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

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Author’s response to reviews: see over
Dear Reviewers,

Re: Responses to reviewers’ comments on the article: Removing financial barriers to access reproductive, maternal and newborn health services: The challenges and policy implications for Human Resources for Health

We very much appreciate the thoughtful and detailed comments you have provided on the paper. Responding to such an extensive set of comments, many of them suggesting further points for inclusion has significantly lengthened the paper. If you consider that it has become too long, it would be very helpful if you could identify those parts that seem less essential.

Please see our detailed responses to your concerns below:

Reviewer 1 comments
General Comments:
It has implications for the focus on Universal Health Coverage and the equity implications therein and also there is useful inter-country similarities and operational differences. Perhaps detailed case studies may be a more useful tool?

The introduction is now framed in the context of UHC.

Information on service availability assessments etc may be a good source of more information on equality of service quality and HR availability across different fee situations. (SARA: Service Availability and Readiness Assessment; SPA: Service Provision Assessments)

A couple of references to SARA have been made in the text.

Some staffing norm availability and utilization in the countries will be useful to understanding the article’s premises

Unable to address this comment as we do not fully understand it and in any case we do not have the data required.

There is need for further commentary on policy making processes and whether countries did make deliberate effort (can be got from key informants) to integrate fee changes and HR policy in any country?

We agree this would be interesting but are not now in a position to conduct more key informant interviews. We do have some information about where linkage of HRH and user fee policies was clear and explicit and where it is stated by other sources as lacking and have now alluded to this on p27.

Article gives impression that staff motivation is only in salary terms as there is not much discussions on the value of local fees as creating management flexibility and ease of doing business/reducing bureaucracy (Avoiding minor shortages etc.,..)
We mention the role played by local fees in staff motivation on p12. Our data do not really allow us to comment significantly on motivational levels and we largely refrain from doing so. We have also now removed this idea from the objective of the research since although it was an objective, it was not really met, so it may be less confusing to remove it.

- Introduction:
  - Is there any influence from informal fees in these issues?
  
  Undoubtedly, the issue of informal fees is tied up in the issues of the paper. We do not have data on the subject so we considered it more appropriate to make this point in the discussion (p28).
  
  - In Ghana where fee removal initially started with 4 regions, movement across region lines for free services occurred and may contribute to some increases seen.

  We don’t think this will have affected our data. The study focussed on two regions. One was in the first wave. The other was in the second. Both saw increases. In the second region (Volta) there would be no incentive to switch across boundaries as all regions were covered by then.

  It was not very clear to me what data was sought and how data absence and poor quality affected the study – i.e., what form or type of data was actually needed?

  A short section has been added which we hope clarifies this at the top of p9

- Literature Review:
  
  - It’s unclear what the literature said on geographical access issues in relation to fee removal and uptake as the discussion seemed to assume equal distribution of service delivery points?

  There is little on this point in the literature – a gap the paper is aiming to fill. Consideration of the geographical maldistribution of service delivery points would further strengthen the argument but we do not have more than general information on this.

  - Some further explanations needed – page “11” – 95% of HC income came from user fees? What does this mean – that no government subsidy is received in any form including salaries; medicines; vaccines etc?

  Changed the text to read “95-96% of their revenues from user fees” which may be clearer. There is some funding of salaries centrally in Senegal, but only for civil servants. All locally employed staff,
drugs, running costs are paid out of facility revenues, which as you see receive very minimal state subsidies, especially at health post level.

o How were replacement funds used differently from user fees revenue?

Further comment on this is now made on p13, together with a reference to a more detailed account.

- Results

o Financing policy and utilization:

# Nepal defines unequal access and change in post fee removal uptake well through the HDI frame. Any way of estimating unequal access for the other countries’?

Unfortunately, we do not have comparable information from the other countries.

# Nepal: what is Aama?

This is defined on p7. It is the policy providing free institutional deliveries in all public and some private facilities.

# I’m not sure the use of % to describe the changes in high and low HDI districts uptake clarifies the story: the movement from 6 to 21% is a 3 fold rise but still a low proportion of the population.

This point is now made.

# Similar availability and access clarification needed for the other countries as well I think. Especially in case of Zambia with variable uptake results across the country.

The point that Ghanaian utilisation rates were low before the policy is made on p15, and the outpatient visit levels under NHIS are compared to SARA benchmark also on p15. Similar points have been added about Sierra Leone. In relation to Zambia, you (implicitly) make an important point that we have added in relation to the relationship between utilisation change and district deprivation score. Revisiting reference [36], this does seem to be a flaw in their analysis.

- Geographical distribution:

o The article is understandably unclear on definition of skilled attendant and use or non-use of auxiliaries. Some more discussion of this or illustrative example would have helped.
A paragraph on the problem is now added, and the point extended to the use of auxiliaries in the discussion of Sierra Leone’s case where this is most important.

- Would have perhaps been more informative to have a country by country result for each question area as done for the fee removal section

We do have the material broken down in this way in our original reports on this study, but there are many similarities in the main points across the country studies leading to a rather repetitive presentation if done this way. The comparative perspective proved more interesting. For example, if presented on a case by case basis, all countries have health staff concentrated in urban areas. It is perhaps more interesting that the extent of this is greater in some countries than in others. We prefer the approach we have taken.

- Perhaps more discussion of private-public distribution differences between countries will be helpful.

A short section describing the public-private employment mix for each country has been added on p19.

- Last sentence on NGO/FBO workforce distribution and public sector in Ghana and Nepal is unclear. This has been rewritten. We hope it is clear now.

- Delivery workload

- Again difficult given the definition of SBA. I understand in Asia (Nepal?) doctor/nurse ratios are 1:1 or higher, unlike in Africa with high nurse-doctor ratios. Is this the case for Nepal? How does that affect the comparisons of access to doctors?

  The ratio in Nepal is about 2:1, somewhat higher than some Asian countries though still lower than most African ones. However, when the additional category ANM is considered, the ratio of ANMs and nurses together to doctors is about 3:1. We think the analysis handles the remaining difference as it treats doctors and nurses/midwives/ANMs differently.

- Remuneration and terms/conditions

- The work on salary comparisons and linkage to GNI gave a good comparative picture and perhaps purchasing power parity and linkage to country poverty line may be other helpful markers

  All estimates other than those of Zimbabwe for which PPP transformations have not been available since dollarization are expressed in PPP terms. We would have reservations about the comparability
of different countries’ poverty lines and don’t have these data for each country. Even in Zimbabwe nurses wages are 5 fold the international poverty line generally used – $1.25/day. Zambian doctors are estimated to be earning 143-fold that.

- DISCUSSION:

  o Concept of “effective care” is an important one to be elaborated

  Agreed, but perhaps not the priority for space in this discussion. The context in which effective care is introduced implies logically that effective care is user defined. This has been clarified, and in the discussion of quality of care, later in the section, a reference is made to an earlier article by one of the team members that further discusses the use of utilisation as a guide to the effectiveness of user fee policy change, is made.

  o A “means tested” changes in utilization apart from Nepal, are poorer areas and people using the free services more?

  A short paragraph indicating that we have some analysis on this in Nepal and Zambia but not in the other countries has been added.

  o Is there any information at all on changes child and maternal mortality or morbidity?

  Comment on this would require considerable space. Clearly there are data on mortality and morbidity of both types in all 5 countries, but linking trends and changes to the policies would be inconclusive. The paper is already rather long for HRH we think, and suggest this challenge might be addressed elsewhere.

  o I think the recognition of the non-coordination of policy is a major issue that merits more detail review and discussion

  We have added a short paragraph and referenced more detailed discussion elsewhere on p29. We have not researched this issue specifically and can add little beyond speculation as to the reasons for poor policy co-ordination.

  o Many African economies are growing and with it private services? Any discussion on how these may affect the study questions?

  Some discussion has been added p27

- Conclusions:

  o My own takes from reading the article include:

  # There is and fragmented parallel policy making without considering implications elsewhere in the health system – are there examples where this works better in
LDC situations? how can we integrate HRH strategy/planning into other cross health systems reforms/changes?

# A very good point made for effective Policy monitoring and some suggestions and examples will be useful for readers.

Good! We think those are the intended messages and we have further explicated the first one, but we don’t have good examples of policy monitoring, unfortunately.

- Authors contributions:
  
  o No mention was made of YC the corresponding author in the line up?

Strange this has been lost from an earlier version. Now corrected.

Reviewer 2
I find that the single point data for Human Resources for Health in the different countries, studied rather difficult to relate to the abolition of User Fees. It would have been more useful if there was information for before and after abolition of User Fees so as to respond adequately to the objective of the research and all the research questions.

We agree – it is disappointing that time series data were not available in more countries on the critical variables. We do think that the data collected do illuminate a number of issues in user fee policy however, and hope the paper is worth publishing despite these problems.

Reviewer 3

Abstract:

There is no mention of improving access to reproductive, maternal and newborn services which is the focus of the paper.

Thanks for pointing this out. We now introduce this in the first sentence.

Methods:

Field studied:

Reasons why only Sierra Leone and Ghana were chosen for field studies are not stated, was this to fill in data gaps from literature review for these countries? In Sierra Leone, no KIs were conducted despite the team being there for a field visit, was the reason time constraint? What kind of questions were KIs
responding to?

The first and last questions are now answered in the text. We intended to do KIs in Sierra Leone but the team spent the entire visit chasing secondary data which proved very difficult to access and quality check. This is what we meant to imply (diplomatically) by the sentence beginning ‘In Sierra Leone.’ on p9.

Literature review:

Para no. 14 starting with ...Very few studies....

The information about Nepal is confusing, authors say, literature cites a shortage in Nepal, and gain say workforce remained stable or increased in Nepal. This needs to be rephrased for clarity.

Ref #19 was mistakenly used to refer to the situation in Nepal. This has now been corrected.

Conclusions:

Second para; among the investments to be made, we also need to highlight addressing the mal-distribution which could be done through incentive schemes.

Authors have highlighted this in earlier sections but need to be stated here as well.

This point has been added.

3. Minor comments:

Introduction section:

The last para. That states the sub-questions. Stock of HRH is mentioned as one of the workforce characteristics but seems to be left out in the sub questions.

Now included.

Methods:

First sentence under –Desk based data analysis and document review –

There seems to be a missing word after Central Statistical Offices and similar ---

Was
Corrected

Please check again.

Results:

2) The geographical distribution of the health workforce.

Para no. 2.

Where are the case study country annexes? Are they part of the reports? If yes then provide reference for these reports for those who want to review them.

Reference to these has been removed and a clearer explanation of the calculation of CIs provided (we hope).

Para after – FIGURE 2 HERE

There is no figure 4, did you mean figure 2?

Yes – now corrected.

Second para after TABLE 2 HERE

Can the authors provide a dollar equivalent for ZK800,000 in brackets please?

Yes – done.

Discussion:

Para 1. The first sentence is not clear, there are five case studies. Authors should look at this again.

We hope the revised version is clearer

Last sentence on this para. May need English correction .... “access to effective are through financing policy change”

Missing ‘c’ now inserted

Last sentence on para 2. I think it would be better to state as GNI/GDP given the order in which countries and mentioned earlier in the sentence.

Yes – now revised

References:

Please check reference 31 again.

The correct paper seems to be –
Reviewer 4

1. This paper could better incorporate and set itself within the global health policy context (i.e. WHO (2010) World Health report on health systems financing) of countries aiming towards universal coverage and strategies such as country level taxation, insurance schemes (pre-payment prior to illness and risk pooling/pooled funding) – as well as development assistance for health. Out of Pocket payments were seen as the main ‘revenue source’ causing problems for human resources for health. One important point is that, despite commitments (e.g. Abuja Declaration) governments are sometimes choosing not to prioritise health care expenditure. In addition, development assistance for health is often directed towards non health priorities (Institute for Health Metrics and Evaluation 2011).

We have now referenced the UHC ‘movement’ in the introduction, but the focus of this paper is very much on the specific issue of user charges and their removal and while we’ve all been extensively engaged in the UHC discussion in various ways, we think that framing the paper primarily within it would require us to address an even broader set of issues than we are attempting to squeeze into a single paper as it is. Some of the issues raised are indeed among those we would need to address, and that’s the problem.

2. In the abstract and introduction removing ‘user pays’ at the service delivery level appears to be put in a negative light - equated with or seen as responsible for loss of revenue, increased workloads for health staff and loss of bonuses or allowances for health staff – in these sections this is not supported by references, this seems to be more related to the findings (the Campbell reference states in the introduction states that support for the demand and supply side needs to be
balanced). Obviously alternative revenue sources are being introduced successfully (i.e. taxation and insurance schemes) and this could be mentioned in the discussion section.

It was certainly not the intention to cast the removal of fees in a negative light and we've looked at the language of the two sections and sought to clarify this. We agree, the literature would largely not support that interpretation- Campbell’s emphasis on balance is what we are trying to convey.

3. User pays- ‘the last decade has seen widespread retreat from user fees’ (no references). I think it would be important to mention that in low and middle income countries the Out of Pocket Payments are still the most common and least equitable form of payment and related to pushing people over the poverty line and being a barrier to health care (and thus good health outcomes).

This sentence is in the abstract where we believe adding references detracts. Relevant references have been included in the main text on this point (p5, p10 and p11) and make the point that out of pocket payments may remain a prevalent source of finance despite policy intentions, also in the main text (p5).

4. The issue of user pays on equity could be mentioned – not just in terms of utilisation (access to services) but also in terms of outcomes. Could mention the example of Rwanda where health care utilisation has increased from 24.7% to 87% in 2009, and the under 5 mortality rate decreased by 50% from 2005-2009 – i.e. consider the community based health insurance scheme and its impact on under 5 mortality

Please see response to your comment 1. above. We think broadening the discussion out this far would further load an already potentially overloaded paper.

Methods

5. This section is quite unclear.

I. Lit Review –what databases or other information sources were accessed?

What years did the review cover?

A more detailed description of the literature review methodology is now included.

II. Desk based analysis and document review. Access to which data sets, for
what purpose? Need to make more explicit that this relates to the lit review
‘criteria’ if it does. Local collaborators were in which countries, when? What period did the document review cover?

More information on all this has now been included. Country level grey literature was searched as a separate exercise from the global level search and time periods were limited only by a criterion of relevance of the documents to the policies under consideration. Local collaborators are permanently based in the countries concerned so it seems most relevant to mention the period over which the work was undertaken – throughout 2011.

III. Field studies – this is vague. Which data? How were the interviewees selected (based on what)? Why was only one country chosen for the interviews?

Please see response to Reviewer 3 (first point under methods).

IV. There is nothing about analysis in the methods section, i.e. how were the document review and interviews analysed? What themes came up from these – this could be discussed in a separate section.

`The way data analysis was done has been described on p12

V. The CI analysis mentioned later in the paper should be in the methods section.

This has now been moved.

VI. The first part of the results section which describes what was actually done should be in the methods section.

This has now been moved.

- Minor Essential Revisions

6. Check for absent full stops or spaces that are there when they shouldn’t be, or aren’t there when they shouldn’t be.

We reviewed the document carefully and found two missing full stops and two or three spacing errors. I wonder if the spacing errors may be created by the PDF process? Hopefully any remaining problems would be picked up at copy editing stage.
Yours Sincerely

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