Author's response to reviews

Title: Health worker perspectives on user fee removal in Zambia

Authors:

Barbara Carasso (barbaracarasso@gmail.com)
Mylene Lagarde (mylene.lagarde@lshtm.ac.uk)
Caesar Cheelo (ccheelo@yahoo.com)
Collins Chansa (kachansa@gmail.com)
Natasha Palmer (natasha.palmer@lshtm.ac.uk)

Version: 2 Date: 7 October 2012

Author's response to reviews: see over
Dear HRH Editorial Team,

Many thanks for the review of the manuscript “Health Worker Perspectives on User Fees Removal in Zambia”, and the feedback received from the reviewers, which proved very valuable. Please find hereby below our point-by-point responses to the concerns raised by the different reviewers. The revised manuscript has been uploaded on the website as requested.

We look forward to hearing back from you again,

With kind regards, the authors

Reviewer 1:

RV1: “My one small methodological question was why the interviews were not recorded – and instead notes were taken. Was there some reason for this as I think that taped interviews are generally a better way of ensuring that what the interviewee said is accurately recorded”

AR: Taped interviews are indeed a better way of ensuring that all responses are accurately recorded. For this study, it was discussed with the local research team from the University of Zambia – who have extensive experience in conducting research and collecting data in the health sector in Zambia on what the best strategy would be. The options were to record the interviews or to take notes during the interview, and compare notes afterwards. It was felt that the presence of a recording device would inhibit interviewees from speaking freely, and it was quite unusual – especially at a health center setting – to use these devices. Therefore, for this study the second method was used: have two people take notes during the interviews and compare notes after the interviews to ensure completeness and accurate understanding of what was said.

RV1: “It was a pity, but understandable if you know the context in which they were working, that there was not reliable utilisation data available to see if workload really increased. The use of the data from the over all study assisted with setting the context. I just wondered where the broader study obtained its utilization data from – was it consolidated data from facilities or did they collect their own data. If it was consolidated facility data was it from the same area where the facility level was shown to be poor quality? If it was there own data why didn’t they collect such data in the facilities visited for this study?”

AR: The reviewer’s comment suggests that this may not be clear in the paper. The paper states “Utilisation data collected at the twenty case study facilities were of poor quality, which prevented us from matching reliable quantified information to health workers’ perceptions at a facility level. However, data on utilisation collected and analysed for the broader study suggest that following fees removal, overall outpatient visits increased in rural districts.”

The broader study used routinely-collected data from the Zambia Health Management Information System (HMIS). It is a requirement for each facility to submit utilization data – disaggregated by OPD/IPD, under/over 5’s – on a monthly basis to the district. Here, data are aggregated and reported to the central level on a quarterly basis. For the broader study,
a request was sent from the Ministry of Health to each district to obtain data disaggregated by month, from January 2005 to December 2007. Out of the 54 districts where health centres and district hospitals removed user fees on April 2006, we obtained usable monthly data from 27 districts. The data obtained where thus district and not facility-level. As there are many more facilities in one district than were visited for the case studies, data from the districts cannot be compared to facilities visited. However, the trend was observed that outpatient visits increased in districts where fees were removed, but there were large differences between districts.

In order to clarify this in the paper, the following sentence has been added: “Utilisation data collected from the national Health Management Information System for the broader study were aggregated by district and could therefore not be matched to the facilities visited.”

RV1: “It has been my experience working in other countries that nurses always complain about workload but that actually workload varies considerably – and often the workload is concentrated in the morning. I wondered what the authors’ impressions were when they visited the facilities and if there is any way this could at least be noted in the article.”

AR: The paper states: “Our analysis also suggested that the number of qualified staff employed in the case study facilities decreased after fee removal. These findings would imply that in objective terms, workload of health workers has increased since the policy change.”

During data collection, the researchers noted that workload was concentrated to the morning hours, and fewer patients would come to seek care in the afternoons, and staff spent time during afternoons on administrative duties. However, the current study was not really designed to look at variation of workload during the day or week, but explored motivation of staff and their perception of changes in workload, and the only objective way to verify changes in workload was to compare utilization data with number of health workers employed. We therefore suggest not adding any additional information on the authors’ impression of workload.

Reviewer 2:

**Minor essential revisions**

RV2: “Table 2. One concern is that a fuller explanation of how the sets of questions in Table 2 were selected needs to be given to the reader as these questions are central to the research and to the conclusions drawn in the paper. If possible also discuss the pros and cons of using these questions.”

AR: We have provided a better and fuller explanation of how the statements for Table 2 were created. This short list of statements was constructed for the purposes of this study based on Hertzberg’s two-factor motivation theory and its distinction between motivating and hygiene factors [24]. The mix of statements allows health workers’ perceptions of various characteristics of the work environment whose absence or inadequate level (e.g. pay, workload) can yield dissatisfaction (hygiene factors) to be captured, as well as intrinsic aspects of the job whose existence (e.g. recognition, responsibility, opportunities) provide positive satisfaction (motivating factors). The list of statements also reflects some of the traditional factors cited by health workers in low-income countries as linked to (de)motivation [10, 13].

RV2: “Background section, paragraph 6. The second objective “it explores the views of health
workers on how the policy change has affected their situation”. I think the term ‘situation’ is too open for interpretation. I think it should be clear what situation you are talking about, for example is it their working practices? Is it their self-esteem? Is it their clinical environment?”

AR: The objective has been rephrased as follows: “it explores the views of health workers on how the policy change has affected their working environment”. Similarly, this has been changed in the ‘results’ section on pp. 11: **How free care changed the working environment of health workers...** In two other instances the paper refers to ‘situation’ (pp. 8 and pp.12), but in these case the ‘situation’ is directly linked to ‘as a health worker’, thereby directly referring to their work situation.

**Discretionary revisions**

RV2: “During in-depth interviews conducted with senior or longer serving staff at each facility, general questions were asked to gather background information about the facility. Furthermore, their perception on issues affecting the different cadres of health workers in the context of the abolition of user fees were documented”. I think it would be good if you provided more details of the actual questions asked to elicit the information so the reader understands what was asked. Possibly explain who these “senior or longer serving staff” are in the context of the paper. Are they the same people who also filled in the self-administered questionnaire? Are they the health workers that are being focused on or are they just general staff giving their perceptions of the different cadres of health workers in the context of the abolition of user fees? The characteristics of the respondents who filled in the questionnaire are shown on Table 3; however the characteristics of the interview respondents are not given.”

AR: The questions asked to the senior and longer serving staff at each facility visited included questions on: 1) general: the facility, number of beds, opening times, services provided, catchment population, ART-provision; 2) user fee policy: purchase of registration book, fee for consultation and/or drugs, fee for delivery, involvement of district/facility in decision policy change, communication channels for policy change, date of implementation policy, response of community to policy; 3) attendance: perception of increase/decrease/stable utilization; 4) revenue: sources of funding facility, mechanism of financing; relative importance income from fees, allocation of fee revenue, coping mechanisms for lack of revenue fees; 5) drugs: mechanisms for drug supply, consumption patterns, shortages/overstock, coping mechanisms patients in case of stock-outs; 6) human resources: number of funded positions over time, vacancies, presence of staff on day, reasons for absence, other issues related to HR; 7) closing: what has been the impact of fee removal on drugs, HR, community? What has been the impact of introduction of free ART?

The ‘senior or longer serving staff’ were in most cases the health managers of the facility, whilst the questionnaires were filled out by health workers attending to patients on a day-to-day basis. However, some of the smaller facilities only employed two or three health workers, one of whom would be both managing the facility and also seeing patients; in these instances, the most senior health worker was interviewed, and all staff was asked to also fill out a questionnaire.

For this paper, only a limited amount of the information collected for the broader study was used. In order to clarify what types of general questions were asked, and who was interviewed, the following sentence was revised:

“At each facility, in-depth interviews were conducted with senior or longer serving staff, mostly the facility managers. General questions were asked to gather background
information on the following: the facility, implementation of the user fee policy (for facilities that removed fees), trend in utilization rates, revenue from user fees, drug management, and overall perception of the impact of the policy change. Furthermore, their perceptions on issues affecting the different cadres of health workers in the context of the abolition of user fees were documented.”

RV2: “Self-reported job satisfaction section. I think there would be value in seeking to explain the quantitative data more, using the qualitative data and other forms of interpretation in this section.”

AR: The authors aimed to present the different parts of the results separately in the results section, and then bringing everything together in the discussion section, where we discuss, compare and contrast the results.

RV2: “Table 1. In table 1 I think it could be made clear whether all mission facilities in the country are non-charging facilities or whether it was the case that the sample had only mission facilities that were non-charging. I think this is important as you note on page 11 that “If staff working in mission facilities are excluded from the analysis, the difference [in levels of satisfaction] between charging and non-charging (government) facilities disappears”. Perhaps in the section titled self-reported job satisfaction you could discuss what this might mean for future analyses that try to understand health worker perspectives and motivations in countries with diversity in health provision (such as in this paper the presence of missionary facilities and government facilities in Zambia). Would you conclude that the presence of religious / culturally rooted facilities matters for future work in this area? In which way? I think your insight on this after doing this research will be valuable to the reader.”

AR: In Zambia, the vast majority of mission facilities are located in rural areas, where user fees were removed. Therefore, by definition, virtually all mission facilities in the country are subject to the policy change and (at least in theory) are non-charging facilities. To further clarify this, the following sentence was added to the footnote (ii) in the background section of the paper: “Virtually all mission facilities are located in rural areas, and hence subject to the policy change.” In the text under the section ‘self-reported job satisfaction’, it already states “Mission facilities are typically located in rural non-charging areas, …” To highlight the potential importance of the difference in staff job satisfaction between mission and government facilities for future work, the following sentence was added to the discussion section: “To be able to tease out these two effects, future research should investigate whether there are systematic differences in the job satisfaction of health workers in government and mission facilities where contextual elements are similar.”

Minor issues not for publication

RV2: “Methods section: 4th paragraph and Table 2. It reads: “In addition to questions capturing their basic descriptive characteristics the self-administered questionnaire contained questions where respondents had to give their level of agreement or satisfaction (on a 5 point Likert scale) with a series of statements relating to various dimensions of job satisfaction (quantitative section, see Table 2).” But your Table 2 heading is “Different domains of motivation assessed in the questionnaire” …. Should table 2 not be called “dimensions of job satisfaction”? As this is how you refer to it in the paragraph on page 7.”

AR: Many thanks for noting, it has been changed as suggested by the reviewer.
Paragraph 4. It is noted at the bottom of page 7 that a preliminary pilot study helped to ensure that the wording made sense in the Zambian context, do you have any comments on this? Were any substantial changes made to your tools as a result of the pilot that might be interesting for the reader to know?

AR: No substantial changes were made to the tools as a result of the pilot. In light of this fact, and the word limit, we suggest not to elaborate on this.

Contextual factors section: 2nd paragraph. The sentence “Ten percent of the revenue raised from fees was reserved for salary top-ups, whereas the rest was used to purchase basic material for the health facility, to hire additional staff (classified daily employees, CDEs or to finance community activities”. As it is mentioned later (p.14), this salary top-up was only made in some districts, perhaps you could make this clear in this paragraph above so that the reader does not assume from this paragraph that all facilities in Zambia pay salary top ups.”

AR: Indeed, the top-up was made in some but not all districts/facilities visited. The following addition was made to the sentence in the ‘contextual factors’ section: “Ten percent of the revenue raised from user fees was used as salary top-ups in some districts visited, …”

Table 3. Write out the word CDE in full.”

AR: Done

Would it be possible to draw a diagram or figure showing the different factors and how these influence the complex motivations of health workers?”

AR: The current study implies that there are indeed a myriad of factors influencing the complex motivations of health workers, including the ones mentioned in table 5 (higher workload, less resources for essentials in facility, drug shortages, personal satisfaction, top-up/bonuses). The request from the reviewer is slightly beyond the scope of the paper, which looks more closely at the experiences and perspectives of health workers on user fee removal. However, we recognize that this is an important issue, and we have therefore added a few references to other conceptual papers providing this type of framework, for reference to interested readers.

Rather more a question, I would be interested in the relationship between patient behaviour/satisfaction and health workers perception of user fee removal, was there anything on this in the interviews.”

AR: In general, facilities where quality of care could be maintained – sufficient medicines, sufficient financial resources to purchase for instance cleaning material & food for patients – patient satisfaction and health workers’ perception of fee removal were higher than in facilities which were confronted with drug and revenue shortages. However, every facility had their own unique circumstances and characteristics, and therefore a case study approach has also been applied to aim and describe the myriad of factors which together influence if, in the end, the policy change has had a ‘positive’ or ‘negative’ impact for the population and the health system. We like to refer the reviewer to the report on “Case Studies in Five Districts” which is available from the authors for further information. In
addition, a case study paper exploring factors ultimately affecting the impact of the policy change is in the process of publication. Discussion of this however goes beyond the scope of this paper.

RV3: “It may be helpful to provide some background information on Zambia in terms of burden of disease and health systems challenges to contextualise.”

AR: A little bit more information was provided after the introduction in the section ‘context of the study’.