CREHS : EXCHANGE newsletter

Introduction

Welcome to the first issue of the Exchange Newsletter which is now produced by the Consortium for Research on Equitable Health Systems (CREHS). CREHS is a DFID funded research consortium which aims to generate knowledge and help strengthen health system policies and interventions in ways which preferentially benefit the poorest. CREHS represents both continuity with past DFID-funded activities of the Health Economics and Financing Programme at LSHTM, and a different way of undertaking collaborative research. In particular, CREHS allows for joint development of research ideas among all 8 partners and adaptation to meet country-specific needs and settings. In addition, it involves shared management, a special emphasis on supporting the development of capacity to undertake health systems and policies research, and a strengthened emphasis on strategies for engaging users in the research process. CREHS partners (listed below) represent longstanding HEFP collaborators, and reflect a mix of universities and research institutions from low and middle-income countries. More information about the Consortium is available on our website, www.crehs.lshtm.ac.uk.

An important area of continuity with the past is this newsletter, *Exchange*, which was previously a forum for communicating HEFP research to a wide audience of policymakers, practitioners and researchers in the field of health economics and policy. We aim to produce issues of CREHS *Exchange* each year to share the results of work undertaken by CREHS partners. Those who wish to keep up with the broader activities of HEFP should visit the website www.hefp.lshtm.ac.uk.

Over its five-year period of funding, CREHS research will focus on 4 main themes:

- Learning lessons from past health sector reforms: Through examination of recent health sector reforms, we are seeking to identify the economic, political and institutional factors that have enabled or constrained policy implementation that preferentially benefits the poorest.
- Financial risk protection: Our objective is to examine how health care financing mechanisms can be combined and implemented to strengthen levels of cross-subsidy in favour of the poorest.
- Health workforce performance: We aim to identify strategies to improve health workforce recruitment, retention, productivity and responsiveness in ways that preferentially benefit the poorest.
- Scaling up: We will examine how strategies for scaling up coverage of priority health interventions can be designed and implemented in order to successfully reach the poorest.

The contributions to this issue of *Exchange* reflect these themes. Lucy Gilson (HEFP and Centre for Health Policy) reports the main findings of a systematic review of the literature on policy analysis as applied in low- and middle-income countries. Walaiporn Patcharanarumol and colleagues from IHPP and the National Institute of Public Health in Lao PDR summarize the results of two linked research projects on user fee and exemption policies in Lao. Mylene Lagarde and Natasha Palmer (HEFP) present the results of their systematic review of the health financing literature. Ongoing CREHS research on the process of implementing health sector reforms in partner countries is summarized by Lucy Gilson.

Kara Hanson, Director and Lucy Gilson, Associate Director

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Understanding the political and social dimensions of health policy change

Policy change is fundamentally a political process, involving contestation among actors – even during implementation. As a result policies that represent good ideas may not be implemented; and many policies that appear to be technically sound do not achieve their stated objectives.

CREHS has undertaken a systematic review of studies published between 1994-2005 that examine the political and social dimensions of health policy change in lower and middle income (LMIC) settings. This review seeks to provide a platform for future research, by:

- mapping the terrain of work already undertaken, and gaps within it;
- considering the methodological approaches used;
- where possible, drawing out overarching insights into the processes of policy change in these contexts.

Formal searches using relevant key words were undertaken of PubMED and the International Bibliography of the Social Sciences (IBSS), and some additional papers were identified through hand-searches. A summary of the initial 322 papers identified as broadly relevant to LMICs will soon be available on the CREHS website, www.crehs.lshtm.ac.uk.

A sub-set of 116 of these papers report national and sub-national experiences of policy change. The main policies of focus in these papers include health financing, broader health sector reform, reproductive health and HIV/AIDS – with attention also being paid to national processes of donor coordination and experiences of policy transfer from the international level. An explicit concern for equity as a policy goal was fairly weak, but most clear in the financing, privatization and community participation papers. Twenty one of these papers focus primarily on processes of agenda setting and formulation, whilst the remainder take account of, or explicitly focus on, the process of policy implementation.

The diversity of the papers is considerable. Only 10 papers present a deliberately constructed cross-country examination of experience around a particular policy. Within the largest single grouping of papers (15 papers), various financing policies are examined in a range of country contexts, considering experience at national, regional or local levels and focusing on different stages of the policy process.

Very few papers have explicit foundations in the policy analysis theory of particular relevance to these types of studies, draw conceptual insights into their analysis or adequately refer to other relevant empirical work. Only a few of the studies reported can fairly be considered formal case studies, although a number present rich narratives around the policy experience of focus. The most authoritative papers combine theoretical insights and empirical experience. Most studies use mixed data collection methods, commonly interviews and document review. Almost half also seem to rely on the authors' own knowledge, but methodological reflexivity is rare.

Drawing conclusions from this diverse set of papers is a challenging task. Their main insights, however, confirm some of the key lines of policy analysis theory and research. These are the:

- ubiquitous influence of norms, values and interests over actors' behaviour;
- centrality of power and resistance to policy change;
- risks associated with policies with conflicting goals or which challenge powerful interest groups;
- influence of the ways policies are framed over actors' responses;
- importance of strategically managing technical inputs and the meanings associated with policies, taking account of context.

A key conclusion for policy makers is, therefore, that process matters – and that taking account of the politics of policy change is essential, even in relation to implementation.

To provide support for policy-makers, researchers must undertake more and better investigation of the processes that influence policy change experiences and consequences. For researchers, the review provides five key lessons:

1. build new work on existing empirical evidence and relevant theoretical foundations;
2. use appropriate study designs and sound methods;
3. be reflective in analysis;
4. deepen understanding by focusing on specific process issues and conducting cross-national research;
5. make a focus on equity explicit.

Lucy Gilson (CHP and HEFP)

Researching user fees and exemption mechanisms in Lao PDR

Two linked studies on user fee exemption policy were conducted in Lao PDR. The first was a collaborative study involving the National Institute of Public Health, Lao PDR (NIOPH) and the International Health Policy Program, Thailand (IHPP) with the support of the Consortium for Research on Equitable Health Systems (CREHS). The study, conducted during April-May 2006, aimed to describe the process of the formulation of user fees and exemption policies, and used a literature review and in-depth interviews of key informants.

The study found that Decree 52/PM, the policy addressing user fees and exemptions endorsed on 26 June 1995, was formulated primarily by key staff in the Ministry of Health. It was developed in the context of the government's new openness towards the market economy (from the mid-1980s) and falling levels of external assistance from socialist countries which resulted in reduced funding for public services, reflected particularly in inadequate drug supplies. In response to this situation a Revolving Drug Fund (RDF) was established in 1990, requiring patients to pay for medicines. The RDF was perceived as a precursor to the introduction of user fees in public health services in Lao PDR. More recently, the Curative Law was endorsed in November 2005, establishing a Social Welfare Fund to ensure access by the poor to essential public health services.

The second study, 'Health Care Financing for the Poor in Lao PDR' was conducted by Walaiporn Patcharanarumol, a research degree student at LSHTM under the supervision of Prof. Anne Mills and funded by the Dorothy Hodgkin Postgraduate Award (DHPA). The study aims to contribute to policy on financial protection of the poor by evaluating government policy and practice of user fees and exemptions; improving understanding of the determinants of health care utilization and household strategies for coping with the cost of illness; and identifying ways of better protecting the poor. Both quantitative and qualitative methods were used for data collection from policy makers, public healthcare providers in various levels and sampled households. The study was undertaken in Savannakhet Province and Vientiane Capital during the period October 2005 - June 2006. The preliminary results identified a large gap between policy intentions and actual implementation. Policymakers had high expectations of the success of Decree 52/PM, while healthcare providers faced practical difficulties in getting policy into practice. Those who qualified for user fee exemptions were usually unaware of their entitlement. Unsurprisingly, the exemption system was not functioning adequately. Households continued to face catastrophic health expenditure and therefore impoverishment. Social networks were the most important mechanism used by households to cope with an unexpected illness cost. Borrowing from neighbours and relatives (neither with credit nor interest) and sales of assets such as poultry and cattle were two important coping strategies.

Following the completion of fieldwork for the two studies, two one-day workshops funded by DHPA and IHPP were held in Vientiane Capital on 17-18 July 2006 to share the preliminary results with decision makers at all levels including policy makers, public health care providers and village heads who were directly involved in the studies as well as CREHS representatives, Anne Mills and Kara Hanson. The feedback from the workshops was very positive. Participants, who included the Vice-Minister of Health, found the main findings to be clear, systematic, comprehensive and very policy relevant. The Vice-Minister of Health acknowledged the value of support from CREHS and LSHTM, and looked forward to future collaborations between Lao, UK and Thailand to strengthen capacity in health policy research, and produce evidence-based policy recommendations to improve equitable access to quality health services in Lao PDR. The immediate consequences for a policy to better protect the poor are not clear because of constraints on government spending and the absence of funds earmarked to subsidise the poor. However, the evidence from the two studies should contribute to the design of the Social Welfare Fund stipulated in the Curative Law.

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Reviewing the evidence on health financing strategies to encourage uptake of health services by the poor

Background

It is increasingly recognized to what extent the poorest remain excluded from basic health care in many low- and middle-income countries. Even services that have been shown to be highly cost-effective are failing to reach the poorest and most vulnerable groups. Financial barriers have been recognized as one important obstacle to accessing health services.

A systematic literature review was funded by the Bill and Melinda Gates Foundation during 2005-2006. Its aim was to synthesize evidence on the effectiveness of four approaches to encouraging the uptake of health care by poorer groups in low and middle income countries. These approaches are at the centre of current debates about how health financing methods can be used to improve service use by the poor. They are: 1) introduction or removal of user fees, 2) risk protection mechanisms, 3) contracting out service provision to non state providers, and 4) conditional cash transfers.

Methods

This review was carried out following the recommendations of the Cochrane EPOC (Effective Practice and Organisation of Care) Group. Both published and grey literature was searched. PUBMED was the main source of information for published articles. For grey literature a number of websites were searched using the same key words as for the PUBMED search. To be included in the review a study had to meet the following criteria:

1) An objective measure of at least one of the following outcomes had to be presented: health care utilization, health expenditure, health outcomes or equity outcomes.
2) It had to have been undertaken using one of the following study designs: randomized controlled trials, interrupted time series analyses, or controlled before-after studies of the impact of health financing policies.

Each study was independently assessed by two reviewers, using a set of quality criteria defined to identify any major bias in the study design or analysis. We re-analysed data from some studies that provided time series data but had not used time series methods to analyse it.

Results

User fees – 19 studies were included, many of which provided time series data which we re-analysed as described above. Reduction or removal of fees at point of use appeared to increase utilisation for poorer groups, although the level of evidence is weak due to small sample sizes, and confounding factors such as increased resource flows to health facilities at the same time as fee removal in Uganda. There is concurring evidence that introducing or increasing user fees had a detrimental effect on utilisation by the poor, although a small number of studies demonstrate that if fees are introduced and quality of care improved simultaneously, this will improve access and utilisation for poorer groups. One problem with many of these studies was that it was not always clear what form of charging took place before the introduction of fees or after their removal eg. whether informal charging was widespread.

Risk Protection – Only one study meeting the inclusion criteria was identified for community-based health insurance. We failed to identify any studies of other mechanisms such as social insurance or prepayment schemes. With so little evidence, it is

not possible to assess whether community based insurance had a positive effect on access to care for poorer groups.

Contracting out services – 3 studies were included in the review. All of them provide evidence that contracting out increases utilisation in previously underserved areas. One study in Cambodia shows that contracting out services increased access for poorer groups. However, while these studies were of the right type of design to be admitted, the evidence they presented was judged to be of low quality due to problems with the study designs. It is also not possible to show that contracting out services would have a greater effect on utilization than spending the equivalent resources on some other form of service delivery.

Conditional Cash Transfers – Evidence from 6 different experiments using conditional cash transfers was synthesised in the review. It shows that introducing conditional cash transfers for poorer groups effectively increased uptake of preventive health services in several settings.

Discussion

With the exception of conditional cash transfers, there is a scarcity of good quality evaluations of financial means to improve access to health services in LMICs. The evaluation methodologies promoted by the EPOC Group are most likely to contribute good quality evidence because these types of study designs can reliably show an effect on chosen outcomes (in our case utilization, expenditures, health outcomes or equity outcomes). However, such study designs are often difficult to implement for something as complex as a health system. They are not always politically acceptable or practically feasible. For example, with the exception of interrupted time series, it is not possible to use them to assess the impact of nationally-implemented policies because there is no comparison group, and it would not be politically feasible to not implement a reform in one area purely for the purposes of research. In addition, health systems are such complex backdrops to implementation that it is not clear that evidence from one setting can be assumed to be replicable in other settings as might be the case with clinical interventions. Gathering quality evidence on the effect of health financing strategies calls for a number of different types of study design to show not just effect, as these designs do, but also reasons for the effects observed. We hope as a next stage of this research to suggest quality criteria that can be applied to a broader range of study designs, including those that focus more on issues of implementation.

Mylene Lagarde and Natasha Palmer, HEFP

Improving equity: what implementation factors affect policy success?

The defining characteristics of any policy change process include contestation, bargaining and negotiation among a range of actors, who either deliberately or by chance make (or fail to make) the decisions that shape policy, including how it is experienced by those it is intended to benefit. Equity-promoting health policies are particularly vulnerable because the more wealthy and powerful groups often unfairly capture their benefits. Policies intended to promote equity may also, like other policies, have unexpected, negative impacts.

Despite the constant generation of new ideas about how to promote equity it is, therefore, not surprising that health systems are often inequitable. Tackling this fundamental health system problem needs new thinking: about what to do, and both more importantly, how to implement policy changes in ways that preserve their equity intentions. Yet few studies have so far examined how the forces underlying the processes of designing and implementing equity-oriented policies influence their achievements and limitations.

To contribute to knowledge on these issues, a set of seven case studies have been initiated by CREHS partners to address the question 'what implementation factors influence the success of policies intended to promote equity?'. Together these studies broadly aim to:

- analyse how actors within and outside the health system influence the success of policies intended to promote equity;
- determine the main factors that shape key actors' practices in policy implementation;
- highlight any major additional influences over implementation;
- derive recommendations for how to strengthen future policy implementation.

As outlined in Table 1, the case studies vary between countries in reflection of country contexts and national policy priorities. They can, nonetheless, be broadly categorised as either examining health care financing policies or policies intended to promote access to health care, particularly by poor and marginal groups. Working within an overarching research design, they all apply policy analysis approaches, still rarely used within studies of low and middle income implementation experience. Together they will, generate an interesting combination of policy and methodological insights of relevance nationally and internationally.

Country	Title
India	The role of Mobile Health Units in improving access to care
Nigeria	Community based health insurance: policy development, implementation and equity effects
Nigeria	District health systems: policy development and implementation process
South Africa	The implementation of user fees with exemptions and the Patient's Rights charter within a hospital setting
Kenya/Tanzania	Integrated Management of Childhood Illness (IMCI) implementation as a case study of policy change
Thailand	Local level responses to new budget procedures within the Universal Coverage system

Summaries of these studies will soon be available at www.crehs.lshtm.ac.uk

Lucy Gilson, HEFP and CHP

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