

FACILITATOR'S NOTES FOR “HEALTH SERVICE ACCEPTABILITY ISSUES”

OBJECTIVES OF CASE STUDY

1. To develop an understanding of the acceptability dimension of health service access, from both the household and frontline health care provider perspectives;
2. To explore ways in which health service acceptability can be promoted.

PREPARATION FOR CASE STUDY

In preparing for facilitating this case study, the following reading will provide a good overview of the issues that will arise during group and plenary discussion:

Gilson L (2007). Acceptability, trust and equity. In: McIntyre D and Mooney G (eds). *The Economics of Health Equity*. Cambridge: Cambridge University Press.

Very little attention has been devoted to the acceptability dimension of health service access. The above book chapter presents a comprehensive review of issues influencing health service acceptability and ways in which acceptability can be promoted. This case study has drawn extensively on this book chapter.

TIMING OF THE CASE STUDY

If an overview of the dimensions of access have been provided previously, it is not necessary to provide any specific inputs prior to this case study. If this has not been done, a brief overview of the concept of access and its dimensions should be provided.

This case study requires about 2.5 hours to undertake. An hour and a half should be allowed for participants to read the information contained in the case study and to discuss the questions posed in groups. An hour should be allowed for plenary discussion. It is recommended that this time *not* be devoted to detailed presentations by each group. Instead, the facilitator could ask one group to present a key

acceptability problem that they had identified, by outlining the problem, underlying cause(s) and possible strategy for addressing the problem. Other groups can then be invited to comment (e.g. did other groups identify other underlying causes of the problem and/or other strategies to deal with it). Another group could then be invited to present another (different) key accessibility problem that they had identified, followed by plenary discussion of this problem, and so on.

KEY ISSUES FOR DISCUSSION

Most acceptability challenges can be grouped within three main categories, as discussed below.

- The fit between lay versus professional health beliefs and perceptions:
 - Sometimes, self-care or traditional healing is seen as the most appropriate response to a particular illness, often based on beliefs about different healing systems.
 - There are also issues around patients' perceptions of the effectiveness of the treatment provided and the likelihood of cure. Being prescribed drugs (and in some countries, being given an injection) is frequently seen as being important to effective care. A particular problem is that generic medicines are frequently perceived by patients to be less effective than branded products. There are also issues relating to the perceived technical competence of providers, and the frequent preference for care provided by doctors over those by nurses. These issues are influenced by the availability of drugs, necessary equipment and qualified staff.
 - Past experience of health services influences patients' perceptions of provider competence and service effectiveness.

Possible strategies for addressing these issues:

- Health professionals need to understand community beliefs and tailor service delivery to their perceptions and needs.
- There is a growing emphasis in many countries on greater engagement between public sector health services and traditional healers to encourage

referral of some patients (e.g. those with severe malaria or AIDS) to public sector health facilities.

- Increased communication with the general public about the bio-equivalence of generic medicines and the price benefits of generics, as well as about the skills of nurses, is also important.
- Provider-patient engagement and interactions:
- On the one hand, patients are sometime unable to exercise ‘voice’ in health care encounters.
 - Patients’ engagement with providers is influenced by their own characteristics and attitudes, and there is often better engagement with providers from the same ‘ethnic group’ or gender.
 - Similarly, provider behaviours and attitudes towards patients influence patient-provider engagements. Providers’ communication practices are particularly important (including whether or not they use the home language of the patient, whether or not highly technical language is used, willingness to involve patient in treatment option decision making, etc.) – some of these issues are related to differential power in the provider-patient relationship. The maintenance of confidentiality is also critical. Providers’ attitudes and communication practices influence the level of providers’ respect and compassion towards patients. There may be stereotyping and discrimination towards groups of patients by providers.

Possible strategies for addressing these issues:

- There should be a focus on developing a client centred approach, including employing members of socially disadvantaged groups (e.g. particular ‘ethnic groups’, women, etc.) and ensuring the availability of signage in different languages and of interpreters.
- There could be interventions to improve the communication skills, and gender- and cultural-sensitivity of providers.
- Patient empowerment initiatives should be explored, such as employing patient care advisors (who provide information on treatment options and help

patients address specific transport, language or other needs) and establishing peer support mechanisms.

- Efforts should also be made to promote longer consultation times (through having an adequate staff workload ratio) and greater continuity of patient-provider contact (e.g. through less movement of staff between facilities etc.).
 - These interventions require an organisational environment within which health professionals work that will engender compassionate, caring and sensitive health care workers and in which discrimination towards particular groups is minimised. This requires changes in organisational management and leadership practices, particularly in relation to human resource management.
 - Provider incentives, including clear career pathways, are also important in influencing provider behaviour.
 - Accountability mechanisms should also be put in place.
- Organisational arrangements and how patients respond to them or the degree of fit between the structure of health services and the routine practices of intended beneficiaries of these services:
- There is often a concern by patients that providers face incentives to pursue personal profit rather than to meet patient's needs or to act in the patient's interest.
 - Lack of continuity in the relationship between the patient and the health service, and specific providers within the service, and the time spent with the provider are also sources of acceptability problems.
 - The absence of institutional guarantees, such as scrutiny mechanisms, adequate training and commitments to ethical practices can also be a source of acceptability problems.

Possible strategies for addressing these issues are similar to those for provider-patient engagement and interactions (e.g. ensuring adequate consultation times, transforming the organisational environment within which health professionals work, establishing accountability mechanisms, etc.). In addition, it needs to be recognised that out-of-pocket payments not only create a financial access (or

affordability) barrier to care, they also create acceptability barriers – if a health care provider takes money directly from a patient, this can create concerns in the patient's mind about the motivations of the provider. This adds weight to calls for the removal of user fees for public sector services, and indicates that informal payments demanded by providers should also be addressed.

It is important to stress that many of the acceptability problems and possible strategies to address these problems relate to the issue of trust: mutual trust between providers and patients; trust in the effectiveness of 'western' health care; trust in government and hence in the services they provide.

It is also necessary to highlight that acceptability issues are nested within a wider context and that there are linkages with other dimensions of access (availability and affordability). For example, a lack of funds to ensure routine availability of medicines impacts on patients' perceptions of health services; organisational culture can prevent the implementation of patient centred care models; and power relationships are strongly influenced by socio-economic relationships in broader society. Thus, addressing acceptability problems requires an integrated and comprehensive approach.