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COMMENT

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Performance-based financing is not on the path towards universal health coverage and equity

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Performance-based financing is most likely ineffective in advancing universal health coverage and equity. It is rooted in mistrust and flawed incentive structures; it often exacerbates inequalities — both at patient and provider level. Addressing structural injustices at the root of inequity requires systemic reforms beyond PBF's limited scope and rhetorical commitments.

Performance-based financing, universal health coverage, and health equity: an invalid combination

The possibility that performance-based financing (PBF) could be a novel approach to advancing universal health coverage (UHC) and equity is no longer a credible proposition. On the one hand, PBF can no longer be considered a novel approach, and on the other hand, its potential to advance UHC is limited. Indeed, as detailed below, the evidence suggests that it may exacerbate inequities. Furthermore, while the issue of equity has always been at the heart of health policy, from Alma-Ata to UHC, social inequalities in health have not improved over time. Despite all the declarations for social justice, inequalities are increasing, and the poorest remain largely excluded from health services, especially in the context of austerity and health financing policies. As a result, PBF can be understood as part of the problem of social injustice, not the solution. Let us explain.

The fundamental principle of PBF involves providing financial (or occasionally non-financial) incentives to an entity or agent based on achieving pre-defined performance targets. These targets may include quantitative and/or qualitative measures, whose attainment must be independently verified before any performance premium is disbursed. PBF typically includes a package of complementary components and incentives [1]. The approach can be applied across different levels or relationships: for example between international donors and recipient countries in the form of performance-based aid (e.g. additional tranches of budget support granted upon meeting specific process conditions or performance targets), between national or international funding entities and implementing agencies (e.g. civil society organisations), or downstream to healthcare providers and healthcare recipients.

PBF has been vigorously promoted in the health sector of low- and middle-income countries (LMICs) since the early 2000s. It is part of the longstanding traditions of "managing for results", and, in fact, some PBF-like models were implemented as far back as the colonial era in Africa. For example, at the turn of the twentieth century, colonial authorities granted the inhabitants of Senegal a bonus for each patient diagnosed as having the plague, with an extra bonus provided for each rat captured. In the 1930s, cash incentives were given to mothers to promote the birth rate, and performance

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bonuses were given to matrons in French-speaking West Africa when deliveries were free of sequelae, especially umbilical tetanus. Yet, these bonuses were never effective and often suffered from stifling bureaucracies and task shifting (Ridde V, Diaw M, Béland D: Health care financing instruments during the colonial period inSenegal: the historical and institutional nature of policy instruments, forthcoming).

The primary aim of PBF is to incentivise beneficiaries to improve their performance. Implicitly, this approach is rooted in a form of mutual mistrust between "principals" (fund holders) and "agents" (beneficiaries, irrespective of their role). Donors mistrust the effectiveness of beneficiaries, while recipients regularly mistrust the intentions of funders, often viewing PBF as an external imposition lacking national ownership and thus a form of neocolonialism. This mistrust ultimately stems from PBF's basis in behavioural economics, which assumes that poor performance is primarily due to inadequate incentives, with the expectation that "corrected" incentives will automatically lead to improvements (particularly in work "cultures"), ignoring other potential constraints and contextual moderators that effect performance.

Over the past two decades, an extensive body of literature has emerged on PBF yet with largely unfavourable findings. Beyond the lack of consistent theoretical foundations underpinning PBF in the health sector of LMICs, recent large-scale realist [2] and systematic reviews [3] of the empirical evidence have reported indeterminant and often disappointing results, suggesting that PBF has not delivered the dynamic reforms it promised.

In 2022, the World Bank, a key proponent of PBF in LMICs, published a synthesis report evaluating the impact of its PBF programmes. The report concluded that while PBF produced some gains in health outcomes compared to business as usual, these gains were unlikely to result from the "mechanistic" effect of performance premiums. Additionally, the high costs associated with performance verification diminished its efficiency. Consequently, the report's authors recommended moving away from PBF while retaining its impactful elements, particularly decentralised financing and decision-making of frontline healthcare providers. Noticeably, the report hardly addresses equity. It "finds mixed but limited evidence of impacts on equity, with PBF projects reducing the disparity in the quality of care received by wealthy and poor women in one instance but increasing it in another" [4]. Despite this, the World Bank continues to advocate for PBF at multiple levels. For instance, despite the fact that any incentive provided to recipient countries is unlikely to "trickle down" to the actors directly delivering results, the new Pandemic Fund operates a "results-based framework" for pandemic preparedness in which all projects should be measured against metrics, although the evaluative element of the framework remains in development.

While UHC is supposedly about reducing inequities in the healthcare system, we should wonder whether PBF diminishes or exacerbates inequities. At the patient level, PBF risks prioritising those who are easier to reach and treat at the expense of the most vulnerable populations—a phenomenon known as "cream skimming". For example, in Rwanda, PBF achieved efficiency gains by improving access to healthcare for relatively affluent patients but was less effective in reaching the poorest, thereby increasing inequity [5]. We have previously argued that there is growing consensus that equity of access for the most disadvantaged populations has not been adequately addressed in PBF programmes across sub-Saharan Africa [6]. The recent example of Burkina Faso confirms this, where equity has once again been forgotten, even though those in charge of the PBF programme had been informed beforehand of PBF's anticipated harmful effects.

PBF is also inherently predisposed to increase disparities among healthcare providers or facilities. This reflects the "Matthew effect", whereby "the rich get richer, and the poor get poorer". Better-resourced health centres can improve performance and earn higher performance premiums, while less-resourced centres struggle to achieve similar gains. This dynamic has been documented in Zimbabwe, where facilities with better baseline access to guidelines, more staff, higher consultation volumes, and wealthier and less remote target populations earned significantly higher bonuses [7]. In recognition of this inherent tendency to exacerbate inequalities, many PBF schemes put in place measures to mitigate this (e.g. one-time investments, trainings, increased supervisions, best practice workshops). Sometimes, adaptations are made to the PBF set-up itself giving higher incentives to rural facilities or adding equity indicators to measure performance. However, the latter do not fundamentally change the inherent Matthew effect [7].

The main issue with these solutions is that they treat equity as a technical problem that can be solved by tinkering in the margins. However, equity is a result of deeply engrained structural power and socioeconomic imbalances. Believing that equity can be addressed by adding new unequal incentive structures to the healthcare system, which the evidence suggests drive inequities, is at best wishful thinking and at worst a masquerade. This masquerade is exacerbated by the limited potential of PBF to foster other health sector reforms towards UHC (e.g. through system-wide efficiency gains) as initially claimed by its advocates, since PBF schemes are often designed as stand-alone interventions, have limited

capacity to drive system-wide reforms [8], often are not efficient, and produce several negative externalities at the national and operational level. Efforts should rather be put on system-wide health financing reforms enabling a reduction in fragmentation and to improve needs-based allocation of resources [9].

Conclusions

In conclusion, one must question why PBF continues to be considered a viable or novel approach for improving equity and advancing UHC, since it sidelines social justice, a key foundation of UHC. This is because combating social injustice requires more precise and proportionate universalism, particularly concerning the upstream determinants of health such as poverty, a key driver of disease. Although there are many theories of justice, and their interpretation can give rise to different pragmatic solutions, their foundations must, at least, be debated with the people concerned and in relation to their needs. All too often, however, these decisions are made by people and institutions far removed from the people concerned, while conflicts of interest regularly influence how these decisions are made. Besides, debates on equity in health are often rhetorical and declarative: this is certainly the case concerning PBF. Thus, international financing and actions implemented on the ground often merely give lip service to combating issues of social injustice, because, like most PBF schemes, it is easier to act for output effectiveness than for health equity.

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