MOMENTUM

Private Healthcare Delivery

Cover photo: Health provider Papa Zebika with a client at Clinic Bomoi, Democratic Republic of the Congo. Copyright PSI.

Research Brief

QUALITY OF CARE FOR FAMILY PLANNING

A Comparison of Private and Public Facilities using Survey Data

BOTH PUBLIC AND PRIVATE FACILITIES play an important role in the provision of voluntary family planning (FP) services. Little is known about if and how quality of care for FP services compares between public and private facilities.

MOMENTUM Private Healthcare Delivery conducted an analysis providing a comprehensive exploration of quality of care across three main components: *structure* (physical setting), *process* (how care is delivered), and *outcome* (impact of care). Findings utilized survey data on 57 indicators across 10 domains, covering seven countries across Sub-Saharan Africa, Asia, and the Caribbean. For the full set of findings, please see the final report at https://usaidmomentum.org/resource/quality-of-care-for-family-planning/.

Key Highlights

An analysis of periodic survey data shows that both the public and private health sectors have varying strengths and weaknesses in delivering quality FP care. Despite assumptions that private sector quality is poorer due to inadequate oversight, the study found that quality of FP services delivered through the private sector is often comparable to that of the public sector. Regardless of managing authority, there is substantial room for improvement in the quality of FP services, as well as in measuring clients' experience of FP care.

WHY STUDY QUALITY OF CARE FOR FP IN THE PRIVATE SECTOR?

The private sector plays a substantial role in the provision of FP in low- and middle-income countries (LMICs).[1] Formal private health facilities are typically registered with public authorities, but LMIC governments often do not have adequate resources to effectively regulate or oversee them. Subsequently, concerns arise related to the quality of care at private outlets.[2] Meanwhile, some studies show that clients may choose private sector services due to perceived higher quality of services.[3-5] However, there is limited information about the actual quality of care provided at formal private facilities.[6] Service Provision Assessment (SPA)Surveys, conducted by The Demographic and Health Surveys (DHS) Program, provide a unique opportunity to examine a comprehensive, standardized set of indicators of quality of care for FP services across several countries.

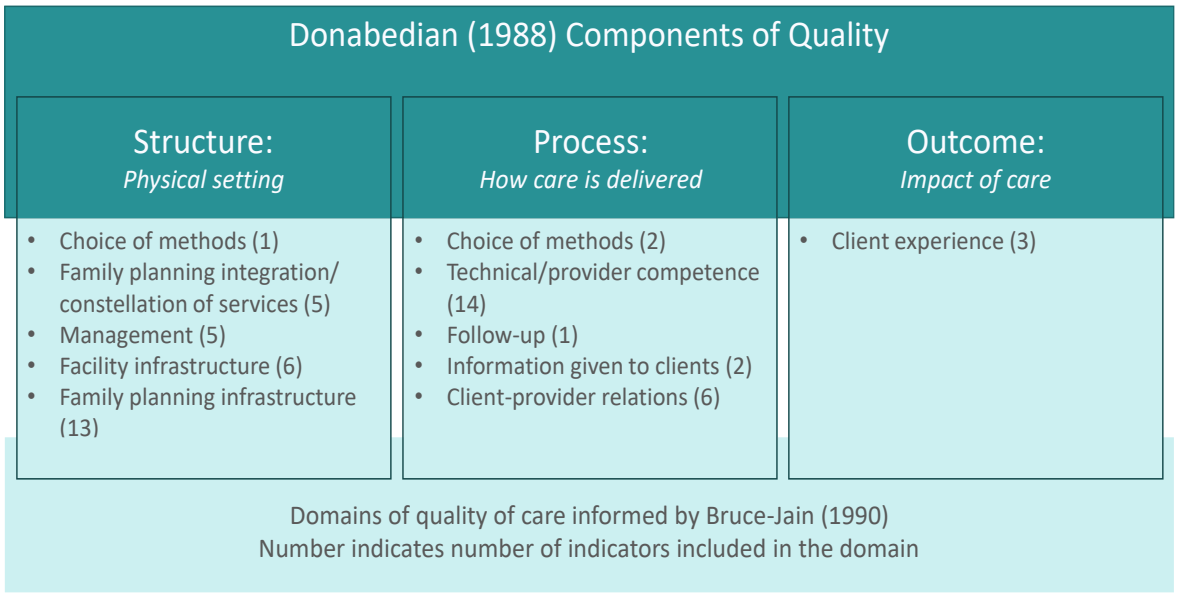
WHAT COUNTRIES WERE INCLUDED IN THE ANALYSIS?

MOMENTUM used data from seven countries with recent DHS and SPA surveys, including Bangladesh (DHS: 2017-18; SPA: 2017), the Democratic Republic of the Congo (DRC) (DHS: 2013-14; SPA: 2017-18), Haiti (DHS 2016-17; SPA: 2017-18), Malawi (DHS: 2015-16; SPA: 2013-14), Nepal (DHS: 2016; SPA: 2015), Senegal (DHS and SPA: 2019), and Tanzania (DHS: 2015-16; SPA: 2014-15).

WHAT METHODS WERE USED TO CONDUCT THE ANALYSIS?

The analysis compared quality of care among different types of formal public and private facilities (excluding individual doctors' offices, pharmacies, or shops). Quality of care was assessed using composite measures reflecting three key components: structure (physical attributes of the facility), process (delivery of care), and outcome (impact of care). Each component is described below using domains of quality of care informed by the Bruce-Jain Framework[7] (Figure 1).

FIGURE 1: QUALITY OF CARE FRAMEWORK AND DOMAINS[7,8]



Differences in quality of care scores were evaluated using regression analyses to control for facility characteristics (for structural quality) and client characteristics (for process and outcome quality) and produced adjusted estimates of quality scores from the marginal effects of the models.

WHAT ARE THE KEY FINDINGS?

The results often indicated that among formal sector health facilities, FP quality at private facilities is similar to what is provided and available in public facilities (Figure 2).

Scores reflecting *structural* quality, particularly 1) management (i.e., supervision, systems for reviewing administrative issues or client feedback, inventory, and organization of contraceptives) and 2) availability of a choice of methods (i.e., at least one each of long-acting, short-acting, and barrier methods), tended to be lower in some types of private facilities. Generally, infrastructure scores tended to be higher in private facilities, but these results were not consistent across countries.

Overall, there was large variation in *process* quality across countries, and scores ranged from the 30-40% range in Nepal to the 65-75% range in DRC. Process quality varied less within country. The only significant difference by managing authority was in Malawi, where nonprofits had (marginally) significantly higher scores than public facilities. Process quality was low for all sectors, especially for domains related to counseling around method choice, information given to clients, and technical competence. This suggests a need at a system level – across all providers – for training that incorporates an emphasis on supportive and respectful counseling approaches as well as for investments in more frequent and intensive coaching and supervision. Some aspects of service delivery or counseling tended to be higher in private facilities, although these were inconsistent, and the differences were often not significant. Clients at private nonprofit facilities in Malawi, private for-profit facilities in the DRC, and private hospitals in Nepal reported better client-provider relations than public facilities, while there were higher technical competence scores at faith-based organizations in Tanzania compared with public (or parastatal) facilities.

Outcome quality was universally high across countries and facility types. There were few differences by facility managing authority, with the exceptions of Nepal and Tanzania.

KEY FINDINGS

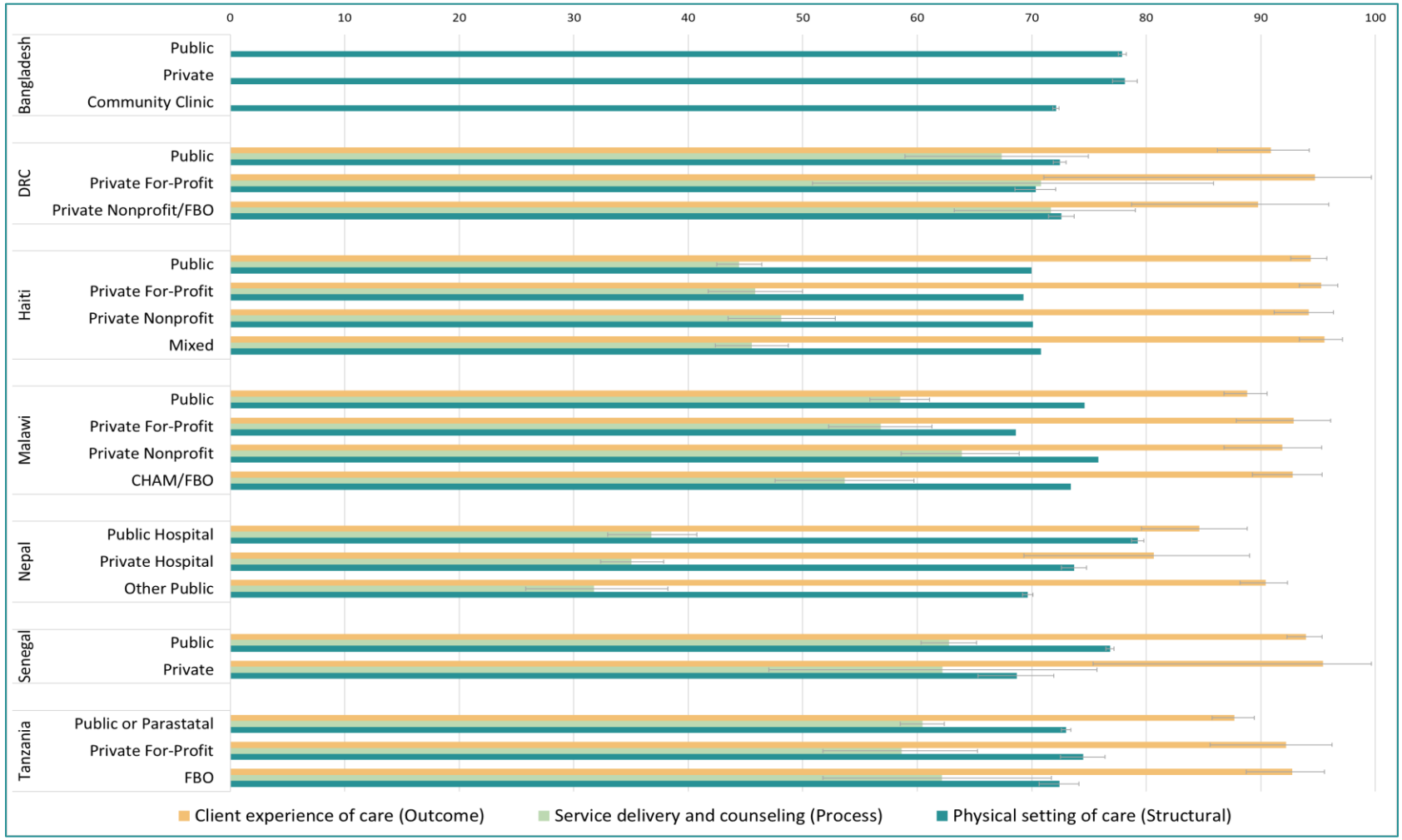
1) Private sector quality of FP care is often similar to what is provided and available in public sector facilities.
2) Structural quality was lower in private for-profit facilities in Malawi, private hospitals in Nepal, and private facilities in Senegal than in public facilities. The management domain, especially in private for-profit facilities, was lower than in public facilities in five countries.
3) Process quality varied greatly across countries but not within each country, except for Malawi. Some aspects of service delivery or counseling tended to score higher in private facilities, although this was inconsistent.
4) Outcome quality was universally high, and there were few differences by facility managing authority.

WHAT DOES THIS MEAN?

The analysis found that in terms of the provision of FP services as measured in SPA surveys, there are not consistent differences in overall quality between public and private facilities. This challenges longstanding assumptions that because private providers are often inadequately regulated, their quality of care is likely poorer than that in the public sector. It also challenges studies that have found that clients generally perceive quality of care in the private sector to be better. Additionally, structural quality domain scores related to management and available method choice were comparatively low for private facilities in most countries, indicating that operational and management support in the private sector is still relevant and warranted. Low scores in process quality, especially for counseling

among both public and private facilities across countries, suggest that quality improvement in this area of FP service delivery is acutely needed across both sectors. Consistently high scores on outcome measures for both public and private providers across countries suggest that 1) better measures may be needed to capture true client experience and satisfaction, and 2) interventions to support clients to elevate their expectations of, and their ability to examine, the care they receive may be equally necessary.

FIGURE 2: FP QUALITY OF CARE SCORES BY COMPONENT



Note: CHAM = Christian Health Association of Malawi, DRC = Democratic Republic of the Congo, FBO = faith-based organization or facility. Estimates based on predicted scores after adjusting for facility type and urban or rural location for structural quality, and for client status (new or returning client), clinical method use, client age, client education for process and outcome quality. Process and Outcome scores are unavaliable in Bangladesh. Detailed results by domain (within each component) and indicator can be found in the full report at https://usaidmomentum.org/resource/quality-of-care-for-family-planning/

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