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Free care in Africa

A realist review of the mechanisms involved in patients' healthcare-seeking behaviours

Emilie Robert

Valéry Ridde

CRCHUM

Centre de recherche du Centre hospitalier de l'Université de Montréal

Outline

1. Rationale for the study
2. Research objective and method
3. Results
4. Lessons from the realist approach

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1. Rationale for the study

- **African countries are abolishing user fees in the health sector to improve access to health services.**
  - '*an official reduction in direct payments for health care, which is targeted by group, area or service*' (Witter, 2009)
  - More than fifteen African countries concerned (Robert & Samb, in press)
  - Heterogeneous body of evidence (Ridde & Morestin, 2010)

- **Traditional systematic reviews provided limited insights.**
  - Focus on efficiency or effectiveness of intervention
  - Exclusion of studies using 'less robust' methods
  - *'Most studies included in this review suffered from serious methodological weaknesses'* (Lagarde & Palmer, 2011)

2. Research objective and method

- **Opening the 'black box' of UF exemption policies:**
  - ***How do UF exemption policies influence healthcare-seeking behaviours in Africa? Under what circumstances?***
- **Purposes:**
  - **Reconciling**: To understand why similar interventions produce different outcomes and what contextual elements come into play.
  - **Juxtaposing**: To refine how mechanisms of similar interventions are triggered in similar contexts.
- **UF exemption policies:**
  - For children under 5, women / pregnant women, elderly
  - Primary care / essential health care for all

2. Research objective and method

STEP 1 — Identifying the intervention theory

STEP 2 — Searching for primary studies and grey literature

STEP 3 — Appraising the relevance and quality of the studies

STEP 4 — Extracting data (NVivo + Prezi)

STEP 5 — Sorting out C-M-O configurations

STEP 6 — Proposing middle-range theory

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3. Results

- **Designing the basic intervention theory**

CONTEXT
Political / Social / Economic level
Health system / Health facility level
Household / Individual level

1) Problem identification	2) Policy planning	3) Staff's compliance	4) Users' propensity to seek care	5) Improved health
•*Problem:* limited financial access to modern healthcare. •*Solution:* identify target population(s) and abolish user fees.	Financing Information diffusion HR support Coordination Monitoring / evaluation Supervision	•Staff adheres to exemption policy principles. •Staff implements policy guidelines. •Staff exempts target population from user fees.	•Users do not need to arbitrate with other expenses. •Users do not need to engage with self-medication. •Users seek modern healthcare according to their needs.	•Reduction of inequities in access to health care •Reduction of catastrophic health expenditures •Improved population health
PROBLEM IDENTIFICATION	**INITIAL ACTIVITIES**	**IMPLEMENTATION PROCESS**	**FINAL OUTPUT**	**LONG-TERM OUTCOME**

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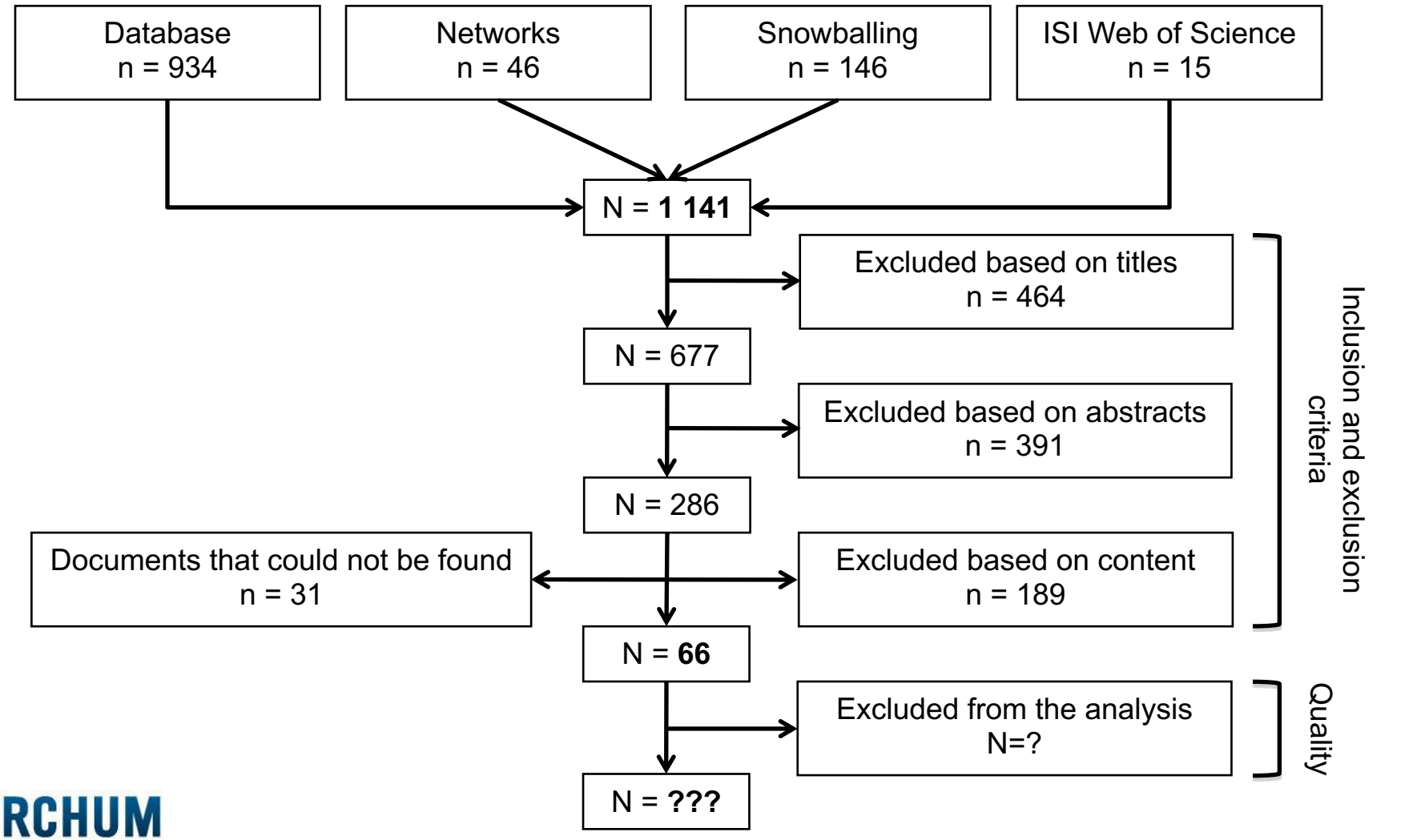
3. Results

- **Searching and appraising the literature**



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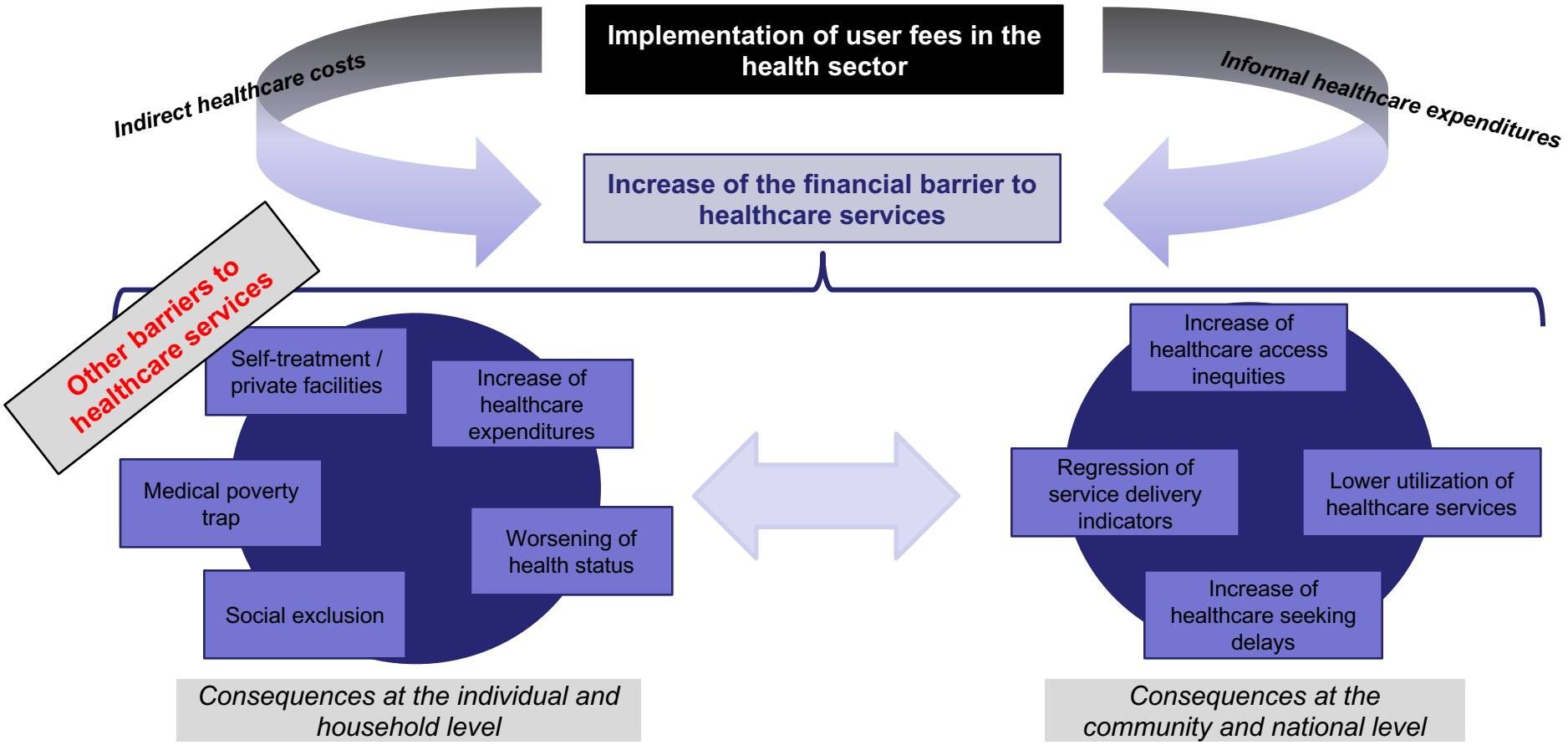
3. Results

- **Problem identification… and solution**



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3. Results

- **Policy planning and implementation (some examples)**

Health system functions	Pressures on the health system
Health information	Lack of information on the number and type of services carried out in the health centres and on the amount of reimbursements.
Drugs and vaccines	Problems of availability of drugs Insufficient drugs and kits to meet local needs Delays and under-distribution of consumables
Funding	Funding unpredictable, insufficient and discontinuous Reverting back to charging for services and drugs Delays in reimbursements
Governance and leadership	Poor planning and communication; poor understanding of the policies Inadequate supervision Complexity of funding procedures

Ridde, Robert et al, 2012

These elements (C) contribute to influence the behaviors and attitudes of both the heath staff and the population.

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3. Results

- **Staff's compliance (some examples)**

Behaviours and attitudes		Examples of empirical data
Adherence to / satisfaction about UFEP	Worries / dissatisfaction related to policy's terms	"*It was reported that registration fees were too low, were often insufficient to meet the running costs of the facility, and that budgetary allocations from the government were inadequate*" (Chuma, 2009)
	Dissatisfaction related to professional and/or personnal spillovers	"*... increased workloads were seen to have had direct negative effects at a personal level for the majority of nurses*" (Walker, 2004)
	Dissatisfaction related to implementation	"*They do not reject the policy or its goals so much as expressing concern about the direct impacts they perceive it to have had on them and the processes through which it has been implemented*." (Nimpagaritse, 2011)
Coping strategies	Adjustment of prices of services	"*... policy modification was by fully exempting some children from all fees while others received a partial or no exemption*." (Agyepong, 2010)

These elements (C) contribute to influence the behaviors and attitudes of the population.

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3. Results

- Users' propensity to seek care

The combination of these elements come into play in users' decision to seek modern care.

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3. Results

- **Sorting out C-M-O configurations**

SEMI-REG 1

Delays and unpredictability in the policy financing at the health facility level (reimbursement or distribution of consumables) **(C)** encourage health staff to adjust the prices of health services **(M)**. As a consequence, users do not consistently benefit from free healthcare **(E)**.

"*After the introduction of the exemptions, funds did not suffice to buy all the drugs needed and the management team at Muramvya Hospital decided that children under 5 simply could not be offered free care at the hospital outpatient clinic. […] Therefore, these financial issues did not allow for the provision of drugs for free to ambulatory patients under 5, although this was included in the announced reform.* " (Nimpagaritse, 2011)

3. Results

- **Sorting out C-M-O configurations**

SEMI-REG 2

Health staff ajusting prices of health services **(C)** leads users to protect themselves from potential costs related to seeking care **(M)** and thus constraints their opportunity to benefit from it. **(E)**.

"*Inconsistent patterns of public service uptake and partial protection from direct costs were, finally, also influenced by specific health service weaknesses including drug […] exemption implementation failures at hospitals*" (Goudge, 2009)

3. Results

- **Sorting out C-M-O configurations**

SEMI-REG 3

Increase in utilization of health services by patients associated with implementation failures **(C)** triggers a deterioration in the initial enthusiasm of health staff for UFEP **(M)**, which in turn contributes to the deterioration of their relationship with users **(E)**.

" *The increase in patient load and reduced drug supply made nurses' relationships with their patients very difficult .*" (Walker, 2004)

3. Results

- **An attempt to theorize…**

CONTEXT (at the health system level)

Weak health system ⟷ **Health providers' coping strategies**

Exemption policy implementation gap

Persistence of fees for supposedly free healthcare → **Deterioration of the patient-provider relationship**

Experience with health system

Persistence of other barriers to accessing healthcare

CONTEXT (at the household level)

Theory of street-level bureaucracy

Determinants of healthcare seeking behaviours

MECHANISMS

Uncertainty ⟷ **Distrust**

Limited propensity to engage with free healthcare

OUTCOMES

Limited decrease in catastrophic health expenditures
Limited decrease in inequalities in access to modern care
Limited improvement in population health

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4. Lessons from the realist approach

- If combined with measures targeting other barriers to access healthcare, user fee exemption policies have a strong potential to produce their intended outputs.

- Implementation gaps strongly jeopadize users' propensity to seek modern care through uncertainty and distrust.

- Street-level bureaucracy and determinants of healthcare-seeking behaviours provide the missing pieces to understand how user fee exemption policies work.

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Emilie Robert is a Ph.D. student in public health at Montreal University and is a fellow of the Global Health Research Strengthening Program, funded by the Canadian Institutes of Health Research and the Population Health Research Network of Quebec.

Contact: **emilie.robert.3@umontreal.ca**

Valéry Ridde and Pierre Fournier are professors at Montreal University.

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CHUM CENTRE DE RECHERCHE

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Réseau de recherche en santé des populations du Québec

IDRC International Development Research Centre / CRDI Centre de recherches pour le développement international

afd Agence Française de Développement

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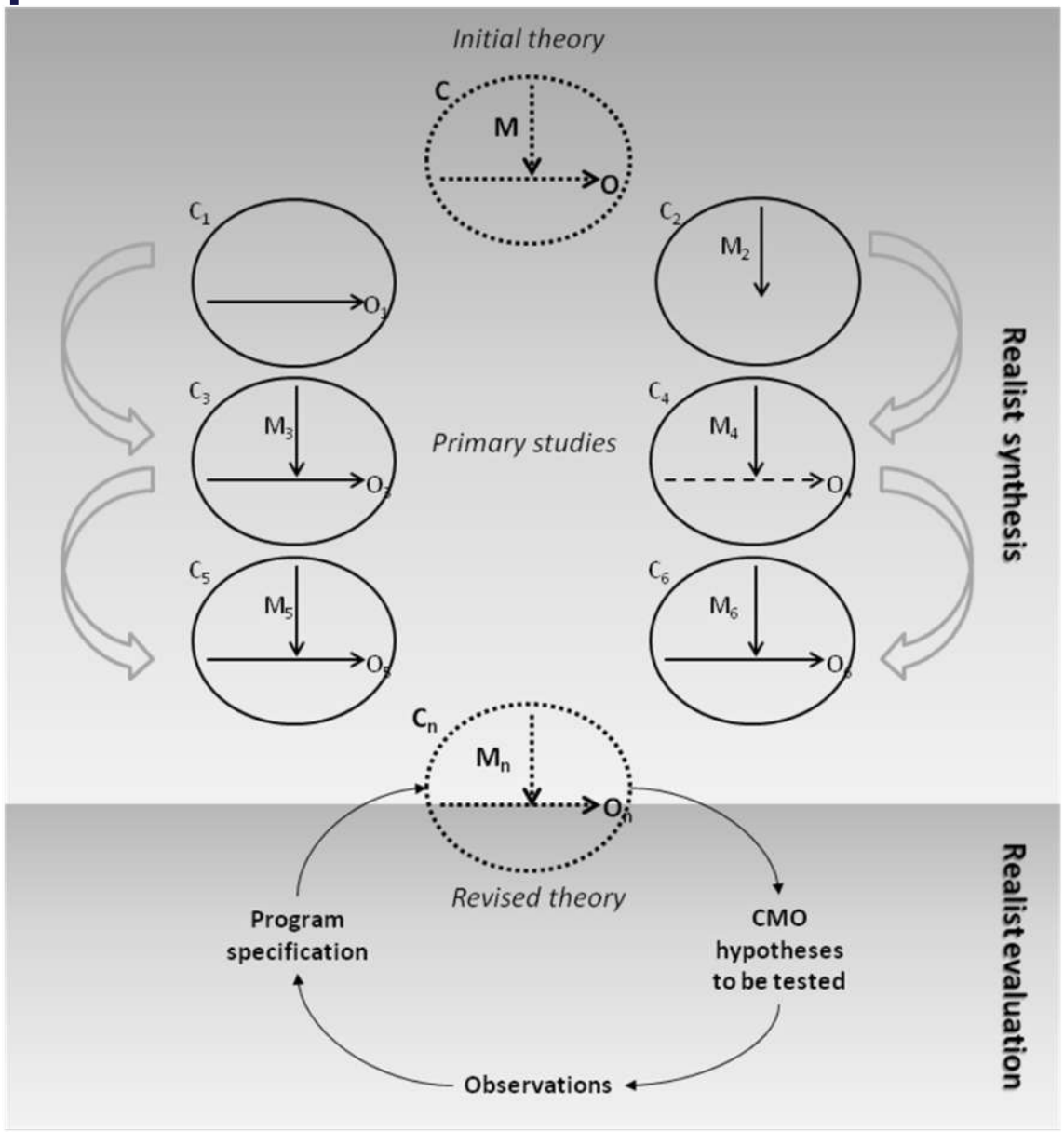
Annex: cumulating knowledge in a Realist perspective



Adapted from Pawson and Tilley (1997) and Pawson (2006).

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