Why there is so much enthusiasm for performance-based financing, particularly in developing countries

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One of the strengths of PBF is its flexibility. Adherents to PBF continuously seek improvements in theory, best practice and instruments. The contributions of Ireland et al.1 and Kalk2 in response to the excellent paper from Meessen et al.3 are therefore welcome. However, some of their points of criticism are based on misunderstandings and they transpose assumptions about behaviour in high-income countries to low-income settings. Ironically, their criticism only strengthens the case for PBF, since the mentioned authors do not propose any alternative for PBF but linger in the status quo, which most people would agree is detrimental to development and health.

Since PBF was first used around 15 years ago, there has been an open debate about its pros and cons. There has been criticism that incentive payments focused too much on quantity and not on quality. We subsequently adapted the incentives towards improving quality with very favourable results shown in recent evaluations from Burundi,4 Democratic Republic of the Congo5 and Rwanda.6

Another point of criticism has been that activities subsidized by PBF were limited to only 6–10 indicators and thereby ignored other health facility activities. In response, for example, the national PBF programme in Burundi introduced 48 indicators (24 at primary and 24 at hospital level). Equity was also a major and shared point of concern. In response, we introduced new PBF mechanisms such as bonuses for remote provinces and health facilities, quality improvement units for dilapidated health facilities as well as individual equity funds. Due to its purposeful broad orientation to health reforms, PBF also developed performance framework contracts for regulators to assure, for example, the quality of pharmaceuticals in a competitive market.

Internal criticism has included evaluations showing that there is a need for more effective community PBF approaches to promote household hygiene, sanitation and birth spacing.

This openness to constructive criticism explains why there is enthusiasm for PBF, particularly in developing countries, and there is little sympathy for the ideas of Ireland et al. and Kalk.

Twenty-two African countries have adopted PBF, are conducting pilots or are planning to start and all this without much external push or promotion. After reflection on the papers from Ireland et al. and Kalk, we conducted a small survey of 38 health workers in Burundi. We asked them whether they would want to abandon PBF and the answer was a wholehearted “no.” This is because PBF is a flexible system that allows health workers, who better serve the public interest, to receive appropriate payment. PBF grants power to autonomous health facilities to make decisions instead of central bureaucrats. It sensibly proposes checks and balances in health systems by separating regulation, input distribution systems, provision, purchasing and fund holding and strengthening community voice empowerment.

Criticism, therefore, has always been embraced. Some criticism, however, is unfounded such as the suggestion that workers in PBF believe that it is a magic bullet. Yes, we deem PBF to be a broad approach, but one that consists of numerous incremental and sensible steps towards improving the health system, with little magic about them. In addition, Ireland et al. wrongly argue that PBF only works in “stable Rwanda” while recent evidence strongly suggests that it is effective in failed states such as the Central Africa Republic and the Democratic Republic of the Congo. We appeal to all colleagues to continue an open scrutiny of PBF; it is the only way forward. However, in doing so, let us work with state-of-the-art evidence and not with mere personal opinion.

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References

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