Author's response to reviews

Title: Removing financial barriers to access reproductive, maternal and newborn health services - the challenges and policy implications for human resources for health in Zimbabwe

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Author's response to reviews: see over
Dear Madam/Sir

Re: MS: 1991027823751317

Research article

Removing financial barriers to access reproductive, maternal and newborn health services the challenges and policy implications for human resources for health in Zimbabwe.
Thank you for the useful comments that we got from the reviewers of the article that we submitted. We have now addressed the comments and would like to submit a revised manuscript. We also want to thank you for allowing us to submit the revised manuscript after the deadline. It was very challenging getting all authors to have some of the issues raised addressed but we are glad this has been achieved. We provide below a point by point response to the reviewers’ concerns.

Responses to reviews

Removing financial barriers to access reproductive, maternal and newborn health services - the challenges and policy implications for human resources for health in Zimbabwe

We would like to thank all three reviewers for taking the time to read and contribute suggestions for improving this article. We have tried to take all comments on board – see responses to each point in blue below.

Reviewer 1 - Diane McIntyre

This article explores an important issue, namely the human resource implications of improving financial risk protection. The scientific basis of the paper is acceptable and methods are appropriate (drawing on a mix of primary qualitative data, analysis of secondary data and review of published literature). However, the paper is unnecessarily lengthy and the structure could be improved – these two factors mean that at present, the line of argument is not sufficiently clear.

MAJOR COMPULSORY REVISIONS
1. I strongly advise reducing the length of the paper. In particular, there are more than 10 pages (pages 8-19) of very detailed background information on the Zimbabwean health system, HR policies and challenges, and user fee policies. In fact, further background information is also included on later pages. This can be substantially reduced – to focus on the really key issues (where it is felt that it is necessary to provide some more detailed information, this could be put in a box) – essentially, it is necessary to provide a relatively brief background section covering key issues only so that readers aren’t overwhelmed by detail before coming to the meat of the stated focus of the paper.

We had the long background as there is relatively little published in international journals on the Zimbabwe health system. However, it is clear that reviewers found there to be too much detail, so we have edited it down to remove earlier history, keeping only recent findings which remain of relevance. Some information has been presented in boxes.

2. There is a need to streamline the structure of the paper – I would quite tightly structure the core of the paper (i.e. after a brief background) in relation to the stated focus of the paper: current financial access to care; scope for increased demand and implications for staffing. At the moment, the length of the paper, particularly the excessive background
information, and poor structure leaves the reader with a lack of clarity about the focus of the paper and the key arguments – it comes across as a very general and very descriptive overview of the history and current challenges of the Zimbabwean health system, with a particular focus on human resource issues, and anything else is buried in this description. At present, the content of the paper does not seem to match either the title of the paper or the stated focus.

We have restructured the paper along the lines you suggest – introduction, methods, brief background, findings on financial access, scope for HR to respond (broken into sections on stocks & gaps; distribution; remuneration; workload; and projected need for additional staff if demand increases), conclusions.

MINOR REVISIONS
3. Title – the content should be revised if this title is to be retained. For example, the authors do not explicitly argue that fee for RMN health services should be removed; even if fees are removed, this would reduce not remove financial barriers (as patients would still face transport and other financial burdens)

We have changed the title to better reflect the focus of the paper (and to make it shorter – see comment by other reviewer)

4. Page 8, first paragraph of background section – suggest removing the word “other” (black people are certainly not a minority in Zimbabwe, so how can one say “black people and other minority populations”.

We have rephrased – thanks

5. Page 11, first line – add the words “expenditure on”, so would read “However, expenditure on public health services ....”

Now rephrased

6. Page 12, last line – unclear what you mean by “20,000 nurses per year” – is this 20,000 additional nurses per year? If so, over what period.

This paragraph has been lost during the trimming/editing process.

7. Page 17, second line – international readers may not know what you mean by “medical aid” (need to explain it is a form of voluntary health insurance)

Thanks, we have added this explanation

8. Page 20, first line – words are missing: “... based on the limited undertaken...”

Added now

9. Page 21, second sentence – It seems a bit of an assumption to state that “Fees levied at government-owned health facilities are reasonable and affordable.” – I would not think that fees of $50-$100 for a normal delivery are not really affordable in a country with such high poverty levels. If this is the view of KI or FGD members, you should say that “Fees levied at government-owned health facilities were seen by X, y ... as reasonable and affordable.”
We have rephrased to clarify the source of the comment.

10. Bottom of page 23 – the explanation of how Figure 1 was derived is very unclear – you simply say that it is ordered by population density .... Was this done for districts?

We had hoped to do this by district but staffing data was only available per region, so this was done by region. We have added this to the title for the figure.

11. Page 24, First sentence under section on workload contradicts the data in Table 4 – Table 4 indicates that there are 12 (not 7) deliveries for each skilled health worker and 313 (not 184) for each doctor

Thanks for picking up this error in the text, which is now corrected.

12. Page27, last sentence of first paragraph – this reads as if it is the authors’ view (which it may be). If this is a finding from the KII or FGDs, this should be made clear, or rephrased as “There is a widespread view that 'people should make contributions'.

We have added the source of this comment, which came from some of the interviews with staff.

13. Pages 29-30, box 1 and Table 5 – Table 5 must make clear that doctors are currently receiving $218 per month, while Box 1 reflects annual salaries

Thanks, this is a good point and has been done

Reviewer 2 Germano Mwabu

The article concerns an important policy issue: the connection between user fees, the health of mothers and that of their newborns; as well as the linkage between fees and availability of medical personnel that provide the services needed by mothers and newborn babies. The general approach (mixed methods of data collection and analysis) used to investigate this issue is appropriate and of general interest. However, no analysis of the link between user fees and availability or distribution of human resources for the services in question is conducted. Further, only partial analysis (using only qualitative data) is done on effects of fees on demand for maternal and neonatal services.

By changing the title we hope we have clarified the scope of the article. It is true that we were not able to provide wide scale quantitative evidence of the effects of fees on demand for services. We have focussed on establishing (1) that fees are creating a barrier to service uptake; (2) that HRH is also facing a range of pressures and (3) that any increase in demand for services would need to be matched by improved distribution and remuneration, with a particular focus on some areas of skills shortages, including midwives.

There is an excellent analysis of the changes and distribution of the number of human resources for health since independence. The authors show that the human resources for health have been badly affected by negative economic shocks – underlying the importance of economic policies for health. A concentration curve is used to show that midwives and nurses are generally equitably distributed. Concentration curves for several time periods (e.g., 1980-1990; 1991-2000 and 2001-2010) could have revealed whether or not this staff distribution is sensitive to economic shocks. The distribution of doctors is highly inequitable, but it is not clear what can be made out of this result because there are too few doctors in the country: there is little to re-distribute.
Analysis of changing distribution over time would be an interesting separate study if data permitted. We were not able to obtain that historical data.

For doctors, we reveal that there are few, but relative to norms for supervision of deliveries, still enough for most regions. The distribution is therefore the main issue, rather than overall numbers.

The article can be much stronger if it were to concentrate on HRH workforce, with some discussion on how fees generally affect the performance of the force. A limited discussion can try to illuminate demand and supply-side effects of fees. Data do not exist to examine rigorously the linkages highlighted in the present paper. (The title is too long).

We hope the editing has achieved the effect suggested here. We have shorted the title too. However, we should note that we do not aim to unpack how fees affect the performance of the force (as they are only indirectly relevant, as a source of revenue for the sector, and that discussion would require a wider analysis of health financing in general).

Reviewer 3 Robert Yates

Major Compulsory Revisions
It is commendable that the authors have looked at this relatively neglected topic as not enough research has been done on what supply side reforms need to be undertaken to accompany the removal of user fees.

Unfortunately though I don’t feel that this research with its small sample size of respondents and its largely descriptive prose adds much to the debate concerning the linkages between HRH policy and the removal of health user fees.

I appreciate it is difficult to collate responses from interviews and FDGs and present these as scientific and statistically significant findings. However the analysis comes across as rather superficial and subjective and one is often left wondering how representative statements are of the whole population.

At present the paper is over long and contains too much text describing the Zimbabwean health system over the last 30 years. It would benefit from a major edit to just focus on the current human resources issues relating to the removal of fees.

We have tried to prune the history and structure it to make the story clearer. The local fieldwork was limited, it is true, but national level interviews with some of the main players in the policy field, and also analysis of national data do bring in a bigger picture which, we believe, is valuable and sheds light on a topic which is both policy-relevant and under-documented in the published literature.

Minor Essential Revisions
Page 7 “Dollarisation” An audience not familiar with the history of Zimbabwe will need this term explaining.

We have added a sentence of explanation

Page 10 para 2 last sentence: This figures quoted for 1990 and 2009 suggest that neonatal mortality actually fell at little from 29 to 27. Perhaps these figures need reversing?
In fact, on checking, the NMR was identical in 1990 and 2009, having risen and then dropped back to 27 over the period. Thanks for picking this up. We have corrected the statement.

Para 10 para 4: These statements seem contradictory. If 65% of the population live in rural areas and in these areas 65% of hospital beds are provided in mission facilities how can the health system be dominated by the public sector?

Well, provision of services is different from bed capacity, so both statements can be true. However, it does sound confusing, so we have dropped the second statistic.

Page 11 Para 1: Should this be public health spending (rather than services) constitute less than 1% of GDP. Also doesn't the 5.3% GDP figure for SSA refer to Total Health Spending not just public?

Thanks, we have clarified this and added another comparator, as the sentence was mixing apples and oranges a bit.

Page 11 last para: “Consequently” – this suggests that all the deterioration of health sector performance has been due to HRH problems whereas reduced access to medicines, diagnostic tests etc will also have had an impact. Maybe best to start this sentence “This has contributed to…”

Thanks, we have rephrased as you suggest

Page 12 para 2. Over what time period did these resignations take place “at the peak of the depression” is too vague
This was from 2008. This was stated higher up, but we have brought it down to make it clearer

Page 12 “Current stocks and gaps” – better to state a specific time when this analysis was undertaken

The analysis was undertaken in 2011, but brings together the findings of relevant studies covering the past decade.

Page 14 Remuneration policies. This figure of 0.3% spending on HRH is incredible. But does this refer to the percentage of the budget allocation or the proportion of the expenditure. These would be very different if the MoF basically stopped disbursing the health budget

This is a quotation from a health system assessment document. It is not entirely clear to us whether this refers to budgeting or expenditure. We agree that the latter seems more plausible, however, it is phrased in this way in the original document, so we propose to leave it as it stands. The essential point is that spending crashed to next to zero.

Page 14 Para 2 Might the reduction in resignations in 2009 be a feature of the workforce being a lot smaller in 2009 following previous mass resignations?

Yes, that is likely to have played a part. However, the situation did improve in general, as shown by reduced vacancy rates over the period etc.

Page 15 Para 2 This economic analysis appears a bit superficial and I would recommend removing this para.

Sorry, we are not sure which section is referred to here – can you elaborate?
Page 16 para 2. How many people were exempted from paying fees and did these exemptions really work?
We do not have figures for the numbers exempted, but the system did not really work, and we think this is made clear in the discussion.

Page 18 Para 2 “Others state” Who?
This has been clarified.

Para 19 Last para – analysis here is very subjective. Some numbers here would be helpful

The prices, based on fieldwork in one district, as stated, are given in Table 2.

Page 20 para 1 FP supplies were seen as affordable. Who said they were affordable – this is extremely important as the views of providers and consumers may well be different. Also might it be the case that the 43 women from the community are more likely to be regular users of services and therefore not representative of women who feel that FP services are not affordable.

The users FGD said that FP was affordable – we have clarified that. There should not have been a bias in this group towards users, rather than non-users, of formal services at least.

Para 20 Perhaps the authors should make more of the finding of women being detained (ie imprisoned) in corridors for non-payment of fees.

We mention it, but it is hard to make more of this as we don’t have wider figures – this comes from one interview with a hospital administrator.

Page 21 “Fees levied at government-owned health facilities are reasonable and affordable” This is very subjective. It would be interesting to see whether the women abscending from corridors in hospitals agree with this statement.

We have rephrased, but the point they were making was that government facilities were more affordable that other types (municipal-run etc.).

Page 22 Last para. “User fees were reported to contribute in the region 10-15%” This sounds like a very rough estimate.

This was the estimate based on the books of one district hospital. However, we have cut this section as part of the pruning.

Page 24 Workload. There are currently around 7 deliveries for each skilled health worker etc Over what time period?! This is a vital piece of information to judge workload.

It is per year. We have added that to the table heading. It is low because total deliveries are divided between all nurses (for SBAs), as there is no breakdown in the routine HR data for midwives versus nurses.

Page 25/26 This long list of failings of the health system should be presented in a more user friendly and readable format.
We think this is a good summary of the HR challenges, as presented by the key informants. So we have kept it but put it in a box.

Pages 25-30 There doesn’t seem to be any analysis of how much user fees (either formal or informal) have been contributing to the remuneration of health workers which one would have thought would have been crucial to this research? On page 27 it says that “there is no direct benefit” because “it is not legal for staff to receive any funds” but is this really the case? Some more indepth analysis here is essential.

We can only go from the information we received in interviews and documents, which was that there is no direct transfer from fees to workers. We did try to probe. This is not an easy topic, of course, so if illegal transfers are taking place, it would require more detailed and indirect methods to assess.

Page 27 Staff maybe supportive of user fees but what about health care consumers and people not currently using services?

We have indicated the barriers from the user perspective and have cut this comment in our pruning in any case.

Other Edits

The references have been reordered in text in the final list because some of the references were lost and new ones were put in where the reviewers had asked us to cite the sources. References have been into square brackets and numbered consecutively according to the Journal guidelines

We hope we have done much to make the article more focused from the thorough review it went through.

Yours Sincerely

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