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Healthcare Quality under Performance Based Financing in Cameroon: Lessons Learned and Perspectives

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ABSTRACT

Healthcare quality remains one of the primary policy concerns towards achieving universal health coverage (UHC) that shapes health sector reform in low- and middle-income countries (LMICs). In this perspective, performance-based financing (PBF) is an innovative well-structured health system financing mechanisms which aims to improve coverage and healthcare quality by incentivizing providers and facilities to achieve specific performance targets, often including quality indicators. During the last fifteen years, Cameroon used the PBF as a key health financing policy while in 2023 the policymakers engaged the implementation of UHC as part of the country effort to improve coverage and access to quality health services nationwide. This paper aims to analyze the healthcare quality under the Performance-Based Financing (PBF) mechanisms' intervention in Cameroon. A qualitative cross-sectional design was undertaken using a scoping review methods for data collection and analysis. The results point out that PBF mechanisms use bonuses or other incentives, which may include equipment or individual staff payments, based on the achievement of some outcome's targets. By linking performance measurement to incentives, PBF helps address quality shortfalls and encourage providers to improve their efficiency and responsiveness to population needs. Incentivizing quality encourage providers to improve healthcare quality by linking bonuses or other incentives to the achievement of specific quality indicators. Focusing on specific areas of healthcare quality improvement, such as maternal and child health or HIV/AIDS care or immunization, nutrition, sanitation, functional infrastructure, medical supplies' availability, hiring qualified health workers, etc. enhanced the overall performance. Improved staff motivation by providing incentives thereby improving process healthcare quality. Increased

facility quality by investing bonuses to improve structural aspects can enhance the healthcare quality. PBF's payments depend explicitly on the degree to which services are of approved healthcare quality, as specified by protocols for processes or outcomes. However, healthcare quality measurement can be challenging, and PBF mechanisms need to develop effective and relevant quality indicators. The effectiveness of PBF mechanisms for improving healthcare quality can vary depending on the context in which they are implemented. Therefore, overall, PBF is a potentially effective tool for improving healthcare quality, but it's essential to consider the challenges and adapt PBF mechanisms to specific contexts and population needs. These results highlight how crucial it is to improve performance metrics, boost domestic funding for UHC, and fortify legislative frameworks in order to guarantee long-lasting gains in healthcare quality. This analysis contributes to broader debates on performance-based financing and health system reform in low- and middle-income countries.

Keywords: Healthcare Quality, Performance-Based Financing (PBF), Universal Health Coverage, Cameroon.

INTRODUCTION

Healthcare quality is currently at the top of both national and international policymakers' agendas[1]. Thus, in low- and middle-income countries (LMICs), major quality gaps have been observed in health facilities even for basic services such as routine pediatric and antenatal care [2-4]. Healthcare quality can be enhanced in low- and middle-income countries (LMICs) by using Performance-Based Financing (PBF) [5, 6]. The ultimate objective of PBF is to use scarce resources more efficiently by incentivizing high-priority, high quality, and cost-effective services, including for hard-to reach underserved populations, while encouraging providers to reduce fees [7-8]. Performance-based financing (PBF) is a type of pay-for performance approach that provides financial incentives to health facilities based on quantity of services, adjusted for quality of care [8]. Following the positive results of an early PBF program in Rwanda [9], similar programs were implemented in several other low- and lower-middle income countries. While PBF mechanisms have shown potential to improve service coverage and healthcare quality in various settings despite the challenges of resource constraints issues [10, 11], however, the effective impact of PBF mechanisms on achieving better healthcare quality outcomes remains uncertain in many low- and middle-income countries (LMICs) [12, 13].

Healthcare quality remains one of the primary policy concerns towards achieving universal health coverage (UHC) that shapes health sector reform in low- and middle-income countries (LMICs), while performance-based financing (PBF) is an innovative well-structured health system financing mechanisms which aims to improve coverage and healthcare quality by incentivizing providers and facilities to achieve specific performance targets, often including quality indicators. During the last fifteen years, Cameroon used the PBF as a key health financing policy while in 2023 the policymakers engaged the implementation of UHC as part of the country effort to improve coverage and access to quality health services nationwide. Cameroon implemented performance-based financing in response to growing healthcare challenges, including resource-constrained environments with limited or inadequate infrastructure and equipment, insufficient personnel, and disparities in urban-rural healthcare access, low quality care delivery for improving health outcomes in the country [14]. The

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Ministry of Public Health and its international technical and financial partners had previously piloted these reforms in a few chosen areas before scaling them up [15]. There are also questions about PBF's capacity to improve healthcare quality in a sustainable and equitable way, despite early evaluations in Cameroon showing an increase in the utilization of services like skilled birth attendance and immunizations[15,16]. Accessibility, safety, effectiveness, responsiveness, and equity of those services, are component of quality care which are not always well reflected by conventional performance measures[17]. There is an urgent need to strengthen the frontline and non-frontline healthcare facilities that accompany the healthcare systems in low- and middle-income countries (LMICs). Due to financial and human resource constraints, this development frequently necessitates major changes to the governance and structure of health systems[18]. With an emphasis on how the incentive structure impacts health facilities' environment, clinical procedures, provider's behaviors, provider patient interaction, healthcare outcomes, and structural readiness, the current study aims to investigate healthcare quality in Cameroon using the PBF model. Thus, this paper helps to highlights the effects of PBF on healthcare quality in the Cameroonian health system. A qualitative cross-sectional study method was undertaken using a scoping review methods for data collection and analysis. The papers is structured in four main sections. The first section describe an overview of healthcare quality in the health system. The second section briefly presents the conceptual framework for ensuring healthcare quality in PBF. The third section analyses how far healthcare quality is effectively taken into account under Performance-based financing (PBF) thereby highlighting the lessons learned. The four section focuses on the policy implications and perspectives for the health system financing to improve healthcare quality.

Overview of Healthcare Quality Issues in the Health System

In general, for health systems reinforcement, the World Health Organization (WHO) has developed a framework for health systems that describes health systems in terms of six building blocks: service delivery, health workforce, information healthcare, medical products, vaccines and technologies, financing and leadership/governance [19]. While healthcare quality can be viewed from different perspectives depending on the context with which the health system is oriented. Thus, the dimensions of healthcare quality will depend on the levels at which the health care system is structured, several research works have varied and complex explanations of quality[20]. In 2012, the Agency for Health Research and Quality (AHRQ) accepted the Institute of Medicine (IOM) definition of healthcare quality, perhaps to emphasize the discussion and defining attributes. The IOM framework, which includes six aims for healthcare (safe, effective, patient-centered, timely, efficient, and equitable), is widely used by AHRQ and other organizations to guide quality improvement efforts. Mansoureh et al. [21], defines quality health care as the degree of obtaining the best health outcomes through the delivery of effective, efficient and cost-benefit professional health services to people and communities. Very comprehensive definitions of quality speak basically of excellence, the outcomes or objectives achieved, and the capability to provide services in line with standards [22]. Donabedian in his work on healthcare quality [17] outlined a quality of care framework consisting of three components as part of its evaluation of quality of care (QoC). This framework is generally known as Structure Process Outcome (SPO): S: structure, which refers to the characteristics of the health facility, such as equipment, human resources and infrastructure related to caregiving; P: process, determines if the services provided to patients are consistent with routine clinical care and current guidelines; and O: outcomes that result from the provision of care, including patient satisfaction. According to Donabedian (1988), healthcare quality is a

multifaceted term that includes clinical procedures (like following treatment protocols), structural inputs (like infrastructure and equipment), and health outcomes (like patient recovery and mortality rates).

Indeed, in the healthcare industry, quality is a multifaceted notion whose definition has changed dramatically over time. Nearly all of the original definitions of healthcare quality were developed by medical practitioners and researchers. The Institute of Medicine's (IOM) definition is arguably the one that is brought up in the literature the most in this context. Chung & Shauver 2008 defined quality in health care as "the degree to which health services for individuals and for the population increase the likelihood of the desired health outcomes and is consistent with current professional knowledge" [23]. This definition was published in 1990. Patient happiness and well-being are reflected in the intended health results. In addition, the IOM definition highlights the importance of health services for persons and populations (rather than just patients) and the connection between prevention, health promotion, and quality. Current professional knowledge is also crucial, highlighting the need for evidence-based care. This suggests that the idea of healthcare quality is dynamic and ever-changing, and that in order for their services to be deemed qualitative, healthcare professionals need evaluate the state of knowledge at the moment [1]. The preferences and opinions of patients, the general public, and other significant players are now more widely acknowledged to have a significant role in assessing the quality of healthcare [24].

A competent, driven, and well-supported health worker is essential. Healthcare professionals strive to give their patients the finest care possible. However, the surroundings and systems they operate in frequently make this endeavor challenging. There are serious shortages in many nations' health workforces, both in terms of number and quality. Of obviously, doctors shouldn't provide all medical treatment. In the twenty-first century, providing high-quality care requires the contributions of nurses, allied and community health professionals, managers, and care coordinators. By utilizing their abilities across the health manufacturing chain, excellent quality can be attained[25]. Technical expertise must be supplemented by teamwork and communication skills, as well as collaboration with patients and their caregivers, in order to deliver high-quality care. Along with acknowledging the "hidden curriculum" that results from the fallibility of human-designed systems, it also calls for a workforce that has been taught in the concepts and methods of continuous quality improvement. Additionally, quality depends on how well efforts are coordinated and integrated with other sectors, taking into consideration relationships, human contact, and behavioral patterns. This in turn depends on the incentives that are in place, which must be properly included into all procedures and establishments. These incentives include funding and compensation, regulation, reporting, and feedback. Ultimately, systems offer rich soil where quality practices and advancements can take place[26].

Although providing everyone with high-quality healthcare may seem like a lofty goal, it is possible in every situation with strong leadership, careful planning, and wise investment. A strategy that involves communities and residents in the design of health care services, for instance, has improved a number of indices in Uganda, including a 33% decrease in child mortality[27]. Through a well-thought-out, resourced, and executed improvement strategy, Costa Rica has seen notable increases in the quality of primary care[28]. Later in this document, instances such as these are given. Addressing quality while establishing universal health care

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presents a significant opportunity for low- and middle-income nations. It is possible to influence, guide, and nurture a developing and established health system in the way that is intended. As the system expands and changes, quality can be incorporated into institutions, procedures, and policies.

Conceptual Framework for Healthcare Quality in PBF

The PBF theory of change would demonstrate how providing these incentives and establishing a system of payment, oversight, and training were meant to support the desired end outcomes. Was it through the hiring of skilled workers, the purchase of new machinery and improved facilities, the adoption of new techniques for proper documentation and protocol application, or the improvement of health service utilization? The program's projected outcomes of expanding care availability, opening hours, lowering absenteeism, lowering care costs, boosting employee engagement, and enhancing protocol adherence would likewise be explained by this theory of change [16].

This framework was modified to fit the logic of Performance-Based Financing (PBF) and is based on Donabedian's Model of Healthcare Quality (structure–process–outcome). It describes how PBF's financial incentives affect inputs, service delivery procedures, and, eventually, care quality [17].

Table 2: Key Components of Conceptual framework of healthcare quality.

Component	Description
Inputs (Structure)	PBF provides financial incentives to facilities. These are used to improve:
	- Infrastructure (equipment, sanitation)
	- Human resources (training, staffing)
	- Drugs and supplies
Processes	Improved inputs are expected to enhance:
	- Adherence to clinical protocols
	- Timeliness and completeness of services
	- Patient-provider interaction
Outputs & Outcomes	Expected results include:
	- Higher service utilization
	- Patient satisfaction
	- Reduced complications/mortality (long-term)
Moderating Factors	Contextual variables that affect success:
	- Facility location (rural vs. urban)
	- Governance and supervision
	- Staff motivation and training
	- Community engagement and feedback mechanisms

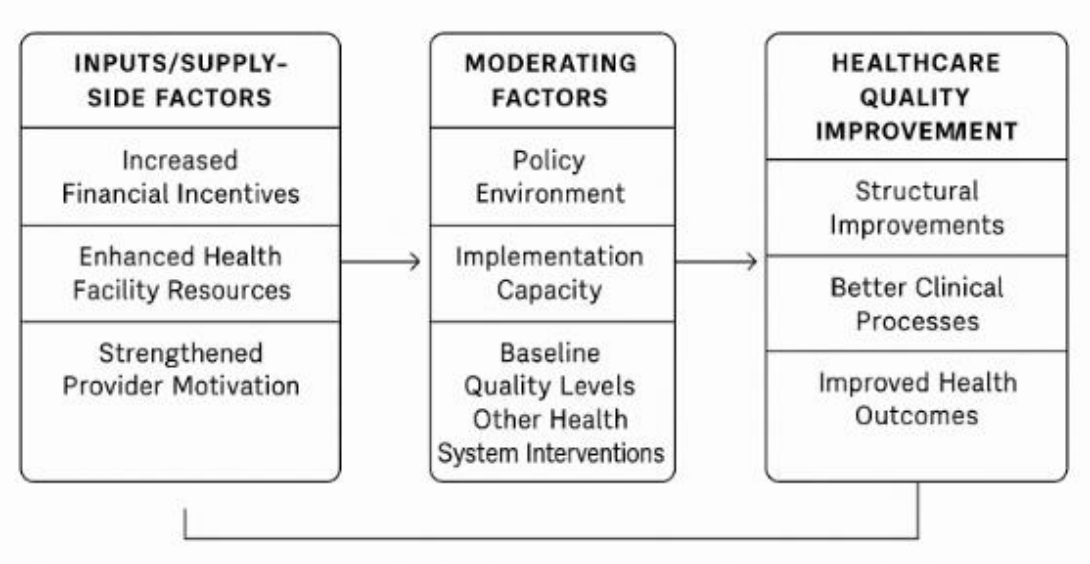

Figure 1: Conceptual Framework of healthcare quality under PBF

Analysis of Healthcare Quality Issues in Performance-Based Financing (PBF)

Performance-based financing (PBF) aims to improve healthcare quality by incentivizing providers and facilities to achieve specific performance targets, often including quality indicators. PBF differs from classical health financing, in the sense that it does not rely on input financing for activities to take place, but directly ties the financing of health facilities and regulatory entities within the health sector to the results obtained. PBF is an approach which is increasingly being used in low- and middle-income countries to improve health system outcomes [29]: it is specifically distinguished by three conditions: (i) incentives are given to providers, not beneficiaries: the financing of health facilities is directly linked to their performance; (ii) awards are purely financial: payment is by fee-for-service for specified services; and (iii) payments depend explicitly on the degree to which services are of approved quality, as specified by protocols for processes or outcomes [30]. In order to strengthen healthcare quality as a major concern in LMICs, PBF aligns with many strategies which are being developed by policy makers to address these problems, including the development of patient care standard procedure manuals, promotion of competition and choice of health services, and various forms of accreditation of the quality of healthcare [31]. Indeed, PBF is a strategic health financing reform that aims to improve the quantity and quality of healthcare services with the emphasis for improving patient satisfaction, clinical standards, and care delivery by tying financial incentives to the achievement of predetermined performance targets[6, 16, 32, 33].

Enhancing the quality of healthcare is a top goal when it comes to health system changes, particularly in LMICs like Cameroon. With assistance from the World Bank, PBF was introduced in Cameroon in 2008 as part of the Health Sector Support Investment Project. Under the Health Sector Support Investment Project, PBF was first implemented in Cameroon in 2008 and progressively expanded throughout the country with technical and financial supports from the World Bank and other partners. By measuring quantitative service delivery and qualitative metrics, the plan seeks to improve accountability, boost facility-level autonomy, and increase provider motivation [34]. Therefore, the program sought to address low employee motivation, inefficiencies in the public health sector, and subpar service quality, especially in underserved

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and rural areas [34]. The infrastructure of health facilities, health workers' performance, medication availability, record-keeping, and patient satisfaction are all evaluated on a quarterly basis using a standardized checklist as part of Cameroon's PBF's quality component [35]. The possibility of gaming behavior, in which suppliers prioritize incentivized indicators over non-incentivized but no less significant services, is another issue. According to Paul et al. (2018), this selective prioritizing may skew the overall quality of care and decrease responsiveness to community health needs. Furthermore, PBF has occasionally resulted in uneven quality improvements, with metropolitan and better-resourced hospitals benefiting more than outlying or rural areas[33]. The health facilities can be measured healthcare quality by clear indicators, for example, the quality, accessibility, and affordability of the services. In PBF, health facilities get incentives based on their agreed results and can invest the obtained funds in further improving their services. The approach also helps reform the health system to become more resilient. It starts with collaboration and a joint understanding of the pursued targets, helped by a strong monitoring system. In terms of quality, PBF has been shown to have a significant impact on the availability of basic supplies and equipment, qualified health workers, and increased patient and provider satisfaction [36]. Similarly, a qualitative research study on the impact of PBF on the availability of essential drugs in Cameroon found that it improved the perceived availability of essential drugs in Cameroon in regions where it has been implemented. The study also found that the change in the availability of essential medicines as perceived by stakeholders was due to multiple sources, including the increased autonomy of facilities, the enforcement of laws by the district medical team, the increased accountability of the pharmacy attendant, and the liberalization of the supply system [37]. Since PBF is evaluated based on a predetermined quality of service and output, it provides an opportunity for those who work hard and strive to achieve good results in the course of performing their duties. In this regard, their incentives are based on the quality of the services they provide. Since funds are also allocated for the purchase of good equipment and training in its use, positive results and greater output are eminent, thus benefiting both parties [37].

Moreover, some of the likely negative effects that financial incentives can have on health worker performance and motivation include distortions – focusing on targeted services to the detriment of others; negative reporting; selection of patients who make it easier to achieve goals; sacrificing quality of services to focus on quantity because it is practically easier to implement and control. It also contributes to widening disparities by rewarding providers and centers that are better able to meet targets and the temporal improvement of services that stop as soon as the target is met.

PBF is also effective and profitable because it benefits the service regulator, health workers and patients. This means that its holistic nature helps to improve the living conditions of the entire community. In general, healthcare providers affirm the implementation of PBF in their facilities, which they believe could mean more financial resources if their performance meets the required healthcare quality standards. In practice, both structural and process quality improved in many health facilities under PBF contracting arrangements. PBF has significantly improved the structural situation in Cameroon. Facilities have reported better infrastructure, more equipment, and more accessible necessary medications[33]. Process-wise, there have been discernible improvements in patient-provider communication, hygiene standards, and clinical documentation. Performance bonuses have also raised employee motivation, which has improved work engagement and timeliness[16]. These advantages do have certain restrictions,

though. Deeper facets of clinical excellence are frequently obscured by the emphasis on quantifiable and visible measures. Health disparities are further exacerbated by rural health centers' inability to keep up with their more advanced urban counterparts. Sustainability issues are still present as well, particularly because of the significant reliance on donor money and the low level of government financial involvement [38]. In contrast, other nations like Nigeria, Rwanda, and the Democratic Republic of the Congo (DRC) provide insightful comparisons. Because of its strong government ownership and integration with national institutions, Rwanda has demonstrated outstanding improvements in both clinical and structural quality [39]. Nigeria and the DRC, on the other hand, have reported conflicting results. Clinical quality and patient outcomes were less constant even while structural readiness increased; this was frequently caused by inadequate supervision, financing shortages, and brittle health systems [40, 41]. Some of these issues are similar in Cameroon, especially when it comes to maintaining the PBF model and converting healthcare quality into real health outcomes as shown in Figure 2 below.

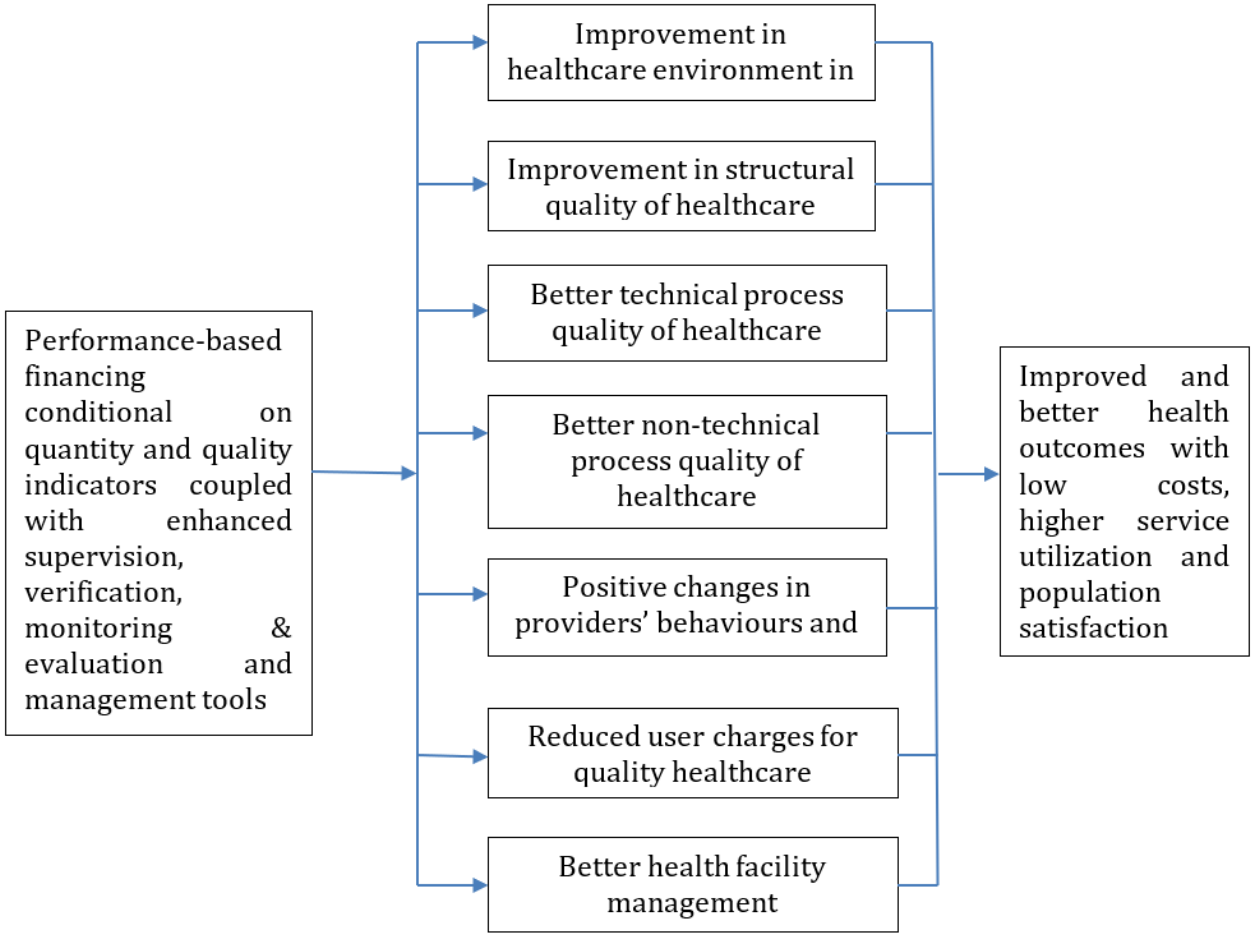

Figure 2: How PBF improves healthcare quality in Cameroon
Source: Designed by the authors

There is a significant difference in the quality of healthcare services before and after implementing PBF in the study site. PBF in Cameroon has improved the procedural and structural facets of healthcare quality. However, sustainability concerns, a lack of clinical

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quality evaluation, and inconsistent regional implementation continue to limit its full potential. For PBF to be more effective, a more balanced strategy involving strong oversight, government commitment, and comprehensive quality indicators is required. Comparative experiences indicate that in addition to financial incentives, more extensive systemic reforms, enhanced accountability frameworks, and stakeholder engagement at all health system levels are necessary for long-term success[16].

Systemic quality issues still exist despite certain documented improvements, such as better record-keeping, easier access to necessary medications, and greater patient-provider communication. Research shows that although PBF has made some surface-level improvements in structural inputs and service readiness, its impact on clinical quality is still minimal, especially when it comes to areas like infection control, emergency obstetric care, and clinical protocol adherence[38,39]. Although the model shows promise, its effectiveness in addressing ingrained quality of care issues is still mixed and highly context-dependent. Critics contend that while many PBF schemes place an emphasis on quantifiable outcomes like service use, these measures may not fully reflect significant advancements in patient safety and clinical treatment. Furthermore, because of their reliance on foreign financing and their poor integration with national health systems, quality improvements may not be sustainable. The success of PBF in Cameroon is moderated by a number of factors to guarantee accountability, governance and efficient oversight are crucial. Sustaining quality gains requires ongoing professional development and staff training[17]. There are still few chances for patient participation and feedback due to the lack of community engagement. Additionally, administrative compliance is sometimes given precedence above clinical brilliance in the formulation of performance metrics, which compromises long-term health results. According to Paul et al. 2018 the dependence on quantitative measurements may potentially unintentionally promote procedures that satisfy reporting requirements without taking patient-centered care into consideration.

Cameroon also has regional differences in impact and implementation. Facilities in the Center and Littoral areas outperformed those in the North and Far North in quality evaluations, according to the World Bank 2020, suggesting unequal access to high-quality healthcare. These discrepancies are frequently linked to variations in security conditions, management capabilities, and the availability of qualified healthcare professionals. Furthermore, socioeconomic and gender disparities further impede fair access to high-quality care, particularly in the area of maternal and child health. However, comparative experiences with the international literature shows somewhat findings. For instance, a meta-analysis that pools the data from the health centers and hospitals in the Democratic Republic of Congo (DRC) pointed out that [7]: "*on average, the PBF program improved structural quality by 4 percentage points corresponding to an 8% increase, mostly driven by changes in health centers, which saw 4 points increase in the availability of basic equipment and a 19 points increase in the availability of family planning products. But there was no improvement in the structural quality of hospitals, which had substantially higher structural quality in comparison with the health centers even in the absence of PBF. Moreover, PBF increased technical process quality by 5 points a relative increase of 9%. Non-technical process quality improved by 2 points, 2% increase, mostly driven by improvements in respectful care during delivery, child curative care, and family planning consultations recorded by clinical observers*".

Recent proposals highlight the necessity of complementary investments in robust data systems, dependable supply chains, supportive monitoring, and health professional training in order to solve these problems. To guarantee significant, equitable, and long-lasting improvements in healthcare quality in Cameroon, it is also believed that PBF indicators must be in line with national quality standards and that local actors must be included in quality improvement planning[6,34]. The table below highlights some challenges related to quality improvements.

Table 1: Key Healthcare Quality Challenges under PBF in Cameroon

Challenge Area	Description	Implication
Superficial quality gains	Improvements focus mostly on infrastructure, records, and checklist-based indicators	May neglect deeper clinical care quality and patient outcomes
Limited impact on clinical care	Weak improvements in protocol adherence, diagnosis accuracy, and case management	Patient safety and clinical effectiveness may remain low
Selective service delivery	Providers prioritize incentivized services (e.g., maternal care) at expense of others	Risk of neglecting non-incentivized but essential health services
Rural-urban disparities	Urban or better-resourced facilities benefit more from PBF than rural ones	Inequity in healthcare quality across regions
Provider gaming and data inflation	Some facilities manipulate data or focus on "ticking boxes" rather than improving real care	Misleading quality scores and poor accountability
Sustainability concerns	Heavy reliance on donor funding and weak integration into national health planning	Uncertainty about long-term impact and system-wide quality improvements
Limited patient voice	Quality measurement often excludes patient satisfaction and experience	Reduced responsiveness and social accountability

Sources: [16,33,34,40]

Policy Implications for Improving Healthcare Quality in PBF

Overall, PBF is a potentially effective tool for improving healthcare quality, but it's essential to consider the challenges and adapt PBF mechanisms to specific contexts and population needs. These findings highlight how crucial it is to improve performance metrics, boost domestic funding for UHC, and fortify legislative frameworks in order to guarantee long-lasting gains in healthcare quality. Targeted policy changes are needed to improve PBF's healthcare quality effectiveness and sustainability in Cameroon.

First, enhancing domestic financing and reducing dependency on external donors is crucial. This means incorporating PBF into regular government health finance mechanisms and increasing national budgetary allotments to health [33]. Program sustainability and continuity would be guaranteed by increased financial ownership by the Cameroonian government, particularly during donor withdrawal periods.

Second, performance indicators' structure needs to be improved. The complexity of clinical care may not be adequately captured by the current measures, which place an emphasis on administrative duties and service counts. In order to better represent advancements in patient outcomes, therapeutic efficacy, and diagnostic accuracy, policy should encourage the

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creation and use of more reliable clinical indicators[16]. A more comprehensive indicator of the quality of care may be obtained by combining quantitative data with qualitative assessments, such as patient satisfaction questionnaires.

Third, capacity-building must be a key component of policy reforms. Healthcare professionals should get ongoing training from the Ministry of Public Health on patient-centered care, data reporting, and clinical care standards. Furthermore, rather than using punitive oversight, supportive supervisory techniques that encourage learning and quality development should be used to enhance supervision structures[35].

Fourth, context-specific interventions are necessary to overcome spatial differences in healthcare quality. By providing additional funding and incentives to institutions in disadvantaged areas like the Far North, East, and Adamawa, policies could encourage fairness. To guarantee health equity at the national level, customized incentives are necessary for the deployment of health workers in rural areas and the construction of infrastructure in underserved areas[34].

Fifth, the PBF framework needs to formalize community involvement. Creating and empowering facility-based health committees can increase openness, create feedback loops, and promote local accountability. In order to match provider performance with user expectations, performance evaluations could be supplemented by community scorecards and patient satisfaction tools[38].

Lastly, integration of PBF with more comprehensive health system policies should be supported by legislative frameworks. Coherence across reform initiatives can be ensured, for example, by matching PBF indicators with Universal Health Coverage (UHC) objectives and primary healthcare strengthening measures. Such integration also minimizes duplication, streamlines resource use, and promotes sustainable health system strengthening.

All things considered, these policy ramifications demand that PBF change from a project-based paradigm to a long-term, systemic reform tool. PBF needs to be incorporated into national health plans, backed by steady political will, sufficient funding, and a performance- and accountability-oriented culture in order to be genuinely revolutionary.

CONCLUSION

The healthcare system in Cameroon has seen significant changes as a result of performance-based financing, particularly in terms of encouraging structural upgrades and rewarding provider excellence. Although the approach has demonstrated potential in enhancing structural and process healthcare quality such as clinical procedures, health outcomes, staff motivation, and facility preparedness, its capacity to consistently raise the overall standard of care is still challenging. The focus on quantifiable but frequently superficial metrics, enduring regional inequities, and the continuous reliance on external funding are important drawbacks. PBF must advance beyond service quantity measures to promote comprehensive healthcare quality, including clinical effectiveness, patient safety, and user satisfaction, in order to fully achieve its promise as an innovative well-structured health financing mechanism. Thus, it is imperative to integrate PBF into national health strategies, improve performance indicators, and strengthen government ownership to make healthcare quality in Cameroon more sustainable. Finally, the

findings of this study highlight how crucial it is to improve performance metrics, boost domestic funding for UHC, and fortify legislative frameworks in order to guarantee long-lasting gains in healthcare quality. This analysis contributes to broader debates and provides insights for further empirical research on performance-based financing and health system reform in low- and middle-income countries.

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Conflict of Interest
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Ethical Considerations
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