Author’s response to reviews

Title: Haiti and the health marketplace: The role of the private, informal market in filling the gaps left by the state

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Author’s response to reviews:

6th July 2014

Dear Editor

Thanks you for the opportunity to revise the manuscript: Haiti and the Health Marketplace: The Results are Perishable. To better reflect the findings we have changed the title to: Haiti and the health marketplace: The role of the private, informal market in filling the gaps left by the state

We have made the revision suggested as outlined below and feel these changes have improved the paper and that it fits the interest of you readership especially given the growing literature on health in fragile states and severely disrupted environments. All authors have contributed to and read the paper. It has not been submitted elsewhere. The study was approved by Ethics approval for the research was obtained from the University of Queensland Research Ethics Committee. The Committee reviewed the research protocols, interview guides, informed consent process and the consent and information forms to be used.

The Ministry of Public Health and Population in Haiti was provided with the research protocol and informed of the ethics approval.

Thank you for your consideration and we look forward to hearing from you.

Yours sincerely

Jo Durham

Ms. Joanne Durham
University of Queensland
School of Population Health,
Centre for International and Tropical Health
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Revisions:
Reviewer's report:
Reviewer 1
Thank you for your comments which we found invaluable and have addressed as outlined below.

Major Compulsory Revisions
1. Abstract: The result in the abstract section needs to encompass one or two of the critical findings.

We have rewritten results section as follows:
The findings show that state fragility has resulted in a privatised, commoditised and largely unregulated and informal health market. While different market segments can be identified, in reality the boundaries between international/domestic, public/private, for profit/not-for-profit, legal/illegal are hazy and shifting. The result is deplorable health indices which are far below regional averages and many other low-income countries.

2. What questions guided this case study?
In the first paragraph under the methods section we have added:
The overall purpose of this larger research project was to provide greater understanding of the provision of health services in fragile states and to examine the ways in which health systems react, adapt and evolve in response to total or partial state failure, and how national and international stakeholders respond to such challenges. The findings of the study have been published in peer reviewed publications and in detailed country reports (15-18). The objective of this component of the Haïtian case study was to examine how the Haitian health market has evolved in response to state fragility.

3. While the overall goal of the study is highlighted, the objectives not specified to enable readers understand whether the content in the results section confirms what was proposed and accomplished.
Please see response to point 2

4. Provide detailed description of procedures used. What issues were explored in the key informant tool? How were the key informants selected from array of actors involved in the policy processes of the market issues explored? What were the inclusion and exclusion criteria for selecting the key informants?
We have clarified:
Qualitative interviews were chosen because of their ability to provide in-depth descriptions of the health system experiential perspectives of stakeholders (23, 24). The topic guide used for the interviews related to the overall objectives of the broader study including health service provision and the impacts of social,
economic and political disruption. While topic guide was used, the interviews also allowed participants to talk about health service provision in their own words focusing on the issues that they felt were important and provided the interviewer with the flexibility to follow up and clarify participant ideas. This means that as is often the case in qualitative research, there were some differences in the ways in which questions were framed and answered (23, 24).

We have also added the following table

Table 1: Summary of participants by category and locations

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5. The authors' should clearly articulate the limitations of the work?

We have added before the conclusion:

As with all research, our research has limitations. Most importantly, the data available primarily refers to the public sector, yet as the case study has demonstrated there is a thriving health market beyond the public sector. There is a need for an in-depth analysis, mapping the supply and demand factors operating within the formal, informal, private, nongovernmental organization and faith-based market segments for Haiti. Secondly, while the approach allowed the collection of rich, qualitative information the study was also constrained by the unevenness of the available information, resulting in uneven insights in relation to the market segments.

Minor Essential Revisions

6. What type of partnerships and communications exist between the various market actors during the period examined and how does this affect decision-making?

The communications between various market actors are blurred as the different actors move between the different market segments. We have described some of
the partnerships and communications under the different market segments in the findings. For example under ‘international market place’, second paragraph:
Respondents explained that the different not-for-profit NGOs work in various ways which include running services in MSPP-owned premises, sometimes with the MSPP providing salaries, or an NGO may pay or top-up MSPP salaries.
And beginning of third paragraph:
In addition to NGOs providers, since 1998, the not-for-profit sector has included services through a bilateral agreement: the Cuban Brigade.
And under governance:
Health partners were reported to often start projects without MSPP authorization or with authorization being sought from health authorities subsequent to activities starting. Lack of regulation and often a bypassing of official procedures were reported to create parallel procurement processes which were also vulnerable to corrupt circumvention of the governmental system. The private sector particularly was reported to be very much beyond the control of the MSPP.
And in the same section:
Despite the weaknesses of the MSPP, donors, UN agencies and those NGOs with any interest in engaging the MSPP, pay formal lip service to the MSPP as if it were fully in charge, as on person reflecting a view of many of our respondents explained, “but the true leadership lies with the international agencies and their implementers, the NGOs”.
Reviewer 2
Thank you for your comments which we found invaluable and have addressed as outlined below.
Uses unclear terms such as healthy marketplace and ‘advanced economies’ (which is an inappropriate term – e.g. ‘high income countries’ is better). The term ‘policy analysis’ is not used appropriately – policy analysis is a distinct approach which the authors have not used – at least not obviously. These and other terms are also used in the body of the paper and should be explained.
The results part of the abstract doesn’t really give the reader a clear idea of the main findings from the study.
We have rewritten the abstract as below:
The findings show that state fragility has resulted in a privatised, commoditised and largely unregulated and informal health market. While different market segments can be identified, in reality the boundaries between international;/domestic, public/private, for profit/not-for-profit, legal/illegal are hazy and shifting. The result is deplorable health indices which are far below regional averages and many other low-income countries.
The findings show that state fragility has resulted in a privatised, commoditised and largely unregulated and informal health market. While different market segments can be identified, in reality the boundaries between international;/domestic, public/private, for profit/not-for-profit, legal/illegal are
hazy and shifting. The result is deplorable health indices which are far below regional averages and many other low-income countries.

We have changed advanced to high-income countries and policy analysis to policy review

We have explained health markets in the first paragraph of the introduction:

Most contemporary health systems are mixed in character. That is, to varying degrees they consist of a mix of public and private healthcare providers, and both bio-medical and traditional practices with a variety of financing mechanisms. In many countries this mix of providers is understood in financial terms, as competing health markets, based on the assumption that competition between public and private sector providers facilitates improvement in the efficiency (1). For competitive health markets to work effectively they need to be regulated through law, regulation, or contracts and in most high-income countries, while health system organisation and finance often varies, relatively well-established market regulation mechanisms exist and are enforced (2, 3). Background

Again, a lot of terms used which should be defined/explained – including ‘modern’, ‘therapeutic modalities’ etc.

For clarity we have removed these terms

The background should lay out clearly what the focus of the paper is

We have shortened and rewritten the background to clearly frame our paper – and indeed the results section

is very general, descriptive and unfocussed (see below). Also, there’s no real justification for the

study/paper – e.g. statement about its contribution to knowledge and value of study for

policymakers, academics and others.

To clarify the last paragraph of the introduction reads:

The challenges of undertaking research in fragile and conflict affected states means the there is a lacuna of knowledge of how health systems work in such environments. Further, much of the health literature related to such environments has focussed primarily on aspects related to Western aid or the public sector even when the state is largely absent. Such a focus however ignores much of the healthcare arena. This paper is important in adding to our current limited knowledge base of how health markets evolve in response to total or partial state failure. It considers the usually overlooked informal mechanisms that allow for healthcare provision in such difficult environments, and points to the need for donors—and governments—to develop new modes of engagement with these emergent service providers. While recognising the challenges, we also call for further research to deepen our understanding of how to optimise the contribution of these health markets that continue, despite social, political and economic disruption, to deliver health in fragile and conflict affected states.
The paragraph explaining the structure of the paper adds little.
We have deleted this paragraph
Through this section there are a lot of generalisations – e.g. it seems to suggest all health systems of ‘advanced economies’ are similar which is clearly not true – take the differences between the US and many European health systems. There are similar generalisations about low and middle income countries.
We have rewritten the introduction
There are several places where references are missing but are needed – e.g. the section describing Haiti.
We have added additional references
Generally the Background including the various sub headings within is rather long winded and so it takes quite a while to get to the Results. Where possible please shorten, and possibly add a table with numerical data.
We have rewritten the background section to more clearly frame the paper and have shortened it
Methods
See earlier comment of policy analysis.
We have amended to policy review
Overall this lacks precision. For example -
A little bit of detail is needed about how the document search was conducted e.g. data bases/sources, search criteria etc.

The research was grounded in an extensive documentary and policy review, based on peer-reviewed articles, books and “grey” literature—government policy and program reports, unpublished research and evaluations, and reviews from key multilateral and bilateral donors, and non-government organisations. A search was undertaken using databases including Ovid Medline, Embase, Web of Knowledge, Web of Science and web-based searches of data available in the public domain . and hand-searching relevant journals. Key words included: health, health systems, health services, conflict and fragile states. Documents were also collected from people working in fragile state including those who were interviewed. Qualitative, quantitative and mixed method studies and documents in French and English documents were included.

I’ve not come across the term ‘thematic guide’ – does this mean ‘topic guide’?
We have changed to topic guide for clarity
More precision is needed about interviewees (without of course revealing their actual identities) e.g. how many of each category, selection criteria and a
justification for the selection
We have clarified:

Key informants were purposively selected, using the organogramme of the MSPP to identify senior administrative staff, and the humanitarian donor coordination list, to identify donor and NGO representatives. These respondents identified further relevant informants, and provided contacts with both the Cuban Brigade and representatives of the Département at Cap Haïtien, and a seminar at the Université de Notre Dame de Haïti allowed us to present the outline of our research, and facilitated introductions. A total of forty-five interviews were undertaken in Haiti with key representatives of the MSPP, multilateral and bilateral donor agencies, academic institutions, NGOs and private practitioners, in Port-au-Prince and Cap Haïtien.

We have added the following table

Table 1: Summary of participants by category and locations

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Something on data quality – what steps were taken to ensure data quality – to reassure the reader the data are valid and reliable and therefore the findings are sound.

We have added:

Triangulation of the qualitative data was achieved by using different methods (program documentation review, interviews) and interviewing participants from different sectors. In addition field notes and contact forms were maintained ensuring an audit trail. Further credibility safeguards included the authors manually coding the data into themes and integrating the interview data with the document review.

What steps were taken to analyse the qualitative data?

MJM and PSH initially coded the interview data reviewing the transcripts in English or French. Coded data was grouped into the key themes guided by the
broader project research questions. Subsequently the Haitian data was reanalysed by JD and PSH, with a focus on those themes relating to health markets and financing. Triangulation of the qualitative data was achieved by using different methods (program documentation review, interviews) and interviewing participants from different sectors. In addition field notes and contact forms were maintained ensuring an audit trail. Further credibility safeguards included the authors manually coding the data into themes and integrating the interview data with the document review.

It may be a problem for the journal if this piece is already published/in the public domain (albeit in French).

This piece is not published elsewhere

Results
The structure is not very strong, and much of the material seems to be a general description of the situation in Haiti – rather than analytical. A strong focus and clearer analytical framing might help strengthen the presentation of results. See also earlier comment on the lack of clear focus to the paper.

We have framed the paper more clearly in the revised introduction

In addition we explain the presentation of the findings in the first paragraph of the ‘findings’ section

The findings of this research are presented using the different market segments to structure the analysis. Using a systems approach to the analysis, enables an examination of the interconnectedness and blurring of boundaries between the different market segments, the financial incentives that drive supply and the formal and informal institutional arrangements that exist and influence outcomes.

We have also revised and shortened the findings section to remove some of the more descriptive sections

I think many of the findings presented are very common experiences in low income countries with lots of donors and other development agencies. So, I am not clear how Haiti is distinct from other low income countries – whether they be fragile, post conflict or otherwise.

Little qualitative data are presented through the results – some examples and quotes are needed to show that the points being made are based on data.

We gave added some quotes and examples in the findings

Discussion
Similar comments to Results – not very analytical, and it is not clear how Haiti is a special case (maybe it faces similar problems to many other low income countries, or worse than most, or some particular problems?). In any case some insights that are useful beyond as well as within Haiti would be useful, and some comparison with other fragile/post conflict countries facing similar problems.

We have added at the end of the first paragraph of the discussion:

What is clear however is that health care has developed into a privatised, commoditised and largely unregulated service. Within this context as in other
fragile states, the amount of public services, including health care provided by the state is extremely limited, yet research has continued to largely focus on the formal public health sector which provides the minority of health care (19-21, 28, 30, 31).

We have added in the conclusion:
To conclude the case study suggests that donors need to develop new ways of working in fragile and conflict affected environments. Further, many characteristics of the health system describe here, such as reduced public provision health, weak regulation, market diversification and the commodification of public goods are seen elsewhere. What this study suggests is the need to accept and work with this blurring of traditional mutually-exclusive categories.

A brief commentary on the limitations of the study/paper is needed.

We have added:
As with all research, our research has limitations. Most importantly, the data available primarily refers to the public sector, yet as the case study has demonstrated there is a thriving health market beyond the public sector. There is a need for an in-depth analysis, mapping the supply and demand factors operating within the formal, informal, private, nongovernmental organization and faith-based market segments for Haiti. Secondly, while the approach allowed the collection of rich, qualitative information the study was also constrained by the unevenness of the available information, resulting in uneven insights in relation to the market segments.

Normally there would be a short ‘Conclusions’ section briefly summarising the main messages from a paper.

We have more clearly signalled the conclusion and summarised the main messages from a paper.

Reviewer 3
This paper could provide an important contribution to our understanding of Haiti’s health system specifically, however, I need some clarification on the research question and the methods to be able to better understand the study and its findings.

Major comments
1. The research question or problematic is unclear to me. What is a 'severely disrupted environment'? Why study such an environment? What is a ‘market perspective’? (Just a reference for this last point might suffice).

We have added clarified the concept of health markets in the revised introduction and in the third paragraph of the introduction:

This research, examining the health markets of Haïti as an example, allows us to explore how these core functions within the healthcare market adapt when the state is unable to meet its responsibilities to provide health services to its population. It examines how the health market evolves in response to state fragility, and what rules — formal and informal— develop in the context of limited
state governance. We argue that in this context the size, scope and reach of public health services are severely reduced, leaving space for the establishment of a mixed, informal health market driven largely by self-interest. The informal health market refers to those providers who deliver health services largely outside of the legislative frameworks governing health care (2, 5).

And in the following paragraph:
The challenges of undertaking research in fragile and conflict affected states means there is a lacuna of knowledge of how health systems work in such environments. Further, much of the health literature related to such environments has focussed primarily on aspects related to Western aid or the public sector even when the state is largely absent. Such a focus however ignores much of the healthcare arena. This paper is important in adding to our current limited knowledge base of how health markets evolve in response to total or partial state failure. It considers the usually overlooked informal mechanisms that allow for healthcare provision in such difficult environments, and points to the need for donors—and governments—to develop new modes of engagement with these emergent service providers. While recognising the challenges, we also call for further research to deepen our understanding of how to optimise the contribution of these health markets that continue, despite social, political and economic disruption, to deliver health in fragile and conflict affected states.

2. The methods section is confusing.
A. What is the research design of the global research project? Perhaps also include a short summary of the project, countries involved, etc and/or link to a reference where readers can get more info on the full study.

We have added:
The six countries were selected for the diversity of their social, political and historical evolution: Afghanistan, Central African Republic (CAR), Democratic Republic of Congo (DRC), Haïti, Palestine and Somalia. The overall purpose of this larger research project was to provide greater understanding of the provision of health services in fragile states and to examine the ways in which health systems react, adapt and evolve in response to total or partial state failure, and how national and international stakeholders respond to such challenges. The findings of the study have been published in peer reviewed publications and in detailed country reports (15-18). The objective of this component of the Haïtian case study was to examine how the Haitian health market has evolved in response to state fragility.

B. What methods were used for the Haitian study - only interviews, there should be a statement that interviews were done prior to stating that a thematic guide for interviews was prepared. In the abstract it does not state that interviews were done, but rather reviews of documents - confusing. Also, what type of interviews were done?

We have amended
What tools were used? How were they validated? What languages were they prepared in? Overview of type of questions asked - possibly put the questions in
an annex. How was the thematic guide modified for the Haitian context? Feasibility study?

We have added:
Qualitative interviews were chosen because of their ability to provide in-depth descriptions of the health system experiential perspectives of stakeholders (23, 24). The topic guide used for the interviews related to the overall objectives of the broader study including health service provision and the impacts of social, economic and political disruption. While topic guide was used, the interviews also allowed participants to talk about health service provision in their own words focussing on the issues that they felt were important and provided the interviewer with the flexibility to follow up and clarify participant ideas. This means that as is often the case in qualitative research, there were some differences in the ways in which questions were framed and answered (23, 24).

C. Why was only oral consent obtained? Please give rationale.
Consent was recorded, we have clarified:
All interviews were undertaken with oral consent (recorded), including consent for recording the interview, and following consent by phone and witnessed reading of information sheet. On-going consent for the interview data to be used by the researchers was confirmed at the conclusion of the interview. Table 1 summarises the number of respondents by category and location.

D. Where did this study take place/where were the interviewees working in Haiti?
We have added:
Key informants were purposively selected, using organogramme of the MSPP to identify senior administrative staff, and the humanitarian donor coordination list, to identify donor and NGO representatives. Respondents identified further relevant informants, and provided contacts with both the Cuban Brigade and representatives of the Département at Cap Haïtien. Forty-five interviews were undertaken in Haiti with key representatives of the MSPP, multilateral and bilateral donor agencies, academic institutions, NGOs and private practitioners, in Port-au-Prince and Cap Haïtien.
This is very important in interpreting findings if the study was localized in Port-au-Prince versus across various departments.

E. There needs to be a description of the sample.
Please see above and we have added
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F. What type of data analysis was done?
MJM and PSH initially coded the interview data reviewing the transcripts in English or French. Coded data was grouped into the key themes guided by the broader project research questions. Subsequently the Haitian data was reanalysed by JD and PSH, with a focus on those themes relating to health markets and financing.

G. Data management processes should be described, including how participant information was protected.
We have added:
Anonymity and confidentiality of participants were protected by the use of coding and strict security measures, which included storing documents and recordings in a locked cupboard and/or on a password protected computer.

3. I find the results section confusing as it is intertwined with the literature – can this section be rewritten to only include data from the study as well as providing supportive evidence of findings (e.g. direct quotations)
The documentary review was part of our study and findings but we have added some direct quotes and further clarified respondent views

4. Study limitations?
We have added:
As with all research, our research has limitations. Most importantly, the data available primarily refers to the public sector, yet as the case study has demonstrated there is a thriving health market beyond the public sector. There is a need for an in-depth analysis, mapping the supply and demand factors operating within the formal, informal, private, nongovernmental organization and faith-based market segments for Haiti. Secondly, while the approach allowed the collection of rich, qualitative information the study was also constrained by the unevenness of the available information, resulting in uneven insights in relation to the market segments.

Minor comments
1. In first para; the word different is used 4 times in the same sentence, consider revising.
We have amended
2. What is 'ensekerite' - is this Creole - clarify.
We have clarified:

These repeated political and natural disasters result in ‘routinized ruptures’ and a continuous state of ‘insecurity’ or ‘ensekirite’ as it is termed in the local Kreyòl, which undermine Haïti’s efforts to consolidate its democracy and create a climate of peace and security.

3. Reference 15 does not demonstrate that there was a rise in chronic disease, given the data cited was cross-sectional.

We have amended

Discretionary comments

1. Although the authors do describe the variety of factors that have shaped the role of the state and the poor health outcomes in Haïti, the authors are curiously silent on the historical role of US and the influence of neo-liberal policies on the Haitian health system, which this reviewer believes to be a critical issue for understanding the Haitian health system today.