



POLICY BRIEF

RECOMMENDATIONS FOR DRIVING SYSTEM-WIDE IMPROVEMENTS IN QUALITY OF CARE IN LOW AND MIDDLE-INCOME COUNTRIES (LMICs)

Purpose of this brief

- Highlight key research findings of a study published in the Lancet, entitled: “A multifaceted intervention to improve clinical quality of care through stepwise certification (SafeCare): a cluster-randomized controlled trial in healthcare facilities in Tanzania”
- Make the study’s findings easily accessible and understandable for a broad range of relevant stakeholders such as government and policy officials, (public and private) healthcare providers, patients, and the global health community.
- Discuss lessons learned and policy implications for improving quality of care in Low and Middle-Income Countries (LMICs).

CONTEXTUAL BACKGROUND

Quality of care is a structural barrier to achieving universal health coverage (UHC)

Poor healthcare quality in low and middle-income countries (LMICs) leads to between 5.7-8.4 million deaths each year, according to the World Health Organization (WHO). And, despite over USD25 billion being invested in combating disease in LMICs each year, the millions of people that lose their lives due to poor quality health services account for more deaths than HIV, Malaria and Tuberculosis combined. Poor quality of healthcare also causes more deaths than a lack of access to care. Along with expanding coverage and financial protection, improving quality of care is a key component to achieving universal health coverage (UHC) and improving health outcomes, especially amongst the most vulnerable groups.

The role of the private sector for UHC in Africa

Healthcare is a fundamental right and a semi-public good, requiring government regulation and financing. In most African countries however, governments have limited resources and weak institutions. About 50% of healthcare in Africa is delivered through the private sector, which is often fragmented, poorly regulated and with highly variable care quality. There are concerns about the scarcity of effective quality mechanisms for this sector. Statutory regulation of private facilities is typically very weak, with rare inspection and erratic enforcement, reflecting inadequate resources and capacity at the national level. Although health-care accreditation systems can, in theory, complement or substitute regulation of the facilities to some degree, the

standards required by international accreditation bodies seem unattainable and the process too expensive for the vast majority of private facilities in LMICs. At the same time, clinics and small healthcare businesses (pharmacies, maternal homes, hospitals, etc.) are seen as a 'risky investment' by local banks and therefore struggle to access capital needed to improve their services and grow their businesses.

Given the private sector's role in care provision, there is a great opportunity to invest in and improve the private sector in order to accelerate efforts towards UHC in the region. Bringing standardization around care quality is integral for improving patients' trust towards care quality, and thus driving improvements around both supply and demand of care.

The term "private sector" in this context should not be misconstrued to mean expensive and profit driven. It is defined as all health providers not owned by government. This diverse group includes profit, not-for-profit and faith based, formal and informal providers. Many people of both high and low-income turn to the private sector to access care, often paying out of pocket. The private sector therefore plays a critical role in the health sector of LMICs, and this study explores how to evaluate and improve quality of the private sector.

BACKGROUND OF RESEARCH STUDY

Background

Quality of care is constantly shown to be inadequate in LMICs and characterized by weak regulation of health facilities. In 2011, the PharmAccess Group and key partners aimed to address this by developing 'SafeCare' - a practical methodology that measures, guides and certifies quality improvement for healthcare providers using a stepwise approach. The SafeCare Standards are international (ISQua/IEEA accredited) clinical standards and tailored for resource restricted settings. These standards comprise of measurable indicators, which are used to assess health facilities and rate them to one of five quality levels from the lowest (level 1) to the highest (level 5). SafeCare covers the full range of clinical and business quality, uncovering gaps and supporting improvement through technical support and tailored quality improvement plans. Clinics are also linked to the Medical Credit Fund, through which they can access loans to invest in quality and grow their businesses. So far SafeCare has been implemented in 14 countries in sub-Saharan Africa in over 2,500 facilities, which receive over five million patient visits per month.

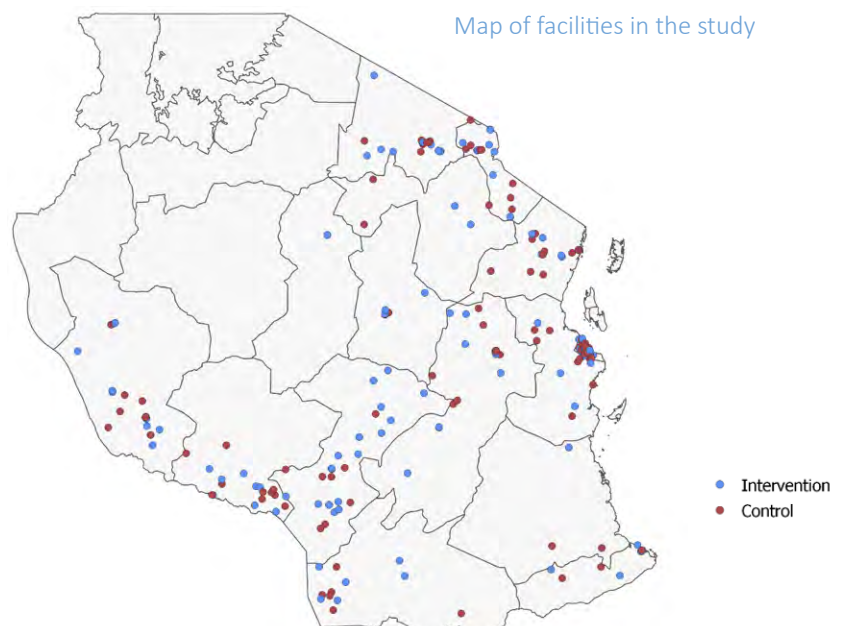
Research Methods

This study was the first evaluation of the effectiveness and impact of SafeCare in measuring and improving clinical quality of care in LMICs. The study ran over a period of five years and was conducted in Tanzania as implementation of SafeCare was widely adopted by local partners CSSC (Christian Social Services Commission) and APHFTA (Association of Private Healthcare Facilities Tanzania), funded by the HDIF (Human Development Innovation Fund).

The randomized controlled trial enrolled 237 health facilities (dispensaries, health centers, or hospitals in faith based and for-profit private facilities). Facilities were randomly assigned (1:1 ratio) to receive the full SafeCare package (intervention group) or only an assessment (control group). The primary outcomes were health worker compliance with infection prevention and control practices (IPC) as measured by observation of provider-patient interactions, and correct case management of undercover patients at 18-24 months.

Participating healthcare facilities

Of the 237 enrolled facilities, 118 were randomly assigned to the intervention group and 119 to the control group. Facilities were spread across urban, peri-urban and rural areas with the majority (81%) located outside Tanzania's commercial capital, Dar es Salaam (see map below). In total, 29,608 infection prevention and control practices (IPC) were observed. More than half (56%) of the study facilities were small and medium-sized health dispensaries. There was no difference in the baseline SafeCare score between the randomized groups.



KEY FINDINGS

- SafeCare score improvement at the endline was larger in the intervention group compared to the control group (4.4 percentage points higher mean SafeCare standards assessment score)
- The increase in SafeCare score reflected improvements in a number of service elements: human resource management, patient rights and access to care, risk management, inpatient care, and support services, most of which were related to so called structural quality indicators.
- SafeCare quality score improvement was not found to be associated with higher clinical quality yet. This was caused by most facilities improving to SafeCare level 2 and 3, which are related to structural quality. Few facilities achieved SafeCare level 4 and 5, the rating that is needed to impact process compliance, which is likely to impact outcomes.
- Improvement of structural and process aspects of quality only, is insufficient for impacting health outcomes (see 'PharmAccess Integrated approach')
- Facility staff were generally positive about SafeCare. The SafeCare standards were seen as well conceived and holistic, while some small facilities perceived them as demanding. All interviewees would recommend SafeCare to other facilities.

LESSONS LEARNED

- SafeCare has over the years been successful in bringing transparency around care quality in LMICs which stimulates trust between providers, patients and payers (governments or insurers).
- Structural improvements like correct waste disposal of sharp materials, implementing a stock management system in the pharmacy and setting up handwashing stations are relatively easy to improve at a low cost. Yet, improving care processes like adhering to clinical guidelines and patient interaction requires substantial behavior change and the right incentives and enforcement, especially for smaller clinics.
- The duration of the project was relatively short, and structured quality improvement and evaluation systems take years to institutionalize.

GOING FORWARD

SafeCare works to realize structural improvement in healthcare outcomes. Going forward it will:

- Roll out and scale up the digital Quality Platform, helping facilities and funders to monitor improvements and gather data in almost real-time. This is a significant upgrade to the SafeCare assessments that only take place at specific moments in time. The wider use of technology and data also provides further transparency and benchmarking on quality for facilities, funders and policy makers.
- Examine whether quality improvement at the facility level is incentivized further by the Quality Platform, by adding a level of peer-to-peer competition. With the platform, facilities can compare their SafeCare scores with other health centers in the region.

- Increase and intensify SafeCare activities at the facility level, with the aim of motivating staff and improving quality compliance. Apart from traditional classroom activities and supportive supervision visits, the Quality Platform contains gamification components that are continuously evaluated. Lastly, patients are informed and stimulated to consider the SafeCare quality level when opting for healthcare services.
- Continue to advocate for governments taking the lead on better regulation and providing clear incentives for the private sector, to compliment the public sector and align with national priorities for UHC. For example, by contracting good performing clinics into health insurance schemes. Or by adding financial incentives to good service performances (Performance Based Financing Contracts)
- Future research should examine the link between structural and process aspects of quality and clinical outcomes when facilities move to level 4 and 5. It is possible that links between structural and clinical quality are stronger as facilities progress to these higher levels, when they have the basics in place and focus more on adherence to clinical standards.

PharmAccess integrated approach

The PharmAccess Group embeds quality in an integrated approach for health system strengthening. In addition to quality improvement, the approach includes sustainable investment and low-cost insurance for vulnerable individuals. The Group engages with public and private stakeholders in sub-Saharan Africa, supporting efforts towards UHC.

Click [here](#) to learn more about SafeCare and our impact

Click [here](#) to read the full study published in the Lancet on Aug 5th, 2021