Bridging the gap between research and policy

Di McIntyre
Health Economics Unit
University of Cape Town

iHEA Early Career Researcher Special Interest Group Webinar
21 September 2018
Introduction

• Focus:
  – Some of the factors that can influence research to policy process
  – Practical tips on communicating research to and building relationships with policy makers

• Perspective:
  – Applied researcher focused on policy-relevant research
  – Experience mainly at macro, health system level
Research-policy diffusion

Ideal model of natural sciences

• Researchers:
  – Do good research, and
  – Disseminate findings

AND

• Policy makers:
  – Read,
  – Understand, and
  – Act on findings

Policy enlightenment model

• Policy change is a result of:
  – Accumulation of evidence, information and knowledge
  – That slowly drips into the policy environment
  – Through information exchange between people
  – With unpredictable impacts

(Walt 1994)
“Decision makers rarely use a regression coefficient to help them solve a particular problem. Rather, over long periods of time, “ideas” enlighten decision makers about a particular issue and how to handle it.”

(Lavis et al. 2003)
Ever since the publication of the 2000 World Health Report, there has been a growing awareness that health financing is not simply about raising money. Instead, there are three key functions of health financing: revenue generation, pooling and purchasing. Nevertheless, global debates tended to continue to focus on the revenue generation function.

More recently, the 2010 World Health Report on financing for universal coverage noted that: “Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayment and pooling. The final requirement is to ensure resources are used efficiently.” This pointed to the importance of the purchasing function of health financing; purchasing is the critical link between resources mobilised for universal coverage and the effective delivery of quality services.

Although the key role of purchasing is being recognised gradually, there remains considerable confusion about what purchasing entails. There is an even greater lack of understanding of what is required for strategic or active purchasing.

This brief attempts to fill this gap by providing an overview of the key activities that a strategic purchaser should undertake. It draws on the limited literature on strategic purchasing, and RESYST (Resilient and Responsive Health Systems) consortium members’ experience and understanding from involvement in supporting the development of purchasers. This conceptual model of strategic purchasing underpins an ongoing analysis of purchasing arrangements in 10 countries across members of RESYST and the Asia Pacific Observatory on Health Systems and Policies.

Some initial concepts

Purchasing refers to the process by which funds are allocated to healthcare providers to obtain services on behalf of identified groups (e.g. insurance scheme members) or the entire population (Kutzin 2001).

Purchasing involves three sets of decisions (World Health Organisation 2000; Figueras, Robinson et al. 2005):

1. Identifying the interventions or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness.

2. Choosing service providers, giving consideration to service quality, efficiency and equity.

3. Determining how services will be purchased, including contractual arrangements and provider payment mechanisms

It is undertaken by a purchasing organization which can be, for example, an insurance scheme, a Ministry of Health, or an autonomous agency. Purchasing should not be confused with procurement, which generally only refers to buying medicines and other medical supplies.

The 2000 World Health Report distinguished between passive and strategic purchasing:

“Passive purchasing implies following a predetermined budget or simply paying bills when presented. Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom.”

Strategic purchasing requires the purchaser to engage actively in 3 main relationships: with Government (Ministry of Health), with healthcare providers, and with citizens.
Factors influencing uptake

• Relevant and timely research

• Research accessible

• Key messages that are actionable

• Relationships between researchers and policy makers
Relevant and timely

- **Policy relevance:**
  - Needs to be made explicit
  - Enhanced if close contact with policy makers to identify priority issues

- **Timely:**
  - Windows of opportunity
  - Time lag in undertaking research
  - Engaging with policy makers can improve predictive abilities
Any questions or comments on what has been covered so far?
CAN YOU COME BACK WITH THAT 3 YEAR STUDY SUMMARISED IN SIX BULLET POINTS IN POWERPOINT

© fran@francartoons.com
Community preferences for improving public sector health services in South Africa

What aspects of public sector health service quality improvements should be prioritised?

Key points

→ Communities view the routine availability of effective medicines as the greatest priority for improved public sector health services; the least important priority is treatment by doctors.
→ Routine availability of medicines is ten times more important than treatment by doctors.
→ A thorough examination and clear explanation of a patient’s diagnosis and treatment by health professionals are also highly valued community priorities.
→ Communities tolerate poor quality public sector service characteristics such as long waiting times, poor staff attitudes and the lack of direct access to doctors if they receive the medicine they need and a thorough examination and if a clear explanation of their diagnosis and treatment is provided.

Introduction

For some time, there has been criticism of the quality of public sector health services. Various aspects of public services have been raised as areas of concern, but these have largely been based on anecdotal evidence. There has been limited research to identify what communities regard as the greatest problems with public sector health services.

This research explored communities’ views on the elements of public health services that they find particularly problematic. It aimed to quantify the priority placed on each of these aspects of public service delivery that requires attention.

Methods

This research used an approach called a ‘Discrete Choice Experiment’ (DCE) (see Box 1 for an explanation of DCE methods). The first step was to identify the aspects of existing public health
services that most concern communities. Several focus group discussions were undertaken at workshops with civil society groups in Mpumalanga, North-West and Western Cape, as well as community-based focus group discussions in the Eastern and Western Cape. The main themes raised in these discussions were:

- Staff attitudes.
- The clinical service experience (particularly whether or not there was a thorough examination and expert advice provided).
- Availability of medicines.
- Whether treatment was provided by a doctor or nurse.
- Waiting times.

These discussions also identified concerns about confidentiality, particularly the use of different coloured folders for patients who are HIV-positive.

These elements of service provision were used as the basis for the DCE questionnaire. Two ‘levels’ of each attribute was identified, being expressed in positive or negative terms (see Table 1, 0 = negative, 1 = positive). It is necessary to have a continuous variable to calculate the strength of preference given to each attribute (i.e. the extent to which respondents’ see that aspect of service delivery as important). As geographic access to health facilities is a major concern in South Africa, transport costs were included as a continuous variable attribute in this study.

Experimental design methods were used to identify the 16 ‘choice sets’ presented to respondents (see Figure 1 for an example of a choice set). As the questionnaire

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff attitude</strong></td>
<td>0</td>
<td>The staff at the health facility do not treat me with respect</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility treat me with respect</td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td>0</td>
<td>The staff at the health facility do not examine me</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility examine me thoroughly</td>
</tr>
<tr>
<td><strong>Expert advice</strong></td>
<td>0</td>
<td>The staff at the health facility do not explain what is wrong with me or what I need to do to get better</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility explain what is wrong with me and give me advice about what I need to do to get better</td>
</tr>
<tr>
<td><strong>Availability of medicine</strong></td>
<td>0</td>
<td>When I go to the health facility, they don’t have the medicine I need and I go away without any medicine</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>When I go to the health facility, I get the medicine I need</td>
</tr>
<tr>
<td><strong>Treatment by doctors or nurses</strong></td>
<td>0</td>
<td>When I go to the health facility, I first see a nurse who is trained to treat most illnesses and only see a doctor if the nurse cannot treat my illness</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>When I go to the facility, I always see a doctor</td>
</tr>
<tr>
<td><strong>Waiting time</strong></td>
<td>0</td>
<td>I spend a whole day in the health facility before I go home</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I spend about half a day in the health facility before I go home</td>
</tr>
<tr>
<td><strong>Transport costs</strong></td>
<td>40</td>
<td>Transport to and from the health facility costs about R40</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Transport to and from the health facility costs about R20</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Transport to and from the health facility costs about R10</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Transport to and from the health facility costs about R5</td>
</tr>
</tbody>
</table>

Figure 1: Example of a choice set
was used in a household survey, which would include respondents with low literacy levels, a pictorial depiction of each attribute level was provided to accompany the textual description (which was translated into the language of respondents: English, Afrikaans and isiXhosa).

Household surveys were undertaken in the Eastern and Western Cape provinces; as we had insufficient resources to undertake a national survey, we selected two provinces that are very different in terms of urban-rural mix and socio-economic status. In the Western Cape, Cape Town, Overberg and Central Karoo districts were sampled, while in the Eastern Cape, the districts of Amathole, Cacadu, Nelson Mandela Bay and Ukhahlamba were sampled in the survey. Approximately 500 households were included in the survey in each province.

Findings

Overall health service preferences

◊ The respondents had an overall preference to not use public sector health facilities.
◊ If they were to use public sector health services, by far the most important preference for such use would be the regular availability of medicines (see Figure 2).

Figure 2: Strength of preference for different service characteristics (whole sample)

◊ The least important preference was direct access to a doctor (as indicated by the weight of one in Figure 2). Thus, respondents were not strongly opposed to seeing a nurse first and only seeing a doctor if the nurse was not able to deal with their health problem.
◊ The availability of medicines was seen as ten times more important than direct access to a doctor.
◊ The next two most important preferences were clinicians providing information on the diagnosis and treatment and undertaking a thorough examination (3.9 and 3.6 times more important respectively than direct access to a doctor).
◊ These were followed by waiting time and staff attitudes (2.4 and 1.7 times more important respectively than direct access to a doctor).

Provincial health service preferences

◊ There were slightly different preferences in the two provinces included in the survey (see Figure 3). However, in both provinces, the greatest preference was availability of medicines.

Figure 3: Strength of preference for different service characteristics (province specific)

◊ For direct access to a doctor, this was the least important preference in the Western Cape, and the second lowest preference in the Eastern Cape.
◊ For staff attitudes, this was the least important preference in the Eastern Cape, and the second lowest preference in the Western Cape.
Clinicians undertaking a thorough examination was also valued quite highly in both provinces, while expert advice was even more highly valued than a thorough examination in the Western Cape and less highly valued in the Eastern Cape.

What do these findings mean?
These findings suggest that communities are prepared to tolerate poor quality public sector service characteristics such as a long waiting time, poor staff attitudes and the lack of direct access to doctors if they are guaranteed that they will receive the medicines they need, a thorough examination and a clear explanation of the diagnosis and prescribed treatment from health professionals.

Limitations of the study
Unfortunately, due to resource constraints, we were only able to undertake the household survey in two provinces. Nevertheless, the fact that similar concerns about elements of service quality in public sector facilities were raised in other provinces during the focus group discussions lends some credibility to the findings in the Eastern and Western Cape.

It is also important to recognise that respondents’ stated preferences are influenced by their personal experience of services. For example, if respondents only have experience of consulting a nurse, they are unlikely to place great weight on consulting a doctor in preference to a nurse.

While the findings indicate a very strong preference for the availability of medicines at public sector facilities, it is unclear whether this relates to addressing an absolute absence of medicines in facilities or the absence of medicines that patients regard as effective (e.g., a patient being given Panado when s/he expected to receive something ‘stronger’). The focus group discussions and feedback sessions with fieldworkers indicated that households are most concerned about the availability of medicines that will resolve their health problems.

Policy recommendations
Given the overall preference not to use public sector facilities, there is an urgent need to introduce demonstrable improvements in the quality of public sector health services. Failure to do this will mean communities do not attend public health services when care is needed.

The study identified the aspects of health services that are regarded as the greatest priorities by communities. Based on the expressed preferences of households surveyed, this brief makes the following policy recommendations:

- Government can achieve ‘quick wins’ by addressing medicine procurement and particularly distribution (potentially through the use of private distributors) so that all public facilities have constant availability of all essential medicines. This will increase the uptake of public health services.

- There should also be efforts to ensure that clinicians undertake adequate patient examinations and explain the nature of a patient’s illness and what is required for successful treatment. This is likely to require improved staffing levels to ensure adequate consultation times and should also reduce waiting times.

- As the priority community preferences for improving public sector health services are addressed, service improvements that take longer to implement, such as changing staff attitudes, will become increasingly important.

Disclaimer: The photographs in this policy brief are used for illustrative purposes only; they do not imply any particular health status, attitude, behaviour, or action on the part of any person who appears in the photographs.
Accessible research

http://www.rationalreflection.net/against-jargon/
Routine availability of medicines is ten times more important than being treated by a doctor.

- Unnecessary to present logit coefficients or WTP data
- Professional, but not technical
- View your reader or listener as an intelligent non-expert
Key messages

• Should be able to pass the ‘elevator test’

Communities tolerate poor quality public sector service characteristics such as long waiting times and poor staff attitudes if they receive the medicine they need.

Government can achieve ‘quick wins’ by addressing medicine distribution (potentially through the use of private distributors) so that all public facilities have constant availability of all essential medicines.

• Distinction between research findings and a message
Simple bit of information

Voluntary Health Insurance as % Current Health Expenditure

Global average = 4.5%

WHO NHA dataset (http://apps.who.int/nha/database/Home/Index/en/)
Different models of pharmaceutical care in South Africa
What is the cost and impact on patients’ access to antiretroviral therapy?

Key points

- South Africa is committed to providing antiretroviral treatment (ART) to all South Africans who need it. There are insufficient pharmacists working in public sector facilities to dispense ART to all these patients, and so dispensing tasks must be shifted to pharmacists assistants and/or nurses ('task-shifting').
- The pharmacists assistant pharmaceutical care model has the lowest cost to the health system and would support a more integrated primary health care service.
- Patients getting their ART by attending pharmacists assistant model and nurse model facilities experienced relatively better geographic access to facilities and lower transport costs, compared to those attending more central facilities that employ pharmacists.
- Patients prefer a nurse to dispense their ARTs as this reduces the risk of being identified by other patients as being HIV-positive.
- The pharmacists assistant model can be made more acceptable to patients by ensuring that there are no differences between patient folders (e.g. those on ART should not have different coloured folders) and dispensing all medication (not only ARTs) in brown paper bags.

Introduction

Given the large number of patients who need antiretroviral treatment (ART) in South Africa, it is necessary to decentralise ART services and integrate them into the primary health care system. This will require pharmacy services to be scaled-up, including pharmaceutical supply systems, infrastructure and staff to dispense ARTs. At the same time, it is important to ensure that the pharmaceutical service is safe and efficient. All of this must be achieved within the context of a scarcity of health care professionals.

Task-shifting has been shown to be an effective and safe way of addressing the problem of insufficient professional staff. Task-shifting refers to the delegation of tasks from highly skilled workers to those with either less training or training in undertaking specific tasks. In South Africa, the shortage of pharmacists in the public sector has led to the use of Pharmacists Assistants (PA) and nurses to support the expansion of the ART programme (see Box 1).

Objectives

The objective of the research reported here was to critically evaluate the two different task-shifting models and the pharmacist model for dispensing ART. The costs and impact on access to ART services for patients of each model were compared. The infrastructure costs of introducing the ISPA model were also calculated to assist in planning for accessible ART services.
Actionable messages

Remove any ART service identifiers from patient folders by ensuring that all patients accessing the facility have the same colour and type of folder.

Improve patient confidentiality in the pharmacy by putting up screens next to the dispensing window, limiting the view from the waiting area, and dispensing all medication (not just ARTs) in brown paper bags.
Any questions or comments on what has been covered so far?
Building relationships

• Invest, invest, invest:
  – Understand the concerns of policy makers and implementers
  – Understand policy processes and environment
  – Build legitimacy, mutual respect and trust
  – Be responsive whenever possible
Where to start?

Research

Teaching

Policy
Be entrepreneurial

• Seek out forums where researchers and practitioners (policy makers, implementers) meet
• Engage with practitioners around research from outset
• Use networks, particularly senior colleagues
• Don’t put all your eggs in one basket given staff turnover
Knowledge brokers

• Need to develop your own skills

• But recognise that sometimes:
  – you will not necessarily be the best messenger
  – may need to find a credible ‘messenger’ that the target audience respects and trusts
Key messages

• Be humble and respectful
• Build long-term relationships with practitioners
• Invest in identifying your key messages
• Keep it simple: brief, clear, jargon-free
• Not just data, also ideas and concepts
References


http://www.publichealth.uct.ac.za/phfm_health-economics-unit-heu

www.facebook.com/uct.heu

@HEU_UCT
Questions and comments

www.healtheconomics.org