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Improving Grievance Redressal System for Service Delivery:

Lessons and Learnings from Sehat Sahulat Program (SSP)

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Acronyms

AJK	Azad Jammu and Kashmir
B-Form	Birth Registration form
CATI	Computer Assisted Telephone Interviewing
CMH	Combined Military Hospital
CMS	Case Management System
CNIC	Computerized National Identity Card
DG Khan	Dera Ghazi Khan
DHQS	District Headquarter
DMOs	District Medical officer
FATA	TheFederally Administered Tribal
GB	Gilgit Baltistan
GR	Grievance Redressal
HFO	Health front desk officer
ICMS	Integrated Complaint Management System
HMIS	Health Management Information System
KP	Khyber Pakhtunkhwa
NADRA	National Database and Registration Authority
NGOs	Non-governmental organization
NRHM	National Rural Health Mission
PHIMC	Punjab Health Initiative Management Company
PMNHP	Prime Minister National Health Programme
PM	Prime Minister
SLIC	State Life Insurance Corporation
SMS	Short Message Service
SSP	Sehat Sahulat Program
SWOT	Strengths, Weaknesses, Opportunities, and Threats
USA	United States of America

Executive Summary

Grievance Redressal (GR) improves trust and confidence in public health service deliveries and promotes equitable health services. The Sehat Sahulat Program (SSP) in Pakistan has been providing indoor health insurance throughout the country, and the program aims to expand its services to all citizens. The current study examined the existing GR/complaint system of SSP by conducting a SWOT analysis.

The evaluation was carried out through qualitative and quantitative approaches, including in-depth interviews with supply-side stakeholders, and household and telephone surveys with beneficiaries. The analysis reveals that although the program offers multiple channels to register a complaint to its beneficiaries, including web portal, email, call center, and postal letter, the main source for complaint registration is the call center. A limited percentage of the beneficiaries and the general public know call centers.

The existing call center has various limitations, including limited deployed human resources, lack of call agent proficiency in the local language, absence of complaint taxonomy, etc. The call center also lacks full automation, i.e., IT-based integration with the stakeholders (including NADRA, SSP, and field offices), and it requires establishing the complete loop of each complaint along with stipulated timelines to resolve the complaints. The addition of dashboards would be helpful to acquire a progress summary of grievances.

The program must also develop an integrated complaint management system where complaints received through various sources should be pooled, analyzed, and concluded effectively. Currently, the program needs a ground-level staff presence to interact with the public and guide them for complaint registration. Such a presence can improve the caseload of complaints and streamline the grievance system.

Current grievances are highly linked with the policy decisions, starting from enrolment and the operational cycle. Effective service delivery is another challenge where a significant population has faced accessibility issues and denial of services besides the poor quality of services in remote areas. For example, increased empanelled hospitals would raise competition among hospitals and reduce the chances of service denial. As an institute, the SSP requires substantial effort to improve its M&E and management information system.

Introduction

1.1. Introduction

Equity in health and health care has been a guiding principle in public health systems where equitable access to health services asserts that poor and marginalized segments must have both access to and affordable health services [1]. The developing countries have three main challenges in their health systems: first, they lack uniform health facilities for various segments of the population across regions where primarily poor mostly face accessibility challenges [2]; second, utilization of health services is often compromised due to various host of challenges including quality, attitude and affordability as these countries lack universal health insurance systems especially for the poor and vulnerable segments [3], and third, the governments lack proper feedback and accountability mechanisms for improving the health service delivery [4].

The improvement in health service delivery requires systematic improvement in the design and service delivery. Besides allocating more resources, one of the essential components to carry out desired improvements is the regular feedback from patients and other stakeholders through monitoring and evaluations [5, 6]. It is worth mentioning that feedback is a dynamic and interactive process that requires regular consultation with stakeholders, and it can help in establishing and improving a robust grievance redressal (GR) or complaint management system in promoting equitable health services where the citizens of a country trust the system [7].

A grievance is a complaint that shows dissatisfaction with the services regardless of whether the service is used. The grievance could be genuine, as every complaint may not be based on an authentic concern from the client or the general public. Sometimes, the program may not be able to respond to the needs of every citizen due to its design or policy; however, the public may consider it a complaint. Considering this, the GR system must be capable of responding to complaints and queries to enrich the knowledge and secure citizens' trust. Various developed countries (i.e., the United Kingdom, the USA, and Australia) have established regulatory bodies and accountability mechanisms to receive and resolve public complaints. In parallel, the authorities must evolve the program by improving its design to cater to the design-related grievances that could exclude specified population segments.

There could be multiple ways to register a complaint, including a patient letter of complaint [8, 9], dedicated offices for complaint registration, and online mechanisms, including email, SMS, and Android application tools. The effectiveness of these methods largely depends on the ease of use, public awareness, and automation level of the GR system. The foremost element of an efficient GR system is its structure:

- Every complaint is seriously treated, and the service providers take action, so the public trusts it.
- The system can handle every sort of complaint.
- The roles and responsibilities and delegation of power are clearly defined.
- Sufficient human resources are available to interact with the public to register and respond to complaints.

In Pakistan, we have various governmental bodies and regulatory forums in the health sector; however, they are not efficient in establishing a robust GR system, i.e., a clear structure of GR system, user-friendly, responsive to deal with all sorts of complaints and

trust of the public. The challenges also prevail on the public side, where most of the population lives in rural areas and needs to be made aware of how to interact with the authorities. They mostly believe in 'word of mouth' and depend on local notables and politicians to register their queries and complaints.

1.2. The Sehat Sahulat Program: An Overview

The Sehat Sahulat Program (SSP) is a breathing window for the poor and marginalized segments of Pakistan as it provides in-door treatments through health insurance. Currently, the SSP is operational in 68 districts where around 60% of the poor families are covered through the provision of health insurance. So far, the program has enrolled around 7.9 million families (above 40% population of the country). The program started its operation in 2016 and has been expanding every year phase-wise.

The prevalent milestone of the program is to expand the in-door health insurance services for every citizen of the country; where so far, the program has launched universal in-door health insurance in various regions of the country, including ex-FATA, Azad Jammu and Kashmir (AJK), Tharparkar, two Divisions of South Punjab (Sahiwal and DG Khan) and for all the districts of Khyber Pakhtunkhwa. The program aims to expand universal health insurance in the entire country in next few months. Such expansion would be a historic milestone, but it will also bring specific challenges as it requires an efficient GR system to cater to citizens' need and to make the program more effective in terms of service utilization. The high service utilization (in-door treatment) will reduce catastrophic health expenditures.

The SSP has the following six main stakeholders:

(i) NGO for enrolment:

The program hired the services of six NGOs for the enrolment of poor beneficiaries having the mandate to deliver SSP health cards and to create awareness. The NGOs managed dedicated beneficiary enrollment centers (BECs) for enrollment, where health cards were delivered along with necessary awareness.

(ii) State Life Insurance Corporation (SLIC):

SLIC is the main stakeholder of the program, having the mandate to arrange empanel hospitals for the beneficiaries, deploy necessary staff in empanel hospitals, and ensure that beneficiaries must get admission and utilize in-door health services. Due to its supervisory role, every grievance related to admission and in-door health services finally pertains to SLIC. SLIC is also managing an inbound call center (0800-09009) to address the queries of the general public and to register complaints.

(iii) Empanel Hospitals:

The empanel hospitals are obligated to provide in-door health services to eligible beneficiaries by charging no money. As per the contract, the hospital cannot deny in-door services and it must provide free-of-cost services by charging no money on admission, surgery, doctor fees, medicine, etc. The hospital will provide five days of medicine and transport charges after a patient's discharge.

(iv) NADRA

NADRA has multiple roles. First, it is involved in data preparation (conversion of BISP's household data into family data). Second, the program's services are linked with B-form and CNIC. NADRA has the legal mandate to issue B-form/CNIC, family information up-dation, i.e., marital status. The SSP regularly receives updated information from NADRA through its integrated health management information system (HMIS). Third, NADRA has been managing an outbound call center for two purposes: guiding the beneficiaries to pick their card from dedicated centers and acquiring feedback from those who have used the in-door health services.

(v) Federal SSP Management:

The federal SSP management is the custodian of the entire program, and it has the centric role of developing policies, regulations, and guidelines and engaging the services of the stakeholders (NADRA, SLIC, NGOs, etc.). Monitoring & evaluating and improving the complaint management system are some of its critical mandates.

(vi) Provincial Health Department:

After the 18th Constitutional amendment, health became a provincial subject; therefore, the benefits of the program would be compromised if provincial governments were not involved in the execution process. Federal SSP management has engaged the provincial health departments in executing the program. Province KP has been managing the program almost independently. In contrast, Punjab is closely working, and it has established the Punjab Health Initiative Management Company (PHIMC) to execute the program in the province. The AJK and GB governments have also been contributing to the program by ensuring that the government DHQs should act as the empanel hospitals of SSP. However, the federal government pays insurance premiums for AJK and GB.

The SSP has established a GR system, both manual and automated, to cater to the needs of its beneficiaries. The manual systems allow the beneficiaries and general public to register their grievances and complaints through multiple ways, including email, complaint box, and postal letter. The automated system includes dedicated call center & Prime Minster Web Portal. The program has placed Health Management Information System (HMIS) in hospitals to facilitate the beneficiaries for enrolment, in-door treatment, data updation, & general information provision to both beneficiaries and non-beneficiaries, i.e., eligibility, details of registered members in the database, balance inquiry, etc. Similarly, there is a dedicated SMS service (SMS CNIC at 8500) through which the public can check their eligibility status.

1.3. Objectives of the Study

The proposed research examines the existing grievance redressal (GR) system of the SSP. The analysis will help improve and upgrade the GR system. A SWOT analysis has been conducted on the existing GR system to determine how much it is capable of addressing the needs of beneficiaries and is overall responsive to the general public. The study revolves around the following objectives:

1. **To describe in depth, the processes laid out as part of the complaint redressal mechanism, identifying the role and responsibilities of various stakeholders including SSP management, SLIC, hospital etc.;**
2. **To understand the functioning of the complaints redressal mechanism as implemented;**
3. **To identify challenges faced in implementing processes as originally envisaged, steps taken by them to overcome these challenges and perceptions of changes required in policies and guidelines to smoothen day to day implementation; and**
4. **Put forth options for action for policymakers at the federal and provincial level.**

1.4. Organization of the study

The current study is organized into seven sections. A literature review is detailed in Section 2, followed by details on data and methodology in Section 3. The supply-side analysis of existing GR system is carried out in Section 4, whereas the demand-side analysis is conducted in Section 5. Recommendations are given in the last section.

Importance of Grievance Redressal in Health System

Information from patient complaints and client's feedback is a widely accepted measure to raise patients' satisfaction with the services they receive [10]. It has a significant impact on improving the quality of health services [11], behavioral change in the attitude of staff, managerial skills, monitoring [12, 13], accountability [14], reduced abuse, assured compliance with standards, and improved overall health systems performance [15]. Therefore, an compelling patient complaint management system is one of the crucial components of well-performing health systems [9].

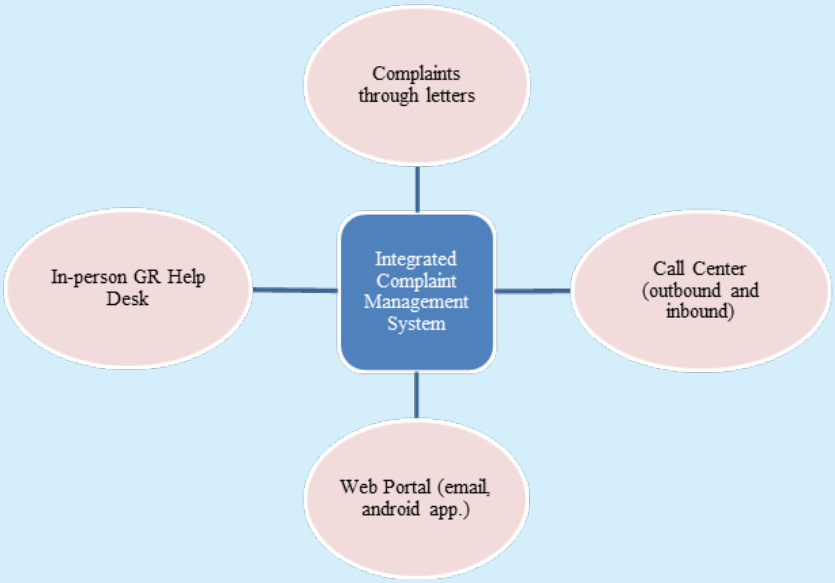
An effective complaints management system involves collecting and analyzing the complaints data, and mitigation measures for complaints. Mostly, the complaint and GR systems face two sorts of issues. First, often, the system does not provide enough opportunities for the patients and clients to provide feedback on their experiences (i.e., the care they receive, staff expertise, and availability of supplies [9, 16]. Second, the GR systems often unable to adequately analyze, respond to, and utilize patient feedback for improving health services [17]. As a result, the public may lose confidence in the system when they don't receive proper feedback or an improvement in the quality of services [18, 19].

A key lesson from the best international practices is to develop an integrated GR system that ensures regular patient feedback and is always responsive to enhance efficiency and accountability [20]. Suppose the public and patients/beneficiaries do not receive a response to their complaints and grievances. In that case, they may feel frustrated and disengage with health services or, even worse, resort to violence [18, 21].

A grievance can be defined as 'any complaint expressing dissatisfaction with any aspect of the operations, activities or behavior of public health systems or its providers, regardless of whether remedial action is requested or not'. Patient complaints usually refer to an 'expression of grievance' and 'dispute' within a healthcare setting [22]. They could often be through formal letters, emails and other established systems, i.e., portals, court cases, etc. Often, complaints are unstandardized by explaining anger and distress in health facilities. Nonetheless, patient complaint data can provide unique patient-centered insights into aspects of care that may not be easily captured through traditional quality and safety metrics. Rigorous and systematic analytical procedures are essential if learning from patient complaints is to be facilitated. For example, in understanding the causes of adverse events, standardized systems are usually developed to analyze the complaint data and establish a GR system [23].

It is necessary to analyze the complaint's data and the existing GR mechanisms for establishing a robust GR system, i.e., complaint coding taxonomy [9]. Ultimately, the data can be used to establish a GR system comprising the four elements: GR help desk, call center, web portal, and integrated complaint management system. All these mechanisms allow the grievances to be registered, the concerned authority to be informed, and feedback to the complainant to be given [24]. All the complaints must be pooled at once, as shown below in Figure 1.

Figure 1: Potential Integration of Complaints



To ensure accountability, nodal persons must be deputed at each level to address the complaints. For example, in India, the National Rural Health Mission (NRHM) had tagged a specific time with each complaint; otherwise, it would escalate to a higher level.

Mostly, the GR system has three processes [24, 25];

(i) Registering the grievances:

A citizen must have multiple options for registration of grievances, including in-person, online, telephone, etc. Every method must facilitate the complainant by providing a complaint ID.

(ii) Process of GR:

As soon as the grievance is registered, the complainant will get an SMS informing of the successful registration of the grievance and a complaint number for tracking the status of grievance. Authorities should review the complaint and take necessary action.

(iii) Resolution of registered grievances:

Every complaint must have a resolution mechanism, where a loop must be completed having dedicated roles and responsibilities for each stakeholder and a time span to resolve the complaint. In case of resolution, the complainant must be updated with the necessary guidelines. Overall, it should not be kept pending for a long time.

While reviewing the literature, we have found that an efficient GR system must possess the following characteristics;

- An efficient grievance process must be in place through which the complainant may track the complaint status.
- The GR system must be capable of registering all potential complaints.
- The GR system must be capable of analyzing and investigating the grievance by segregating the complaints.
- Authorities/nodal officers at the appropriate level will check the web portal daily and be responsible for resolving the grievances within a specified time.
- There must be a dedicated web portal to pool all sorts of complaints (i.e., GR helpdesk, call center, complaint management system, email, etc).
- To ensure accountability, nodal persons must be identified at each level to resolve the grievances in a time-bound manner. If unresolved within the stipulated time, the grievance will escalate to a higher level.
- The roles and responsibilities of each stakeholder must be clearly defined.
- The GR system must be simple and user-friendly for the public.
- The GR system must evolve, considering the dynamic nature of challenges, and must be aligned with changes in policies and guidelines.

Data Collection & Methodological Framework

The current section explains the data description and methodology, keeping in view objectives of the study, detailed in Section 1. We have used multiple data sources, both primary and secondary, for analysis. An attempt is made to review the existing GR system by interacting with all the stakeholders to identify gaps and to suggest the way forward.

3.1. Analytical Framework

Not every complaint qualifies as a genuine grievance as there could be specific complaints related to the information, or some non-eligible can submit an application with the request for enrolment in the program. However, the program may not be able to enroll him/her, considering the eligibility criteria and certain thresholds as defined in policy documents. An analytical framework for analyzing the GR system of the Sehat Sahulat Program (SSP) is built, as shown in Table 1.

Table 1: Category-wise Possible Grievances in SSP

Type of grievance	Details
Enrolment related grievance	• A beneficiary considers him/herself eligible, but data is not available or database shows non-eligible • Non-delivery of health card • Wrong data entry or skipping some of the family members in the database due to incomplete registration with the NADRA • Lack of facility in the system to update the data
Health Card related grievance	• Health Card is lost, captured or replaced • Health card is misused by someone else • Sufficient balance is not there or balance checking facility does not exist • Facilitation in HMIS for data up-dation i.e., addresses, telephone number, name correction, enrolment of non-registered family members
Service related grievance	• No in-door treatment exists near beneficiary • Non-availability of staff in the hospital
Denial of benefits	• Denial of services by hospital or SLIC • Non-availability of medicines and other accessories i.e., diagnostic facility • Cash benefits are not provided • Certain incentives as detailed in the program i.e., transport charges; burial support, free post follow-up visit etc. are not provided
Poor quality services	• Sub-standard care provided by hospital • Poor attitude of staff (SLIC or hospital) • Regular cleanliness and replacement of linen, etc • The patient's experience with clinical processes is not upto the mark
Administrative procedures	• Admission process is complex • Administrative procedures are complex
Corruption/bribe	• Any staff asking for any monetary/non-monetary benefit

3.2. Data and Methodology

Various factors contribute to the inadequate addressing of grievances, leading to diminished beneficiary confidence in the program. For instance, the current GR system may suffer from inadequate accessibility for a significant portion of the population and complex, manual procedures that hinder effective complaint resolution. The following methodology and data description outline the approach:

1. Analysis of Existing GR System:

We have analyzed the existing GR system, which has multiple types that facilitate the public and beneficiaries registering complaints. It includes a call center, email, web portal, HMIS, PM Portal, etc. We have reviewed all these sorts of systems, including their placement (i.e., national, provincial, district, and hospital level), functionality, efficiency, and accountability. The analysis is conducted through in-depth interviews with all the stakeholders. A detailed evaluation checklist is placed in Annexure A to review the existing GR system.

2. Analysis of Call Centers Managed by SLIC and NADRA:

We have analyzed the call centers managed by the SLIC and NADRA. NADRA has been managing an outbound call center, whereas the SLIC has been managing an inbound one. The outbound call center is responsible for informing the pending beneficiaries to pick up their cards from dedicated disbursement centers and acquiring feedback from those who receive in-door treatment. The inbound call center is for information provision and complaint registration. It is worth mentioning that while acquiring feedback from treated beneficiaries through an outbound NADRA call center, a complaint is automatically registered if a beneficiary reports some grievances, i.e., non-provision of good quality services, non-provision of medicine, money taken, etc. The role of the SLIC call center is crucial in registering complaints as it is almost the sole source for registering complaints by the public and beneficiaries. We have also reviewed the complaint report and dashboards as managed by the SLIC.

3. Analysis of Registered Complaints Data:

We have analyzed the existing data complaints registered at the SLIC and NADRA call centers. There were more than 50,000 registered complaints. We have reviewed the leading causes of complaints and their evolution over time, sources of complaints, channels used to register complaints, functioning in terms of reliability to establish turn-around times to settle complaints or escalate to a higher level, feedback provided to beneficiaries, etc. We have analyzed the complaints registered through email, website portal, letters, and PM Portal, as they need a proper taxonomy.

4. Secondary Data Set Analysis:

The secondary dataset analysis has been reviewed to determine how effective the system is in lodging a complaint, automation, clearly defining the roles & responsibilities, responsiveness to all the possible complaints, etc. The analysis has also covered the following aspects:

a. **Is there a proper mechanism to maintain the record of all sorts of complaints?**

b. **How much the complaint record mechanism is functional, efficient, effective and accountable?**
c. **What are the main sources of lodging a complaint (i.e. email, portal, call center etc).**
d. **Complaint data analysis, including region-wise complaint launched, the channel used for complaint registration, resolved and pending complaints, etc.**

5. Survey and Interviews:

Using the existing complaint database, we have drawn a random sample of 750 beneficiaries and the public that have registered complaints during the last year, either on the NADRA or SLIC call centers. The sample was extracted with the potential category of complaints and province/ region kept in view. We conducted a Computerized Assisted Telephonic Interview (CATI) survey to acquire their complaint registration and resolution feedback. The reason for the CATI survey is that these complainants are scattered all around the country; therefore, a door-to-door survey was not feasible. The questionnaire for the CATI survey is placed in Annexure B. Since the same team managed another study on health utilization behavior, where a door-to-door household survey was carried out in 13 district beneficiaries, we added a complaint module to that survey as well. The questionnaire of the complaint module is placed in Annexure C. A total of 647 beneficiaries were interviewed for feedback on the complaint registration process.

6. SWOT Analysis:

To understand the challenges in existing GR system, we have conducted in-depth interviews with all the supply-side stakeholders. The stakeholders are concerned NGOs, SLIC, NADRA, hospitals, representatives of SLICs in each district (including district medical officer-DMOs and front desk officers-HFOs), management of SSP, provincial health department, etc. The challenges of complaints and the nature of complaints may vary across the provinces and regions. For example, there might be more non-enrolment rates in urban areas due to migration. On the other hand, the grievance of non-availability of health facilities may prevail in remote areas. Similarly, the nature of complaints by patients on sub-standard clinical care may also vary across regions when the program attempts to provide a similar package of services (with cost) throughout the country. Therefore, it is worth capturing the regional heterogeneities while conducting in-depth interviews with the supply-side stakeholders.

The objective of conducting in-depth interviews with the supply-side stakeholders is to conduct a SWOT analysis of the existing GR system. The detailed check-list is listed below that covers three main aspects (efficiency, effectiveness, and accountability):

A. **What are the main challenges is faced by the supply-side stakeholders (other than beneficiaries) in registering the complaints? The challenges may include:**

i. Availability of information to general public at complaint points (i.e., hospitals, BECs and other focal points)
ii. Ongoing communication strategies for beneficiaries regarding awareness of GR system
iii. Availability of staff and complaint load
iv. Insufficient GR touch points for beneficiaries
v. Accessibility challenges for the beneficiaries to visit complaint points
vi. Potential conflict of interest in existing GR system
vii. Efficiency of existing GR system to register all sorts of complaints

viii. Automation of system for follow-up, trace a complaint, time-bound redressal
ix. Accountability as defined in the existing system

B. What are the challenges being faced by the beneficiaries in registering the complaint?

i. Accessibility issues
ii. Information and awareness related challenges
iii. Cultural constraints, language barriers

C. How much the existing system is efficient and automated in registering the complaints?
D. How much the existing system is capable in registering all sorts of complaints.
E. How the existing GR system can be improved, i.e.?

i. Automation and user friendly
ii. Convenient and accessible to beneficiaries.
iii. Having clear roles and responsibilities
iv. Removal of conflict of interests
v. Time-bound resolution of complaints

F. How the capacity of the GR system can be enhanced?

i. Training required to the field staff
ii. Deployment of more staff
iii. Automation system and link all the system with centralized complaint management system.

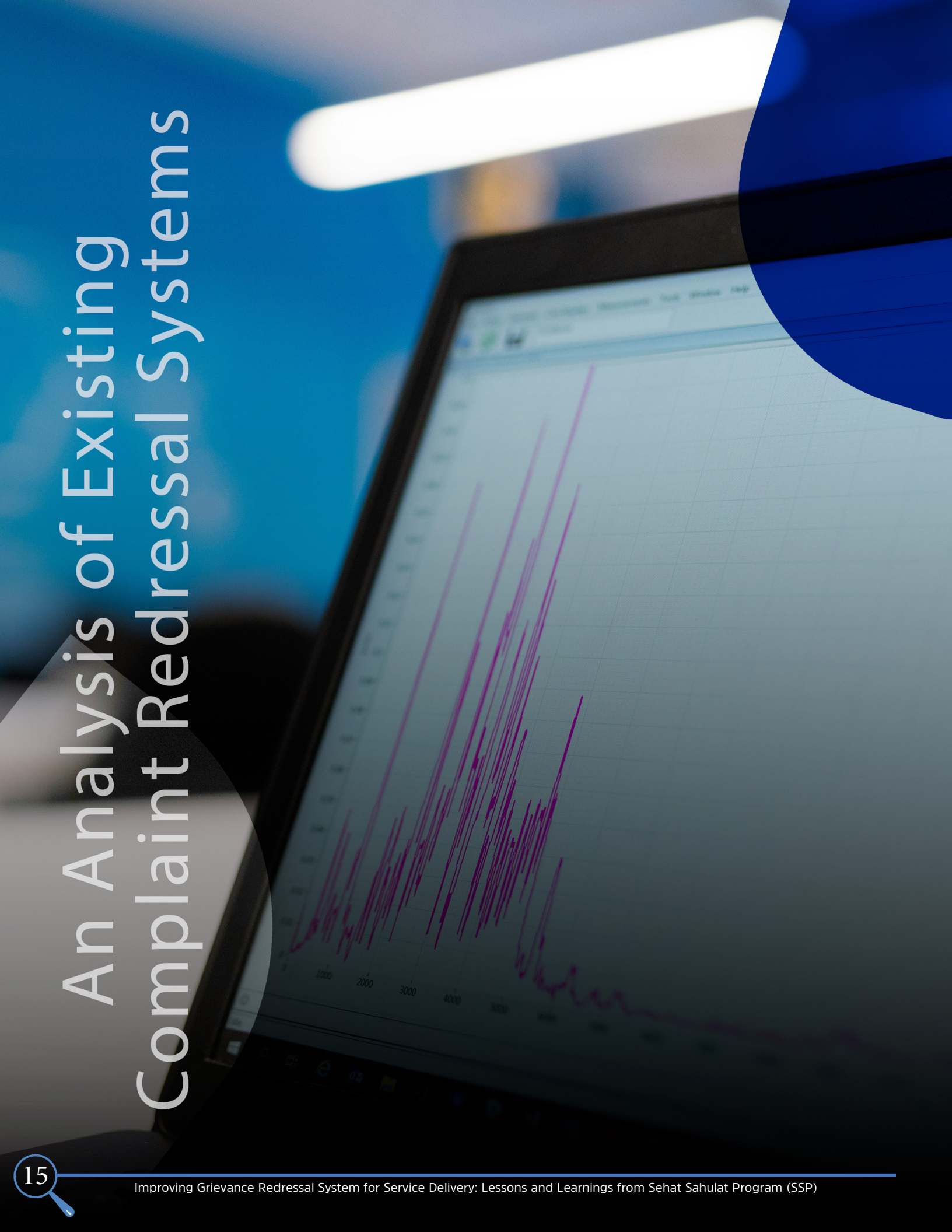
Since the main tier of the GR system is empaneled hospitals, DMOs and HFOs, therefore, we have visited 15 districts throughout country where in-depth meetings were conducted with the hospitals, DMOs, HFOs, etc. We have visited more than 40 hospitals and also interacted with the admitted beneficiaries. The interview with the beneficiaries has focused on the following aspects:

- Accessibility challenges to acquire in-door treatment.
- Any challenge faced during in-door treatment
- Satisfaction level on in-door treatment
- Knowledge on existing GR system.

Table 2: Districts where in-depth interviews were conducted with hospitals, HFOs & DMOs

Province/region	Name of districts
AJK	Bhimber, Neelum, Bagh, Muzafarabad
ICT	Islamabad, Rawalpindi
Ex-FATA	Peshawar, Khyber
GB	Hunza, Astore, Gilgit, Ghizer
Punjab	Gujrat, Sargodha, Bahawalpur, Rajanpur, DG Khan, Lahore
Sindh	Tharparkar, Karachi

An Analysis of Existing Complaint Redressal Systems



The current section manages a SWOT analysis of the program's existing complaint/grievance redressal systems, available to both the public and beneficiaries. The current section has focused on the supply-side analysis, whereas the forthcoming Section 5 explains the demand-side research.

4.1. Existing GR System

Currently the following five sorts of complaint redressal systems and information tools are operational for both the public and beneficiaries:

(i) SMS service:

The SMS service (8500) is available for the public to check their eligibility status. The service responds to citizens to determine whether their family is eligible. Eligible families also acquire the details of unmarried children registered with the parents. The service has been initiated with the support of NADRA.

(ii) Web portal for complaint:

A complaint form is placed on the SSP website for complaint registration. Details are available on *https://www.pmhealthprogram.gov.pk/complaints/*

(iii) Dedicated emails for complaint registration:

The program has placed multiple email addresses on the SSP website for complaint registration through email. The citizens can email their grievances to the SSP authorities.

(iv) Call Center:

SLIC has been managing an inbound call center (0800-09009) to address the queries of general public and to register citizen's complaints. The Call Center is available 24/7 where a citizen can register a complaint. It is worth mentioning that NADRA has been managing an outbound call center to acquire feedback from those beneficiaries who have utilized the in-door health services. During feedback, if a beneficiary reports some complaint (i.e., bribe or on service delivery), it is forwarded to SSP management for necessary action.

(v) Health Management Information System (HMIS):

The HMIS is placed in hospitals for multiple purposes:

a. **Verification of beneficiaries, including the registered members, eligibility status, etc.**
b. **Information update, i.e., enrollment of those family members who are not registered.**
c. **A family's complete record, including enrolment details, admission, balance amount, etc.**

Besides there are some other complaint registration mechanisms deployed by the government authorities other than the SSP. For example, the Prime Minister (PM) Web Portal application allows citizens to register complaints against government departments. The complaint is forwarded to the concerned Department to respond within a stipulated time. In case of non-responding, the complaint is escalated, and a dedicated unit in the PM Secretariat monitors the entire process. Another method of registering the complaint is through a letter, where the public can register a complaint through a letter to concerned departments. The governmental departments are legally obliged to review, analyze, and respond to the complaint. Our analysis has not covered two sorts of grievances:

i. Contractual-related grievances within the supply stakeholders and not related to the beneficiaries, i.e., among NADRA, SLIC, SSP, hospital, etc.;

ii. Analysis of grievances and complaints registered through postal letters, emails, web portals and Prime Minister web portal. It was suggested by the SSP management to have a focus on call centers—the main source of complaint registration. They reported that they lack capacity to analyze such complaints.

The role of both the call centers (one is managed by NADRA and other by SLIC) is quite crucial for complaint registration.

NADRA Call Center:

NADRA's call center has been acquiring feedback from all those beneficiaries who have used in-door health services. After acquiring the treatment, the call center generates a call on the registered beneficiary's mobile number and acquires feedback on service delivery during in-door treatment on five questions. If a beneficiary reports some dissatisfaction with service delivery during the feedback, it is automatically converted into a complaint and forwarded to the SSP management for action. The feedback from beneficiaries has led to significant pressure on improving service delivery and avoiding any charging amount from the beneficiary as the hospital knows well that every beneficiary will be telephonically followed for feedback after discharge. As a result, the satisfaction rate is much higher, as reported by the NADRA's call center (Figure 2). The call center also informs and guides those beneficiaries who still need to receive them to pick up their health cards from designated points.

Figure 2: Beneficiary Satisfaction Rate (only those who used in-door health services)

Source: Retrieved on October 31, 2021 from SSP website

SLIC Call Center:

SLIC, as the sole vendor, is the leading actor in reviewing and resolving every complaint. The program has developed a complaint flow management cycle where every complaint registered through multiple sources is forwarded to the SLIC for review and action. The complaints to the SLIC portal can be received either from its call center or NADRA call center, complaints received by the SSP for various sources, etc. As detailed in Figure 3, once a complaint is received by SLIC either through NADRA or the SLIC call center, it is forwarded to the concerned department, having a multi-tier process. A complaint is escalated to the higher level in case of non-response by the lower tier. As explained in Section 4.3, the complaint loop is not currently automated; hence, the automatic escalation process is not implemented.

Similarly, currently, the SSP lacks sufficient manpower to analyze the complaints registered through postal letters, email, and web portals. Still, complaints are not integrated through various sources due to the lack of an integrated complaint management system. The SSP needs more capacity to analyze complaints registered through email, web portal, and postal. Only the complaints registered through the call centers are analyzed.

SLIC has a dedicated call center that is operational 24/7. The call center is located in Islamabad, where around 18 agents are available to serve the general public and beneficiaries for both awareness and complaint registration. So far, the program has registered more than 56,000 complaints, both through NADRA and SLIC call centers, with a complaint resolution rate of around 92% along with a satisfaction rate of 97% against the in-door service delivery (Figure 4).

Figure 3: Complaint Management Flow Chart

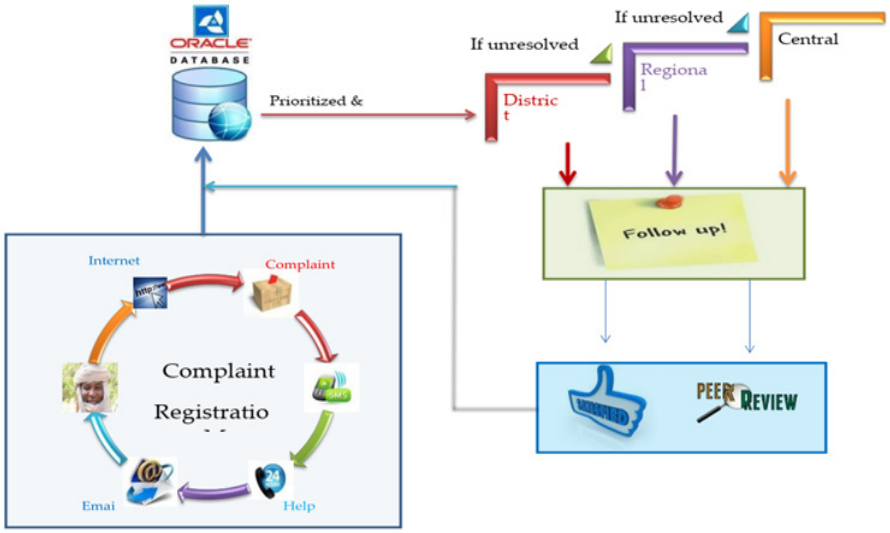


Figure 3: Complaint Management Flow Chart

Source: Retrieved on October 31, 2021 from SSP website

4.2. Analysis of Secondary Complaint Database

The SSP provided the complaint database for the analysis, covering the complaints registered through the NADRA and SLIC's call centers. It is worth mentioning that only the complaint data of the NADRA call center is analyzed, and we have not analyzed the entire outbound data of the NADRA call center due to non-provision of data; hence, we may not be able to analyze the provincial/regional complaint rates among those beneficiaries who received in-door treatment.

Table 3 shows that most complaints are from Punjab and are received by the NADRA call center rather than the SLIC call center. Ideally, the caseload of the SLIC call center should be much more than the NADRA call center as the NADRA's call center lacks an inbound facility for the general public and thus only registers complaints that are routed during feedback from health utilizers. It reflects the under-utilization of the SLIC call center.

Another point is the complaint data from Khyber Pakhtunkhwa province, where significant complaints have been received. It is worth mentioning that province KP has been managing the SSP with little technical assistance from the federal government. Minimal complaints have been reported from Gilgit Baltistan.

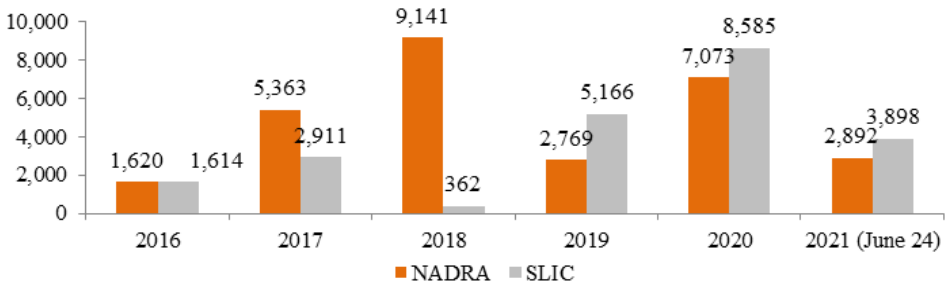
Table 3: Province-wise Secondary Complaint Database (in numbers)

Region	NADRA	SLIC	Total
AJK	3,174	1,764	4,938
Balochistan	862	3,442	4,304
Ex-FATA	2,481	80	2,561
GB	471	132	603
Islamabad	2,137	405	2,542
Khyber Pakhtunkhwa	2,683	5,992	8,675
Punjab	15,034	7,086	22,120
Sindh	2,016	3,635	5,651
Total	28,858	22,536	51,394

Source: Complaint database provided by SSP till June 24, 2021

Figure 5 shows that there is a rising trend of complaint registration over time. Around five times more complaints have been registered in 2020 than in 2016. It reflects more awareness among the public about call centers. With time, the SLIC call center has also witnessed a rising caseload of complaints, especially in 2019 and 2020. It is worth mentioning that the data lacks details of those calls where the public/beneficiary has made a call for information purposes as still the SLIC call center is not fully automated to provide a good summary report and to automatically record every sort of call, whether it is for information or a complaint.

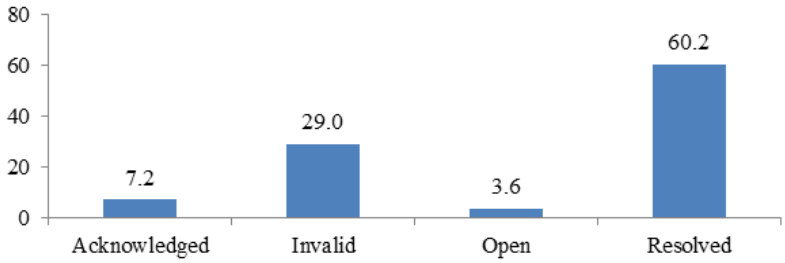
Figure 5: Complaint Registration Overtime (in numbers)



Source: Complaint database provided by SSP till June 24, 2021

Out of the total registered complaints, the analysis shows that 60% of the complaints have been resolved, 29% are invalid, 7% have been acknowledged, and 4% are still not resolved (Figure 6). The invalid number is relatively high as it shows that a complaint is registered, but after investigation, it is found invalid, so it is closed. We recommend that SSP conduct a sampled-based inquiry against the 'resolved' and 'invalid' marked complaints by the SLIC either through itself or through the NADRA call center through a telephonic survey. During our telephone survey, we found various such complaints where the respondent (beneficiary) has shown dissatisfaction, and, according to their view, the complaint has not yet been resolved.

Figure 6: Complaint Resolution Status (% distribution)



Source: Complaint database provided by SSP till June 24, 2021

There are also some data issues with the 'acknowledged' complaint category. Overall, 3,716 complaints are 'acknowledged,' where the resolution date is not reported as it is not considered a formal complaint. These complaints have been registered during the 2016 to 2020 periods. However, while reviewing the complaint details, we found that these complaints are not just for information; specific grievances are associated with them, as detailed in the table below. We need to find out why an 'acknowledge' status is reported against such complaints as they have grievances, and ideally, they must be probed, and their resolution status should be reported in the database (Table 4). SSP should conduct periodic analyses on particular complaints, especially those marked as 'invalid,' 'acknowledged,' and resolved through a telephonic survey either through itself or through the NADRA.

Table 4: Nature of Complaints that have been 'acknowledged' in Database

Nature of complaint	Number	Frequency
Transportation charges are not given	800	21.5
Additional charges taken	344	9.3
Asking bribe to issue card	23	0.6
Bad service given	17	0.5
Beneficiary deceased	1,067	28.7
Card lost	66	1.8
Card registration problem	198	5.3
Center does not exist/could not find..	143	3.9
Hospital staff misbehave	35	0.9
Medicines not available	4	0.1
No attendant at hospital	17	0.5
Not allowed by SLIC/PMNHP represent..	4	0.1
Paramedic staff negligence	2	0.1
Payment for admission discharge	44	1.2
Payment for medicine	82	2.2
Payment for tests	109	2.9
Service not given by hospital	104	2.8
Treatment not availed	259	7.0
Update CNIC in record	398	10.7
Total	3,716	100

Source: Complaint database provided by SSP till June 24, 2021

Another limitation in the data is found that there was very limited caseload on SLIC call center for various grievances, especially related to the service delivery. It is the SLIC call center that has been widely communicated to the beneficiaries to register complaints through various communication campaigns; however, Table 5 shows that it is the NADRA call center that has been registering complaints while acquiring feedback from beneficiaries after their discharge from the hospital, i.e., transport changes not given, additional payment taken, beneficiary deceased, certain payments are taken by the hospital against medicine, lab tests, etc. Around two-thirds of the complaints reported on SLIC call entre pertains to just enrolment or data up-dation, whereas very limited grievance related to the service delivery is reported on SLIC. The under-utilization of the SLIC call center requires multiple attention, including an upgrade of the call center in terms of both manpower and IT equipment.

Conflict of interest is a significant issue in the SLIC's call center. Since SLIC is a vendor, registration of complaints and analysis itself by the SLIC would compromise the service, and that's why we observed more efficiency in NADRA's call center (although it is just to acquire feedback) than the SLIC's call center.

Table 5: Nature of Complaint as Reported by the Call Center

Nature of complaint	NADRA	SLIC	Total
Transportation charges are not given	12,191	56	12,247
Additional charges taken	4,798	127	4,925
Ambulance not available	0	2	2
Asking bribe to issue card	7	179	186
Bad service given	0	330	330
Beneficiary deceased	5,874	5	5,879
Card lost	0	1,616	1,616
Card registration problem	0	2,397	2,397
Center does not exist/could not find	54	11,821	11,875
Hospital staff misbehave	0	130	130
Medicines not available	0	103	103
No attendant at hospital	0	108	108
Not allowed by SLIC/PMNHP represent..	0	18	18
Not allowed by SLI/PMNHP doctor	0	2	2
Paramedic staff negligence	0	3	3
Payment for admission discharge	857	31	888
Payment for medicine	1,939	46	1,985
Payment for tests	2,365	34	2,399
Service not given by hospital	0	2,626	2,626
Treatment not availed	773	460	1,233
Update CNIC in record	0	2,441	2,441
Total	28,858	22,536	51,394

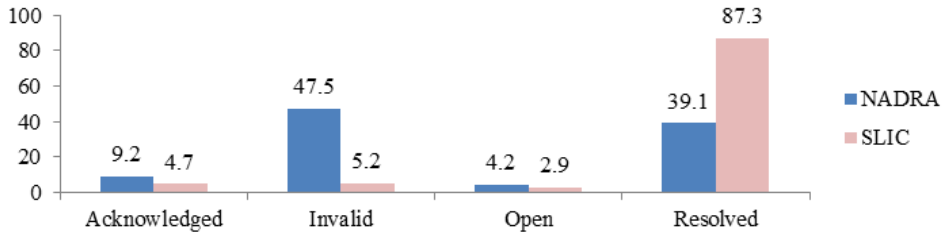
Source: Complaint database provided by SSP till June 24, 2021

The SSP authorities should carefully look the resolution status of complaints by the type of call center. Interestingly, the SLIC has been reporting a significant percentage of the complaints as 'invalid' as reported by the NADRA call center. Similarly, the resolution rate of complaints reported by the NADRA is very low as compared to the SLIC call center (Figure 7).

Two reasons may hold: first, most of the complaints reported through the NADRA call center are on service delivery, it is unlikely that around half of the complaints are 'invalid', so there is a matter of

'conflict of interest' as the complaint against SLIC is probed by the SLIC itself so intentionally they may declare it 'invalid'. Second, the lower resolution of the complaint by the NADRA and more by SLIC depends on nature of complaint as complaints reported on the SLIC call center are mostly on data-related issues rather than service delivery.

Figure 7: Complaint Resolution Status by call Centers



Source: Complaint database provided by SSP till June 24, 2021

Table 6 shows that a significant percentage of complaints about the service delivery have been declared invalid, i.e., transportation charges are not given, additional charges are taken, and certain payments are taken during treatment. We probed, and authorities have had no response. The SSP team needs more investigation and data analysis capacity.

Table 6: Nature of Complaint by Status of Resolution

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	800	8,751	3	2,693	12,247
Additional charges taken	344	1,797	183	2,601	4,925
Ambulance not available	0	2	0	0	2
Asking bribe to issue card	23	17	1	145	186
Bad service given	17	63	28	222	330
Beneficiary deceased	1,067	1,321	693	2,798	5,879
Card lost	66	23	8	1,519	1,616
Card registration problem	198	69	37	2,093	2,397
Center does not exist/could not find	143	173	367	11,192	11,875
Hospital staff misbehave	35	7	0	88	130
Medicines not available	4	14	3	82	103
No attendant at hospital	17	11	4	76	108
Not allowed by SLIC/PMNHP represent..	4	1	1	12	18
Not allowed by SLIC/PMNHP doctor	0	0	0	2	2
Paramedic staff negligence	2	0	1	0	3
Payment for admission discharge	44	274	37	533	888
Payment for medicine	82	605	141	1,157	1,985

Source: Complaint database provided by SSP till June 24, 2021

An encouraging element is the improvement in turn-around time of complaint resolution. Table 7 shows that the turn-around time significantly reduced overtime; currently, around 98% of the complaints have been resolved within 30 days.[1] In earlier years, a significant percentage of complaints took a lot of time (i.e., more than 90 days) to resolve, whereas now the percentage is negligible. It shows the efficiency of the call centers where the GR system has improved its operations. Such improvement positive impacts stakeholders, especially on the public, that programs have been effectively responding to the population.

Table 7: Turnaround Time to Resolve Complaints

Number of days	2016	2017	2018	2019	2020	2021	Overall
Overall							
Within 30 days	69.2	46.5	61.4	77.3	90.0	97.6	75.7
31 to 60 days	3.8	6.0	26.4	8.2	7.3	1.5	9.8
61 to 90 days	9.3	2.0	6.9	6.4	2.0	0.5	3.8
91 and above days	17.7	45.5	5.4	8.1	0.7	0.3	10.7
Total	100	100	100	100	100	100	100
NADRA Call Center							
Within 30 days	37.2	21.7	60.6	90.1	84.9	96.2	64.0
31 to 60 days	6.4	8.5	26.9	5.0	10.9	2.3	14.1
61 to 90 days	18.2	2.7	6.9	2.2	3.5	0.8	4.8
91 and above days	38.3	67.1	5.6	2.7	0.7	0.7	17.2
Total	100	100	100	100	100	100	100
SLIC Call Center							
Within 30 days	96.2	98.9	82.4	71.2	94.2	98.3	89.7
31 to 60 days	1.5	0.7	12.5	9.7	4.3	1.2	4.6
61 to 90 days	1.9	0.4	5.1	8.4	0.8	0.4	2.7
91 and above days	0.4	0.0	0.0	10.8	0.8	0.2	3.0
Total	100	100	100	100	100	100	100

Source: Complaint database provided by SSP till June 24, 2021

4.3. Weakness in the GR system & Way Forward

The analysis in this section is mainly limited to the SLIC and NADRA call centers as we have yet to receive the complaint data through a web portal and email. The management accepted they needed more human resources to analyze complaints registered through email and postal letters. The following weakness may be noted in the existing GR system, along with recommendations.

i. The program interacts with the poorest of the poor beneficiaries; however, it lacks dedicated in-person GR centers where a beneficiary or public can visit and register complaints. The program requires some sort of ground-level GR system (i.e., field offices

[1] The secondary database has both the dates of complaint registration and resolution.

to interact with the general public as keeping in view the literacy rate a minor percentage of the population knows about the call center.

i. Although many complaints data is reported through emails, postal letters, and the SSP web portal, SSP lacks sufficient manpower to review, categorize, and analyze these complaints. As a result, most of these complaints are pending, and no investigation has been carried out. The SSP must deploy sufficient manpower to review the manual complaints and respond to the public accordingly.

ii. Overall there is no integrated complaint management system. The complaints registered through postal letters, email, and web portals are pending. The NADRA Call Center is not integrated with the SLIC Call Center. Most complaints found through the NADRA call center during outbound calls to the beneficiaries are emailed to SSP management. The SSP management handed these complaints over to SLIC for investigation. An integrated complaint management system is required, along with dashboards to monitor all sorts of complaints, where the desired summary report can be generated to gauge the progress on various sources of complaints. The dashboard must provide regional, district, and hospital-level analysis of complaints.

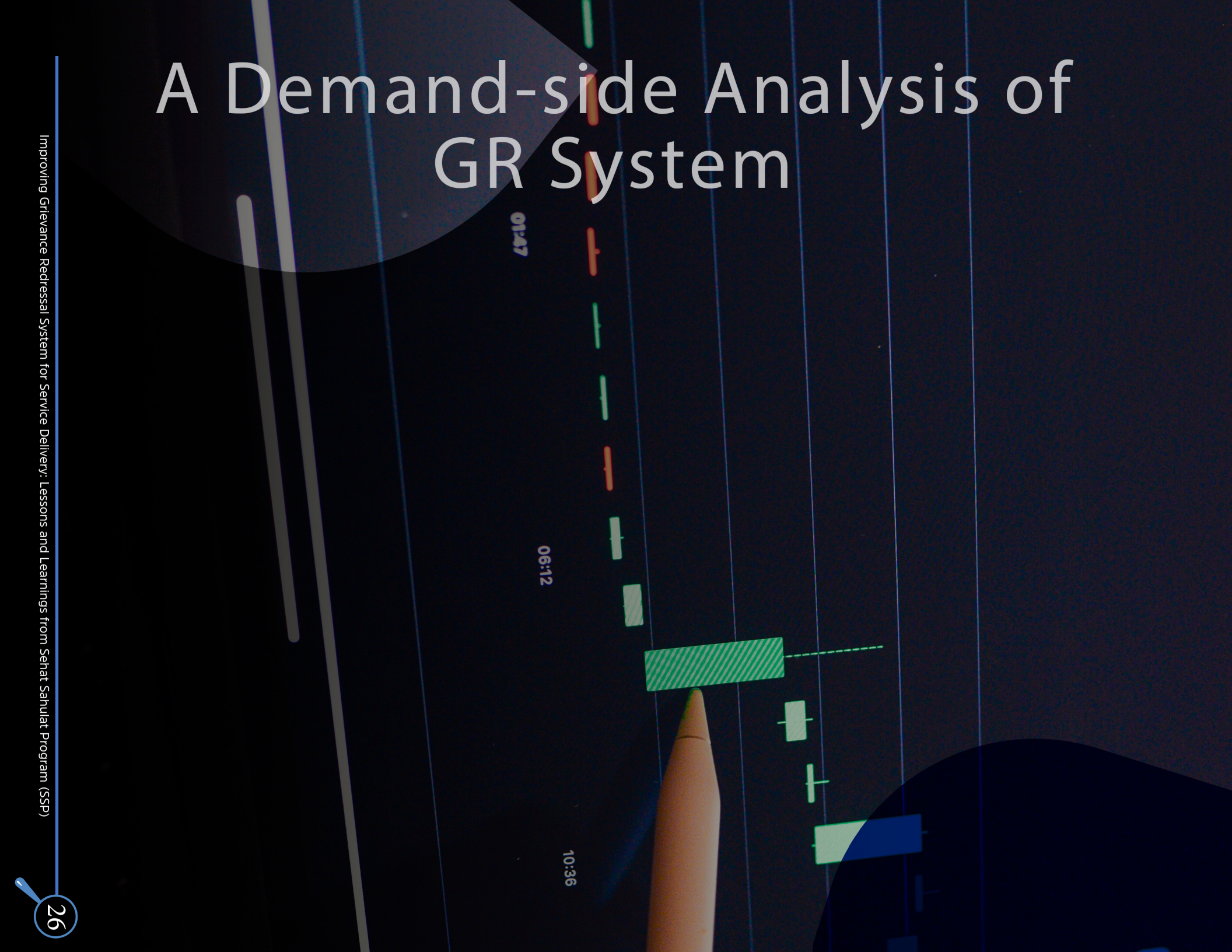
iii. The program interacts with the poorest of the poor beneficiaries, and the SLIC call center is the main source to register grievances. However, it needs operators who speak regional languages and a call transfer facility. Considering the caseload, the call operators must belong to every region and have sound proficiency in the regional language. The call center requires various updates, including call transfer facilities from one agent to another.

iv. The complaints must be correctly categorized in the SLIC call center. Ideally, it must have some complaint taxonomy. Currently, SLIC registers the complaint in Excel format and lacks a proper Android application. Currently, no stipulated time and loop is defined against a complaint to whom the complaint will go. Defining an appropriate loop of complaints along with escalating time is a fully automated method to register complaints. The call center is not integrated with the HMIS and field team. For example, if a complaint is related to the hospital, the DMO should receive a complaint on his/her portal, integrated with the call center. The DMO is informed through messages/WhatsApp, and his/her response is registered manually. It can lead to various errors, wrong responses, etc, and we have found such errors in the database. The call center requires a robust Android application to register all sorts of complaints and a taxonomy of complaints. The loop and time framework of each complaint must be defined. It requires horizontal (with SSP and NADRA) and vertical (with field offices) integration.

v. If a beneficiary registers a complaint, the call agent can inform him/her of the complaint number through verbal communication. Ideally, such a complaint number should be texted to the registered mobile number on the call center. There must be an online facility through which a complainant can also trace his/her complaint.

vi. The SSP management lacks its own M&E capacity to conduct specific periodic analysis on registered complaints, especially those reported as 'resolved' by the SLIC. During our telephonic survey, we found that various complaints that have been tagged 'resolved' in the database have not been practically resolved as reported by the respondents. Ideally, the SSP should manage the call center itself as it is a 'conflict of interest' that SLIC has been providing and managing the services of call center. Currently, the SSP must conduct a sample-based analysis either through itself or the NADRA call center on 'resolved' complaints as reported by the SLIC. NADRA can be tasked to acquire a secondary review on 'acknowledge,' 'resolved', and 'invalid' complaints as tagged by the SLIC.

A Demand-side Analysis of GR System



The analysis in this section primarily covers the demand side challenges related to the grievances currently facing the beneficiaries. It is worth mentioning that grievance is not an isolated subject; it is largely linked to all three stages of health insurance, including enrollment, admission, and post-enrollment.

The analysis in this chapter is carried out by using multiple information sources gathered from both the beneficiaries and other stakeholders. It includes:

i. Household survey data carried out from 650 beneficiaries through face-to-face interviews in 13 districts.
ii. Telephonic survey from 705 beneficiaries who interacted with the program through the call center.
iii. Interaction with admitted beneficiaries during field visits in 40 hospitals located in 15 districts.

5.1. Constraints of Beneficiaries

One of the main constraints of beneficiaries is a lack of sufficient information about the program, and they often don't know where they should go for information as the program lacks ground-level field offices for personal interaction. Key issues identified during interaction with the beneficiaries include:

(a) Enrolment-related issues

i. A significant percentage of eligible households, especially the children, lack Birth Registration forms. Although the SMS service facilitates the population to verify the registration status at the family level, it is linked with birth registration and CNIC. When a family goes to a hospital for treatment, it is often asked first to get registration with the NADRA, which takes time. Citizens, particularly women residing in remote areas, often need CNIC and thus need help with enrollment.

ii. Most beneficiaries don't know the processes if their health card will be lost. Although treatment is linked with the CNIC, they lack such information, and even in hospitals, HFO demands an SSP card. Complaints are received at the call center where denial of services is made due to the non-availability of an SSP card.

iii. If the cardholder dies, their family does not know about the 'next of kin' policy. In other words, who will be the subsequent cardholder in the family?

iv. The update of marital status is a critical issue. In case of a change in marital status, newly married females face the problem of both enrolment and treatment. Currently, newly married women cannot receive treatment due to a change in marital status. As a result, many deliveries are paid from their pocket.

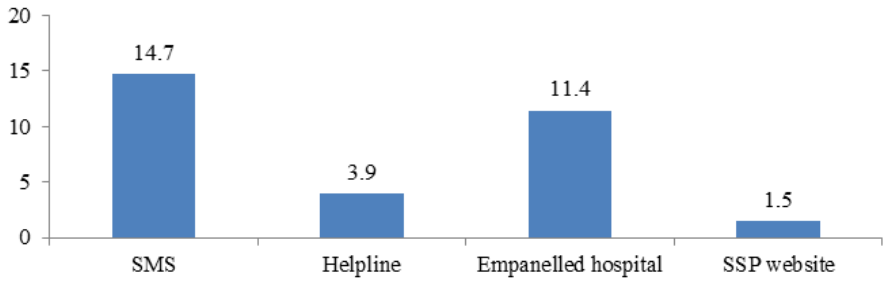
v. Data updation is limited to the addition of new family members. There could be certain other data update features currently missing, i.e., address change, mobile phone number change, name correction, marital status change, death reporting, etc. Such features should be added to the HMIS system.

vi. If a beneficiary has a name mismatch on the SSP card and CNIC, s/he doesn't know how to correct it.

vii. The beneficiaries of Mehmand district (ex-FATA) have different temporary and permanent addresses and have been facing the denial of services. It requires an inevitable reunion with the KP government as the program perceives that the KP government has been facilitating the beneficiaries.

Mostly, the beneficiaries need more information on their eligibility threshold, card expiry, and package amount. Only a minor proportion of the beneficiaries know or have used the various communication tools of SSP. Only 7% know of SMS service, and 4% use the helpline (Figure 8).

Figure 8: Knowledge or Used Communication Tools (in %)



Source: SSP Beneficiary Survey 2021

(b) Service-related Issues

Overall, the household survey reveals that a certain percentage of beneficiaries face accessibility and denial of services issues due to the limited hospitals in some areas and the quality of available services. The household survey shows that:

i. Around 4% of the beneficiaries reported facing a situation where indoor health facilities were required for a family. They had an SSP card but had yet to visit the hospital. The key reason was that s/he didn't know where to go for treatment and lacked the requisite documents.

ii. Around 3% of the beneficiaries visited the empanel hospital but could not utilize the SSP card. The main reason was multiple issues, including lack of data, treatment non-availability, etc.

There are specific grievances where, right now, the authorities need to address the accessibility challenges as well as improve the quality of services. Right now, the authorities are trying to address these grievances, but if they receive some complaints, they may need help to address them adequately. For example:

i. The empanel hospitals are limited in various parts of country. If a hospital does not exist in the area, there is no solution to address the complaint.

ii. Certain grievances are already known to SSP and SLIC management. For example, there is the

non-availability of 24-hour medical stores in the Mirpur and Bhimber districts or the provision of medicine as per contract by the CMH Muzafarabad. There is a need to define the process of such grievances, as such complaints are currently totally unresolved and pending.

iii. Various managers of the empanel hospitals reported that there is a denial of services due to package constraints. The SLIC and SSP management can only do something if a hospital is involved in the denial of benefits.

iv. Several government hospitals are part of the program in AJK and GB. It will take a certain amount of time to address the attitude and behavior issues of staff belonging to the government hospital. Currently, they have no financial incentive to be given by the hospital management, so the program's success largely depends on their attitude and behavior.

v. Until sufficient empanel hospitals are available, the beneficiaries will face certain service compromises. Right now, there are certain areas where a single hospital has been offering the services at a secondary level. Despite complaints, the authorities cannot close it as all the beneficiaries will suffer. For example, the management knows CMH Muzafarabad needs to provide adequate medicine, but there is no option to close it. Similarly, the government hospitalsof Bagh, Bhimber, and Mirpur have not been giving transport charges to the beneficiaries.

(c) Stakeholder-related Issues

i. No operational manual outlines clear roles and responsibilities for all the stakeholders. The absence of such a document often causes certain anomalies and confusion.

ii. According to the Managers of governmental hospitals of AJK, they lack sufficient guidelines and clarity on the program, both from SLIC as well as from AJK government. The program is operational, but they don't know how to utilize the funds generated through service provision.

iii. As reported by various hospitals, they have serious reservations about treatment packages. The reservations are mostly held in big cities and well-off areas, i.e., Gujrat, Sargodha, Faisalabad, etc. As a result, hospitals are making 'pick and choose' behavior and providing in-door treatments against that sickness where they have profit and denial for the others, i.e., medical-related sickness.

iv. Currently, the referral system is missing. HMIS must have the features of a referral system.

5.2. Knowledge on Complaint Registration

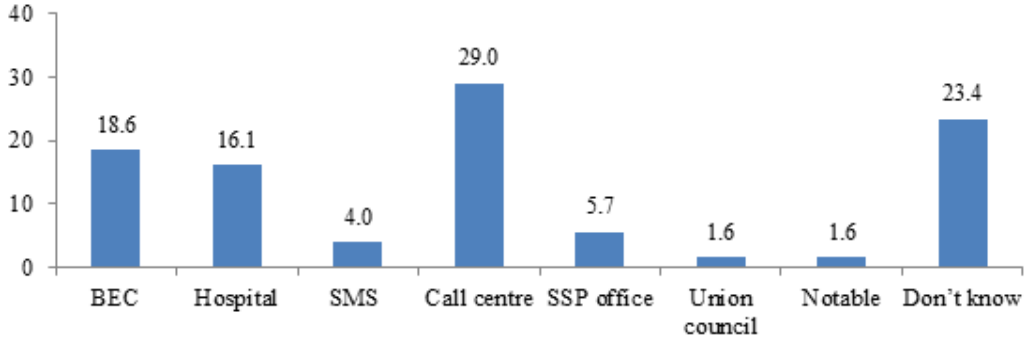
Out of the 650 beneficiary households that were surveyed through face-to-face interviews, only 0.6% have registered a complaint, 1% have attempted to register a complaint, and the remaining 98.4% have never registered a complaint. Among those who have attempted or never registered the complaint, only 1% know how to register the complaint, and the rest, 99%, don't need to learn the complaint registration mechanism.

This information is mainly consistent with our finding that the program requires a massive focus on guiding the beneficiaries about the program's features and complaint registration mechanisms. Most beneficiaries live in remote rural areas and usually need to learn how to interact with the authorities. The public mostly believes in "word of mouth" or the desire to interact with some office to report their grievances; however, currently, the program lacks a ground-level presence where the representatives can interact with the beneficiaries. Although the forum of empanel hospital allows the beneficiaries to retrieve information, this forum largely ignores registering the complaints due to conflict of interaction as the hospital, or SLIC, cannot register complaints itself.

5.3. Findings from Telephonic Survey

As detailed in the methodological section, we conducted a telephonic interview with 750 beneficiaries, where a random sample of these beneficiaries was taken from the NADRA and SLIC call centers. The sample has been extracted considering the potential category-wise of complaints and province/region. The analysis shows that almost half of the calls were made using the NADRA data, whereas half of the calls were made using SLIC data. 81% of the respondents reported that they are beneficiaries or they belong to the beneficiary family, whereas 17% reported that they are not beneficiaries. The overall response rate was around 31%, so we had to make over 2,300 calls to gather a sample of 750 respondents.

Figure 9: Mechanism used by Non-beneficiary for Information Acquiring

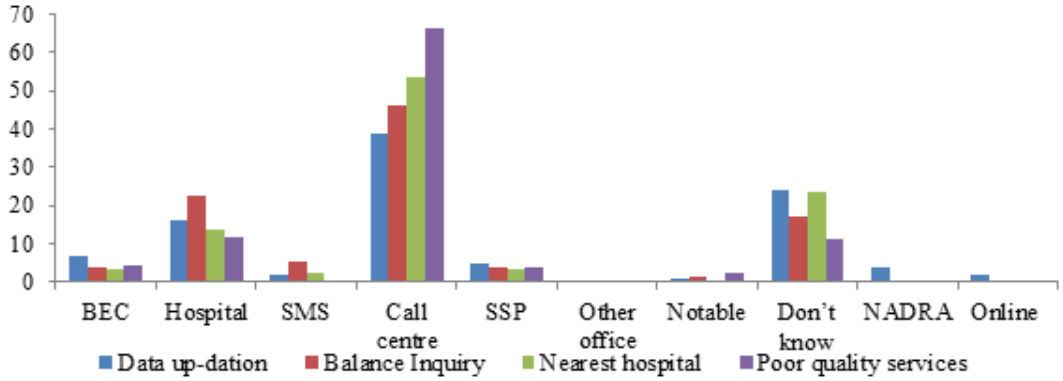


Source: Telephonic survey from beneficiaries, 2021

We questioned those who reported that they are non-beneficiary and that if they require information about eligibility or specific details on the program, what mechanism will they choose. 29% responded that they would call the call center as they have already interacted. Most respondents are unaware of which mechanism they should use (Figure 9).

We have asked the beneficiates which mechanism they will use if they require specific information about the SSP program. A vast majority rely on the call center or on the hospital, whereas a significant percentage even don't know the mechanism of where they should go if they require specific information about the program (Figure 10).

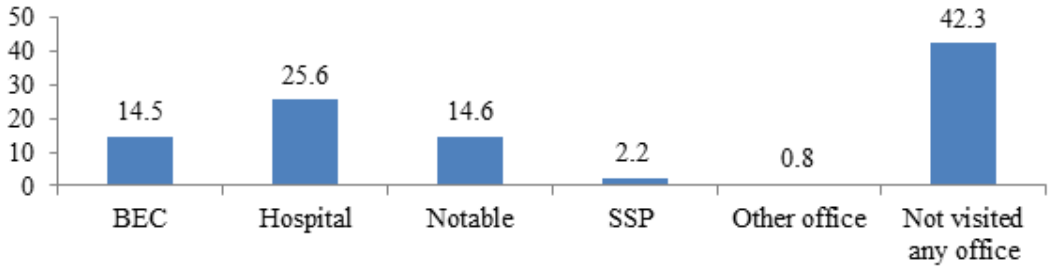
Figure 10: Mechanism used by Beneficiary for Acquiring Information



Source: Telephonic survey from beneficiaries, 2021

Before registering the complaint on the call center, a significant percentage of the beneficiaries have not visited any other office; however, the rest have visited some office to seek support on complaint registration. The other main visiting points were the hospital, BEC, and notables. The key sources that provided information about the call center are communication material given with a card (40%), notable/friends and family (21%), hospital (13%), BEC (6%), and others, including the

Figure 11: Status of Visiting some office before Complaint Registration through call

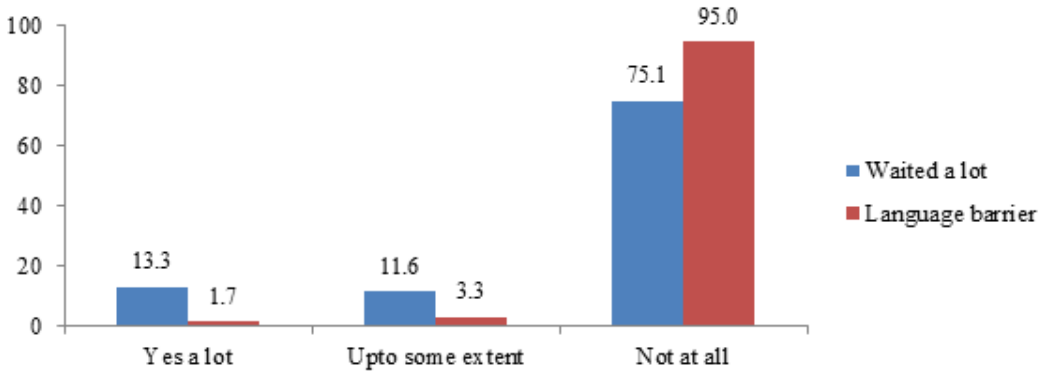


Source: Telephonic survey from beneficiaries, 2021

SSP website, etc.

Overall, the respondents reported having not faced such significant difficulty while interacting with the call agents. 75% reported that they don't have to wait a lot to talk with the call agent, whereas around 95% reported that they have not faced any language barrier. However, most reported that

Figure 12: Difficulty in Interacting with Call Agent



Source: Telephonic survey from beneficiaries, 2021

they were not given a complaint ID (59%).

An interesting element was the need for proper awareness about whether the beneficiary's complaint was resolved. A significant percentage reported that they were not properly informed whether their complaint was resolved. For example, the Call center database shows that 57 complaints are invalid. However, the respondent considers that they are not resolved. Similarly, the call center data reports that 250 complaints are resolved; however, according to the respondents,

Table 8: Complaint Resolution Matrix (in numbers)

	Resolution matrix	Call center database			
		Invalid	Open	Resolved	Total
Reported by beneficiary	Fully Resolved	26	12	131	169
	Partially Resolved	7	1	16	24
	Not Resolved	57	48	250	355
	Don't Know	1	0	13	14
	Not applicable	6	6	44	56
	Total	97	67	454	618

Source: Telephonic survey from beneficiaries and database, 2021

Conclusion and Way Forward

(i) Call Center

The call Center requires a massive up-gradation including:

A. **A fully automated call center integration with all the stakeholders and no manual system.**
B. **Taxonomy of complaints for quick analysis.**
C. **The dashboards associated with the call center and HMIS show the summary of progress and generate desired reports.**
D. **The loop and time framework of each complaint must be defined.**
E. **An integrated pooling of complaints as received through various sources.**
F. **The pooling of complaints requires improvement.**

The SSP should manage the call center itself as it is a 'conflict of interest' that SLIC has been providing the health services and the same institute/vendor has been also managing the call center and investigating the complaints. Currently, the SSP must conduct a sample-based analysis either through itself or the NADRA call center on 'resolved' complaints as reported by the SLIC. NADRA can be tasked to acquire a secondary review on 'acknowledge', 'resolved', and 'invalid' complaints as tagged by the SLIC.

(ii) Integrated Complaint Management System

The complaints registered through web portals, emails, and letters are not correctly recorded, analyzed, and investigated due to limited manpower. These complaints must have a complete record for analysis. All the complaints must be pooled into a single system, which may be called ICMS, where the taxonomy and loop of each complaint must be defined along with the stipulated time for complaint resolution. Currently, the complaints received at the call center are managed in an Excel sheet, and then they are informed to the HFO/DMO through email/WhatsApp, which can lead to many errors and skipping. All this must be done through an integrated system linked with HMIS and the call center, and relevant access should be available to all the stakeholders. Even the NADRA call center can be integrated with the SLIC call center.

(iii) Ground-Level Presence

The program must have its ground-level offices at the district/tehsil level to interact with the public, guide them, and register their complaints. It will improve communication and awareness, making it easier to streamline the grievance system with proper understanding.

(iv) Improvement in Service Delivery

Certain grievances are pending and linked with the policy and efficient service delivery. For example,

i. The enrolment in the program requires a policy-level decision to enroll the newly married couples and declare them a separate family.
ii. HMIS requires up-gradation to resolve certain data-related grievances, i.e., name mismatch, temporary address issue, etc.
iii. A sufficient number of the hospitals will resolve certain grievances, i.e., denial of services, doctor's availability, provision of medicine, etc.
iv. The live data integration with the NADRA can resolve the demand of B-form for enrolment.

(v) Training of HFOs

HFOs are the face of program as they interact with the beneficiaries and general public in hospitals. We observed that their knowledge varies and ultimately communication with the beneficiaries sometimes yields misleading guidelines. SLIC must have an operational manual where roles, responsibilities, and guidelines for each stakeholder must be mentioned.

References

1. Balarajan, Y., S. Selvaraj, and S. Subramanian, *Health care and equity in India*. The Lancet, 2011. 377(9764): p. 505-515.
2. Lorenz, C. and M. Khalid, *Regional Health Accounts for Pakistan–provincial and district health expenditures and the degree of districts fiscal autonomy*.
3. Bredenkamp, C., M. Mendola, and M. *Gragnolati, Catastrophic and impoverishing effects of health expenditure: new evidence from the Western Balkans*. Health policy and planning, 2011. 26(4): p. 349-356.
4. Al-Abri, R. and A. Al-Balushi, *Patient satisfaction survey as a tool towards quality improvement.* Oman medical journal, 2014. 29(1): p. 3.
5. Murante, A.M., et al., *Does feedback influence patient-professional communication? Empirical evidence from Italy*. Health Policy, 2014. 116(2-3): p. 273-280.
6. Coulter, A., R. Fitzpatrick, and J. Cornwell, *Measures of patients' experience in hospital: purpose, methods and uses.* 2009: King's Fund London.
7. Conway, L.J., et al., I*mplementation and impact of an automated group monitoring and feedback system to promote hand hygiene among health care personnel*. The Joint Commission Journal on Quality and Patient Safety, 2014. 40(9): p. 408-417.
8. Reader, T.W. and A. Gillespie, *Patient neglect in healthcare institutions: a systematic review and conceptual model*. BMC health services research, 2013. 13(1): p. 1-15.
9. Mirzoev, T. and S. Kane, *Key strategies to improve systems for managing patient complaints within health facilities–what can we learn from the existing literature?* Global health action, 2018. 11(1): p. 1458938.
10. Piette, J.D., et al., *Structured caregiver feedback enhances engagement and impact of mobile health support: a randomized trial in a lower-middle-income country.* Telemedicine and e-Health, 2016. 22(4): p. 261-268.
11. Bouwman, R., et al., *Patients' perspectives on the role of their complaints in the regulatory process*. Health Expectations, 2016. 19(2): p. 483-496.
12. Barragry, R.A., et al., *An analytic observational study on complaints management in the general practice out of hours care setting: who complains, why, and what can we do about it?* BMC family practice, 2016. 17(1): p. 1-7.
13. Ivers, N., et al., *Audit and feedback: effects on professional practice and healthcare outcomes.* Cochrane database of systematic reviews, 2012(6).
14. Schedler, A., L.J. Diamond, and M.F. Plattner, *The self-restraining state: power and accountability in new democracies*. 1999: Lynne Rienner Publishers.
15. Brinkerhoff, D.W., *Accountability and health systems: toward conceptual clarity and policy relevance*. Health policy and planning, 2004. 19(6): p. 371-379.
16. Thi Thu Ha, B., T. Mirzoev, and R. Morgan, *Patient complaints in healthcare services in Vietnam's health system.* SAGE open medicine, 2015. 3: p. 2050312115610127.
17. Mshelia, C., et al., *Can action research strengthen district health management and improve health workforce performance? A research protocol*. BMJ open, 2013. 3(8).
18. Lancet, T., *Violence against doctors: why China? Why now? What next?* 2014, Elsevier.
19. Bawaskar, H.S., *Violence against doctors in India*. The Lancet, 2014. 384(9947): p. 955-956.
20. Jonsson, P.M. and J. Øvretveit, *Patient claims and complaints data for improving patient safety.* International journal of health care quality assurance, 2008.
21. Ambesh, P., *Violence against doctors in the Indian subcontinent: A rising bane*. Indian heart journal, 2016. 68(5): p. 749-750.
22. Lloyd-Bostock, S. and L. Mulcahy, *The social psychology of making and responding to hospital complaints: an account model of complaint processes*. Law & Policy, 1994. 16(2): p. 123-147.
23. Reader, T.W., A. Gillespie, and J. Roberts, *Patient complaints in healthcare systems: a systematic review and coding taxonomy*. BMJ quality & safety, 2014. 23(8): p. 678-689.
24. Chakraborty, D., M.S. Ahmad, and A. Seth. *Findings from a civil society mediated and technology assisted grievance redressal model in rural India. in Proceedings of the Ninth International Conference on Information and Communication Technologies and Development*. 2017.
25. Rana, N.P., et al., *Adoption of online public grievance redressal system in India: Toward developing a unified view.* Computers in Human Behavior, 2016. 59: p. 265-282.

Annexure

Annexure A: Mapping of existing Complaint Redressal System

A. Types of existing GR systems available to beneficiaries: call center, email, web portal, CMS, complaint portal managed by SLIC, PM Portal

B. Functionality of the existing GR systems:

   a. **Number of complaints received**
   b. **Complaint load**
   c. **Available staff to deal with complaints.**
   d. **Functionality level (national, provincial, district etc).**
   e. **Persons available to deal with complaints**
   f. **Roles and responsibilities defined in each of the GR system**

C. Efficiency of the existing GR systems:

   a. **Level of automation**
   b. **Capable to deal with each sort of complaint. None of the complaint is left.**
   c. **Sufficient staff is available to deal the grievances**
   d. **System is user friendly**
   e. **Single window system to register the grievance**
   f. **System can track and follow each of the complaint**
   g. **The system is capable to manage the workload of complaints.**
   h. **Time bound redressal of complaints.**
   i. **The system is available near to beneficiary's access.**
   j. **The information related to the functionality of the system are available to beneficiaries.**
   k. **Grievance mechanism is clearly defined to give feedback to complainant.**
   l. **The system is efficient in localize context (i.e., in case of a complaint in local language, the system is capable to respond it).**
   m. **Integrated system linked with various complaint forums (i.e., class center is linked with the CMS).**
   n. **All the complaints are segregated into various parts and loop is defined against each of the complaint including roles & responsibilities, time-lines and escalating process.**

D. Accountability of the existing GR systems:

   a. **Roles and responsibilities are clearly defined and mapped in the existing GR system.**
   b. **No conflict of interest prevails in managing the existing GR system among the supply side stakeholders.**
   c. **The complainant can track the complaint.**
   d. **Ensure confidentiality of complainants' details.**
   e. **Acquire feedback from beneficiaries after services (i.e. robo calls to a random number of beneficiaries).**
   f. **Accountability is defined in case of careless attitude by the staff.**

E. Training and complaint manual exist and available to stakeholders.

   a. **A complaint manual is developed in which all the GR systems are defined and mapped.**
   b. **Sufficient training is given to the staff on managing the GR system.**

F. Explore the options to liaison the GR system with other social protection authorities for ensuring to available the system near to beneficiaries home. For example, in far-flung areas, there could be some other social protection offices, that can help the SSP in floating certain information related to the GR through collaboration manner.

Annexure B: Telephonic Survey from Complainants

1. Enumerator name: ----------
2. Complaint ID (from data): ----------
3. Call center (from data): **[1] NADRA** **[2] SLIC**
4. Call pick status:

   [1] Yes attended and interview conducted
   [2] Yes attended, but interview was not conducted due to language barrier *(» End of interview)*
   [3] Incorrect number/respondent did not know *(» End of interview)*
   [4] Not attended *(» End of interview)*
   [5] Number was off *(» End of interview)*

5. If call was attended, who responded call?

   [1] Complainant his/herself
   [2] Other family member/relative etc. responded who know the complainant

6. Name of respondent: ----------
7. Age (in completed years): ----------
8. Education (in completed years): ----------
9. Province name (take from data----------
10. District name (take from data) ----------

11. Are you or your family is beneficiary of SSP?

    [1] Beneficiary **[2] Non-beneficiary** **[3] Don't know**

12. If Non-beneficiary, and want to become a beneficiary or want to acquire some information about program, where you will go or will contact to acquire information?

    [1] BEC **[2] Hospital** **[3] SMS** **[4] Call Center**
    [5] SSP **[6] Other office (name)** **[7] Notable** **[8] Don't Know**

13. From beneficiary, If you want to enroll another member of family or any other data up-dation i.e. marital status, where you will go or contact?

    [1] BEC **[2] Hospital** **[3] SMS** **[4] Call Center**
    [5] SSP **[6] Other office (name)** **[7] Notable** **[8] Don't Know**

14. If you want to get information about balance or card limit, where you will go or contact?

    [1] BEC **[2] Hospital** **[3] SMS** **[4] Call Center**
    [5] SSP **[6] Other office (name)** **[7] Notable** **[8] Don't Know**

15. If you want to get information about the nearest hospital or treatment facility, where you will go or contact?

    [1] BEC **[2] Hospital** **[3] SMS** **[4] Call Center**
    [5] SSP **[6] Other office (name)** **[7] Notable** **[8] Don't Know**

16. If during treatment someone will not provide you medicine or poor quality services or demand money or denial of services, where you will register complaint?

    [1] BEC **[2] Hospital** **[3] SMS** **[4] Call Center**
    [5] SSP **[6] Other office (name)** **[7] Notable** **[8] Don't Know**

17. Have you ever registered the complaint or contact call center for information?

    [1] Yes **[2] No** *(end of interview)* **[3] Don't know** *(end of interview)*

18. Before contacting with the Call Center have you visited any other office?

[1] BEC **[2] Hospital** **[3] Notable**
[4] SSP **[5] Other office (Name) ------** **[6] Not visited anyone**

19. Who told you about the call center?

[1] Communication material given with card **[2] BEC** **[3] SSP Website**
[4] Hospital **[5] Notable/friends/family** **[6] others (Name) ------**

20. Type/reason of complaint/information

[1] Information (balance check, eligibility check, other information including hospital address)
[2] Enrolment/eligibility related issue
[3] Data up-dation/marital status/family member addition
[4] BEC related complaint (staff attitude, bribe)
[5] Denial in provision of card
[6] Card lost
[7] Denial of health services
[8] Money demand during treatment, purchase medicine, lab test, medicine not available
[9] Poor quality of health services during treatment
[10] Poor attitude of front desk officer in Hospital (HFO)
[11] Transport charges not given after treatment
[12] Others (specify ----------

21. While registering the complaint or acquiring information through call center, has you faced difficulty that you waited a lot?

[1] Yes alot **[2] Upto some extent** **[3] Not at all**

22. While registering the complaint through call center or acquiring information, has you faced language barrier while interacting with call agent?

[1] Yes alot **[2] Upto some extent** **[3] Not at all**

23. While registering the complaint through call center or acquiring information, did the call agent told you the complaint ID or your received on your mobile?

[1] Yes **[2] No**

24. According to your knowledge has your complaint resolved?

[1] Fully resolved (25 , 26 and 28) **[2] partially resolved** *(Go to»27 and 28)*
[3] Not resolved *(Go to»28)* **[4] Don't know** *(Go to»28)* **[5] Not applicable** *(Go to»28)*

25. According to your knowledge has your complaint resolved?

------ Months **------ Years**

26. If complaint is resolved, have you been fully explained on the resolution of complaint along with necessary details?

[1] Yes alot **[2] Upto some extent** **[3] Not at all**

27. If complaint is still pending, have you been informed over the reasons along with necessary details?

[1] Yes alot **[2] Upto some extent** **[3] Not at all**

28. Overall, how much you are satisfied while registering the complaint or acquiring information and response/ information provision by call agent?

[1] Highly satisfied **[2] Moderately Satisfied** **[3] Not satisfied**

Annexure C: Complaint module in household survey

L1 - Have you ever registered a complaint regarding the SSP program?

[1] Yes *(»L7)* **[2] Attempted but not registered** **[3] Not registered** *(»L4)*

L2 - If attempted but not registered, what was the nature of complaint? ----------

L3 - If attempted but not registered, why you had not registered? ----------

L4 - Do you know how to register a complaint?

[1] Yes **[2] No** *(If No, end of interview)*

L5 - If yes, please report the method. ☐☐☐

[1] SMS at 8500 **[2] Call at helpline** **[3] Post Hospital Call**
[4] Visited empanel hospital **[5] Visit SSP website** **[6] Visit some office (name) ----------**
[7] Seek support of notable **[8] Visited BEC** **[88] Others (specify) ----------**

L6 - Who told you about the complaint registration method? ☐☐☐

[1] Radio **[2] TV** **[3] Newspaper**
[4] Internet/social media **[5] Leaflet** **[6] Word of mouth (neighbor/relative)**
[7] Through Community notables **[8] Mosque based announcement**
[88] Others (specify)

(End of Interview)

L7 - What was the nature of complaint? ☐☐☐

[1] Enrolment related issue **[2] Money demand during treatment**
[3] Poor attitude of hospital staff (doctor/nurses) **[4] Poor quality of health services**
[5] Poor attitude of front desk officer **[6] Denial of health services**
[7] Denial of up-dation of data **[8] Demand of money while provision of card**
[9] Denial in provision of card **[88] Others**

L8 - Complaint pertains to: ☐☐☐

[1] SLIC **[2] Hospital** **[3] Front desk in hospital**
[4] BEC **[5] NADRA** **[6] SSP** **[88] Others (specify)**

L9 - How the complaint was registered? ☐☐☐

[1] Through SMS **[2] Called at helpline**
[3] Website **[4] written application to hospital, SLIC, SSP**
[5] Email **[6] Complaint to PM Portal, wafaqi mohtasib, DC etc**
[7] Denial of up-dation of data **[8] Demand of money while provision of card**
[9] Denial in provision of card **[88] Others**

L10 - Overall, how much you are satisfied on the complaint registration process? ☐

[1] Highly satisfied **[2] Moderately satisfied** **[3] Not satisfied**

L11 - Status of resolution of complaint.

[1] Totally resolved *(»L13)* **[2] Partially resolved** **[3] Not resolved**

L12 - If complaint is partially resolved or not resolved, whether you have been enough explained why the complaint is not resolved? ☐

[1] Yes, alot **[2] Partially explained** **[3] Not explained at all**

L13 - Overall satisfaction on the response of staff in responding the complaint. ☐

[1] Highly satisfied **[2] Moderately satisfied** **[3] Not satisfied**

Annex Table 1: Nature of complaint by status of resolution (NADRA)

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	794	8,735	0	2,662	12,191
Additional charges taken	336	1,756	182	2,524	4,798
Asking bribe to issue card	0	3	0	4	7
Beneficiary deceased	1,067	1,320	693	2,794	5,874
Center does not exist/could not find	13	14	0	27	54
Payment for admission discharge	40	267	35	515	857
Payment for medicine	81	599	139	1,120	1,939
Payment for tests	106	801	139	1,319	2,365
Treatment not availed	227	216	26	304	773
Total	2,664	13,711	1,214	11,269	28,858

Source: Complaint database provided by SSP till June 24, 2021

Annex Table 2: Nature of complaint by status of resolution (SLIC)

Nature of complaint	Acknowledged	Invalid	Open	Resolved	Total
Transportation charges are not given	6	16	3	31	56
Additional charges taken	8	41	1	77	127
Ambulance not available	0	2	0	0	2
Asking bribe to issue card	23	14	1	141	179
Bad service given	17	63	28	222	330
Beneficiary deceased	0	1	0	4	5
Card lost	66	23	8	1,519	1,616
Card registration problem	198	69	37	2,093	2,397
Center does not exist/could not find	130	159	367	11,165	11,821
Hospital staff misbehave	35	7	0	88	130
Medicines not available	0	0	0	1	1
No attendant at hospital	4	14	3	82	103
Not allowed by SLI/PMNHP pre-present	17	11	4	76	108
Not allowed by SLI/PMNHP Doctor	4	1	1	14	20
Paramedic staff negligence	2	0	1	0	3
Payment for admission discharge	4	7	2	18	31
Payment for medicine	1	6	2	37	46
Payment for tests	3	8	0	23	34
Service not given by hospital	104	603	177	1,742	2,626
Treatment not availed	32	123	3	302	460
Update CNIC in record	398	10	6	2,027	2,441
Total	1,052	1,178	644	19,662	22,536

Source: Complaint database provided by SSP till June 24, 2021

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