# Evidence as Cliché: Using Trials to Tamper with Governance

*For... [] there are experimental methods and conceptual confusion… The existence of the experimental method makes us think we have the means of solving the problems that trouble us; but problem and method pass one another by.*

— *Ludwig Wittgenstein (1889-1951)*

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## Introduction

In 2018, I was invited by the *Cochrane Database of Systematic Reviews* to review a manuscript. It was a systematic review on the impact of decentralised governance on health services. I was happy to have been asked. The protocol for the review was published in 2013,[1] and I had read it with a mix of excitement and scepticism. *Cochrane* places much emphasis on evidence from randomised controlled trials, and the authors had proposed in their protocol to review evidence from experimental and quasi-experimental studies on decentralised governance.[2] Knowing that decentralised governance (as a policy intervention) is not readily amenable to such methods of inquiry, I wondered where the authors would find the studies to include in their review. Decentralisation is often implemented as part of all-encompassing political reform process in a country.[3] So, how do you separate decentralised (experimental) from centralised (control) districts?

I was therefore not surprised to note that the authors were able to identify only one eligible study. But even that study was not really eligible. As I wrote in my review:

> "…the authors define decentralisation and centralisation only in relation to governments. The challenge of such a limited definition is two-fold – 1. Decisions of governments to (de)centralise the governance of services between levels of government are made in such a way that it is hard, if not impossible, to subject to experimental evaluation – hence it is not surprising that the authors found no such study that meets their inclusion criteria; 2. The only study that meets the authors' inclusion criteria does not really meet their inclusion criteria – this study examined decentralisation within an organisation (and not from one level of government to another). The authors have the option of re-writing or reframing their review and how they define (de)centralisation in a broader sense that goes beyond what happens between [or] among governments to [include] the governance structure within organisations."

When I wrote those open peer review comments, I had thought that most (if not all) experimental studies of decentralised governance will potentially amount to large scale tampering with health system governance. I still think so. However, I have since changed my mind on the potential to find such studies on decentralised governance. Over time, I came to the view that the name of a well-known health policy intervention *performance-based financing* – which has repeatedly been subjected to experimental and quasi-experimental inquiry,[4] is a misnomer. It is decentralised governance in disguise, just like purchaser-provider split and community engagement in governance. Whether or not these trials are useful, or should have been conducted, they exist. They should have been considered as eligible for inclusion in that proposed Cochrane review on decentralisation. But I had not thought so at the time. I did not make the link.

## Elements – governance as core, incentives as adaptable

With pilots or full-scale programmes in at least 32 out of 46 countries, performance-based financing is one of the most widely implemented health policy measures in sub-Saharan Africa.[5] Its spread is backed by a well- nurtured 'nexus of strongly dedicated diffusion entrepreneurs', working in, funded by, or supported through bilateral and multilateral development banks and agencies, especially the World Bank.[6] Trials have played a central rhetorical role in legitimising performance-based

financing initiatives across Africa. Even though the results of those trials are hardly ever impressive, decisions to scale up the initiative within a country or to spread it to other countries were often made 'before research results were made available, or in spite of them'.[7] The literature on performance-based financing does not position *decentralisation* as its core feature, framing it instead by a relatively marginal, and often adaptable feature – i.e. incentives given to health facilities or peripheral governing entities to improve the quantity and quality of their services.[8]

In implementation science, programmes are described as having 'core elements' and 'adaptable elements'. Core elements are features which are directly or primarily responsible for programme impact. Adaptable elements are features that are modified to align with contextual nuances.[9] The core feature or element of performance-based financing is often framed as the incentive to improve performance. However, at the core of the initiative, is the transfer of power, resources, and responsibilities from central to peripheral actors in the health system.[10] The transfer may occur between the national and sub-national governments, between a government and health facilities, or between a government and community groups (e.g. community health committees).[11] Thus, the core feature is decentralisation – 'performance-based financing' is decentralised governance by another name. Without decentralisation reforms, health facilities, sub-national governments, or community groups cannot receive, use, and make decisions based on performance incentives.

I put this conceptual confusion down to the problem of gaze, the foreign gaze.[12] The framing of performance incentives as being at the core of performance-based financing makes it amenable to evaluation through randomised control trials. The alternative is much more difficult. Asking directly for the decentralisation of health system governance, is tantamount to asking for a likely unwelcome wholescale tampering with health systems; a complex, contested, threatening, and long process of reforms, retooling, and negotiations. The 'simplification' of performance-based financing lends it, in turn, to the generation of simple and apparently compelling evidence on its effectiveness through randomised controlled trials; and makes it 'marketable' to a funder or policy actor at a distance – to the foreign gaze. The language of 'performance-based financing' offers decentralisation through the backdoor – *after all, rather than an extensive reform, it is quite a specific intervention.* The core element (i.e. decentralisation) thus becomes a relatively silent consideration.

## The non-problem of mixed results

Much like decentralisation,[13] efforts to quantify the effects of performance-based financing[14] on health system performance have yielded mixed results, and inevitably so. In spite of repeated efforts, (including the use of trials in the case of performance-based financing) to demonstrate their effectiveness, or lack thereof, it has proved to be an impossible and perhaps, unnecessary endeavour. After all, their effectiveness could not possibly be proven one way or another, or proven once and for all. They are complex social (and/or political) interventions. Their effects result from the many interacting and varying behaviours and interests of the individuals and groups, who design or implement them, or are their targets or intended beneficiaries. Their effects also depend on their design, i.e. decentralisation or performance-based financing in one place is necessarily different from an intervention that carries the same label elsewhere.

While their effects vary from place to place, and from time to time, there may be tendencies and identifiable patterns in how these complex social interventions and phenomena perform when introduced or activated in a particular place or setting.[15] But even those tendencies are always contingent on context. For example, in a setting where X exists, and people have experienced Y and so reason in a particular way Z, favourable outcomes result from decentralised governance or performance-based financing. Hence, for a policy-maker, the question is not so much whether to decentralise governance (in settings where they have the power to do so) or implement performance-based financing, but rather, how will it work in a setting where X does not exist, but rather there is A, where instead of Y, people have experienced B, and so, are likely to reason in way C when decentralised governance or performance-based financing is introduced.

Understanding the knowledge and evidence needs on complex interventions and phenomena in terms that acknowledge their complexity should be the starting point of inquiry, and not the conclusion. Too often, it is the other way around – the studies, often experimental, randomised controlled trials, has been set up, and conducted in multiple places, often at great cost, only to conclude, after their results accumulate over time, that the evidence is mixed. Of course, the

evidence is mixed. It is a misuse of the experimental method. But the practice persists. And the question is why? In the case of performance-based financing, once you see it as decentralised governance, the question becomes even more difficult to answer. Decentralised governance is an ongoing process that involves continued tensions and negotiations and learning. It is never complete. Any evidence on its effectiveness is at best tentative; and generously interpreted, it is cliché; and at worst, it is a disingenuous, cynical (if sometimes useful) excuse for tampering with health system governance.

If the question is, should a country adopt performance-based financing, these randomised controlled trials cannot answer it. If the question is, what kind of performance-based financing a country should adopt, these randomised controlled trials cannot answer it either. And if the question is, how a country should modify its own performance-based financing initiative to suit its context, these randomised controlled trials cannot also answer it. So, what are they good for? Why does randomised controlled trial evidence remain important (even though whether its result is positive or negative, whether it demonstrates effectiveness or not, it has little to say about what is really a reform effort)? Who is the audience of these randomised controlled trials? The foreign gaze? It is perhaps an easier way to convince funders and unsuspecting, distant, governments who will accept the result as unthinkingly as its cliché deployment by policy entrepreneurs.

## What RCTs enable – foreign, surgical, simplicity

Using randomised controlled trials to assess performance-based financing initiatives is like judging a cake by the cherry or icing on top of it; the cake here being the core, underlying layers of decentralisation reforms and processes, on top of which the 'performance incentive' rests. In these trials, it is the whole package that is being evaluated, even though the evidence is typically presented as evidence on 'performance incentives' component. When the evidence is mixed, it is often because the context asserts itself, again and again. So, to know why evidence from randomised controlled trials could have been considered useful at all, one can only infer from the rhetoric implicit in such trials – i.e. that there are benefits to 'simplifying' a complex intervention, and to the wishing way of context, such that even when context is to be taken seriously, the aspects of context which are considered are those that readily lend themselves to simplification.

These wishful assumptions relate, in part, to the origin story of performance-based financing. Early evidence came from post-conflict states undergoing or considering sweeping governance reforms.[16] The first scale up effort was in such a peculiar setting – Rwanda – evaluated in a randomised-controlled trial,[17] showing success in improving health system performance, a result which has since been challenged, and has hardly been replicated elsewhere, despite repeated efforts.[18] However, outside such atypical settings with ongoing governance reforms onto which performance-based financing can position itself as cherry or icing on the cake (e.g. Rwanda, Burundi, and Zimbabwe) it is indeed rare for national governments to devote significant domestic funds and other local resources to support, implement or scale-up performance-based financing initiatives.[19] Those funds have typically come from outside – from donors, notably, the World Bank.[20]

In the absence of ongoing reforms or a national or sub-national willingness to undergo such reforms, efforts to introduce or scale up performance-based financing (usually accompanied with randomised controlled trials), may therefore require unwelcome tampering with health system governance. And given that existing governance arrangements are typically entrenched, context reasserts itself in the (in)effectiveness of such efforts. Tampering may cause unintended consequences. But masquerading a reform (e.g. decentralised governance) as an intervention (e.g. performance-based financing), may also work as a deliberate backdoor strategy to introduce a necessary and desirable reform into a health system which powerful interests in the system would otherwise have resisted. Regardless of such a coy strategy, the foreign gaze has an appetite for simple, rather than complex interventions, so much that it will simplify a complex intervention.

I experienced this appetite, first-hand, in Nigeria, 2013. I was working at the National Primary Health Care Development Agency, Abuja – the implementing agency for Nigeria's performance-based financing initiative. I had volunteered to help during the fieldwork for a study. There was sub-optimal uptake of services in pilot health facilities for the initiative. The World Bank wanted to know why. One consistent finding was that where local decentralised governance structures (community health committees) were active, service uptake was high, and where they were not, uptake was low.[21] However, this was not reflected on the list of recommendations in the draft report shared with the rest of the team by the lead World Bank

consultant. It focussed on a reasonable but much less compelling idea of using transportation vouchers to improve uptake. I raised this glaring omission. The consultant replied that they would correct it. In the final report, there was hardly a mention of community health committees; the focus remained transportation vouchers.[22]

The foreign gaze had held on to a tangible, 'surgical' intervention – something simple, something that could be readily sold to a funder who is looking or acting at a distance, something that could be proven, once and for all, to have worked. Here is my interpretation of that experience: when you are looking from a distance, you see 'concrete' things like money, funds and performance incentives, things that could come from outside, and surgically (or magically) make things better, like transportation vouchers; rather than thing that are organic, thing that requires on-the-ground retooling, negotiations, fixing, learning, something like local community health committees, like decentralised governance. Transportation vouchers are tangible, they can be measured, and evaluated, and implemented in the same format, from place to place, like a traveling model. It is easily imagined as scalable. It is discrete. It is new. It appears attractive at a distance.

## What RCTs constrain – rich, organic, learning

If performance-based financing were re-framed as a form of decentralised governance, then how would it be studied? Before I came to this understanding of performance-based financing, I had, myself, conducted an evidence synthesis on how decentralised governance influences health system performance,[23] and I had left out the literature on performance-based financing. Looking back, this omission leaves me with deep and regretful appreciation of what must be many such potential opportunities for learning that we so easily miss due to how we frame interventions or programmes in a way that makes their adaptable elements seem like core elements. As a result, potential learnings on core elements are not optimised – learning across interventions (that belong in the same "core elements" family) and learning across settings.[24] This likely does incalculable harm to our ability to solve the problems that trouble us in global health and development.

However, the evidence synthesis on decentralisation that I conducted began with a premise of complexity. It acknowledged that what is useful evidence is not whether decentralisation 'works' but how, for whom, and under what circumstances it 'works' or not.[25] It acknowledged that what is called 'decentralisation' is often limited by a focus on its top-down connotations as an 'intervention'; that decentralised governance may also be seen as a common phenomenon; as how things are regardless of a formal policy to enact (de)-centralisation as an intervention – e.g. the decentralised ways in which local community health committees govern their local health system; through the exercise of local agency. Hence, one can study decentralisation not only as an 'intervention'. These conceptual moves meant that I could cast wide the net of studies to include in the evidence synthesis, thus enriching the range of potential insights and learnings.

While none of the included studies was a randomised controlled trial, in retrospect, I realise that trials could have met the inclusion criteria. But such trials are rare, precisely because decentralised governance involves iterative social and political decision-making processes that resist randomisation. Trials assume standardised interventions across sites; decentralisation is about continuous local learning and adaptation. Unfortunately, the 'surgical' appetite of the foreign gaze means that researchers who are inclined to understand from the bottom up, to engage in the organic process of change, may feel the need to apologise for their superior choice, to justify why they 'have not developed a traditional intervention',[26] and risk being seen as 'academic lightweight, producing nothing of substance', or as researchers who 'answer questions which are dull, not novel (little contribution to the scientific literature), or not generalizable (focused on local issues)'.[27]

Trials do not entirely preclude asking nuanced questions, but make it much more difficult to ask them. In the context of a trial, such questions are an afterthought (when embedded within the trial), are limited (by the very nature of assumptions made in trials), or are wrong (e.g. when asked in binaries if whether something is good or bad, whether it works or not).[28] But what is really important are nuanced questions of process or more fundamental questions of appropriateness, of fairness, of justice, or overarching systems, or of the ongoing, iterative, long-term effects of health system interventions, processes, phenomena, and outcomes that trials are ill-equipped capture: What does a system need to improve? Are performance incentives (beyond salaries) necessary? Why? Are there locally-informed strategies to address the reasons? Do they require local political engagement? How do you support local political process to generate change?

Much like randomised controlled trials, performance-based financing has generated serious debate.[29] Both debates are linked. The opportunity and transaction costs of implementing performance-based financing are cited by those challenging it. They also cite trials showing its failure, just as the other side can easily cite trials showing its success and make the case that any failure is due to 'context'. It is a cliché debate that shows the limits of trials. Notably, in their defence of performance-based financing initiatives, a group of local health systems practitioners across six African countries did not cite evidence from trials. For them, it is a "reform approach" in "constant evolution" "over time", which builds capacity at different levels of decentralised governance, to improve "coordination, decentralisation, accountability… including community engagement in … governance)".[30] To the local gaze, performance-based financing is decentralised governance.

## Conclusion

Early 2020, I visited the Cochrane website to check the status of the review on decentralisation. I was keen to see the direction in which the authors had taken their review in response to my and others' peer review comments. Unfortunately, I found a notice, dated September 2019, stating that the editors of the *Cochrane Database of Systematic Reviews*, have "withdrawn it from publication" because "this protocol has not been successfully converted into a full Cochrane Review within established timelines due to lack of resources to complete the review."[31] The two authors of the review protocol and the potential systematic review are based in Malaysia, which may explain their limited resources. I thought, what a loss. By broadening the scope of the systematic review and redefining its parameters, their review would have been an opportunity to deepen and enrich the literature on the impact of decentralisation on health systems and services.

However, I am left wondering what the results would look like of a systematic review on decentralisation that includes evidence – both qualitative and quantitative – on performance-based financing initiatives. It could be an extension of the evidence synthesis that I had conducted, or a revision of the planned systematic review, which, for lack of resources, and the preference of the *Cochrane Database of Systematic Reviews* for experimental studies, may never be completed. The result of such evidence synthesis or review would have looked different – 'performance incentives' would have only featured as one among many contextual factors that may enable or constrain outcomes such as quality, equity, and efficiency. The literature is poorer for lack of (and for not normalising) such a complexity-informed review.[32] This is one of the costs of randomised-controlled trials – how it can obscure conceptual connections. We must find ways to count this cost too.

It is important to make sense of the costs of randomised controlled trials in health systems, global health, and development research. In the example that I have presented here, in part due to the rhetorical, if cliché, advantage of randomised controlled trials in feeding the appetite of the foreign gaze, a policy measure that was indeed designed to strengthen decentralised governance is largely mis-named (as performance-based financing), mis-valued (using evidence from randomised controlled trials), and mis-marketed (like a Trojan horse) to governments, as an excuse (sometimes desirably?) to tamper with health system governance. The literature on performance-based financing should have been part of the literature on decentralised governance. That it is not, limits the learning that could have taken place between both literatures. The cost of simplification – aided by randomised controlled trials – is that it unwittingly limits learning.

## Notes


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