



Incentive Scheme to Serve the Poor and to Enhance Program Cost Recovery



NGO Service Delivery Program

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Overview of NSDP

35 NGOs

61 districts

85 municipalities

6 city corporations

317 Clinics

8,302 Satellite Spots

6,330 Depotholders

1.7 million customer served/ month

Basic Service Package

Comprehensive FP & RH Services

Child Health services

TB in urban areas

ANC and maternal health

Limited Curative Care

BCC activities



Overview of NSDP

Continued...

Objectives

- Expand the range and improve the quality of the essential services package (ESP)
- Increase the use of the ESP provided by NSDP NGOs, especially by the poor
- Increase the capacity of NGOs to sustain clinic and community-based service provision, institutionally and financially
- Collaborate with the Government of Bangladesh, in coordination with other donors, to expand the role of NGOs as providers of the ESP within the National Health System



Overview of NSDP

Continued...

Pricing strategy to enhance cost recovery

- NGO determined
- Flexibility (in rate and frequency) allowed
- Community involved

Safety net to ensure access to services for the poorest of the poor

- Identify the poorest of the poor
- The poorest of the poor are given health benefit cards
- Services are provided free



Disincentives to NGOs

- Accumulation of revenue funds
 - NGOs do not have immediate access to revenue fund account
 - Use revenue fund for non-productive solutions
 - Low incentive for NGOs to further increase cost recovery
- Foregone Use Fees
 - Burden on NGOs for serving more poorest of the poor customers
 - Poorest of the poor are identified but may not be served



A incentive scheme was designed to

Motivate NGOs to increase cost recovery

Serve more poorest of the poor



How does it work?

- Create a health equity fund (HEF) to reimburse NGOs for the foregone user fees for serving the poorest of the poor
- NGOs and health workers are rewarded with cash bonus when their cost recovery rates improve
- Extra revenues earned are distributed three ways:
 - 50% to HEF
 - 25% to NGO
 - 25% to provider



Health Equity Fund: Removing Financial Burden for Serving the Poor

- Poorest of the poor become “regular paying customers”, which motivates NGOs to serve them
- Cost burden shifted from NGOs to NSDP
- More affluent customers will subsidize poorest customers
- NGOs and providers rewarded financially for serving ALL clients, not just paying clients



NGOs have more flexibility in spending revenue

- Additional revenue no longer added to program income
- NGOs use of revenue less restricted
- Flexible spending creates NGO ownership
- Funds can be used for new business development



Implementation Requirements:

- Underutilized service capacity at clinics (ability to increase client/provider ratio)
- Ability to identify, recruit and serve poorest of the poor
- Ability to continue to recruit paying customers
- “Extra” revenues generated to contribute to HEF



Piloting an Incentive Scheme

- A quasi-experimental design piloting for 7 NGOs (4 urban and 3 rural; 4 intervention and 3 control group) with similar characteristics in
 - Identification of poorest of the poor
 - Cost recovery rates & MOCAT
 - Pricing adjustment
- Pilot period: 6 months (March – August, 2005)
- Preliminary results indicate the incentive scheme has significant impacts



Testing the Impacts of Incentive Intervention

Cost Recovery Rates

	Previous Year	Pilot Period	Rate of Increase
Intervention	20.41	26.12	28%
Control	15.98	18.11	13%



Testing the Impacts of Incentive Intervention

The increase in cost recovery rate of the intervention group is twice as fast as the control group



Testing the Impacts of Incentive Intervention

Number of Poorest of the Poor served

	Previous 6-month	Pilot Period	Rate of Increase
Intervention	8,495	11,982	41%
Control	2,821	2,262	-20%



Testing the Impacts of Incentive Intervention

The intervention group has a 41% increase in the number of poorest of the poor served while there is a 20% decline of poorest of the poor served by the control group



Statistic Analysis of Impacts of Incentive Intervention

Using clinic data, statistic tests are conducted to determine whether the incentive intervention has made significant impact on cost recovery rates and the number of customers who are classified as the poorest of the poor



Testing the Impacts of Incentive Intervention

Rate of increase of Cost Recovery Rate

	Intervention Group	Control Group
Number of Clinics	70	39
Mean	26.02	20.28
Standard Deviation	23.42	19.47



Statistic Analysis – Increase of Cost Recovery Rates

- A one-tailed two-sample t-test is performed
- The t statistics is 1.37
- The p-value is 0.0870
- The null hypothesis that there is no difference in the mean rate of increase is rejected
- The results support the hypothesis that incentive intervention increases the cost recovery rates of the NGOs in the intervention group



Testing the Impacts of Incentive Intervention

Percentage Increase of Poorest of the Poor Customers

	Intervention Group	Control Group
Number of Clinics	8	6
Mean	38.28	-27.04
Standard Deviation	52.15	22.69



Statistic Analysis – Increase of Poorest of the Poor Customers

- A one-tailed two-sample t-test is performed
- The t statistics is 3.17
- The p-value is 0.005
- The null hypothesis that there is no difference in the mean rate of increase is rejected
- The results support the hypothesis that incentive intervention increases the poorest of the poor customers served by the NGOs in the intervention group



Extra Revenue Generated and Utilized – Example of one NGO

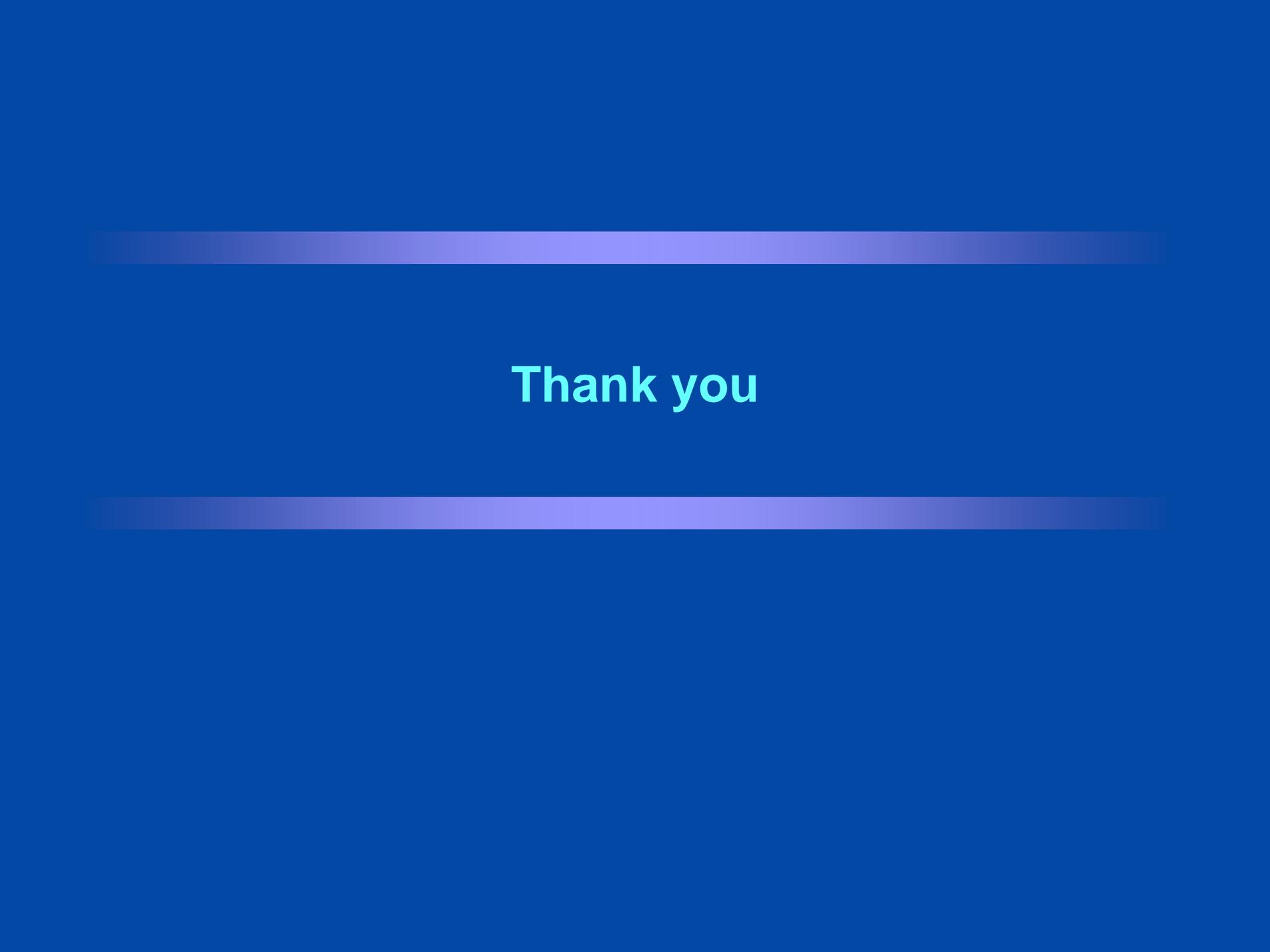
- Reimbursement from HEF = \$46
- Total revenue = \$98,205
- Extra revenue = \$26,088
- Bonus to NGO =\$6,522
- Bonus to each clinic =\$362
- Bonus to each health provider =\$30
- Contribution to HEF =\$13,044
- Net flow to HEF =\$12,988



Summary

- With incentive scheme, clinics serve more customers and achieve higher cost recovery rates
- Incentive scheme turn static cash reserves into dynamic and productive fund flows
- Extra revenues provide bonus to NGOs and health workers
- Contributions to Health Equity Fund build resources to serve the poorest of the poor
- Incentive scheme promotes cross-subsidization from the non-poor to the poorest of the poor





Thank you