Accelerating Improvement in Health Care in facilities supported by CSSC: the need for linking PBF/P4P with Quality and Safety Initiatives

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The concept of quality and safety in health care, as it has been introduced, basically indicates that lack of attention to quality and safety is costly and harmful to staff and patients. There is sound evidence indicating that costs related to investments and activities to improve the quality and to increase safety are less than the benefits. This awareness creates a sound basis for advocacy for action in the field of quality and safety, which already is highlighted by the large numbers quality and safety programs around the world.

Recognizing the urgent need to improve CSSC's performance and utilization health care facilities, it is important to systematically address quality and safety issues in areas where improvement is most needed. Carefully designed quality and safety improvement projects have the potential to increase utilization rates and quality of essential services by motivating additional effort and inspiring innovation. A structured approach to improve performance in priority areas certainly could have a positive effect on the overall performance and utilization of CSSC health care facilities and the network in general.

The aim of the PBF/P4P approach is improving the performance of individual health facilities and, in the end, the performance of the CSSC network as a whole. Key areas or topics of services delivery of which we know they are related to, for example, high cost or risk to staff or users or serious quality problem causing high complication rates, can be identified and selected. These priority areas are included in the essential health care package, as defined in the national health policy documents and other related policies (*references to be specified*). For most of the service delivery areas there are standard management and treatment guidelines that are essential in assessing and improving the level of quality of health care (*references to be specified*). Additionally, specific areas of quality improvement pertinent to national policy initiatives can be identified and selected from the Tanzanian Quality Improvement Framework (*reference needed*) and in "Indicators of Quality of Care in Tanzania (*CSSC, 2008?*).

A core element of the PBF/P4P approach is the development of "performance" or "quality and safety" indicators. Performance indicators, in general, relate to how and to what extent health care professionals and institutions carry out their defined functions, meet core objectives, and achieve set-out targets in a balanced way and within a stated time-frame. If no explicit distinction is made between performance and quality, performance indicators often consists of a mixture of volume/output-indicators (e.g. number of outpatients, inpatients, deliveries) and quality and safety indicators (e.g. presence of guidelines, delivery by qualified midwife, infections or death rates). Quality indicators on the other hand point to healthcare quality such as safety, efficiency, accessibility and patient centeredness of health care. Providing the users of indicators information about whether the right things (what) are done, in the right way (how), to the right people (to whom), at the right time (when), and right the first time. Indicators for quality and safety need to be developed in a proper way as such that they actually measure what they are intended to measure (should meet certain quality criteria). Quality indicators can be structure, process and outcome indicators.

Structure indicators in this program could be developed and used to evaluate and recognize a health care facility as meeting pre-determined requirements or criteria for joining the PBF/P4P program. These indicators or criteria could be many, but standards often used are the presence of a Quality and Safety Committee (meeting regularly and making minutes), formalized structures for peer review, audit, and other quality improvement mechanisms, or the presence or development of a quality and safety improvement plan. Thus, for the PBF/P4P program it is suggested to develop and use structure indicators that provide a basis for accreditation (i.e. selection of eligible health facilities).

Process indicators might best be developed and used for as part of improvement programmes within the health care facility. This can be done through expert groups from different facilities coordinated at CSSC level, or by individual facilities (depending on whether areas for improvement are selected at CSSC or local level). Process indicators often usually actionable, provide timely information, and can be linked directly to quality and safety improvement. Disadvantages of process indicators are 1) provide a fragmented picture because they focus on specific aspects of care, 2) they are easier to manipulate and 3) are difficult to verify by external visitors. The latter makes them less attractive for external stakeholders who often look for overall figures of performance. In other words, process indicators will not directly used as a basis for bonuses.

Outcome indicators will mainly be used as a basis for payment variability. The advantages of outcome indicators are 1) they measure something that is important in its own right, 2) reflect the outcome of more health care processes and not only those that are measured, and 3) closely linked with the targets of health care policies. It is however important to be aware that the disadvantage of outcome indicators are that they are more sensitive for noise, meaning variations in case-mix and other factors not related to the performance of the health care provider.

Although we have given a general direction for how and which type of indicator to use, given the purpose of the indicator, there can be overlap. The PBF/P4P program might still be interested to measure, if selected as a priority topic, the extent care is actually provided in daily practise. For instance, if antenatal care is selected as priority area, there could be interest in including the percentage of women having at least four ANC visits before pregnancy (process), in stead of complications that might lead to death (outcome). The same holds for example for the presence of particular structures not included in the criteria for inclusion in the PBF/P4P program, like qualified personnel with midwifery skills or equipment (structure).

The different type of indicators each play their own role and the selection of indicators will depend on the information needs by the different stakeholders (e.g. CSSC headquarters, a Diocese, Cordaid, health care professionals in the facilities, community members).

A further part of the implementation perspective is that in the initial stages of the quality and safety project it seems most sensible to start with indicators from data that are already collected. The main advantage is that the data definitions, the rational for the use and data collection procedures are already part of the system. In the case of Tanzania this could mean: to start using data that is already included in the Mtuha books, i.e. the national HMIS system. This would make the introduction of the quality and safety programme fairly easy and would avoid delay of progress because of technical and practical issues. When required, then the development of new indicators could be undertaken at a later stage, when the focus on quality and safety has been more firmly integrated into the health systems involved.

To be effective in implementing positive change and improving the functioning of CSSC health care programs and facilities, specific, well-planned programs combining different interventions are needed. Multifaceted interventions, i.e. combining different strategies for implementing change in health care, is believed to be the most effective approach to improvement. This could for example lead to a combination of;

1) financial incentives (e.g. PBF/ P4P),
2) training in the area of quality management (e.g. mechanisms, tools and techniques),
3) interventions focused on professionals directly (e.g. guidelines, training, audit and feedback, peer review),
4) organisational structures (e.g. changes in physical structures, equipment, quality management mechanisms).

It is the combination of interventions that builds the strength of the approach. The presence of financial incentives may not be effective in creating improved performance without a stimulating quality culture and the presence of enabling knowledge and skills.

The above indicates that training and hands-on assistance is needed. At the level of CSSC headquarters, capacity in the area of quality and safety improvement is needed. This will help CSSC headquarters to take the lead and sends a clear message that quality and safety improvement is an important goal, a goal that all members of the CSSC network should strive to attain. Also to promote the fact that quality and safety should be a critical component in any CSSC health care facility's overall strategic plan and to incorporate the topic into the strategic planning process. Within the CSSC health care facilities, Quality and Safety Committees (or Therapeutic Committees) but also management teams need to receive training to develop the knowledge and skills required to really make a difference in the facility's performance.