ADDRESSING QUALITY IN THE PRIVATE SECTOR:

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Findings from an impact evaluation of the SafeCare model in Tanzania

This policy brief highlights findings from an impact evaluation of the SafeCare model developed by PharmAccess. SafeCare aims to improve quality of care in health facilities through a stepwise certification model. It has been widely implemented in public and private facilities across many African countries.

We studied SafeCare in private health facilities, which provide a significant and growing share of care in low and middle income countries, including Tanzania.

As in the public sector, there are concerns about safety and quality of care in private health facilities. Traditional hospital accreditation is only available to the highest-end facilities, and there is limited evidence on the effectiveness of other quality improvement interventions.

SafeCare is a model for addressing this gap. It seeks to raise both quality of care and business performance, with the intention that improvements in quality attract more patients and increase revenue, and improved business performance facilitates greater investment in quality improvement.

What we did

The impact evaluation aimed to determine whether SafeCare could improve the clinical quality of care provided to patients. We did a randomised control trial over two years to compare 118 intervention facilities, which received the full SafeCare package, to 119 control facilities, which received SafeCare assessments at baseline and endline, but no additional support. SafeCare was implemented by APHFTA and CSSC in their member facilities.

We used two methods to measure clinical quality of care: undercover standardised patients, and observations of infection prevention and control (IPC) practices. Standardised patients were trained to mimic real patients, and measured whether correct treatment was received for four tracer conditions: asthma, malaria, TB and URTI. To measure compliance with IPC practices, staff were observed in the consultation room, laboratory and injection and dressing rooms.

A patient exit survey measured patient satisfaction, out-of-pocket payments and socioeconomic status, and a facility survey measured patient utilisation and revenue. The perceptions and experiences of facility staff and implementors were explored through in-depth interviews.

Figure 1: The SafeCare quality improvement model

1 Appropriate quality standards	SafeCare assessment based on realistic standards for healthcare providers in resource-restricted settings. ISQUa approved
2 Step-wise approach	Step-wise improvement process through five SafeCare quality levels
3 Support for quality improvement	Support through quality improvement plans, mentoring visits, classroom and on-site training, with improvements rewarded with certificates
4 Access to capital for investment	Enable facilities to access investment capital by guaranteeing loans through local banks with the Medical Credit Fund
5 Local capacity	Build local capacity, and integrate with existing health system initiatives (governments, health insurers, social franchises, banks)

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Evaluation results

SafeCare assessment scores increased in both intervention and control facilities, but the increase was larger in intervention facilities (Fig 2). This suggests that the SafeCare model was effective in improving the structural and managerial quality of health facilities, as measured by the SafeCare score.

However, our findings suggest that SafeCare was not effective in improving clinical quality of care. At endline, compliance with IPC, and correct treatment of standardised patients were very similar in intervention and control arms (Fig 3).

Intervention facilities reported higher patient numbers and monthly revenue, though confidence intervals were too wide to draw firm conclusions.

Figure 2: Change in SafeCare score between baseline and endline

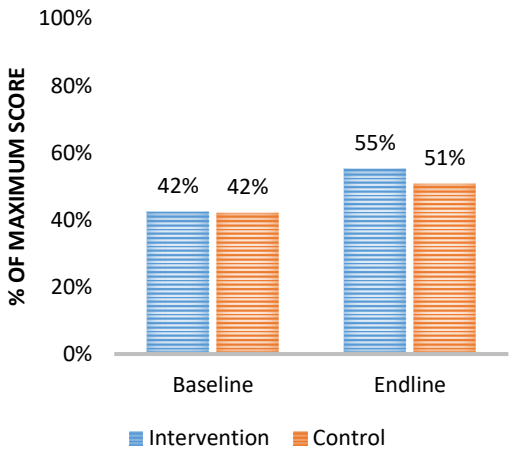
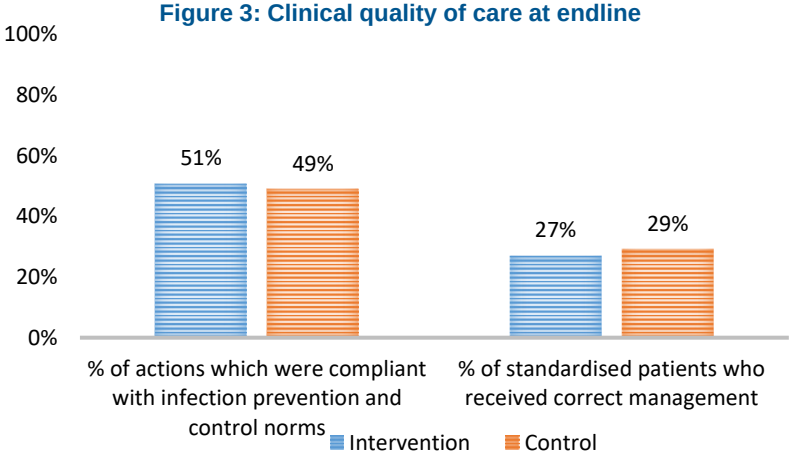


Figure 3: Clinical quality of care at endline



Explaining the findings

Facility staff were positive about SafeCare. They found the standards appropriate, the staff polite and friendly, and appreciated the mentorship visits. However, they said these visits were insufficiently frequent. This reflected lower than planned implementation, with facilities receiving less than two-thirds of the planned mentoring and training sessions.

Facilities achieving higher SafeCare levels were more likely to provide correct care to standardised patients, though quality still needed substantial improvement even in higher scoring facilities.

What we learned

This impact evaluation highlights a number of issues for policymakers:

Implementation at scale

- APHFTA and CSSC embraced the SafeCare approach, delivering an innovative standards-based approach, which was well-received by facilities
- However, achieving frequent facility contact was challenging at national scale

Clinical quality generally low

- IPC compliance and correct treatment of standardised patients were low in all facility types

Hard to improve clinical quality

- SafeCare was effective at improving the SafeCare score a little, but not clinical quality
- Even though there was a relationship between SafeCare score and clinical quality, this was not strong enough to see any improvements

Future programmes should consider

- Stronger financial and regulatory incentives for quality improvement
- Greater focus on improving care processes
- Targeting fewer high volume facilities to achieve impact
- Exploring digital strategies to increase intervention intensity

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