Why and how fee exemption policies are adopted by district-level health managers:

Methodological lessons from a series of realist case studies in Benin, Burkina Faso and Morocco

OVERVIEW

Prompted by Millennium Development Goal targets, and the drive to ensure universal access to health care in low- and middle-income countries, there has been a steady stream of publications assessing of fee exemption policies or the abolition of user fees for maternal health care. Most studies show that these policies are not always as effective as hoped. The aim of this FEMHealth study was to better understand the critical issue of why fee exemption policies are taken up (or not) and the conditions for success. In the course of this study we captured methodological learning which will help support similar research in the future.

The methodological approach used was inspired by realist evaluation principles. A series of case studies were carried out in 2 districts in Benin, Burkina Faso, Mali and Morocco. Our hypothesis was that health staff can merely adopt a change in policy, adapt it positively or negatively, or not implement it. Personal commitment, perception of opportunity, local pressure, alignment with local needs and enforcement by hierarchy are among the factors that may facilitate adoption and positive adaptation. We met some methodological challenges, including the development of the initial hypothesis - the initial middle range theory, in realist jargon - the issue of what constitutes a mechanism of change and the challenges of implementing a realist evaluation in a multi-centre, multi-disciplinary and multi-lingual consortium.

KEY MESSAGES

- Policies to reduce the financial barriers to care for pregnant women have been introduced in many countries to impact upon inequality of access to care, household impoverishment and maternal and neonatal morbidity and mortality. But there is often a gap between policies and their actual implementation.
- The policy implementation process and context can explain to a certain extent the adoption (or not) of policies by key stakeholders, the depth of implementation and consequently the effectiveness of the policy.
- In each of our case study districts, the policy was generally well adopted by the hospital managers. Nurses and midwives in general also perceived the policy as a positive one. Doctors, and especially specialists, were often found to use their power position to implement the policy half-heartedly or to change it to their advantage.
- Formal acceptance of the policy in most cases did not lead to pro-active adaptation of the policy to local contexts. Where the local organisational culture is one of laissez-faire, the policy is implemented on paper and to a minimum degree.
- To implement the policies as intended, managers require adequate margins of freedom in terms of health workforce management and reliable supplies of drugs and equipment, regular reimbursements and clear operational guidelines.
- Managers also require a strong public service ethos, reflected in stewardship, which ensures that conducive decision spaces and resources are used in the interest of the public, or effective enforcement by higher hierarchical levels. Supportive supervision, either by the regional directorate or by the agency/ department responsible for the policy, is also important.
- The realist approach is ideally carried out by multi-disciplinary teams. It is demanding in terms of analytical capacity and time, but allows for better understanding of how context shapes policy adoption and implementation.

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MAIN PROBLEM ADDRESSED

Policies aiming at reducing financial access barriers to care for pregnant women have been introduced in many countries and the number of studies on fee exemption is growing rapidly.

Most publications on fee exemption report on the effectiveness of these policies look at whether the policy worked and how much. Many papers and studies present best practices and evidence of effectiveness. Some note, however, that scaling up policies can be hampered by implementation capacity constraints related to the health workforce, infrastructure and accessibility of services in general. While the gap between policy and implementation is thus acknowledged, few studies actually focus on the reasons for this gap.

We examined the policy-implementation gap from the perspective of local health system managers and providers. We aimed to answer the question: "Why is the fee exemption policy taken up (or not) and what are the conditions for effective implementation?".

The research questions

We identified the following research questions:

- How is the fee exemption policy being implemented and to what degree?
- What are the perceptions of the health service managers and providers in terms of challenges related to this policy change?
- What are the mechanisms of change that explain uptake and implementation of the policy?
- Which context elements facilitate the adoption of the policy?

The methodological approach

We adopted the realist evaluation approach which was developed by Pawson and Tilley (1997). They argue that in order to be useful for decision-makers, evaluations need to indicate what works, for whom, in what circumstances, in what respects, over which duration and why, rather than only respond to the question "does it work?".

Figure 1 presents the realist evaluation cycle. The initial middle range theory (MRT), which is nothing more than a detailed hypothesis, states how the intervention is expected to lead to its effect and in which conditions. It can formulated on the basis of existing theory, past experience, previous evaluations or research studies and insights and perceptions of the involved actors. In a next step, the design of the study is chosen and data collection tools are developed and tested. Realist evaluation is method-neutral: the study design and data collection methods should allow 'testing' of the key elements and assumptions. Often both quantitative and qualitative data are collected, as required by the MRT. The data collection phase is followed by data analysis, whereby realist evaluation uses the context-mechanism-outcome (CMO) configuration as the main analytical tool. The resulting CMO configurations, which summarise the findings, are then assessed to see whether they hold as plausible explanations that clarify how the intervention brought about the observed results. These CMOs are finally compared with the initial middle range theory, which is then refined. This kicks off a new study in a cycle that refines the theory through accumulation of better insights (Pawson and Tilley, 1997).

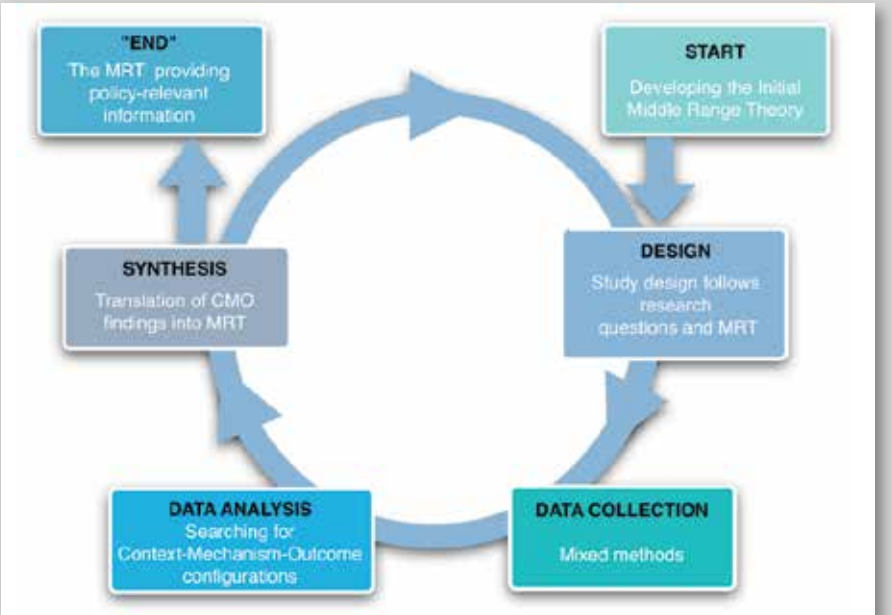

Figure 1 – The realist evaluation cycle

The initial middle range theory on policy adoption

To find out which theories or frameworks are used to assess the adoption and implementation of fee exemption policies we conducted a review of the literature on fee exemption for maternal health services. This showed that there are few studies that explore how and why policies are not being implemented beyond examining factors of policy formulation and support.

We carried out a second review that focused on policy implementation literature from political science, public administration and policy analysis. This review suggested that the following points are important to policy implementation and informed our MRT (see figure 2):

- The policy needs to be adopted not only by health service managers, but also by providers. At both levels, the policy can be adopted, be adapted positively or be captured in a negative sense, or be stopped.
- The degree of implementation of the policy depends on how local service managers, providers and the community adopt it (or not). They are influenced by factors at organisational and local community-level as well as at the programme and policy-level.
- The policy is more likely to be fully adopted by service providers and service managers if they feel a commitment towards it, feel obliged to adopt it or believe they may gain from it in terms of financial or social benefits.
- Facilitating factors include good alignment of the policy with personal goals and with organisational goals and culture, adequate resourcing and organisational support, and an effective monitoring and sanctions system (including local political pressure or pressure from the public).

The latter in turn requires that community representatives are well informed about the policy and have effective voice and participation channels. If such facilitators are absent, the risk of capture by elites is higher.

- The programme is likely to be adapted in a positive sense if service providers and managers believe it can be improved. Besides motivated staff, this requires adequate capacity and decision spaces to adapt the programme to the local situation.
- Adoption by service managers and providers will be enhanced if there are clear operational guidelines that indicate the goals, the target groups and the implementation modalities. Other facilitating factors include good availability of necessary inputs (funding, consumables), training (when necessary) and compensation for lost revenue. A dedicated agency with a clear mandate may facilitate implementation.
- Besides these technical inputs, processes matter. The degree of consensus on the goals, target groups and implementation modalities (low levels of ambiguity and of conflict) influences the passage from policy to implementation.

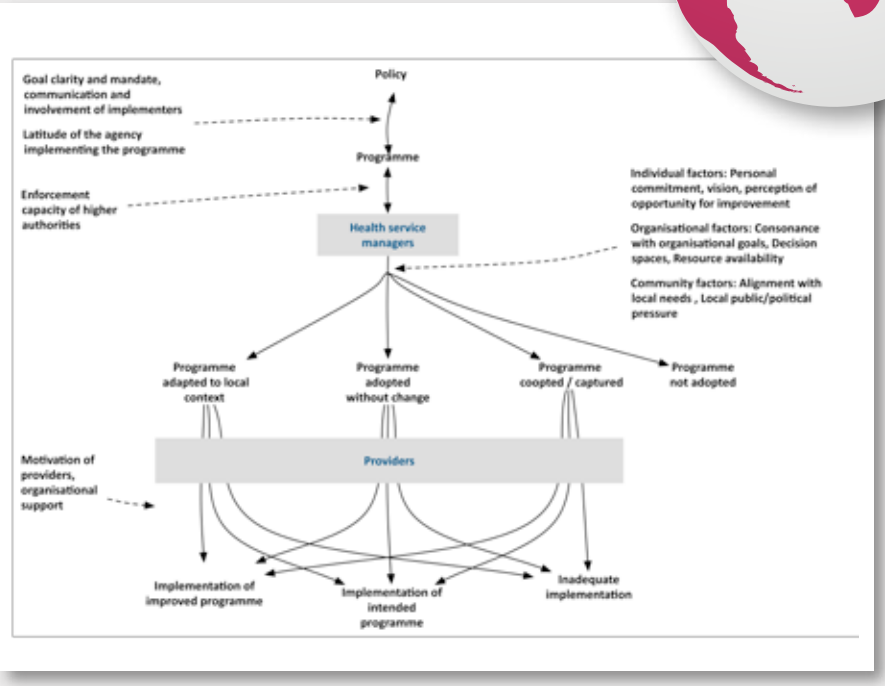

Figure 2 – The initial middle range theory

Methods

To test this hypothesis, we adopted the comparative case study design. We report on the studies carried out in Morocco, Benin and Burkina Faso. In each country, two districts were selected among the FEMHealth sites on the basis of a previous study on the effects of the policy at the local health system's level. In line with realist evaluation principles, the case selection was purposive. To investigate the gap between policy and implementation, we selected one district with strong implementation and one with weak implementation of the policy. Data were collected through in-depth interviews and document review. Key respondents included health service managers (district health management team, hospital management team and mid-level cadres), and health care providers at hospital level. We used the data collected for FEMHealth's Policy Effects Mapping study as the primary data (see POEM Policy Brief). Additional interviews were carried when deemed necessary.

The analysis was structured along the following steps:

- Description of the study site
- Description of the policy as it was implemented
- Analysis of the implementation process
- Analysis of the policy adoption process, focusing on the hospital managers, doctors, midwives, nurses, district health management team and regional health management team
- Synthesis of findings and comparison with the initial MRT and cross-case comparison

Results

The analysis shows that in each study district, the policy was generally well adopted by hospital managers. Nurses and midwives in general also perceived the policy as a positive one. In any case, because of their relatively weak position of power, they could do little else than to implement it as prescribed. Doctors, and especially specialists, were often found to use their position of power to implement the policy half-heartedly or to change it to their advantage.

Local context matters

However, formal acceptance of the policy in most cases did not lead to pro-active adaptation of the policy to local contexts. We found that local context matters: where the local organisational culture is one of laissez-faire or of formal compliance, the policy is implemented on paper and to a minimum degree. In Morocco, for instance, we found cases where the specialists formally adopted the policy, but took a literal reading of the minimum requirements to implement the policy. For example, they used quality criteria included in the policy as a pretext not to organise a permanent on-call system. The policy was formally adopted, but also used to maintain a situation comfortable for the providers but negative for the patients. Such practices were condoned by the administration, who claimed to be powerless vis-à-vis the specialists and who did not wish to disturb the negotiated order with these providers.

Mission valence

In other cases, we found that the local organisational context was favourable to policy implementation, or vice versa that the policy was found to be favourable to the organisational mission – a case of strong mission valence. For instance, in one hospital in Benin, the management team used the generous reimbursements to strengthen other non-targeted services

and to better remunerate all staff, not because the policy document said so (it was silent on this topic), but because the management team recognised the opportunity and used it strategically to strengthen the service delivery of the whole hospital.

Freedom and support

The study confirmed that to implement the policy as intended, managers require adequate margins of freedom in terms of health workforce management, but also reliable supply of drugs and equipment, regular reimbursements and clear operational guidelines. At least as important is a public service ethos that ensures that conducive decision spaces and resources are used in the interest of the public, and/or an effective enforcement by higher hierarchical levels. Indeed, effective stewardship, as found in a hospital in the north of Benin and in a district in the south of Burkina Faso, is essential. Health staff are more likely to positively adapt the policy to the local context if they are given supportive supervision, either by the regional directorate of by the agency/department responsible for the policy. In Benin, we found examples of how the agency responsible for programme implementation and monitoring provided effective support and helped in adapting the policy to field realities.

Methodological learning

The first challenge is the choice of the theory that will be used to formulate the initial MRT. In realist evaluation, the starting point is derived from the existing body of knowledge, but it is clear that despite more than 40 years of research, there is still little consensus in the field of policy implementation studies on the theoretical principles and research methods. Second, it is striking that most theoretical, methodological and empirical work has been carried out in North America, the UK or Scandinavia. This emphasises the need to pay sufficient attention to the broad governance structures and arrangements in the study countries, as well as the nature of the bureaucracies and other organisations that intervene in the implementation.

A second challenge concerned the definition of 'mechanism'. In the realist literature, there is as yet no consensus on the interpretation of 'mechanism'. Some authors stick to the definitions provided by Pawson and Tilley (1997): "*A mechanism is not a variable but an account of the behavior and interrelationships of the processes which are responsible for the change. A mechanism is thus a theory*". Such abstract definitions need to be translated into more practical terms. In the policy implementation literature, 'authority', 'common interest' and 'exchange' are mentioned as the 3 types of inducement for cooperation that contribute to good policy implementation. We found that structural factors have a great influence on local agents. Indeed, in most countries, the policy was adopted by the implementers by default. They perceive that it is not possible to formally go against a central dictum, in this case the policy as imposed by the central administration. This perceived coercion is stronger where the bureaucratic system is well developed. Such perceived pressure, however, just leads to adoption, not automatically to good implementation.

The third challenge concerned the use of the realist evaluation approach, an approach with which few research centres have a strong experience. Familiarising and training researchers was a first step. We introduced the basic concepts during the consortium's planning meetings and through dialogue with researchers. Follow-up was ensured during research workshops and meetings on the research protocol. Email contact and personal discussions during field visits added opportunities for knowledge and skill transfer. This process took more time than planned.

Once all teams were at the same level of understanding of realist evaluation, the rest proved much easier. Indeed, realist evaluation is method neutral, and we could call upon the quantitative and qualitative research skills and competences of the research teams during the phase of data collection design. However, explaining the analytical approach required to make sense of data in a realist evaluation was found to be more challenging. Each team member responded to the realist analytical approach based on his/her scientific education or disciplinary background. Some sociologists had no trouble with realistic evaluation and quickly grasped the essentials. For some public health doctors, realistic evaluation opened new horizons, providing an innovative way to approach and analyse health systems problems.

KEY SOURCES

Marchal B, Van Belle S, De Brouwere V, Witter S: Studying complex interventions: reflections from the FEMHealth project on evaluating fee exemption policies in West Africa and Morocco. BMC Health Services Research 2013.

Marchal B, Van der Veken K, Essolbi A, Dossou JP, Richard F, Van Belle S: Methodological reflections on using realist evaluation in a study of fee exemption policies in West Africa and Morocco (2013) Aberdeen: FEMHealth.

Pawson R & Tilley N (1997) Realistic Evaluation, London, Sage.

FEMHealth Policy Effects Mapping tool brief ('how to evaluate the effects of a policy on the local health system') (2013) http://www.abdn.ac.uk/femhealth/about/programme-outputs/

Yet other researchers were less charmed by the approach and preferred sticking to their usual methods. Continuous dialogue and discussion proved the only way to deal with such different interpretations. More details can be found in the reflection paper by FEMHealth researchers (Marchal et al., 2013).

Contact

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About FEMHealth

FEMHealth is a FP7-HEALTH-2010 collaborative project funded by the European Commission and runs from January 2011 to December 2013. *FEMHealth* stands for 'Fee Exemption for Maternal Health care'.

The overall aims of FEMHealth are to improve the health of mothers and their newborns by performing comprehensive evaluations of the impact, cost and effectiveness of the removal of user fees for delivery care and Emergency Obstetric Care (EmOC) on maternal and neonatal health outcomes and service quality. FEMHealth research was carried out in Benin, Burkina Faso, Mali and Morocco. All have recently introduced national policies to reduce financial barriers for delivery or emergency obstetric care. More information can be found on the website of FEMHealth (www.abdn.ac.uk/femhealth).