Health Systems Improvement Process under RHSDP: A Study

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Contents

Acronyms

ANM	Auxiliary Nurse Mid-wife
BPL	Below Poverty Line
CHC	Community Health Centre
CM&HO	Chief Medical & Health Officer
CR and CF	Complaint Redressal and Consumer Feedback
DH	District Hospital
DPC	District Project Coordinator
DPM	District Program Manager
Ge H	Geriatric Hospital
GH	Government Hospital
HAF	Hospital Assessment Formats
HCWM	Health Care Waste Management
HSIP	Health System Improvement Process
HSIT	Health Systems Improvement Team
IEC	Information Education and Communication
IPD	In-door Patient
MO	Medical officer
MO I/C	Medical Officer In-charge
NRHM	National Rural Health Mission
NS	Nursing Staff
OPD	Out-Door Patient
OT	Operation Theatre
PC	Patient Counselor
PHC	Primary Health Centre
PMO	Principal Medical Officer
PMU	Project Management Unit
RCHO	Reproductive Child Health Officer
RHSDP	Rajasthan Health Systems Development Project
RMO	Rural Medical Officer
SC/ST	Scheduled Caste/tribe
SIHFW	State Institute of Health and Family Welfare
SMO	Senior Medical Officer
WB	World Bank
WBI	World Bank Institute

Executive Summary

Quality improvement in the institutions is to be done in order to achieve the objectives laid down by the Rajasthan Health Systems Development Project (RHSDP) for itself. It was a mutual understanding between RHSDP and World Bank that only by institutionalization of the quality improvement in all the facility, actual performance improvement can be observed. A three tier system was put in place under Health Systems Improvement Process (HSIP) with Health Systems Improvement Team (HSIT) at the facility level, Health Systems Improvement Committee (HSIC) at district level and Health Systems Resource Team (HSRT) at the state level.

To assess the quality of services rendered by any hospital, complaint reorganization and management is a critical issue. By obtaining the patient feedback in health facilities system quality of hospital can be improved. Under RHSDP complaint redressal and consumer feedback system was introduced in selected facilities of 5 districts. Like all other customers, the patients want three Cs: **Convenience, Care** and **reasonable Cost**. The patient also expects that he/she should be treated quickly, courteously and correctly.

A study was conducted mainly to assess the functioning of the HSIP and CR & CF. In this study a sample of 24 facilities was selected through purposive random sampling for HSIP. The sample selected was a equal representation of desert, tribal and plain; Urban and rural, 100+ bedded, 50 bedded and 30 bedded. All the 23 facilities where CR &CF was introduced were selected.

The findings of HSIP indicate that the meetings at the facility and district level were held regularly but meeting at state level need to be more regularized. Majority of the participants were clear about the objective of the team/ committee. Minutes of meeting were being sent to the next higher level.

As per the guidelines, teams of the HSIC members were created that go to the facilities to assess its performance. Problems that could not be solved at the facility level were escalated to the HSIC and that in case remained unresolved there then were transferred to the state resource team.

In most of the HSIT and HSIC meetings- placement and appointment for filling the vacant posts, hospital supplies, hospital services, infrastructure, drinking water, cleanliness related issues were discussed. HCWM, financial, training and skill improvement were some other issues raised and resolved in the meetings.

Minutes of the meeting provided the evidence of sorting out the problems raised during the meeting by HSIC. In some special cases, decision was taken at the level of Principal Secretary (Health) to resolve the problem. Intervention of PHS and District Collector in HSIP process is a good example of success of the activity.

At the state level, HSRT members were supposed to meet every quarterly but they could not due to incomplete quorum.

In CR&CF, MO I/C, patient counselor and patient accepted that redressal mechanism exists and had helped in solving the problems of patients on daily basis.

Support from state and district level need to be evolved in more systematic way by providing training to the team, creating the quality assessment teams to visit at facility in a certain period and provide some bench mark for the improvement of the performance.

To obtain the feedback from patients and attendants in facility Exit interviews were conducted but systematic tools to obtain the information was not developed at any facility.

Under complaint redressal mechanism, facilitation of patients is required by educating them to be vigilant about their rights and duties, a format to lodge complain can be developed and displayed containing the messages how, whom and where any person can lodge complain.

Over all findings of the study is that the HSIP and CR&CF are a well understood and conceived concept properly implemented by project in a successful manner, need is to refine and reframe and sustain them by making provisions under NRHM.

Introduction:

Increased investment by the government in social sectors like health and education over the last few years has generated widespread interest not only in the outcomes but also raised serious concerns about the quality and sustainability of these outcomes. In the past twenty years , the concept of improvement of health systems has moved away from top down control, compliance and punishment towards bottom up development, self –regulation and incentives; quality measurement has also shifted from resource inputs to performance outputs. It is widely acknowledged that in spite of the wealth of experience in quality the problem frequently faced by policy-makers at country level is to know which quality strategies complement or can be integrated with existent strategic initiatives to have the greatest impact on the outcomes delivered by their health systems despite available funds.

The experience with quality assurance has mainly been in the form of successful (and some not so successful) vertical interventions in areas like family planning, reproductive health, HIV and TB. There are conceptual frameworks for dealing with quality, and these have been used to generate operational tools such as forms, checklists, manuals, scoring sheets and report cards. Most of these have been implemented through distinct projects that ultimately do not integrate within the functioning of the line health agency. From a technical standpoint, quality measurement has relied on international and national norms and guidelines. In institutional terms, quality circles, groups and cells have been experimented with.

Currently in India the environment is very conducive for integrating strategies to improve quality in the health system into the national and state level policy frameworks. There is a strong political commitment for such action and increased funding to the sector.

Approaches to quality improvement under a rave review from WHO have been classified under following categories (also called the strategic framework for Quality):

- Empowerment of consumers
- Institutional development
- Management development
- Clinical practice development
- Professional development

It has been clearly established that any sustainable change in terms of institutionalisation of Quality Assurance (QA) will come from within the system and not from outside. The initiatives of RHSDP have aptly supported the Health care delivery system to develop a comprehensive framework and an achievable plan to improve the quality and safety of the health system. Hirschman AO: Exit, voice and loyalty: responses to decline in firms, organization and states, Cambridge, Mass, 1970, Harvard University Press; said that People who are dissatisfied with hospital service have four choices.

- They 'Voice' a complaint, choose another provider ('Exist');
- Continue to use service despite being dissatisfied (remain 'loyal'), or
- Continue to use the service and keep complaining to friend and family,
- Influencing their behaviour and creating 'negative image' of the hospital.

Like all other customers, the patients want: **Convenience, Care** and **reasonable Cost**. The patient also expects that he/she should be treated quickly, courteously and correctly.

A successful complaint management system contain the following components :(Singh H: Industry Characteristics and consumer dissatisfaction, Journal of consumer affairs 1990 25:19-56)

- Positive approach demonstrating sincerity and concern.
- A system to track, investigates, resolve and document the complaint.
- Follow up and reporting mechanism.
- A complaint tracking system.

Most of the doctors recognise where a patient is frustrated and dissatisfied. By simply saying, 'you seem upset, may I help?' or sending a colleague to investigate the perception will resolve the problem; or else the patient goes dissatisfied and lodges a complaint.

People with complaints want one or more combination of the following:-

a. **Respect and Understanding**: It is necessary for complainant to believe that you sincerely want to hear and resolve the issue.
b. Immediate **Investigation** and follow-up
c. **Censure**: Some complainants believe satisfaction can best be achieved by some form of punishment, reprimand or censure.
d. **Assurance** that the problem will not reoccur: If the complainant is assured than he/she will walk away with feeling that he/she has improved the system.

The then existing situation suggested that rather than merely relying on intricate quality checklists and forms, better governance and checks and balances within the health system would help immensely. Hence, better governance framework and particularly one that adopts a rights and entitlements framework including participation (by users and community members), accountability (to the system and to the community) and equity (greater investment for marginalized communities), is desired. Under this background RHSDP adopted a strategic approach for Hospital Systems improvement process (HSIP

One of the innovations that the project has fostered is the **Health Systems Improvement Process (HSIP)** which has been institutionalized in all the 238 secondary level facilities. It includes the functioning through a matrix of Health Systems Resource Team (HSRT) at the State level; Health Systems Improvement Committees (HSICs) at the district level; and Health Systems Improvement Teams (HSITs) at the facility level. The overriding objective of HSIP was to institutionalize facility based quality improvement system. While facilities lower than district hospitals have the entire health staff participating in the HSITs as team members, at higher facilities heads of various departments, counselors and administrative staff participate in the HSIC meeting.

Typically, an HSIT meeting involves review of hospital performance data, identification of issues affecting performance; short listing causes of poor performance; suggestions on potential solutions to the causes; implementation of solutions; observation of positive impact of intervention; and focus on emerging issues. This innovative approach leads to team building, evidence based planning, empowerment, improved performance and accountability in the system.

The thrust on quality, equity and access to secondary health services from within the system as a result of the HSIP has found a supportive ally in a consumer feedback and complaint redressal initiative which was started at **23 facilities in five Districts (Alwar, Bikaner, Ganganagar, Hanumangarh, Jhalawar) of the State in December 2009**. The pilot involved patient counselors at 50 bedded and above hospital attending consumer feedback and complaints and forwarding to appropriate level for redressal and ensuring disclosure of action taken on raised issues to complete the feedback loop.

Since lots of efforts have been made by RHSDP with support of World Bank for improving quality, equity and access by introducing HSIP in health system; it was planned to evaluate the

effectiveness and efficiency of quality improvement system by external agency. SIHFW undertook the task at a short notice

The Study:

Scope of work-

1. Develop the study design
2. Develop a study protocols
3. Sharing and Finalizing study protocols with RHSDP and world bank
4. Devise an appropriate sampling plan and field test the draft questionnaire
5. Orient and train Interviewers
6. Data collection
7. Data entry ,cleaning and Validation
8. Tabulation and Analysis
9. Document the findings in the report
10. Sharing of Draft Report and Final report

Objectives:

The main objective of the study was to assess institutionalization of HSITs, HSICs and HSRT and to underline the contribution of HSIP in health systems strengthening.

Specific Objectives-

- Assessment of the HSIP institutionalized in the State with a thorough review of the functioning of HSITs, HSICs and the HSRT.
- Identify the contribution of HSIP in health systems strengthening. Clarifying the gaps or missing links which compromised the effectiveness and efficiency of the quality improvement forum.
- Review the efficiency and complementary role of the consumer feedback and complaint redressal initiative in improving quality of public health care.

Approach:

Study Universe-

The Study Universe for HSIP consisted of 238 secondary level facilities of RHSDP. For consumer feedback and complaint redressal (CF&CR), which started in 23 facilities of 5 districts as pilot, all were selected.

Sampling-

Purposive random sampling was done to get an equal representation of tribal, desert and plain districts and equal representation of urban and rural secondary level(DH/ CHC/ UPHC) facilities.

Because of time restraint 6 districts were selected (2 each from Plain, Tribal and Desert region) and categorized it facility wise (DH, CHC and Up PHC)

Total districts selected: 6

- Plain - Bharatpur, Jhalawar
- Desert - Bikaner, Jodhpur
- Tribal - Dungarpur, Chittorgarh

Total facilities selected: 24

- 150 and above bedded: 4
- 50 bedded: 8
- 30 bedded: 12

Respondents-

Discussion cum interviews was done with the representatives of HSRT/ HSIC/ HSIT

State level –

- Chairman -1
- Member –Secretary – 1
- Member - 3

District level -

- CMHO or his representative -1; DPC – 1; Member – 1

Facility level -

- Convener – 1; Team member – 2; Non members of HSIT – 2

Complaint Redressal –

- Total districts: 5 (Alwar, Bikaner, Ganganagar, Hanumangarh, Jhalawar)
- Total facilities: 23

At facility level interviews was done with –

- MO-IC/ PMO -1
- Patient Counselor -1
- Patient – 1

In the HSIT, members and non members with longer stay at the particular facility were interviewed.

Study Protocols

The protocols were developed with inputs from RHSDP and World Bank. The interview schedule contained questions on knowledge regarding constitution of the teams/ committee, documents maintained for the meeting. In addition, response on various parameters that contribute to proper functioning of team/ committee such as total complaints received annually and total complaints escalated to the next level. A few open ended questions were also included such as interviewee's point of view regarding success of HSIP.

For CR &CF questions were asked to the MO-IC and from patients to understand the perceived role of the patient counselor.

Orientation of team and Data Collection-

Briefing of the interviewers (SIHFW staff) was done on overview of the study, questionnaires and field visit, during second and third week of September.

Software development, data entry, analysis and report writing

The data entry was done using MS Excel and Tabulation was done by using the statistical software-SPSS. This was followed by report writing.

Result and Discussion

1. Desk Review

Desk review included peeking through documents on, Hospital Activity Format (HAF) for last five years, *Aide Mémoire,* HSIT tool kit, PIP, HSRT meeting minutes, India Health Beat, Consumer feedback mechanism and complaint redressal system of different states including Tamil Nadu and Bihar, .

The major inferences were:

HSIP is a performance monitoring system that utilizes data from facilities (at Facility, District and State level) to assess performance during the month. Following indicators were used for assessing the performance of the facility.

- Number of outpatient visits hospital admissions
- Proportion of BPL outpatients among all outpatients
- Proportion of ST outpatients among all outpatients
- No. of hospital admissions
- Proportion of BPL inpatients among all inpatients
- Proportion of ST inpatients among all inpatients
- Proportion of BPL outpatients exempt from OP registration fees
- Proportion of BPL inpatients exempt from OP registration fees
- In case of a CHC, no. of deliveries conducted in a month (target at least 10)
- Bed occupancy statistics
- No. of LAMA/absconded cases
- No. of patients seen in OPD per doctor per day
- No. of laboratory investigations done per laboratory technician per day.

Table1.1: Indicator wise achievement

Indicator	Baseline 2006	Achievement in June '09	Achievement in June '10	Achievement in June '11
Percentage of Community Health Centers (CHCs) conducting greater than 10 deliveries a month	60.0% (111)	97.3% (180)	97.28% (179)	96.63% (178)
Staffing according to norms		**(236 facilities reporting)**	**(236 facilities reporting)**	**(236 facilities reporting)**
Doctor availability	59.8%	60.3%	64.5%	64.2%
Nurse/ANM availability	89.5%	108.5%	114.4%	117%
Lab technician availability	105.4%	79.49%	85.7%	91.5%
Staffing according to norms in tribal areas		**(49 facilities reporting)**	**47 facilities reporting)**	**(47 facilities reporting)**
Doctor availability	49.6%	44.5%	47.6%	47.3%
Nurse/ANM availability	90%	96.94%	104.8%	108%
Lab technician availability	91%	70.2%	78.8%	66.7%
Percentage of drugs that are in stock of 15 vital/essential drugs across all project facilities in a quarter	-	[Facilities reporting for the quarter: 711 Total facilities 714 (283 x3)] 92.2%	[Facilities reporting for the quarter:710 Total facilities 714 (283 x3)] 84.51 %	[Facilities reporting for the quarter: 704 Total facilities 714 (283 x3)] 86.0 %
Percentage of facilities conducting monthly HSIT meetings and submitted minutes of meeting to the PMU	-	97.5% (232 facilities reporting)	95% (226 facilities reporting)	85.3% (203 facilities reporting

Source: Aide Mémoire, December 2010

Progress made against the indicators were complimentarily supported by project and NRHM including additional manpower provisioning under NRHM , Infrastructure support from RHSDP and NRHM but contribution of HSIP cannot be ignored for the regular monitoring of the performance of facility services.

To enable smooth functioning the toolkit developed by PMU defines HSIT functioning, outlines roles of all members, clarifies expectations from meetings minutes, defines various points of escalation and roles at each level, provides case studies of quality improvement using the HSIT process and outlines monitoring and evaluation of quality in service delivery.

95% of facilities were having HSIT meetings regularly. Those failing to organize the meeting on regular basis were informed and reminded through feedback mechanism *(Source: RHSDP and Aide Memoire, September, 2009)*.

Gradual overall improvement has been reported in the performance of facility where HSIT, HSIC meetings were held; which emphasizes on proper functional HSIP in the system.

Table 1.2: Achievement against indicators:

Indicator	**Baseline 2006 (reporting facilities)**	**June 2011 (reporting facilities)**
Percentage of BPL populations among out patients seen at all project facilities i.e. district (DH) and sub divisional hospitals (SDH & CHC)	8.74%	16.6%
Percentage of BPL among inpatients seen at all project facilities	8.5%	17%
Percentage of ST populations among inpatients seen at all 49 project facilities in six tribal districts i.e. at district (DH) and sub divisional hospitals (SDH & CHC) in six tribal districts	8.34%	24.8%

* Source: *Aide Mémoire, June 2010*

As per decision in meeting of HSRT on Jan 3, 2008 following were to be included as member of HSIC

1. JS in charge at CHC (clinical)
2. Senior most JS (in absence of SMO or MO)
3. Block Health Managers
4. Data Managers

In minutes of meeting of HSRT held on April 9, 2008 it was instructed to all CM &HOs to include following issues into the report:

1. Institutional deliveries

2. To maintain a separate record of BPL, poor and free attending the facility to maintain a separate record for the drugs supplied to BPL, poor and free to include repeat patients in OPD register

Decision in meeting on April 9, 2009, following is to be included in the HSRT as members:

a. Officer HMIS
b. Officer QI
c. Consultant HCWM

2. Findings from HSRT:

To support HSICs/HSITs, a State Level Health Systems Resource Team (HSRT) was constituted in June, 2007. HSRT works under the chairmanship of Director-Hospital Administration, other members of the HSRT are Additional Director, CAEI, AD (OI), AD (EPMC), and AD (HR). This team meets once in every quarter.

It was expected from the HSRT members that they would:-

- Participate in HSIC monthly meeting
- Share experiences of other districts
- Assist in resolving problems at local level as well as those needing attention at state level
- Implement recognition system.
- Visit each of the six priority districts each quarter planned in the first phase. All districts are to be covered every quarter

SIHFW team visited PIU and interacted with the Chairman and 3 members of the HSRT. Some background material was also collected to analyze the roles and key functions of the HSRT.

All the four members interviewed were well acquainted with HSIP and role of HSRT which was cross verified through their awareness about meetings, agenda and issues that were discussed and resolved by HSRT.

The PIU mandate indicated that meeting of HSRT were supposed to be held on quarterly basis but in last five years only 12 meetings were held (5 in 2008). But for 2008, meetings were held biannually.

Table: 2.1: Frequency of HSRT meetings

S.No.	Year	Meeting Held	Number of Issues discussed
1	2007	17.07.2007	12
		04.10.2007	4
2	2008	03.01.2008	6
		09.04.2008	5
		23.06.2008	7
		22.09.2008	5
		30.12.2008	14
3	2009	23.04.2009	8
		21.08.2009	11
4	2010	28.04.2010	15
		26.07.2010	13
5	2011	17.02.2011	5

Reasons provided by members for not holding HSRT regularly:

1. Overwork with the quality cell during extension phase
2. HSIP consultant removed
3. Officer QI post abolished in extension phase
4. Retirement of QI cell head in Jan 2010.

The major issues raised by HSIC, according to HSRT members, were related to regularity of meeting, supply of equipments, repair, installation of equipments, training, filling of vacancies, HCWM burial pits, signage and display material. Zonal level training plan Performance of the facility and HAF were also discussed in HSRT meetings. HSRT also addressed the issue of convergence with other program especially with NRHM. The same was found in desk review of Meeting minutes of HSRT.

Minutes of the meeting are testaments that issues raised during the meeting were sorted out by HSRT. In special cases, decision was taken at the level of Principal Secretary (Health) to resolve the problem. Efforts on the part of PHS and District Collector in HSIP; is a good example of commitment and initiative on part of governance.

HSRT members were supposed attend the meeting of HSIC and HSIT, to review the progress by conducting independent field visits but for the role ambiguity amongst HSRT members such visits never were taken up except for participation in zonal meetings and training programs held.

Non-availability of complete quorum in HSRT meetings was the major concern aired by HSRT members.

Manpower/equipment related problems required intervention from appropriate level. Sustainability of the intervention after RHSDP gets over was also poses a challenge, which, hopefully, shall be addressed by NRHM and Twelfth Five year Plan approach.

3. Findings from HSIC

HSICs were established in all the districts, with CM&HO in chair, to deal with the problems unresolved at HSIT and provide guidance and support for quality improvement at the facility level. HSIC members were supposed to make visits at the facilities, cross check the reports of HSIT, conduct the exit interviews for assessing the patients' satisfaction and review and monitor the progress of the facility.

A total of 18 members of HSIC were interviewed in the six study districts and data on their awareness about objectives were **compiled on basis of geographical distribution**.

Table 3.1: Knowledge about HSIC and its objective

S. No.	Category of district	Objectives of HSIC (%)
1.	Plain (6)	6 (100)
2.	Desert (6)	4 (66.6)
3.	Tribal (6)	5 (83.3)
Total (18)		15 (83.3)

83.3% had knowledge about the objectives of HSIC. Knowledge was good in the districts from plain region followed by tribal and lastly by desert.

Table 3.2: Knowledge about Members of HSIC and role of DPC

S. No.	Category of district (n)	Members of HSIC (%)		Role of DPC (%)	
		Fully Aware	Partially Aware	Fully Aware	Partially Aware
1.	Plain (6)	0 (0.0)	6 (100)	5 (83.3)	1 (16.6)
2.	Desert (6)	0 (0.0)	6 (100)	6 (100)	0 (0.0)
3.	Tribal (6)	4 (66.6)	2 (33.3)	5 (83.3)	1 (16.6)
Total (18)		4 (22.2)	14 (77.7)	16 (88.8)	2 (11.1)

When respondents were asked to indicate the members of HSIC, out of the 18 respondents only 4 (that too from tribal districts) were fully aware rest 14 were partially aware.

When enquired about the perceived role of the DPC in HSIC, 16 out of 18 were able to state correctly.

Table 3.3: Participation in the meeting

S. No.	Category of district	Yes (%)	No (%)
1.	Plain (6)	6 (100)	0 (0.0)
2.	Desert (6)	6 (100)	0 (0.0)
3.	Tribal (6)	4 (66.6)	2 (33.3)
	Total (18)	16 (88.8)	2 (11.1)

Regarding regularity in attending meeting, 16 out of 18 HSIC members voiced that they regularly attend the meeting. Only Chittorgarh DPC and CM&HO said that they could not attend the meeting regularly because they both were fledglings to the system with total experience of 7 months and 1 year, respectively.

Regarding the constitution of HSIC in the district all stated that it was established in 2006 and meetings were held regularly monthly now.

Ten out of 18 respondents said that there was a fixed day/date scheduled for the meeting and it was held on that particular day/date only.

Seventeen out of 18 agreed that agenda and related issues were prepared in advance but when asked for a copy of the agenda only two districts - Dungargarh and Jhalawar were able to share it. For timely intimation/ notice regarding meetings, 15 said that they received either as a call/ SMS/ notice or e-mail.

Table 3.4: Types of issues discussed in the meeting

S. No.	Category	HR related (%)	Hospital supplies (%)	Infrastructure and ancillary services (%)	HCWM (%)	Various dept. & auxiliary services (%)	Trainings (%)	Financial services (%)	Process related (%)	Related to malpractices (%)
1.	Plain (6)	6(100)	6(100)	6(100)	6(100)	6(100)	6(100)	6(100)	6(100)	6(100)
2.	Desert (6)	6 (100)	6(100)	5(83.3)	5(83.3)	6(100)	6(100)	6(100)	6(100)	4(66.7)
3.	Tribal (6)	6 (100)	6(100)	6(100)	6(100)	6(100)	6(100)	5(83.3)	6(100)	6(100)
Total (18)		18(100)	18(100)	15(83.3)	15(83.3)	18(100)	18(100)	15(83.3)	18(100)	14(77.8)

*** Multiple responses**

A number of concerns were raised and discussed in the meeting, the major ones included HR related issues, hospital supplies, hospital services, infrastructure, drinking water, cleanliness, financial and training related issues.

The variety of issues discussed in the meeting suggests that HSIC is a useful interactive platform to consultative process where even the trivia are resolved democratically which is critical to smooth functioning of the facilities. The RHSDP initiative on this account deserves kudos.

There was general consensus on the timely sharing of minutes of meeting with PIU and all committee members.

As per the guidelines provided by PIU, HSIC members were supposed to undertake the field visit and monthly participate in the HSIC meeting and review the progress of individual facility on the periodic basis.

When asked about constitution of any such team, 17 agreed to it and 16 of them said that this team visited different facilities on monthly basis.

When asked about whether the team carried out exit interview of patients during visits, 15 out of 17 agreed to it but only 13 out of 15documented it as report. Only one HSIC provided a format of exit interview but that was specifically related to patient counselor's working and not to the facility feedback.

Table 3.5: Areas to be assessed in exit interview

S. No.	Category	Availability of IEC material (%)	Working of registration counter (%)	Skill and behavior of staff (%)	Feedback of treatment (%)	Various diagnostic services (%)	Availing of govt. scheme (%)	Ancillary services (%)
1.	Desert (6)	6 (100)	6 (100)	6 (100)	6 (100)	6 (100)	6 (100)	6 (100)
2.	Plain (6)	3 (50.0)	4 (66.7)	5(83.3)	6 (100)	5(83.3)	4 (66.7)	4 (66.7)
3.	Tribal (6)	4 (66.7)	3 (50.0)	4 (66.6)	4 (66.6)	4(66.6)	4 (66.6)	4 (66.6)
Total (18)		13 (72.2)	13 (72.2)	15 (83.3	16(83.9)	15 (83.3)	14 (77.8)	14 (77.8)

*** Multiple responses**

As per the findings, Feedback **on treatment** (16), **diagnostic services (15),** Skill **and behavior of staff** (15) were the keys areas covered in the exit interview.

Out of the total respondents, 15 said that they crosscheck the report sent from HSIT to HSIC during this visit.

When asked about whether the unresolved problems were forwarded to HSRT, 14 agreed that had referred the issues to HSRT but out of them only 9 stated that they had received feedback based on which implementation was made.

All the HSIC members were aware about budgetary allocation of Rs. 5,000/- per meeting; however, only 4 districts could share the year wise expenditure details, as under:

Table 3.6: Year wise Allocation and Expenditure

S. No.	Category of	2006-07	2007-08	2008-09	2009-10	2010-11
1.	Dungarpur	Nil.	Nil	3,431	2,980	1,145
2.	Jodhpur	Nil	15,829	45,595	45,810	1,46,300
3.	Jhalawar	4,592	4,053	2,371	14,694	4,592
4.	Bikaner	13,883	36,151	50,766	54,976	53,224

On the issue of allocation of funds, for 7 out of 18 members timely release of funds was a problem. One of the reasons may be that timely submission of UC & SoE was not done. In one district, lack of guidelines was stated as an issue regarding allocation of funds.

As per the desk review of the documents of HSIP, zonal workshops were planned and organized for orienting the HSIC teams. Out of total respondents, 13 of the HSIC members said that they got orientation regarding HSIC before the committee was constituted, 3 said that they got orientation within 3 months of inception.

It had been observed that all the members were satisfied with the HSIC performance and they considered it as a success. It had helped them to prudently reallocate various resources within the district.

4. Findings from HSIT

HSIT were constituted in all 238 secondary level project facilities with the aim of institutionalizing the performance and quality improvement mechanism.

Total 72 members of HSIT were interviewed from the six districts. These included 40 Doctors (PMO, MO In charge, JS etc.), 20 Nursing staff and 12 representatives from hospital staff.

Some of the positive findings show that all the respondents were aware about the –

- HSIT and its constitution at Facility,
- Purpose and Objective of establishment
- Role and functions of the members (100% desert districts, 87% plain and 915 Tribal districts)
- Role of MOI/C
- Role of DPC

Table 4.1: Knowledge about members of HSIT

Members of HSIT	Desert (n=24)	Plain (n=24)	Tribal (n=24)
PMO/MO-IC	24 (100)	24 (100)	24 (100)
Nursing Superintendent	22 (91.7)	22 (91.7)	24 (100)
Pathologist	4 (16.7)	4 (16.7)	18 (75.0)
Dept Head	5 (20.8)	9 (37.5)	16 (66.7)
DC/HM	12 (50.0)	8 (33.3)	18 (75.0)
Store Officer	15 (62.5)	9 (37.5)	21 (87.5)
Patient Counselor	14 (58.3)	12 (50.0)	18 (75.0)
Waste Management Officer	15 (62.5)	7 (29.2)	21 (87.5)
IV Class Rep	22 (91.7)	21 (87.5)	21 (91.3)
Others	0 (0.0)	9 (37.5)	1 (4.2)

All the respondents were aware that the PMO or MO in-charge was the member and was designated as chairperson of the HSIT. More than 90% said that nursing staff also had representation in HSIT. But the respondents were not fully aware about the other members i.e. department heads, DC/HM, store officer, patient counselor; class IV staff.

Table 4.2: Orientation of HSIT and Participation

District category	Orientation conducted regarding HSIP (%)	Did You attend the orientation (%)	Facilitator of the training				
			HSRT member (%)	HSIC member (%)	DPC (%)	Don't Know (%)	Total (%)
Desert	22 (91.7)	21 (95.4)	2 (9.5)	0 (0.0)	10 (47.6)	9 (42.9)	21 (100.)
Plain	8(33.4)	8 (100)	1 (12.5)	0 (0.0)	2 (25)	5 (62.5)	8 (100)
Tribal	11 (45.8)	9 (81.8)	0 (0.0)	5 (55.6)	2 (22.2)	2 22.2)	9 (100.)
Total	41 (56.9)	38 (92.6)	3 (7.9)	5 (13.2)	14 (36.8)	16 (42.1)	38 (100)

Under the HSIP component, HSIT Members were supposed to be trained. This orientation was to be organized by HSIC/DPC or the MO In-charge. Out of total respondents interviewed 91.7% in desert districts, 33.4% in plain districts and 45.8 % in tribal districts admitted that such kind of orientation was held. Of those who said that orientation was conducted 92.6% stated that that they had attended the orientation. 36.8% shared that DPC was the facilitator of the training but 42.1% were not exactly sure about the facilitator of the training.

Table 4.3: Establishment of HSIT

Year of establishment of HSIT	Desert – n=24 (%)	Plain– n=24 (%)	Tribal– n=24 (%)	Total (%)
2006	12 (50.0)	3 (12.5)	5 (20.8)	20 (27.8%)
2007	2 (8.3)	7 (29.2)	12 (50.0)	21 (29.2%)
2008	3 (12.5)	0 (0.0)	5 (20.8)	8 (11.1%)
2009	3 (12.5)	5 (20.8)	0 (0.0)	8 (11.1%)
2010	0 (0.0)	5 (20.8)	0 (0.0)	5 (6.9%)
2011	0 (0.0)	1 (4.2)	0 (0.0)	1 (1.4%)
Don't Know	4 (16.7)	3 (12.5)	2 (8.3)	9 (12.5%)
Total	24 (100)	24 (100)	24 (100)	72 (100.0%)

As per documents available at State PIU, HSITs were created in all the facility till 2008. Some of the respondents were not aware about the timing of creation of HSIT and even reported it in 2010 and 2011. It is quite possible that respondents who were unaware about the time of establishment of HSIT at the facility were not posted there at the time of its formation.

Table 4.4: HSIT meeting

Category	Meeting Held Monthly (%)	Fixed date (%)	Agenda prepared (%)	Agenda circulated (%)
Desert (24)	24 (100)	21 (87.5)	24 (100)	18 (75)
Plain (24)	23 (95.8)	17 (70.8)	20 (83.3)	16 (69.6)
Tribal (24)	24 (100)	16 (66.7)	24 (100)	13 (59.1)
Total (72)	71 (98.6)	54 (75)	68 (94.4)	47 (68.1)

As per the guidelines and HSIT Tool kit provided by PIU to the facilities, there is provision of regular monthly meetings preferably in the first week. The action taken report of present meeting is supposed to be evaluated in the next meeting.

Out of total respondents, 98.6% agreed that regular meeting of HSIT was held and 75% stated that the meetings were held on fixed date with 94.4% affirming that agenda was prepared and another 68.1% said that the agenda was circulated. Supporting evidence was available as copy of attendance of the meeting, agenda and the minutes. The same finding was revealed from HAF reports submitted to PIU. WB Team during one of its visit has testified that "97.5% (of 232

facilities reporting) of facilities were conducting monthly HSIT meetings and submitted minutes of meeting to the PMU" (Aide Memoire, September, 2009).

Table 4.5: Minutes of meeting

Category	Sent to the DPC/PIU (%)	Shared with members (%)
Desert (24)	24(100)	24 (100)
Plain (24)	19 (79.2)	21 (87.5)
Tribal (24)	24(100)	24 (100)
Total (72)	67 (93.1)	69 (95.8)

HSIT tool kit provided by PIU mentioned that every meeting should be recorded. Chairman of the meeting must assign the task of making note of proceedings during the meeting to a responsible person. The minutes of the meeting should be recorded and the same sent to the DPC/PIU within three days of holding the meeting. **Circulation of minutes of meeting,** as early as possible after the meeting, keeps everyone in loop, besides building ownership. A written record is to be prepared of the decisions arrived at on the basis of consensus.

Assessment team collected the evidence of the minutes of the meeting. Respondents (95.8%) also supported that they were regularly receiving the minutes of the meeting of HSIT, circulated by designated person.

Regarding identifying the issues for improvement of the facilities various mechanisms have been suggested. Staff members are encouraged to enunciate their concern regarding facility performance, services, quality, individual problems etc, during the HSIT meeting so that overall performance of the individual and facility can be improved. To avoid the personal differences installation of suggestion/complaint Box has helped in getting to know of the problems / issues at the facility.

Table 4.6: Availability of complaint box

Category	Availability and visible location of complaint box (%)
Desert (24)	21 (95.5)
Plain (24)	17 (70.8)
Tribal (24)	19 (79.1)
Total (72)	57 (98.3)

As per observation, Complaint box were available at most of the facilities. Members of the HSIT were asked about the availability of the complaint box, proper placement and mechanism of opening the box in a prescribed interval by an authorized person. As per findings 65% of the

respondents admitted the availability of complaint box and its location at a visible location. This number is higher (95.5%) in desert districts in comparison to tribal and plain districts.

There is provision of periodical opening of the Complaint Box at each facility but duration varies from facility to facility. Mostly, it was opened once in a month but in some of the facilities this was done weekly, fortnightly or even on daily basis. The box was only opened by a designated person (96.2%).

Table 4.7: Participation of DPC in HSIT meeting

Category	Participation of DPC in HSIT meeting (%)
Desert (24)	24 (100)
Plain (24)	17 (70.8)
Tribal (24)	15 (65.2)
Total (72)	56 (78.9)

Role of DPC is very important to make the HSIT functional. As per guidelines, District Project Co-coordinator was expected to attend maximum HSIT meetings, not only as facilitators, but with a proactive role in improving the performance of the facilities of the district, besides ensuring that meeting are held regularly and minutes reach the PIU timely. He should share methodology of the problem solving and experiences of meetings of HSIT of other facilities. The DPC should help try to solve the problems during the meeting at the facility level and see that the unsolved ones are addressed in the HSIC. The DPC should not act as a vehicle for passing on the reports to the PIU but use his analytical skills.

As per findings of assessment, 78% of respondents admitted that DPC were participating the meeting of HSIT regularly. Participation of DPCs in the HSIT was better in the desert districts than in others.

Table 4.8: Decisions of last meeting reviewed

Category	Decisions of last meeting reviewed (%)
Desert (24)	23 (95.8)
Plain (24)	16 (66.7)
Tribal (24)	17 (85)
Total (72)	59 (84.3)

There is specific role of the Facility In-charge in HSIT. He should ensure the review and performance of the facility through the HSIT. Along with other members, DPC was asked whether issues of last meeting were discussed during the current session of HSIT. 84.3% reported that issues of last meeting were discussed. Comparatively respondents from desert districts (95.83%) turned out to be much smarter on this account.

Table 4.9: Referring of unresolved issues to HSIC (at district level)

Category	Referring of unresolved issues (%)
Desert (24)	17 (73.9)
Plain (24)	5 (20.8)
Tribal (24)	9 (42.9)
Total (72)	31 (45.6)

HSIC is one of the platforms to support the HSIT in solving the issues and problems that are not resolved at facility. In case of problems not resolved at facility, the MO I/C, who is also the chairman of HSIT needs to refer the unresolved cases of HSIT to HSIC. Only 31 (45.6%) of respondents said that issues of HSIT were referred to HSIC. Desert district facilities were more active in referring the issues to HSIC compared to Tribal and plain districts. The inference is obvious, either the desert has more complicated issues or DPCs in Tribal or Plain areas were confident to handle them locally.

As per finding most of the facility in charges were attending the meeting of HSIC on regular basis (96.9%).

Table: 4.10: Document maintained at HSIT

Category	Attendance (%)	Complaint Register (%)	Minutes Register (%)
Desert (24)	16 (66.6)	14 (58.3)	22 (91.6)
Plain (24)	19 (79.1)	11 (45.8)	17 (70.8)
Tribal (24)	16 (66.6)	10 (41.6)	18 (75)
Total (72)	51 (70.8)	35 (48.6)	57 (79.1)

HSIT is supposed to maintain the records and reports of the facility. Formation of HSIT, Meeting records, agenda, minutes, HAF reviews, problems referred to HSIC/HSIT, HCWM, Human Resource, training, complaint redressal are some the record HSIT can kept for reference. Some of the records are vital and essential to keep as evidence of the functionality of the HSIT.

A copy of these records was also collected in the study. Out of total 70.8% respondents said that attendance of the participants; complaint register was maintained at facility (48.6%).

Almost all of respondents were in favor of HSIT as tool of success for improving the performance of the individual and facility to impart the services.

Table: 4.11: HSIT a success

Category	Yes (%)	No (%)
Desert (24)	23 (95.8)	1 (4.2)
Plain (24)	24 (100)	0 (0.0)
Tribal (24)	24 (100)	0 (0.0)
Total (72)	71(98.6)	1(1.4)

Under the project, HSIP was barged in as a strong interventional management tool for improving the process. The degree of empowerment that is provided at the facility and district level has been appreciated by all the members, which facilitates reallocation of resources on priority. All respondents from Plain and Tribal districts considered HSIT as a success.

Findings from Non-member of the HSIT

It was expected that member of HSIT would obviously conceit. Without getting carried away with narcissism, independent opinion about the HSIT performance was sought from other non-members amongst the hospital staff. A total of such 48 nonmembers were interviewed from the 24 facilities.

Table: 4.12: Opinion of Non-members about the overall performance of Facility

Category	Highly satisfactory (%)	Satisfactory (%)	Neither satisfactory nor unsatisfactory (%)	Unsatisfactory (%)
Desert (16)	1(6.2)	13(81.2)	0(0.0)	2(12.5)
Plain (16)	1(6.2)	13(81.2)	2(12.5)	0(0.0)
Tribal (16)	2(12.5)	14(87.5)	0(0.0)	0(0.0)
Total (48)	4 (8.3)	40(83.3)	2 (4.1)	2 (4.1)

91.6% of the respondents were satisfied with the performance of the facility but 4.1% percent were unsatisfied. Unsatisfied non-members, primarily, hailed from desert district facilities.

Table: 4.13: Area of concern

Category	Area of concern						
	Insufficient Staff	Duty Roaster	Grievance of Patient and staff	Office procedures	Equipment maintenance and availability	Drinking water, toilets cleanliness etc.	Safety of staff
Desert (2)	2	2	2	2	1	0	1
Plain (2)	2	0	0	2	1	1	0
Total (4)	4	2	2	4	2	1	1

When those who responded “neither satisfied nor unsatisfied” or “unsatisfied” were asked about the main issue of concern, they reported “insufficient staff” and “office procedures” as probable prime reasons.

Table: 4.14: Mode of placing the complaint

Category	Through Department Head (%)	Through MO-IC office (%)	Verbally to MO-IC (%)
Desert (1)	1 (100)	0 (0.0)	0 (0.0)
Plain (2)	1 (50)	1 (50)	0 (0.0)
Tribal (3)	0 (0.0)	1 (33.3)	2 (66.7)
Total (6)	2 (33.3)	2 (33.3)	2 (33.3)

The non members were asked if they had ever complained about any issue; only 6 reported for it. Ideally if any staff of the facility has any complain from the facility he should bring it in the notice of the HSIT but most of the complaints were registered through MO/IC or department head.

Though the mechanism exists, people would simply nurse the grudges and murmur rather than scribbling or airing the concern on right platform as the common psyche is “why me, somebody else will”.

Table: 4.15: Knowledge about existence of HSIT

Category	Provision of committee (%)	Correct Name of Committee (HSIT) (%)
Desert (16)	16 (100)	16(100)
Plain (16)	14 (87.5)	14 (87.5)
Tribal (16)	12 (75.0)	12 (75.0)
Total (48)	42 (87.5)	42 (87.5)

Non-member staff of the desert facilities was fully aware about the provision of a committee in a hospital to reviews the problems on monthly basis and provide appropriate solution to the issues and problems raised by staff as well as patients or other stakeholders.

Out of total non-members interviewed from the facility 87.5 % were aware about the complete name of HSIT.

Most of them (97%) were aware that meetings of the HSIT held regularly every month. 68% of the respondents said that the decision taken during the HSIT meeting was related to them. It suggests that problems and issues raised during the HSIT meeting had addressed the concerned and 93.2% were satisfied with the decision as it was as per their expectations.

Table: 4.16: Expected action time on a decision

Category	Same day (%)	Within a week (%)	2 Weeks (%)	A month (%)
Desert (16)	6 (37.5)	4 (25)	4 (25)	4 (25)
Plain (16)	5 (31.2)	7 (43.7)	1 (6.2)	1 (6.2)
Tribal (16)	3 (18.7)	8 (50)	0 (0.0)	3 (18.7)
Total (48)	14 (29.7)	19 (39.8)	5 (10.4)	8 (16.6)

Action time on decision of HSIT time to resolve a problem by HSIT should be not more than a week according to the 39.8% of the respondents whereas 29.7% expected “miracles” to happen on the same day.

Some of the respondents felt that it depends upon the nature of problem so time may vary from 2 to 4 weeks.

Table: 4.17: Positive changes in functions and services of the facility and contribution of HSIT

Category of district (n)	Increase in patient load (%)	Increase in service utilization by BPL and underserved population (%)	Quality of service Improved (%)	Patient satisfaction increased (%)	Clinical Service improved (%)	HCWM improved (%)	Improved ancillary services (%)
Desert (16)	13 (81.2)	15(93.7)	14(87.5)	14(87.5)	14(87.5)	14(87.5)	16(100)
Plain (15)	10(66.6)	9(60.0)	9(60.0)	7(46.6)	11(73.3)	12(80.0)	13(86.6)
Tribal (15)	10(66.6)	10(66.6)	9(60.0)	10(66.6)	10(66.6)	9(60.0)	11(73.3)
Total (46)	33(71.7)	34(73.9)	32(69.5)	31(67.3)	35(76.0)	35(76.0)	40(86.9)

*** multiple responses**

At most of the facilities people with longer stay at the particular facility were interviewed so that they could provide the better view of changes in the performance made in past 4-5 years.

It was asked from the respondents if they perceived any positive change in function of services of facility in last five years. Out of total 48, 95.8% (46 respondents) observed the positive changes in the performance of the facilities and 89.1% (41 respondents) of them credited the HSIT for this improvement.

Those who applauded HSIT for improvement also stated that major changes came in ancillary services, clinical services and HCWM. The service utilization by BPL and underserved population also increased.

The non-members also expressed their concern for sustaining this initiative after the project gets over.

5. Findings of Complaint Redressal and Consumer Feed Back System

All the departments have a system/ mechanism for receiving complaints through customers. Complaint management are considered to be critical components of the patient care, handled properly, even a dissatisfied and angry patient/ attendant can be satisfied. Generally, people are dissatisfied because their expectations go unmet. The patient's expectations from health care providers go beyond clinical competence of the doctor. Generally, the complaints are related to quality of care, length of stay, attitude of the provider and the cost of care etc. Majority of complaints lodged against workers are related to attitude and poor communication.

RHSDP initiated the Consumer feedback and complain redressal mechanism in 23 of the facilities of 5 districts on a pilot basis. Patient Counsellors appointed in 50 bedded hospitals were made responsible to support patients in accessing the services and respond to complaints of clients, if any. A complaint box was placed at facility level to collect the grievances and compliants of the clients.

Patient Counsellors placed at hospitals by project had opportunity address patient expectations. The hospital administration suggested for evolving an effective complaint management system in the hospital. On receipt of a complaint, it should be handled properly, responded quickly by the administrator. The appropriate management of complaints, including their trend analysis (which points at certain deficiencies) helps to improve the system.

Objective of CR&CF

- To give an opportunity to the users of the Government health institutions to air their grievances
- To reduce the delay in the provision of care by prompt response to the grievance of the clients
- To encourage the users to offer their suggestions for the better functioning of their institutions.
- To analyze the grievances and suggest appropriate changes in the functioning of the Government health institutions and to monitor the improvement in the performance of the institutions.
- To create awareness among the public about the services available in the Government health institutions and sensitize their rights to use the Government health institutions

It was expected that grievances redressal system in the Government Hospitals in the State would not only help the poor to get good quality care without delay but also bring in a sense of accountability among the service providers. The prompt response would encourage people to be more vocal about the problems they face. In addition to grievances, this system should also encourage users to offer suggestions for the better functioning of the hospitals.

To assess the CR&CF process, SIHFW team visited all the pilot districts and collected the primary data from the facilities. From each facility Medical Officer In charge, Patient counselor and patients were interviewed. Out of total 23 facilities 20 MOs were interviewed (at 2 facilities- Jhalawar and Bikaner, In-charge were representing two facilities).

At Raisinghnagar, Sri Ganganagar, MO In-charge was not available at the time of the field visit and could not be contacted even through telephone and email.

A total of 18 Patient counselors and 20 patients were interviewed.

Responses of MO In-charge:

Table 5.1: Awareness about Complaint System at Facility

Category of facility	System of CR&CF	Committee for CR &CF	
	Yes	Yes	No
DH/SH/GH/Gen H (6)	6	2	4
CHC (13)	13	7	6
Up PHC (1)	1	1	0

Total (20)	20	10	10

To assess the complain redressal and consumer feedback system, feedback from MO I/C was obtained. All MO I/Cs were aware of the existence of complain redressal and consumer feedback system at their facility but only 50% stated that they had a specific committee for this purpose.

Table 5.2: Information mechanism regarding complaint

Category of facility	Display board and complaint box	Patient Counselor	IEC material placed in hospital premises	Hospital staff
DH/SH/GH/Gen H (6)	6	5	4	2
CHC (13)	11	12	4	3
Up PHC (1)	1	1	0	1
Total (20)	18	18	8	6

* **Multiple responses**

The MO-I/Cs was asked how the beneficiary was informed about the system of complaint redressal. It was observed that in most of the facilities, information was given either through the display board along with complaint box or through Patient Counselor.

Sixteen out of 20 MO I/Cs knew that keys of suggestion box were kept with the Patient Counselor and 19 MO I/Cs stated that the Patient Counselor discussed the complaints with them.

Table 5.3: Periodicity of discussing the complaints

Category of facility	Daily	Weekly	Monthly	As & when required	Total
DH/SH/GH/Ge H (6)	3	1	1	1	6
CHC (13)	9	1	1	2	13
Up PHC (1)	0	0	1	0	1
Total (20)	12	2	3	3	20

When asked how often the complaints are discussed, 12 said that the problems were discussed on the daily basis, 2 said on the weekly basis and 3 said that complaints are discussed during monthly meetings.

Table 5.4: Method of redressal complaints

Category of facility	Response level			
	DH/SDH/GH/ Geriatric Hosp.	CHC	Up PHC	Total
Matter placed in HSIT	3	10	1	14
Matter solved at individual level	3	3	0	6
Both	3	7	0	10

For the redressal of the complaints 14 respondents out of 20 (3 from DH/GH/SH & 11 from CHC) replied that they placed the matter in the meeting of HSIT. Six MO I/Cs replied that they tried to solve the problem independently at a facility level and 10 MO I/Cs shared that they opted for both the options depending on the severity and complexity of the complaints.

Table 5.5: Resolving the problem within time limit

Category of facility	Yes
DH/SH/GH/Ge H (6)	6
CHC (13)	13
Up PHC (1)	1
Total (20)	20

All the MO/IC responded that most of the complaints were resolved within the time period.

Table 5.6: Utility of CF & CR in quality care

Category of facility	Yes	No	Total
DH/SH/GH/Ge H (6)	6	0	6
CHC (13)	11	2	13
Up PHC (1)	1	0	1
Total (20)	18	2	20

Maximum MO I/Cs (90%) recognized the utility of Complaint Redressal system in providing quality of care to the patients, and this also led to building of trust towards government facilities.

Table 5.7: Unresolved matters referred to the HSIC

Category of facility	Yes	No	Not replied	Total
DH/SH/GH/Ge H (6)	2	2	2	6
CHC (13)	8	2	3	13
Up PHC (1)	1	0	0	1
Total (20)	11	4	5	20

At times it is not possible to resolve all the problems at the facility level and unresolved issues need to be referred for intervention to higher level. 55.0% of MO I/Cs (11 out of 20) had referred the unresolved issues to HSIC in case HSIT was not able to resolve the problem. 4 did not refer to HSIC and tried to solve at their own level even if it took time and 5 did not respond.

Table 5.8: Feedback to the complainant about solution

Category of facility	Yes	No	Total
DH/SH/GH/Ge H (6)	4	2	6
CHC (13)	9	4	13
Up PHC (1)	1	0	1
Total (20)	14	6	20

Maximum MO/IC (14 out of 20) replied that the complainant was informed about the action taken on his/ her complaint.

Responses of Patient Counselor

Consumer feedback and complaint redressal was piloted in 5 districts. Under this intervention a patient counselor was placed in all the secondary level facilities of pilot districts. Patient counselor is supposed to act as a link between patient and hospital administration, get the complaint registered, and counsel the patients especially the BPL and underserved.

Out of the total 23 facilities surveyed for consumer feedback and complaint redressal, response of only 18 patient counselors could be recorded. Majority (10) of the patient counselor agreed that the complaints received are solved by either himself or MO I/C.

Table 5.9: Complaint received from patient or attendant

Facility Category	Yes	No
DH/SH/GH/Ge H (7)	6	1
CHC (10)	9	1
Up PHC (1)	1	0
Total (18)	16	2

16 out of 18 patient counselors at different facilities had been receiving complaints reflecting on the clarity of role and responsibility.

Mechanism to receive complaints

By and large, all, patient counselors get the complaints registered in a register maintained at OPD/ registration counter but for one who said that he uses other mechanisms such as exit interviews, complaint register & complaint format to register the complaint.

Table 5.10: Suggestion/ complaint box in the facility premises

Category	Yes	No
DH/SH/GH/Ge H (7)	7	0
CHC (10)	8	2
Up PHC (1)	1	0
Total (18)	16	2

Proper placement of a complain box means visibility and accessibility. If a complainant wants to give his/ her feedback confidentially about the service availed then he/she can put it in complaint box. At most of the facilities (16 out of 18), there was a functional suggestion box in the facility near the registration counter along with the display board placed near it.

Table 5.11: Information to patient about Redressal system

Category	Yes	No
DH/SH/GH/Ge H (7)	7	0
CHC (10)	10	0
Up PHC (1)	1	0
Total (18)	18	0

All patient counselors agreed that they were informing patients about the complaint redressal system. Majority also affirmed that they play a role in complaint redressal.

Table 5.12: Procedure of obtaining the complaints

Category	Through suggestion box	Written or verbal	Both
DH/SH/GH/Ge H (7)	0	1	6
CHC (8)	2	1	5
Up PHC (1)	0	0	1
Total (16)	2	2	12

Those who had responded “yes” for a role played in complaint redressal, were asked how the complaints came to them; most of the respondents answered (12 out of 16) that they received complaints through suggestion box as well as through written and verbal communication. It shows that the patients were aware about the mechanism of the registering any complaint.

Discussions on complaints

When asked about how often complaints were discussed with the MO I/C 15 out of 18 patient counselors said that they shared complaints with the MO I/C on daily basis. If a complaint required urgent attention of the MO I/C then it was shared immediately.

Table 5.13: Method of Redressal of complaints

Category	Matter placed in HSIT	solved at individual level of in charge	Both	Nothing
DH/SH/GH/Ge H (7)	1	5	1	0
CHC (10)	0	6	3	1
Up PHC (1)	0	1	0	0
Total (18)	1	12	4	1

When the method of complaint redressal was asked from the respondents' majority of the respondents (12 out of 18) said that most of the issues were resolved at the level of MOI/C. Only 1 respondent replied that they placed the matter in HSIT meeting and 4 replied that they opted for both the options depending on the nature of the problem.

Maximum respondents (11 out of 18 - 9 from CHC & 2 from DH) replied that if a complaint could not be resolved at the facility level then it was referred to HSIC.

Unsolved complaints at the HSIC are further placed at HSRT through DPC as reported by 12 out of 14 (8 from CHC & 4 from DH) respondents. Two of the respondents said that it was through CM&HO.

Table 5.14: Feedback to complainant

Category	Yes	No
DH/SH/GH/Ge H (7)	3	4
CHC (10)	6	4
Up PHC (1)	0	1
Total (18)	9	9

The complainant expects an action on his registered complaint. It is the responsibility of the patient counselor to respond back to the complainant about the status of the complaint to build up trust. But 9 (50%) confided that getting back to complainant was not the practice.

When asked to provide evidence of the feedback to the complainant 4 out of 9 patient counselors stated that they were informed telephonically, while others did not respond.

Table 5.15: Training or orientation

Category	Yes	No
DH/SH/GH/Ge H (7)	6	1
CHC (10)	9	1
Up PHC (1)	1	0
Total (18)	16	2

Patient counselor's assignment needs the behavioral skills along with proper understanding of the system that makes the work successful and in imparting these skills training plays an important role. 16 out of 18 patient counselors said that they received orientation training and 15 agreed to receiving guidelines for CF&CR which they were using.

Table 5.16: Number of complaints received

Category of Facility	2009-10		2010-11		2011-12 (April to Sep.)	
	Complaint registered	Complaints resolved	Complaint registered	Complaints resolved	Complaint registered	Complaints resolved
DH/SH/GH/Ge H (7)	126	121	138	135	106	75
CHC (10)	123	123	192	128	79	79
Up PHC (1)	No system existed		8	7	5	0
Total (18)	249	244	338	270	190	154

The trend of the complaints received could be used as one of the indicator of the performance of the working of patient counselor. The table above is a representation of the total complaints received by 16 of the counselors as 2 of the counselors said that they did not receive any complaints (Jhalawar District hospital and CHC- Aklera). It is clear from the above table that there was a gradual increase in the registration of complaints, showing that patients were aware about the grievance redressal system and the suggestion box and complaint registers were maintained well. When further asked about how many of the complaints were resolved, more than 86% of the complaints were resolved and most of complaints were resolved within the facility, reflecting on effectiveness of the complaint redressal system.

Table 5.17: Complaints transferred to HSIC

Category	2009-10	2010-11	2011-12	Total
DH/SH/GH/Ge H (7)	17	27	12	56
CHC (10)	11	9	11	31
Up PHC (1)	0	1	0	1
Total (18)	28	37	23	88

Fifty six from DH/SH/GH/Ger H and 31 complaints from CHC (April 2009- Sept 2011) were placed in HSIC. This implies that HSIT is capable to resolve most of complaints. Most of the complaints that were sent to HSIC were regarding either the equipments or filling of vacancies. Similarly a total of 14 complaints were sent to HSRT in the same time duration related to HCWM, staff vacancies and equipments etc.

Responses of Patients

Patient is always central to any of the intervention in the health system. To increase the trust of beneficiaries in the system, a mechanism was developed to receive his point of view. Perceived quality of the health system can only be improved if patients who avails the services are heard.

A total of 20 patients were interviewed out of them 19 said that they regularly visited the facility.

Table 5.18: Complaints lodged

Category of Facility	Yes	No
DH/SH/GH/Ge H (7)	4	3
CHC (12)	6	6
Up PHC (1)	1	0
Total (20)	11	9

When asked about whether they have ever complained about any of the service of the facility, 11 responded affirmatively for it.

Table 5.19: Addressing of complaint

Category	Doctor	Patient counselor
DH/SH/GH/Ge H (4)	1	3
CHC (6)	6	0
Up PHC (1)	1	0
Total (11)	8	3

When further asked to whom the complaint was addressed, it was observed that patients prefer to complain to the treating doctor. Complaint was registered through the patient counselors only in the 100+ bedded hospitals.

When further asked about how they expressed their complaint, 9 out of 11 said they verbally expressed it, while 2 said that they gave it in writing. At CHC and Up PHC level, all the complaints were expressed verbally.

Table 5.20: Type of complain

Category of Facility	Availability of Staff	Staff behavior	Infrastructure	Medical procedure	Cleanliness	Logistics
DH/SH/GH/Ge H (4)	1	0	1	2	0	0
CHC (6)	0	1	1	0	1	3
Up PHC (1)	0	0	0	1	0	0
Total (11)	1	1	2	3	1	3

So far as nature of complaints goes; of the total 11 complaints registered, majority of the complaints were regarding medical procedures and logistics. Logistics and cleanliness related complaints were registered only at the CHC whereas those related to medical procedures were relatively more at district level facilities.

Table 5.21: Resolution of a complaint expressed in verbal

Category of Facility	Yes	No
DH/SH/GH/Ge H (2)	2	0
CHC (6)	5	1
Up PHC (1)	1	0
Total (9)	8	1

Out of the 9 verbal complaints, 8 were resolved and only one remained unresolved. Out of these 8 resolved complaints, 3 were handled by patient counselor, 2 each by treating doctor and IV class and 1 by nursing staff.

Table 5.22: Time taken to resolve the verbal complain

Category of Facility	On the spot	1hr-6hr	24hr	4-5 days
DH/SH/GH/Ge H (2)	1	1	0	0
CHC (5)	3	0	2	0
Up PHC (1)	0	1	0	0
Total (8)	4	2	2	0

The action time on a complaint resolution matters a lot as it affects the satisfaction of the patient. Out of the total 8 verbal complaints that were resolved, **4 were solved on the spot** but 2 were resolved within a time interval of 1-6 hrs and other 2 were resolved in 24 hrs.

Table 5.23: Availability of patient counselor in the facility

Category of Facility	Yes	No
DH/SH/GH/Ge H (7)	6	1
CHC (12)	10	2

Up PHC (1)	0	1
Total (20)	16	4

When all the 20 patients were asked about the availability of patient counselor in the facility, most of the patients were very well aware of the patient counselor in the facility. When further enquired about whether patient counselor visited the patients, 15 out of the 16 patients agreed to it and that is quite creditable an effort on part of RHSDP.

A question regarding perceived role of patient counselor in the facility was asked to all the patients and most of the patients said that their main role was to facilitate the treatment and guide the patients and attendants for proper treatment.

Table 5.24: Level of satisfaction

Category of Facility	Highly satisfied	Satisfied	Neither satisfied nor Dissatisfied	Highly Unsatisfied
DH/SH/GH/Ge H (4)	1	3	0	0
CHC (6)	1	4	0	1
Up PHC (1)	0	1	0	0
Total (11)	2	8	0	1

Out of the 11 patients who had registered complaint, all of them agreed that their problem was resolved and **8 were quite satisfied, 2 were highly satisfied** and 1 was highly unsatisfied.

Recommendation

Health System Improvement Process adopted by RHSDP is a successful intervention. It can further be strengthening by providing proper training; periodical reviews, documenting the best practices and sharing them.

Implementation and sustainability of quality improvement program necessitated the establishment of a dedicated team at every facility with representation from each cadre of personnel.

- A mechanism of follow up on the action suggested by HSRT (QI cell) has to be developed. This can be developed through constant qualitative review of compliance of each of the decision taken.
- HSRT at state level need to expand by incorporating some other people as a member- Director Public Health, consultant-Hospital Management, Consultant- Quality Assurance, State Program Manager, NRHM and Director SIHFW.
- For further improvement, quality assurance teams should be created at district level with specific TOR. Teams should also visit the facility on regular interval and should provide the bench marks to the facility for improvement.
- IPHS and NABH standards need to be disseminated to the team members of the facility. If a facility is able to achieve the certain benchmarks, the facility should be facilitated to procure it. Exposure visit of the HSIT teams in NABH accredited hospitals can be one of the innovation to boost up their energy and provider the learning opportunities.
- Trainings related to team building and communication should be imparted to empower them to improve the facility.
- Consumers need to know where and how to file complaints. A place is selected to receive complaints, which is visible and accessible to consumers and is well-publicized to encourage consumers to voice their dissatisfaction.
- Complaints need to be prioritized on basis of severity level. Complaints which are more important should be addressed first.
- All complaints should be acknowledged.
- For Health system Improvement suggestions and contribution from users can be obtained. Workshops or citizen conferences can be organized to obtain the suggestions.
- Health system Improvement committee can be expanded by incorporating some members from community also. Donors, Philanthropist, social service provider’s can contribute along with service providers in the improvement of the system.

- To achieve success in complaint management, it is necessary to identify a single nodal person to assume responsibility for the overall management of complaints in the hospital. He should be someone who has the authority and the leadership skills to create change.
- Illiterate clients can register their complaints through phone calls if introduced for the purpose.
- The feedback from the public can be conveyed to practitioners, so that they can change their approach by which they are causing discomfort to the patients.
- CR&CF should be scaled up to other facilities also through NRHM.
- The patient counsellors should be introduced in all health facilities in a phased manner, particularly now in view of the RMSCL launched.