CHAPTER VI : QUALITY OF HEALTH CARE

6.1 National Quality Assurance Programme

The National Quality Assurance Programme (NQAP) launched by the Ministry in November 2013, and the underlying Quality Assurance guidelines are intended to create an inbuilt and sustainable quality for public health facilities that deliver quality health services. The guidelines define relevant quality standards, system of measuring these standards and institutional framework for its implementation. The Ministry, *inter-alia*, provides support to the States to establish the required institutional framework and to monitor the programme.

6.1.1 Institutional Framework

The quality assurance guidelines prescribe the setting up of organizational arrangements at National, State, District and Health Facility levels with defined roles and responsibilities for each level. The progress in this regard is discussed below:

A) National Level

➢ In terms of the quality assurance guidelines, the Ministry constituted a quality assurance team in December 2015 comprising of representatives from the programme divisions of the Ministry and National Health Systems Resource Centre[1] (NHSRC) to provide overall guidance, mentoring and monitoring the efforts for providing quality health services in the States. However, the team is yet to meet till date (February 2017).

➢ Audit observed that the quality assurance team had not made any visit to States to monitor the quality of services. The Ministry stated that such visits were undertaken by NHSRC. The reply is unacceptable. The tour and related records reveal that these visits of NHSRC during 2014-16 related to the conducting of training in the States, and not for the purpose of monitoring the quality of services in the States.

➢ Audit also observed that NHSRC did not review the quarterly reports sent by the state quality teams and submit reports to National Health Mission

[1] NHSRC was established in 2007 with the mandate to assist in policy and strategy development in the provision and mobilization of technical assistance to the States and in capacity building at the Centre and the States.

division incorporating recommendations for improvement. The Ministry accepted the facts.

B) State Level

(i) State Quality Assurance Committee

The guidelines require each State to constitute State Quality Assurance Committee (SQAC) for providing overall guidance, mentoring and monitoring of quality assurance efforts in the State. Though SQACs have been constituted in all States/UT (except the **Andaman and Nicobar Islands),** they failed to perform mandated activities like holding of half yearly review meetings, monitoring of Key Performance Indicators (KPIs)[2] etc., as discussed below:

SQACs did not hold any review meeting between 2013-16 in seven States (**Assam, Jammu and Kashmir, Jharkhand, Manipur, Punjab, Telangana** and **Tripura**). The shortfall ranged between 25 and 80 *per cent* in 12 States ((**Andhra Pradesh, Arunachal Pradesh** (80 *per cent*)**; Chhattisgarh, Meghalaya, Mizoram** (75 *per cent*)**; Bihar, Karnataka, Kerala** (50 *per cent*)**; Himachal Pradesh** (33 *per cent*) and **Madhya Pradesh, Odisha** and **Sikkim** (25 *per cent*)).

(ii) State Quality Assurance Unit

State Quality Assurance Unit[3] (SQAU) provides support to the SQAC for implementation of quality assurance activities in the State. Its main activities are to conduct six monthly independent/joint visits for assessment of health facilities, compile and collate monthly data on KPIs received from the districts, hold half-yearly review meetings and prepare reports.

State specific findings are discussed below:

- SQAU was not constituted in three States (**Assam, Meghalaya** and **Odisha**).

- In 12 States (**Andhra Pradesh, Arunachal Pradesh, Gujarat, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Manipur, Telangana, Tripura, Uttarakhand** and **West Bengal**), SQAU was constituted but no review meetings were conducted during 2013-16.

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[2] KPIs pertaining to Reproductive and Child Health include, Infant Mortality Rate, Maternal Mortality Ratio, Ante Natal care, Institutional Deliveries, Post Natal Care, Immunisation coverage etc.

[3] SQAU is headed by the SQAC member secretary and includes other state programme officers.

- In five States (**Jharkhand, Rajasthan, Telangana, Uttarakhand** and **West Bengal**), no field visits for assessment of facilities were made. However, few visits were made in eight States (**Andhra Pradesh** (3), **Arunachal Pradesh** (2), **Chhattisgarh** (8), **Himachal Pradesh** (7), **Karnataka** (8), **Kerala** (21), **Tamil Nadu** (5) and **Tripura** (21). In Tripura, 21 field visits were made, but no reports were prepared.

- The SQAUs in **Jharkhand** and **West Bengal** were non-functional due to non-appointment of members.

Non-assessment of facilities by SQAU

- In **Bihar** out of 10,391 facilities[4], only 69, 13 and 65 facilities were assessed during 2013-14, 2014-15 and 2015-16 respectively.
- Though **Chhattisgarh** has 27 internal Quality Assurance Assessors, they assessed only four District Hospitals (Korba, Kanker, Durg and Raipur) during the entire audit period.
- In **Tamil Nadu**, the facilities in the selected Districts were not assessed.

Absence of functional quality committees /units implies that services delivered at the health facilities were not assessed. This meant that no monitoring of quality assurance activities particularly relating to Reproductive and Child Health (RCH) like Ante-natal care, Post-natal care and immunization were being undertaken for remedial action.

C) District Level

(i) District Quality Assurance Committee

The District Quality Assurance Committee (DQAC) is responsible for monitoring the quality assurance efforts at District levels. Test check of 96 selected districts in 23 States/UT revealed the following:

- DQAC was constituted in 75 districts (78 *per cent*) only.
- Only 211 out of required 692 review meetings during 2013-16 were conducted with a shortfall of 70 *per cent*.
- DQAC was not constituted in any of the selected districts of two States (**Jharkhand** and **Meghalaya**).

[4] HSC: 9696; PHC: 534; CHC/RH: 70; SDH: 55 and DH: 36.

- No required quarterly review meeting was conducted in seven States (**Himachal Pradesh, Karnataka, Manipur, Odisha, Tamil Nadu, Tripura** and **West Bengal**), though DQAC was constituted.

- The reports were not shared with SQAC in four States (**Andhra Pradesh, Assam, Jharkhand** and **Sikkim**).

(ii) District Quality Assurance Unit

District Quality Assurance Unit (DQAU) provides support to DQAC and is responsible for undertaking various[5] activities, which among others, are to assess the facilities on quarterly basis and share the findings with SQAU.

Test check of 61 selected districts in 17 States/UT revealed the following:

- DQAU was not constituted in any of the 21 selected districts of six States/UT (**Andaman and Nicobar Islands, Assam, Jammu and Kashmir, Manipur, Meghalaya** and **Uttarakhand**).

- In the remaining 40 selected districts of 11 States (**Andhra Pradesh, Arunachal Pradesh, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Mizoram, Odisha** and **Tamil Nadu**), DQAU was not constituted in 10 districts (25 *per cent*).

- Though DQAU was constituted in 18 selected districts of seven States (**Arunachal Pradesh, Jharkhand, Karnataka, Kerala, Mizoram, Odisha** and **Tamil Nadu**), no assessment was done in any of the facilities during 2013-16.

- In three States, substantial shortfalls against the prescribed assessments (**Andhra Pradesh:** 85 *per cent*, **Haryana:** 88 *per cent* and **Himachal Pradesh:** 98 *per cent*) were observed.

- In **Andhra Pradesh**, 35 field visits were conducted during 2015-16, but no reports were prepared. As a result, there was no follow-up action on the findings of field visits.

[5] Roll-out of standard protocols for RCH services, conduct independent and joint visits to the health facilities; prepare draft report and recommendations based on the field visits, mentor the facility in-charge at the districts for implementing quality improvement measures, compile and collect monthly data received from facilities on outcome level indicators.

(iii) Formation of District Quality Team at District Hospitals

The quality assurance guidelines provide for constitution of District Quality Team (DQT) at the District Hospitals (DHs). It was however, noticed that out of 1,151 DHs, DQT was constituted in only 723 DHs resulting in shortfall of 33 *per cent* (March 2016).

- In seven States (**Assam, Karnataka, Nagaland, Meghalaya, Tamil Nadu, Kerala** and **Uttar Pradesh**), the shortfall was between 50 *per cent* and 76 *per cent* whereas in another seven States (**Andhra Pradesh, Gujarat, Haryana, Punjab, Sikkim, Uttarakhand** and **West Bengal**), the shortfall ranged between 20 *per cent* and 45 *per cent*.

- DQT was not constituted in any of the DHs in four States/UT (**Andaman and Nicobar Islands, Jammu and Kashmir, Telangana** and **Tripura)**

- The DHs in various States were in different stages of implementation of Quality Assurance Programme. 306 DHs were reporting KPIs, 250 DHs had implemented Standard Operating Procedures and 268 DHs had conducted periodic Patient Satisfaction Surveys (March 2016). The percentage of DHs reporting on all these three indicators was low ranging from 22 to 27 *per cent* indicating that the work of assessment of quality assurance was in the initial phase.

D) Facility Level

(i) Formation of Quality Assurance Team

The in-charge of each health facility is required to form an internal quality assurance team (IQAT), having representation from all departments, nursing staff, laboratory and support staff. The team is to meet periodically to discuss the status of quality initiative in their area of work.

It was noticed that out of 716 facilities in 19 States, IQAT was constituted in only 308 facilities (43 *per cent*). State-wise analysis revealed that the shortfall was between 75 to 95 *per cent* in 11 States (**Arunachal Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan** and **Tamil Nadu**). In three States (**Andhra Pradesh, Gujarat** and **Tripura**), the shortfall was between 53 to 67 *per cent*.

IQAT was not constituted in any of the selected 171 facilities in the six States/UT (**Andaman** and **Nicobar Islands, Assam, Jammu and Kashmir, Meghalaya, Telangana** and **West Bengal**). Thus, no activities under quality assurance programme were carried out in these States/UT.

(ii) Periodic internal assessment

In 541 selected health facilities of 15 States, the system of periodic internal assessment was formulated only in 114 (21 *per cent*) facilities.

In five States (**Arunachal Pradesh, Jharkhand, Telangana, Uttar Pradesh** and **Uttarakhand**), none of the 205 selected facilities had the system of internal assessment. Thus, due to absence of internal assessment at the facility level, there was no mechanism to identify the gaps in the services provided and their quality by the facility.

In 114 facilities of 15 States, the regular quarterly assessment was not done by IQAT. Against 1,368 quarterly assessments due to be carried out during 2013-16, only 574 (42 *per cent*) assessments were made.

As a result of shortfall in quarterly assessments, the lowest performing areas of the facilities remained unidentified for further analysis and corrective action.

(iii) Patient Satisfaction Survey

The quality assurance guidelines provide for a feedback (OPD – 30 patients, and IPD – 30 patients in a month, separately) to be taken on a structured format by the hospital manager. This feedback was to be analysed to see which are the low performing attributes and further action be planned accordingly. It was noticed that in 737 facilities of 20 States, only 8,167 feedbacks (0.5 *per cent*) against 15.92 lakh patient feedbacks were taken during 2013-16. In 11 States (**Arunachal Pradesh, Himachal Pradesh, Jharkhand, Mizoram, Rajasthan, Tamil Nadu, Telangana, Tripura, Uttar Pradesh, Uttarakhand** and **West Bengal**), no feedback was taken from the patients. Whereas, in the remaining nine States (**Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Karnataka, Madhya Pradesh, Odisha** and **Punjab**), the feedback taken from the patients was insignificant ranging from 0.01 to 6 *per cent*.

In the absence of patients' satisfaction surveys, gaps in the quality of service provided by the health facility could not be identified and addressed.

(iv) Monitoring of Key Performance Indicators

Hospital Managers are required to collate critical data from the departments and calculate KPIs to monitor them on monthly basis and report these indicators to DQAC and SQAC. It was, however, noticed that:

- KPIs were not monitored in 267 facilities of eight States (**Arunachal Pradesh, Andhra Pradesh, Himachal Pradesh, Jharkhand, Mizoram, Telangana, Uttarakhand** and **Uttar Pradesh**).
- Out of 411 facilities in 10 States, only 79 facilities (19 *per cent*) monitored the KPIs.

Since KPIs were not captured at the facility level, the monitoring of indicators pertaining to RCH viz., mothers receiving antenatal care, institutional deliveries, safe delivery, mothers receiving post natal care and immunisation coverage could not be monitored by DQAC and SQAC for evaluation and remedial measures. State wise details of monitoring of KPIs are given in **Annexure-6.1**.

(v) Standard Operating Procedures and Work Instructions

For standardizing the clinical and management processes at facility level, each facility is required to document and implement the standard operating procedures (SOPs). Appropriate training is also to be provided to the staff on SOPs. Audit noticed that:

- Out of 746 facilities in 20 States, SOPs were documented in only 219 facilities (29 *per cent*).
- In five States (**Andhra Pradesh, Himachal Pradesh, Jharkhand, Telangana** and **Uttarakhand**), SOPs were not documented in any of the selected facilities.
- In 10 States (**Arunachal Pradesh, Bihar, Chhattisgarh, Gujarat, Haryana, Karnataka, Odisha, Punjab, Rajasthan** and **Tripura**), shortfall of facilities having SOPs ranged between 75 and 96 *per cent* whereas in three States (**Madhya Pradesh, Mizoram** and **Tamil Nadu**), shortfalls ranged between 40 and 70 *per cent*.
- Out of 219 facilities where the SOPs were documented, staff of only 125 facilities was oriented/trained for SOPs. State wise details are given in **Annexure-6.2**.

6.1.2 Review of maternal and infant death cases in the selected districts

(i) Maternal death review

Maternal death review is an important strategy to improve the quality of obstetric care and reduce maternal mortality. Every health facility is required to conduct death audit for all deaths happening in the facility. The facility should also report the data relating to maternal and infant deaths to DQAU on monthly basis.

In 66 selected districts of 13 States/UT, it was noticed that maternal death review was not carried out by the facilities in respect of all the death cases occurring therein during 2013-16. Out of 4,846 maternal death cases reported at facilities, records on 2,917 cases (60 *per cent*) were examined in audit. It was revealed that no maternal death review was conducted by facilities in **Himachal Pradesh**, while in eight States (**Andhra Pradesh**, **Assam, Bihar, Jharkhand, Rajasthan, Tamil Nadu, Uttar Pradesh** and **West Bengal**), seven to 87 *per cent* cases were reviewed. In three States (**Chhattisgarh, Maharashtra** and **Sikkim**), all the cases were reviewed.

Further, only 315 cases of death (7 *per cent*) in the 66 selected districts were reported to DQAU. Four States (**Andhra Pradesh, Telangana, Uttar Pradesh** and **West Bengal**), did not report any death case to DQAU, while in the six States (**Assam**, **Chhattisgarh**, **Jharkhand**, **Maharashtra, Rajasthan** and **Tamil Nadu**), four to 52 *per cent* cases were reported to DQAU.

From the death review reports, it was noticed that the main causes of maternal deaths were anaemia, delay in transportation, non-availability of blood for emergency transfusion, improper ante-natal check up, post-partum haemorrhage, insufficient equipment and inadequate knowledge of ANM/ASHA, etc.

(ii) Infant death review

In 52 selected districts of 11 States/UT, out of 10,930 infant death cases reported at the facilities, only 2,320 cases (21 *per cent*) were reviewed. State-wise analysis revealed that no case was reviewed in **Himachal Pradesh** and **Sikkim** whereas, in eight States (**Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Rajasthan, Tamil Nadu** and **Telangana**), only one to 88 *per cent* death cases were reviewed. It was noticed that the majority of infant deaths occurred due to low birth weight and respiratory problems indicating poor quality of ante and post natal services delivered at the public health facilities and failure to take appropriate action on time.

6.1.3 Results of facility survey

The facility survey conducted in 134 DHs, 300 CHCs, 514 PHCs and 1,425 SCs revealed shortfall in the quality indicators as detailed in **Table-6.1** below:

Table-6.1: Availability of quality indicators in the health facilities

Sl. No	Quality Indicator	*Per cent* of selected health facilities where the quality indicators was not available			
		DH	CHC	PHC	SC
1.	Prominent display board with name of the facility in local language which is readable at night.	15	19	26	44
2.	Citizen Charter displayed at OPD and Entrance in local language including patient's rights and responsibilities.	32	25	43	69
3.	Suggestion/complaint box.	13	19	51	82

The Ministry admitted that though many States made provision for Quality consultant position under National Health Mission (NHM), the recruitment process was slow because there were not enough trained quality professionals available.

6.1.4 State and National level certification of health facilities

Quality assurance guidelines have a provision for state and national certification of public health facilities. Once a health facility complies with National Quality Standards for Public Health, the state level certification can be granted and thereafter the national certification.

Only a few health facilities have been granted quality certification. Out of 42,503 Public Health facilities (DH, CHC and PHC), 106 facilities have received State level Quality Assurance certification (**Gujarat-90, Haryana-7, Kerala-4, Mizoram-1, Odisha-1, Rajasthan-1** and **Sikkim-2**) and four facilities have received national certification (**Haryana-2, Kerala-1** and **Odisha-1**) (March 2016).

Thus, implementation of quality assurance programme is deficient even after three years of its commencement.

6.1.5 Allocation of funds for Quality Assurance and its utilisation

States are responsible for including the requirement of funds for Quality Assurance Programme in the annual state Programme Implementation Plan.

In 18 States, against the requirement of ₹ 132.83 crore, reflected in State Programme Implementation Plans during 2013-16, ₹ 85.64 crore was allocated. States were not able to utilize even the allocated amount with the spending remaining low at ₹ 42.89 crore. It was noticed that the reasons for low utilization of funds were delay in constitution of Quality Assurance Committees/Units, Non-recruitment of Human Resources; Inactive quality assurance Committees/Units and Non-organizing of training for health personnel on Quality Assurance.

The Ministry stated that the initial two years' time was introduction phase where efforts were invested in spreading awareness, instituting the policy and organizational framework in States and it was expected that in coming years, the program will multiply its dividends in terms of number of quality certified facilities and better quality and safe care at public health facilities.

6.2 Monitoring

Successful implementation of the Mission greatly depends on proper monitoring and evaluation whereby, elaborate organisational arrangements have been prescribed at Central, State, District, and Gram Panchayat level with clearly defined roles and responsibilities at each level. The following was observed:

- At the Central level, the Mission Steering Group (MSG), headed by the Union Minister of Health and Family Welfare is the highest policy making and steering institution under NHM. Audit observed considerable delays, up to 248 days, in conducting the meetings of MSG raising important issues of governance.

- Common Review Mission (CRM) is one of the important mechanisms under NHM. Teams were constituted comprising Government Officials, Public Health Experts, Representatives of the Development Partners and Civil Society Organisations. Although the CRM team has been pointing out various deficiencies in the functioning of health centres subsequent to their field visits, these have not been effectively addressed.

- At the State level, the Mission functions under the overall guidance of State Health Mission (SHM) with Chief Minister as Chairperson, the State Health Society (SHS) headed by Chief Secretary, and the State Project Management Unit headed by the Mission Director. Audit evidenced large shortfalls, ranging from 29 to 100 *per cent,* in holding

of meetings by the committees of SHM and SHS as detailed in **Annexure-6.3**.

- At the district level, the District Health Mission (DHM) is headed by the head of the local self-government i.e. Chairperson Zila Parishad/ Mayor and every district has a District Health Society (DHS), headed by the District Collector. The monitoring at district level is mainly undertaken by the District/ City Level Vigilance and Monitoring Committees (D/CLVMC), headed by the local Member of Parliament. The committees were required to meet quarterly. In **Arunachal Pradesh** and **Himachal Pradesh**, no meetings of DHM and DHS (Governing Body) or DHS (Executive Committee) were held in any of the selected districts during 2011-16. Significantly, in three States/UT (**Andaman and Nicobar Islands, Jammu and Kashmir** and **Meghalaya**), no meetings of D/CLVMC was held in any of the districts during 2015-16.

- As per the IPHS, Monitoring Committee, comprising Panchayati Raj Institutions (PRIs), representatives of user groups, community based organizations, NGOs etc., needs to be formed at village, block and district levels. The Committee is required to monitor and validate the data sent to higher authorities by the ANM and other functionaries of the public health system. These committees were not constituted in the selected districts of four States (**Assam, Odisha, Sikkim** and **Uttarakhand**). In **Haryana,** PRIs were not involved in these committees.

- The shortcomings in respect of Village Health Sanitation and Nutrition Committees (VHSNC) are as detailed below:

  a. In **Himachal Pradesh** and **West Bengal** shortfall of 81 *per cent* and 35 *per cent* respectively was noticed in formation of VHSNC.
  b. In **Sikkim**, monitoring of PHCs was not being done through PRIs/VHSNC
  c. In **Tripura** none of the VHSNCs in two selected districts had prepared Village Health Action Plans during 2011-16

- The framework for implementation of NHM 2012-17 provides for establishing an accountability and governance framework that includes Social audit. Under this, community members are to assess, review and suggest recommendations in the implementation of health programmes, which will enhance participation of people in planning, implementing,

monitoring and evaluation of public health programmes. In the selected districts of eight States (**Andhra Pradesh**, **Arunachal Pradesh**, **Assam, Himachal Pradesh, Odisha, Sikkim, Telangana**, and **Uttar Pradesh**), social audit of the health facilities was not conducted. In **West Bengal**, records related to social audit, were not provided to Audit.

6.3 Evaluation

The erstwhile Planning Commission (now NITI Aayog) was to evaluate the implementation of the programme. An evaluation study on NRHM in seven States (**Assam, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Orissa, Tamil Nadu** and **Uttar Pradesh**), was conducted by it in February 2011 i.e. during the 11th Plan period. However, no evaluation study was conducted subsequently.

6.4 Beneficiary Survey

Sampled beneficiaries were interviewed during the course of audit to ascertain the quality of health services offered and difficulties faced by them during their visit to government health facilities i.e. District Hospital (DH), Community Health Centre (CHC), Primary Health Centre (PHC) and Sub-Centre (SC).

Within each SC, 10 women beneficiaries, who had their deliveries during the last 24 months, were selected by Systematic Random Sampling without Replacement (SRSWOR) method from the consolidated list of beneficiaries prepared using records maintained at the SC, records maintained by ASHA and JSY database of each selected SC. 13,835 beneficiaries were interviewed in 28 States and one UT. The sample size of beneficiaries varied from 71 in Mizoram to 1,650 in Uttar Pradesh. The beneficiaries were interviewed through a structured questionnaire which apart from capturing basic information about the beneficiaries (age, education level, etc.) also sought to capture information on their awareness about ASHA and ANM, antenatal care, delivery, postnatal care, quality of services etc. The results of Beneficiary Survey are detailed in **Annexure-6.4**.

Conclusion

The institutional framework for implementation of National Quality Assurance Programme was either not in place or if present, was not effective in assuring quality of services across all levels viz. national, state, district and facility. Low number of internal and external assessments of health facility, inadequate reporting, non-evaluation of key performance indicators, absence of periodic review meetings, non-conducting of field visits indicated that quality

assurance and monitoring systems were not in place. Non- availability of staff and lack of capacity building through training and orientation on quality assurance activities were other impediments. Utilisation of funds under the programme continued to be poor. Thus, even after a lapse of almost three years, the implementation of Quality Assurance Programme was in a nascent stage.

The inspections and monitoring system devised for successful implementation of the Mission were not being wholly implemented at the Central, State and District levels.

The beneficiary survey brought out lower awareness levels among the beneficiaries about various services delivered under NRHM and its access to the people. The results of the survey indicated moderate level of satisfaction among the beneficiaries with respect to programme delivery.

Recommendations:

- The Ministry and the States should secure compliance with the operational guidelines for quality assurance at all levels.
- Assessment of health facilities on the defined parameters should be documented and reviewed on a consistent basis for taking appropriate follow up action.
- Provision for monitoring the implementation of National Quality Assurance Programme may be made in the Health Management Information System.
- The Ministry/State governments need to strengthen the monitoring mechanism at all levels.
- To achieve the objective of NRHM to deliver reliable and efficient health care to the needy rural population, the Government should strengthen the institutional and quality control systems. The Ministry in coordination with the State governments also needs to address the systemic inefficiencies pointed out in this Report.