Grievance Analysis & Systemic Reforms Recommendation

GRIEVANCE DATA ANALYSIS PROJECT

(Objective & Outcome)

Context

Department of Administrative Reforms & Public Grievances (DAR&PG) administers a public grievance portal - Central Public Grievance Redress and Monitoring System (CPGRAMS). This is a portal where the citizen can register his/her grievances pertaining to any of the 94 Central Government Departments/Ministries.

This portal receives ~3,00,000 complaints annually across the 94 Departments/Ministries and the number of grievances registered has gone up from 1,32,751 between May 2014 to September 2014, to 4,66,406 in the same period, i.e., from May 2015 to September 2015, due the Prime Minister's personal interest.

The grievances received on the portal are rich data points, especially in terms of the type of reforms (administrative and policy) that would create maximum positive impact on the citizens.

Objective

The objective of the diagnostic study undertaken by the Quality Council of India, as per the mandate given by DAR&PG, was two fold:

1. Grievance Data Analysis (in bold): Analysis of the grievances being received by the respective Departments/Ministries on CGPRAMS and identification of key issues
2. Systemic Reforms Recommendation: Identifying key systemic reforms that can be implemented to resolve these issues to prevent recurrence of these issues

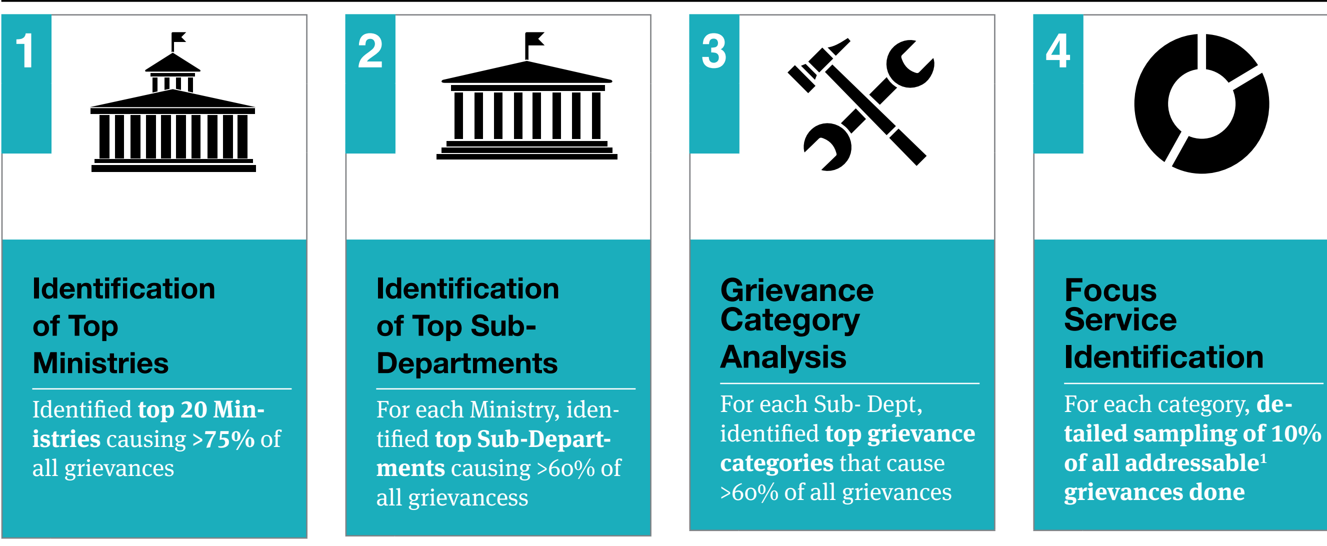
Approach

To ensure that the above objectives are achieved, a 3 point approach has been used, which has been detailed below:

1. Data analysis of the grievances across top 20 (based on number of grievances received) prioritized Ministries with a structured approach which has been detailed in the diagram below.

Data Analysis Process for all Ministries

Focus on identifying services that cause maximum number of grievances



2. Root cause analysis of the above grievances in conjunction with the respective Departments/Ministries, explained in detail on page 7.
3. Systemic and structural changes reform recommendations after discussions with the Department/Minsitry based on learnings from global and domestic best practices

Identification of the top 20 Department/Ministries for initial focus of efforts

The first step of the effort, as per the approach mentioned earlier, is the identification of the top 20 Ministries, which has been done based on the number of grievances being received by the particular Department from 01.01.2012 to 19.08.2015. The findings have been summarized in the table below and for the scope of this particular report we will be focussing on the Department of Health and Family Welfare (rank 9).

List of top Ministries/Departments based on combination of quality parameters

		No. of Grievances recieved		No. of Grievances pending (> 12M)		No. of Grievances pending (6M - 12M)	
Overall Rank	Ministry	Rank	No. of Grievances	Rank	No. of Grievances	Rank	No. of Grievances
1	Department of Telecommunications	1	161,014	13	11	11	126
2	Ministry of Railways (Railway Board)	2	76,776	3	878	2	1,750
3	Department of Financial Services (Banking Division)	3	65,095	16	-	13	43
4	Ministry of Home Affairs	4	41,443	11	47	12	73
5	Central Board Of Direct Taxes (Income Tax)	5	38,825	5	381	9	200
6	Department of Higher Education	6	34,594	2	1422	1	2,143
7	Ministry of External Affairs	7	30,780	16	-	17	-
8	Department of Posts	8	27,552	14	9	15	17
9	Department of Health & Family Welfare	9	27,552	10	52	10	160
10	Ministry of Petroleum and Natural Gas	10	26,836	7	83	8	447
11	Ministry of Labour and Employment	11	25,835	16	-	17	-
12	Department Of Defence	12	25,423	1	1877	6	744
13	Department of School Education and Literacy	13	23,862	8	68	3	1,114
14	Department of Personnel and Training	14	21,681	12	12	16	14
15	Ministry of Road Transport and Highways	15	20,660	6	198	4	984
16	Ministry of Urban Development	16	15,187	4	400	7	459
17	Department of Justice	17	13,879	16	-	17	-
18	Central Board Of Excise and Customs	18	12,698	15	3	14	27
19	Department of Revenue	19	12,616	9	64	5	954
20	Department of Ex Servicemen Welfare	20	12,062	16	-	17	-

SOURCE: DARPG Data (01-01-2012 to 19-08-2015)

Focusing on these 20 ministries/departments will target ~73% of the overall grievances in Central Govt.

DEEP DIVE ANALYSIS

Introduction

Ministry of Health and Family Welfare, as the name suggests, is the ministry responsible for the developing of health policy in India. The Ministry has two major Departments that are responsible for execution of the various policy matters, namely: (1) Department of Health and Family Welfare, and (2) Department of Health Research.

The Department of Health and Family Welfare oversees the policy development, and the delivery of primary healthcare services to the citizens. The department has oversight over the process for selection of doctors, and rules for their practice, and they also design control measures for the drug and food quality. In addition to monitoring the policies for these processes, the department is also responsible for the running of the government healthcare services centers made available to the citizens and the special provisions for the government employees, pensioners and ex-servicemen.

The following document contains an evaluative study of the delivery of these services to the citizens, based on the grievances received by the Health & Family Welfare Department.

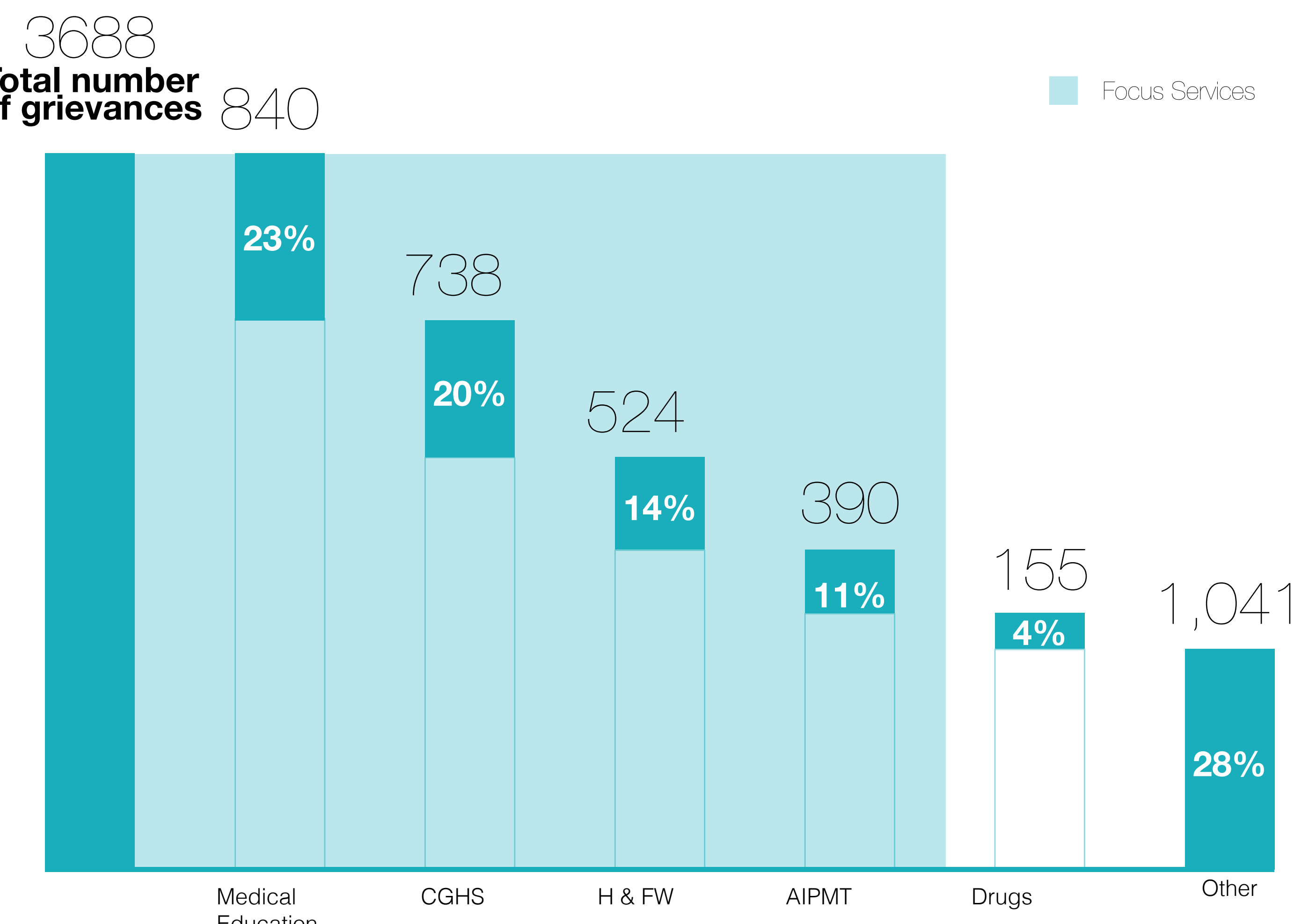
Identification of top Sub-Departments

As per the methodology mentioned above, the first step was to break the grievances down in terms of the sub -departments it was being forwarded to.

These sub-departments have been defined as per the officer-in-charge who it is forwarded to within the Department/ Ministry, as defined by the respective Department/Ministry.

For the Ministry of Health & Family Welfare, the sub-departments receiving maximum number of complaints have been defined by service/responsibility of that Director. The highest grievances have been received by the Medical Education Dept -led by Deputy Secretary S S (as defined by the Ministry), and the next highest grievances received by CGHS - Director Central Government Health Scheme.

The figure below depicts the sub-departments that receive the maximum number of grievances for this particular department, and a detailed category wise analysis for the sub-departments is shown below. The top 4 departments, account for ~70% of all grievances and have the grievances received by these sub-departments have been analyzed further.



Identification of Focus Service

The next step as defined in the process earlier, is to grievance-by-grievance analysis for a sample of the grievances received by the top 4 sub-departments, namely, Medical Education, Central Government Health Scheme, Health & Family Welfare and All India Pre-Medical Test (AIPMT).

For the Ministry of Health & Family Welfare, the top recurring addressable issues across the sub-departments have been summarized below in the table.

The top most issue for the Ministry is the quality of service at the CGHS centres which accounts for ~25% of all addressable grievances, followed by the Enforcement of MCI norms which account for 18%. The specific details of these two type of grievance issues and the other grievances issues have been detailed out in the table below

4 services identified to focus on for designing process reforms

Focus services for deep dive

	Top Grievance Causing	Impact %[1]	Details
1	CGHS Center Service Quality	25%	• Doctors & staff are unavailable, no appointments system; long waiting times • Service quality level is low (customers are mistreated)
2	CGHS Reimbursements (Servicemen & Pensioners)	7%	• Reimbursement process cumber some & slow (frequently takes >30 days) • Reimbursements not completed, de spite "Transferred" status in CGHS system
3	CGHS Drugs Availability & Purchasing	7%	• Drugs are very frequently unavailable; restocking takes very long • Customers are asked to come multiple times to buy drugs (after consultation)
4	MCI Enforcement of Norms	18%	• Colleges not functioning as per norms – Fake compliance of MCI Norms; insufficient oversight of compliance
5	FMG (Foreign Medical Graduates) Examination	7%	• License exam very tough for FMGs, very few seats • Unclear awareness of expectations & content of FMG exams

3688 grievances received by Dept. of Health and Family Welfare between 1/4/2015 and 31/8/2015

1 Impact is defined as a fraction of all addressable grievances - those that can be solved through administrative reforms

Conclusions

For the focus services identified, the ones that are addressable and with maximum impact have been selected for further analysis. For the given department, the top 4 grievance causing services are chosen for further deep-dive and root cause analysis.

The issue regarding, "Regulations regarding Foreign Medical Graduates Examination", has been de-prioritized as it primarily is a policy concern, and the following conclusion was reached after consulting with the department representatives.

The following section details the process flow for the root cause analysis, and the procedure followed for coming up with systemic reforms for each one of the service issues

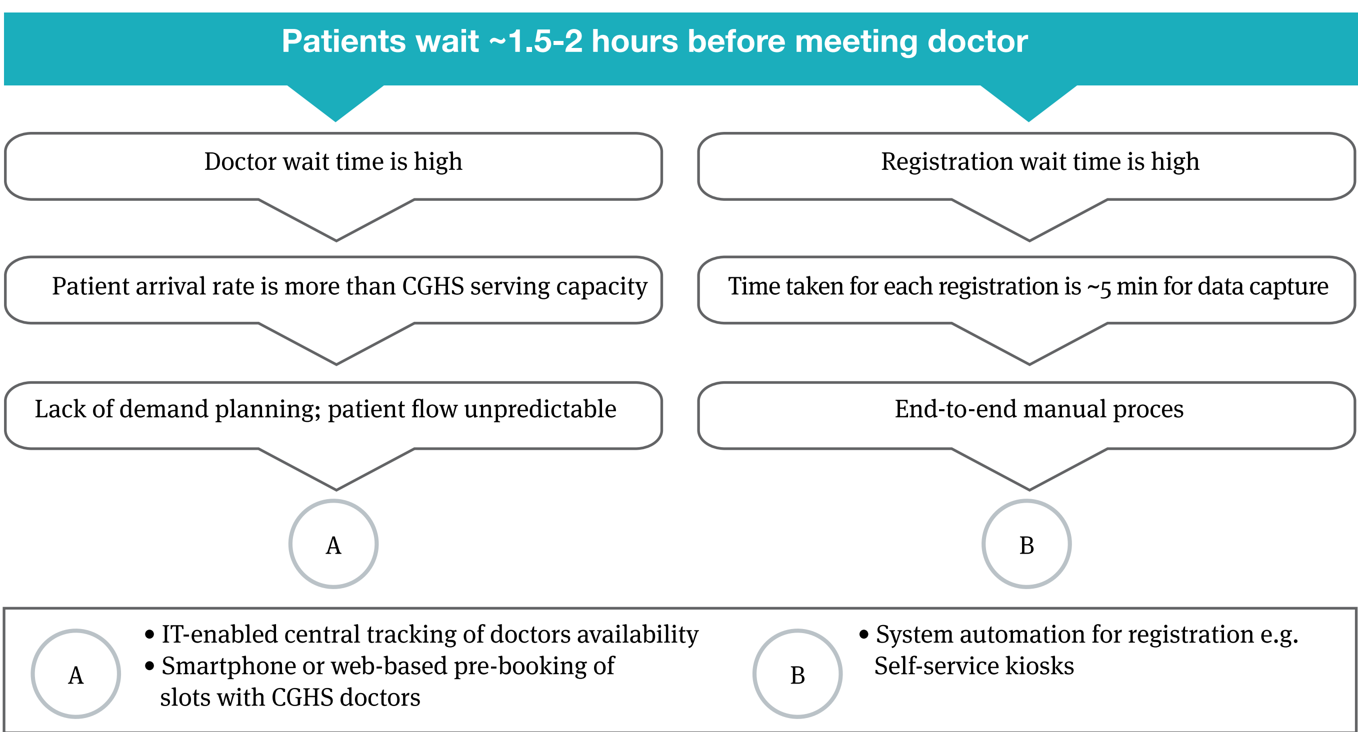
ROOT CAUSE ANALYSIS

Conducted detailed discussions with each Ministry to define root cause for each focus issue

For each of the focus service issues that has been identified, the study tries to evaluate the root cause behind the lack of quality implementation of that service. The study team has spent time with each one of the implementation bodies within that department to understand the core process, accountability and performance tracking, and also the training aspects for the leadership and frontline staff.

The root cause analysis has been detailed out for one of the issues below, to give a flavor of the process followed for identifying the types of interventions required for better delivery of that service.

Problems High wait time for patients at CGHS center



"For instance, in CGHS Centers, "High wait time for patients" was one of the recurring issues and the study team analyzed from two perspectives, (i) Doctor wait time being high or (ii) Registration wait time being high.

For the high doctor wait time, the team spoke to Director, CGHS and other Central Govt. employees to understand that the patient arriving were much higher than the CGHS serving capacity, and there was a lack of demand planning.

From best practices from the private industry, and easy solution for that would be to have an IT-enabled central tracking of doctors availability, and an easier app-based or web-based pre-booking of slots with CGHS doctors. A similar analysis was done for the high registration wait time, and self-service kiosk at the CGHS center has been proposed"

Quality implications

Quality failures

Manual process is redundant and time- consuming Limited CGHS staff and doctors on-time Peak times are understaffed, lean times are overstaffed

Culture and capability building failure

Lack of citizen centric culture, leading to unhappy citizens/customers Discomfort with using IT tools to simplify processes

STRUCTURAL REFORMS DESIGN

(Initial thoughts & next steps)

The focus services identified for further analysis are studied in detail. The processes for the delivery of the service, the monitoring mechanism, and other aspects of service delivery have been studied as a part of the project.

For each one of the issues, the key root cause for the improper delivery of service is identified and studied, and a corresponding solution or recommendation is designed. These recommendations are arrived at in conjunction with the ministry representative, and are based on global best practices. These solutions have been finalized post interactions with experts from that particular field or experts who have implemented similar solutions.

The utility of these systemic recommendations is to serve as starting points for improving the quality of services, and the final solution would take shape after further discussions. The following table summarizes the reform recommendations across all sub-departments and issues, and tries to capture the ease of implementation of these recommendations. The detailed root cause analysis for each of the issues follows thereafter, giving an understanding of the procedure used to arrive at these recommendations.

Summary: MoHFW Top Process Reforms

	Process Reform	Description	Proposed Owner	Ease of implementation	Impact (% grievances)
1a	CGHS IT enabled Attendance System	**Aadhar linked attendance tracking of doctors & staff at CGHS Centers**	DG, CGHS	Medium	2%
1b	CGHS Doctor Appointment Mobile App	**Mobile & web app to pre- book appointments at CGHS Centers**	DG, CGHS	Medium	4%
1c	CGHS Self Service Kiosks	**Training on improving customer-employee interaction; NPS tracking**	DG, CGHS	High	4%
1d	CGHS e-Card system	**Dismantle physical card system; allow bar-code enabled self-printed "cards"**	DG, CGHS	High	9%
2a	CGHS Online Reimbursement System	**IT enabled system for CGHS reimbursements for servicemen & pensioners**	DG, CGHS	High	4%
2b	CGHS Tracking of Defaulting Hospitals	**Tracking & penalizing system for private hospitals demanding onsite payment**	DG, CGHS	Low	4%
3a	CGHS Pooled Procurement Drug System	**Centralized procurement for drugs across all 300 CGHS facilities**	DG, CGHS	Low	4%
3b	CGHS Decentralized Drug Distribution System	**Optional home delivery & dedicated pick up points for drugs**	DG, CGHS	Medium	7%
4	IT enabled tracking of MCI accreditation	**Shift to e-tracking system with central database of all MCI colleges & staff**	DDG, MCI	Low	16%

Ease of implementation: Medium (yellow), High (green), Low (red)

For each one of the reforms summarized in the above table, a detailed description of the root cause for the below par service quality, a proposed solution based on global and local best practices, and the current status of such an initiative being undertaken by the government has been mentioned in the following part of the report.

For each one of the issues, the problem has been broken into multiple parts in order to ensure that each aspect of the problem is addressed independently, while ensuring maximum impact.

Inadequacy in quality of CGHS Services

Issue analysis and proposed solution

Focus issue	Root Cause	Proposed solution	Current status
Unavailability of doctors and hospital staff	Doctors, staff frequently late; No tracking system to keep checks No central performance monitoring leads to zero risk of penalty IT systems exist but not functioning	•**Biometric attendance** system, with central tracking of CGHS employees •**Link KPIs with attendance;** will also conduct dashboard analysis e.g. on-time staff, hours off, patients returning, etc to levy penalty e.g. Attendance system at GoI offices for staff	Similar initiative being implemented by NIC in New Delhi (to be completed in ~6 months) Rollout plan unclear
CGHS Cards not issued on time	End-to-end manual process Outsourced to third party leads to no control on printing process	•**e-CGHS card download** system, with same validity as original one •**User IDs linked to Govt.** IDs; allow multiple downloads (card loss/misplaced cases) e.g. e-Aadhar card system	Similar initiative being ideated by CGHS
High wait times for customers to meet with doctors	End-to-end manual process No tracking of doctor's availability 7AM-9AM rush hours, limited supply of doctors	•**Smartphone app or web based** pre-booking and checking of availability of CGHS doctors e.g. Practo app for booking doctor appointments •**Self-service kiosks** for cutting registration wait time e.g. New York self-serve channel (~4000 city services), SBI self- service kiosks	Similar initiative being implemented by NIC in Bengaluru for specialists (no plan to extend to GDMOs)
Citizen-staff interaction not friendly	No fear of job loss or of punitive action on citizen's complaint	•**Customer feedback collection** and live display on MoHFW website •**Mandatory training** on soft skills, to coach front line personnel e.g. Soft training in service firms	No plan currently in place

CGHS Reimbursements

Issue analysis and proposed solution

Focus issue	Root Cause	Proposed solution	Current status
Delayed & Incomplete Reimbursements	End-to-end manual process; physical document requirement leads to postal delays Handwritten details leads to incorrect bank account numbers	•**IT-enabled online expense** reimbursement, with required approvals still resting with Pay & Accounts Department •**User IDs linked to Govt. IDs & Aadhar**; will also enable creation of Employee Medical Records. e.g., e-filing system of Income Tax Dept.	Similar initiative implemented for bulk claims from listed hospitals No plan for individual claims in place
Empanelled hospitals demand payment despite cashless system (pensioners)	CGHS reimburses amounts much lower than market-rates for a service in a private hospital Doctor incentivized to charge more	•**Dedicated grievance** redressal system for this issue •**Hospitals with track** record of demanding payment to be blacklisted	No plan currently in place

CGHS Drugs Availability & Purchasing

Issue analysis and proposed solution

Focus issue	Root Cause	Proposed solution	Current status
Drugs are frequently unavailable in CGHS dispensaries	Each CGHS independently sources drugs from a different supplier Demand forecasting difficult ineffective Given single-tender, no incentive for supplier to ensure high standards	•**Pooled drug procurement** system for all CGHS centers – All CGHS centers to source from predefined set of suppliers with centralized tendering •**Demand forecasting to be done individually,** purchasing done centrally e.g., WHO Global Drug Facility, TNMSC[1], Tamil Nadu State Govt.	Supplier monitoring system being planned, but retaining independent sourcing
Large wait times for customers while purchasing drugs	Insufficient capacity in CGHS centers to handle demand Dispensaries not open throughout the day	•**Decentralized drug collection** – 3rd party tie-up (e.g. pharmacy) to install CGHS pick-up counters for drug collection – Optional home/office delivery through outsourced vendors e.g., NHS Choices (UK), Medicaid (USA)	No plan currently in place

Enforcement of MCI Norms

Issue analysis and proposed solution

Focus issue	Root Cause	Proposed solution	Current status
Colleges not functioning as per MCI norms	Ineffective monitoring & approval system Collusion b/w inspectors & colleges	• **Primary issues being resolved** through other efforts • 3rd party assessment of MCI colleges; ensuring checks conducted with no pre-intimation e.g. 3rd party inspection of ITIes by QCI, Independent assessors under FSSAI	All initiatives being implemented through the New MCI Act
Doctors register presence at multiple colleges	Verification process conducted manually and paper-based No centralized database of medical practitioners	•**Link Unique ID with MCI** registration ID of every doctor •**IT-enabled tracking of all doctors** present during inspection; system to flag when discrepancies present •**Inspection to be conducted online;** data to be automatically uploaded on completion e.g. Aadhar card system	No action plan in place although conceptual plan exists

For each one of the suggestions/recommendations given above we would plan to sit with the Ministries and chalk the way forward, with ownership of these reforms lying with the respective owners of these projects. These will serve as starting point for further discussions within the Departments to ensure quality delivery of services to the citizen.

It is important to understand that each one of these Ministries will have their own final definitions of these reforms which will be developed based on further discussions and deliberations.

GLOBAL BEST PRACTICES

The objective of the study, as mentioned earlier was to identify interventions in the execution of the services provided by the government. These issues faced by the departments at the Central level in India have been faced before by other organizations in both the private and public sector in both India and globally. The global and local learning's have been incorporated into the recommendations made for each one of the process reforms. The details of the global best practices for pool procurement and other suggestions have been listed below.

CGHS Drugs Availability

8 Pooled Procurement Organizations (PPOs) were profiled to understand key trends

GAVI ALLIANCE	CLINTON FOUNDATION	Pan American Health Organization	TNMSC		SADC	Stop TB Partnership GLOBAL DRUG FACILITY	OECS
76	**70**	**23**	**1** STATE IN INDIA	**7** IN THE MIDDLE EAST	**15** IN SOUTHERN AFRICA	**~90**	**9** IN EASTERN CARIBBEAN AREA
NA (10 COMPANIES)	~40 (8 COMPANIES)	~115	~270	~9000	~50	120 (22 COMPANIES)	~700 (365 COMPANIES)
6 (PENTAVALENT, MENINGITIS A, YELLOW FEVER, PNEUMOCOCCAL, ROTAVIRUS, MEASLES	3 (HIV, AIDS, TB)	~5 (HIV, TB, MALARIA ETC.)	N/A	N/A	~6 (MALARIA, TB, HIV ETC.)	1 (TB)	N/A
GENEVA, SWITZERLAND	BOSTON, USA	WASHINGTON D.C, USA	CHENNAI, TN	RIYADH, SAUDI ARABIA	GABORONE, BOTSWANA	GENEVA, SWITZERLAND	CASTRIES, ST. LUCIA
2000	2003	2000	1994	1976	2014	2001	1986

Key themes around processes and organization structure/location seen across the 8 PPOs

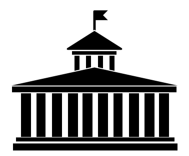
PPO Processes

Demand Forecasting

Member countries determine future demand and communicate to PPOs; PPOs provide tech assistance

Examples

2

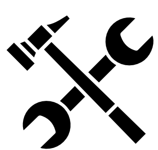


Ordering

Centralized restricted tendering process with **annual tender** by almost all PPOs

Examples

3

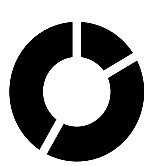


Payment

Group payment (countries pay PPO, PPO pays supplier)

Examples

4



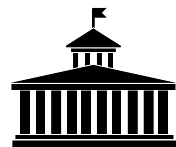
Procurement

- **Direct shipment from supplier to member country.**
- Member country distributes from port of entry

Examples

All (wherever data available)

PPO Processes



Organisation Structure

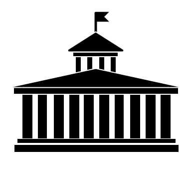
PPOs managed by **central PMO team**, with **member countries MOHs** convening regularly to decide policy

Have **tender/bidding** teams, **technical** teams and on-ground **country experts**

Examples

All (wherever data available)

2



Location

Location specific PPOs headquartered **in capital of a member state**; global PPOs headquartered in the West

Examples

All (wherever data available)

CASE STUDIES

Organization of Eastern Caribbean States Pharmaceutical Procurement Service

KEY DETAILS

# of countries
9 Eastern Caribbean countries

# of diseases
Unknown

# of drugs, suppliers
Approximately 700 items from 365 approved manufacturers

Size
N/A

Location
Castries, Saint Lucia

Founded
1986

SPECIFICS

“How they order?”
Centralized, restricted tendering system

“How they procure?”
OECS/PPS awards annual contracts, place orders directly with suppliers, and monitors delivery and supplier performance

OECS/PPS does not warehouse supplies, but instructs suppliers to ship consignments directly to participating countries which in turn reimburse their respective ECCB drug accounts

“How do they fund the order?”
Eastern Caribbean Central Bank has individual country drug accounts

“Who forecasts demand?”
Countries are equipped with tailor-made database that maintains a perpetual inventory record of all issues and receipts

OECS/PPS convenes seminars on inventory management to ensure that the health facilities have a regular supply of pharmaceuticals

OECS / PPS Policy Board

Comprised of Ministers of Health (assisted by their Permanent Secretaries), the OECS Director General, the ECCB representative and the OECS/PPS Managing Director;

Exercises overall responsibility for the policy directives of the Unit

OECS/PPS' management is part of the sub- committees

1 Technical Advisory Committee (TAC)

Comprised of a senior doctor and the Supplies Purchasing Officer from each Ministry

2 Country-based Committees

Ensure participatory decision- making and commitment by Ministries of Health

3 Tenders Sub-Committees

Subset of TAC

Includes only the Supplies. Officer from each country