**References**

1. Earl S, Carden F, Smutylo T. *Outcome mapping: building learning and reflection into development programs*. Ottawa: International Development Research Centre; 2001.
2. Ireland M, Paul E, Dujardin B. Can performance-based financing be used to reform health systems in developing countries? *Bull World Health Organ* 2011;89:695–698.
3. Sterman JD. Learning from evidence in a complex world. *Am J Public Health* 2006;96:505–14. doi:10.2105/AJPH.2005.066043 PMID:16449579
4. Plsek PE, Greenhalgh T. Complexity science - the challenge of complexity in health care. *BMJ* 2001;323:625–8. doi:10.1136/bmj.323.7313.625 PMID:11557716
5. Bandini S, Manzoni S, Vizzari G. Agent based modeling and simulation: an informatics perspective. *J Artif Soc Soc Simul* 2009;12:4.

## 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 Kalk[2] 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 Congo[6] and Rwanda.[5]

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**

1. Ireland M, Paul E, Dujardin B. Can performance-based financing be used to reform health systems in developing countries? *Bull World Health Organ* 2011;89:695–698.
2. Kalk A. The costs of performance-based financing. *Bull World Health Organ* 2011;89:319. doi:10.2471/BLT.11.087247 PMID:21556295
3. Meessen B, Soucat A, Sekabaraga C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? *Bull World Health Organ* 2011;89:153–6. doi:10.2471/BLT.10.077339
4. *Performance-based funding household and quality study report 2006, 2008, 2010*. The Hague: Cordaid; 2011. Available from: http://www.cordaidpartners.com/groups/?address=performance-based-financing@cordaid&page=publications [accessed on 4 July 2011].
5. Basinga P, Gertler PJ, Binagwaho A, Soucat ALB, Sturdy J, Vermeersch CMJ. Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. *Lancet* 2011;377:1421–8. doi:10.1016/S0140-6736(11)60177-3
6. Soeters R, Peerenboom PB, Mushagalusa P, Kimanuka C. Performance-Based Financing Experiment Improved Health Care In The Democratic Republic Of Congo *Health Aff* 2011;30:1518–27.

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