Performance-based financing (PBF) in low- and middle-income countries:

What is the theory of change, actually?

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Introduction

Performance-based financing (PBF) is expanding in LMICs, despite it has been criticised for potential perverse effects (Paul et al. 2015); unintended effects are demonstrated (Traoré-Trimbley et al. 2017). Attributing results to PBF as such is difficult because (i) health systems inherently comprise “structural” incentives and are subject to various reforms; and (ii) there are misunderstandings and controversies about the mere definition and the theory behind PBF. PBF schemes encompass different components (e.g. financial premiums conditioned on reaching pre-agreed results, focus and feedback on key performance indicators, coaching, additional resources at facility level, …) and their designs may infinitely vary. Yet, we still do not have a clear and consistent explanation of why and how PBF is supposed to produce results.

Much of the current cross-disciplinary PBF research lacks a sound theoretical basis (Selviaridis & Wynstra 2015)

Objective

To explore (i) the theoretical justification of PBF and (ii) the theory of change (ToC) in the health sector in LMICs

Theories

- Fragmentation of the literature and abundance of (often overlapping) theories explain the rationale and functioning of results-based financing approaches (Jahn et al. 2013, Selviaridis & Wynstra 2015, Paul & Renmans 2018)
- Sina Health (2017) PBF course identifies a number of so-called ‘theories underlying PBF’: Systems analysis; Public choice; Contract theory; Microeconomics and free market principles; Health economics & public health; Decentralisation; Good governance
- Most commonly used theory to justify PBF = the principal-agent theory:
  - Objective: to better align healthcare providers’ incentives with populations’ interests
  - Rests on very restrictive assumptions (see below)
- Other currents referred to justify PBF belong to the broad New institutional economics – Property rights theory (Meessen 2009), Transaction cost economics (Selviaridis & Wynstra 2015) – as well as: Behavioural economics (Eichler 2006, Chowdhury et al. 2013), Political economy theories (Norad 2015a)
- Few non-economic approaches: Management control theory (Selviaridis & Wynstra 2015), Operations and supply management (Selviaridis & Wynstra 2015), Contingency theory (Baines et al. 2015)

Discussion

- Validity of economic rationale behind PBF is limited
- Principal-agent theory does not hold in complex systems such as health:
  - Multitasking problem ⇒ multiplicity of outputs
  - Outputs are not observable at no cost, without noise ⇒ difficulty and cost of correctly measuring performance
  - Some outputs are not dependent on agents’ efforts
  - Agents are not risk-neutral ⇒ unfairness of transferring risk to healthcare providers
  - Complexity of health workers’ remuneration schemes ⇒ incoherence of incentive scheme
  - Health workers are not pure homo oeconomicus
  - Elusion of auxiliary components beyond financial premiums
  - Does not take context into consideration
- Little empirical endorsement of the P-A theory (Prendergast 1999)
  - Growing consensus on the fact that the principal-agent theory is not appropriate to justify PBF (Baines et al. 2015, ToC working group 2017, Paul and Renmans 2018)
- Review of experiences: “all [PBF] programmes had weak theories of change at start-up” (Notar 2013b)

Theory of change (TOC)

- Theory-based evaluation has progressively imposed itself as more appropriate approach to study complex issues
- There are few theory-based evaluations and partial attempts to “open the black box” of PBF and identify its ToC / programme theory / causal pathways / mechanisms / transmission of effects,…
- World Bank’s RBF evaluation toolkit (Vernimmen et al. 2012): outlines some possible ToCs
  - Perakis and Savedoff (2015): 4 kinds of channels through which results-based approaches could produce results: (1) financial incentive; (2) results indicators; (3) accountability; (4) autonomy
  - Ninongeris et al. (2016): tracks for transmission of effects for health facility performance: (1) income; (2) cash; (3) incentive; (4) information; (5) supervision & enforcement; (6) culture at provider level; (7) health system
  - Lohmann et al. (2017): six categories of motivational mechanisms: (1) periodic wake-up call to deficiencies in day-to-day practice; (2) direction and goals to work towards; (3) strengthening perceived ability to perform successfully at work and triggering a sense of accomplishment; (4) instilling feelings of recognition; (5) altering social dynamics, improving team work towards a common goal, social pressure; (6) offering a ‘nice to have’ opportunity to earn extra income
- More elaborate intents of ToC found in literature include for instance:

Conclusion

- The theories used to justify PBF to date are few and insufficiently credible
- Studies aimed at uncovering the ToC of PBF are recent and unfinished
- Most existing PBF ToCs are not theory-based
- Actors need to make the theories underlying their interventions more explicit, disentangling the PBF package
- Performance premiums conditioned on reaching a number of predetermined performance criteria may not be justified
- If PBF is justified neither by strong theoretical arguments, nor by generalizable evidence, it is definitely marked by a neoliberal ideology, and the promotion of lack of trust and competition over cooperation between actors in the health system
- Taboo: Is the debate over PBF definition a way to conceal the debate over PBF ideology?

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