	<ul style="list-style-type: none"> • Up to 5% in additional payment if all health facilities earn full RBF incentive

Conclusion

SSQH-CS is committed to find a balance of a faithful implementation of the MSPP’s RBF scheme, adjustments of SSQH-CS activities to make implementation feasible and to moderate risk to service delivery institutions. The scenarios detailed above illustrate potential funding options for Year 1 implementation in Nippes and Grand Anse. As we work to mitigate the many challenges apparent in the implementation we also look forward the opportunity RBF provides to improve the quantity and quality of health services.