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Exploring Beneficiary Awareness and Access to Grievance Redressal Systems in Government-Sponsored Health Insurance Schemes in Gujarat, India

Mayur Trivedi
Yogita Chaudhary

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Exploring Beneficiary Awareness and Access to Grievance Redressal Systems in Government-Sponsored Health Insurance Schemes in Gujarat, India

Mayur Trivedi and Yogita Chaudhary

Abstract: *The Government of India launched Pradhan Mantri Jan Arogya Yojana (PMJAY) in 2018 to mitigate catastrophic out-of-pocket health expenditure. This government-sponsored health insurance scheme is implemented through six digital portals, including a grievance redressal system, with the involvement of multiple stakeholders. The grievance redressal mechanisms in PMJAY are aimed at ensuring access to information, contribute to the responsiveness of the scheme and safeguard it against any fraudulent practices. As a pioneering effort, this research explores the role and experiences of grievance redressal systems by exploring the following research questions: 1) What are the processes of collecting and responding to grievances in PMJAY? 2) How is the awareness about the Grievance Redressal System among the beneficiaries?, and 3) What is the experience of beneficiaries of interaction with the Grievance Redressal System of PMJAY?. A cross-sectional descriptive study was conducted from January 2022 to August 2023 in Gujarat, using a mixed-method approach to data collection from various primary and secondary sources. The findings from the study show that multiple formal and informal channels are active with varying accessibility among the beneficiaries. A significant proportion of beneficiaries were unaware of their entitlements and grievance redressal mechanisms. Awareness was low regarding internet-based formal channels and communication through letters or emails. The findings underscore the necessity for enhanced outreach efforts, using detailed information dissemination via print and outdoor media. Building trust in the grievance redressal system is essential to increase its use and demand among the beneficiaries. Insights from this study will be useful to strengthen the grievance redressal system of the PMJAY scheme or similar government schemes.*

Keywords: *Beneficiaries, Central Grievance Redressal Management System, Government-Sponsored Health Insurance Schemes, Grievance Redressal, Pradhan Mantri Jan Arogya Yojana.*

Exploring Beneficiary Awareness and Access to Grievance Redressal Systems in Government-Sponsored Health Insurance Schemes in Gujarat, India

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1. Introduction

India had a total health spending of around 3-4% of gross domestic product (GDP) across the National Health Accounts (NHA) estimates of 2004-2005 and 2019-2020. This is a low level of health spending as compared to other developing countries, like China (5.4%) and Thailand (5.2%). It witnessed some improvement in per capita spending, a reduction in the share of private and out-of-pocket (OOP) spending, and a modest increase in health insurance expenditure in this period (Hooda, 2015; Jakovljevic et al., 2017; National Health Systems Resource Centre, 2023; Rao, 2017). The high OOP spending remains a significant challenge in attaining universal health coverage in India. Poor people may forego treatment because of unaffordability, resulting in poor health outcomes and a continued high burden of diseases (Gumber, 2021; Sen et al., 2018). Catastrophically high expenditure on treatment could broaden and deepen poverty when people spend on their treatment by exhausting their savings, selling assets, or borrowing (Akhtar et al., 2024; Doorslaer, 2007; Flores et al., 2008; Gupta & Joe, 2013). Other strategies like decreasing consumption and sending children to work can lead to long-lasting effects on the well-being of families (Dhanaraj, 2016; Sriram & Albadrani, 2024). Government-Sponsored Health Insurance Schemes (GSHIS) are advocated as an equitable approach to protecting poor families from the impoverishing effects of health expenses (Forgia & Nagpal, 2012; Sriram & Khan, 2020).

The Government of India introduced the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) in 2018. This flagship GSHIS scheme was launched in response to the commitment made in the National Health Policy 2017, which aimed to raise government health expenditure from 1.3% in 2017 to 2.5% of GDP by 2025. PMJAY merged the existing state and national level GSHIS, that is, Rashtriya Swasthya Bima Yojana (RSBY) (Dubey et al., 2023; Garg et al., 2020; Trivedi et al., 2022).

As a measure towards health system responsiveness, GSHIS are expected to respond to the needs and expectations of the community, with an equitable focus on the vulnerable and marginalized sections (World Health Organization, 2007). PMJAY uses centrally managed digitalised systems to ensure access to information by all stakeholders. Among these are 1) a Citizen portal to check the eligibility of beneficiaries, 2) Beneficiary Identification System (BIS) for beneficiary registration, 3) Hospital Empanelment Module (HEM) for empanelling the health care service providers, 4) Transaction Management System (TMS) for claims management, 5) Central Grievance Redressal Management System (CGRMS) for the grievance management, and 6) PMJAY Technical Support Centre for providing support to the stakeholders. These measures ensure access to information, contribute to the responsiveness of the scheme and safeguard it against any fraudulent practices.

A lack of information in GSHIS can amplify information asymmetry and lead to grievances among beneficiaries. Evidence indicated that lack of coordination and inadequate information dissemination hindered RSBY implementation in India, affecting its enrolment and uptake (Devadasan et al., 2013; Nandi et al., 2013; Raza et al., 2016; Seshadri et al., 2012; Sinha, 2018; Thakur, 2016; Thomas et al., 2021). Evidence also pointed to the limited role of RSBY and Mukhyamantri Amrutam (MA) scheme – a Gujarat-sponsored state health insurance scheme – in reducing OOP expenditure among the enrolled beneficiaries, leading to dissatisfaction and potential grievances (Bhatt & Rana, 2019; Prinja et al., 2017). Lastly, studies on the early implementation of PMJAY in Gujarat and Madhya Pradesh showed improved government involvement in information dissemination but highlighted OOP payments by marginalized individuals (Saxena et al., 2022; Trivedi et al., 2022). These experiences emphasize how financial burdens can lead to dissatisfaction, undermining the responsiveness and financial protection goals of GSHIS. Better dissemination of information, improved coordination of processes and implementing a robust grievance redressal mechanism in GSHIS can contribute to the reduction of such financial burden. Acknowledging and resolving grievances can help beneficiaries to understand their entitlement. It can also empower marginalized individuals who otherwise remain unheard and powerless by giving them a voice.

The responsiveness and accountability of the system are connected to the importance of the grievance redressal (GR) system as a response mechanism for addressing complaints (Brinkerhoff, 2004; Thi Thu Ha et al., 2015). The Indian government has a separate Ministry of Personnel, Public Grievances and Pension, that sets the policy to manage grievances at all levels of governance. The National Health Policy 2017 and Indian Public Health Standards stressed the importance of GR mechanisms and community involvement (Khanna et al., 2024; Pinto, 2021; Priya, 2022). The Indian commercial health insurance industry has multi-level ombudsmen to handle and resolve customer complaints, although little is known about their effectiveness (Goda, 2019; Putturaj et al., 2021). Some research documented the positive effects of GR mechanisms on the quality of care in Indian community health insurance schemes (CHIs) (Devadasan et al., 2006; Michielsen et al., 2011). Various Indian GSHIS were developed and implemented top-down, with communities being rendered as mere passive beneficiaries. Only a few GSHIS in the 2000s had sophisticated GR mechanisms, while

most only responded to local media issues (Forgia & Nagpal, 2012). Highlighting the absence of a forum for vulnerable population groups to voice their concerns, a study emphasised the need for investment in more politically neutral processes to reach out to the most vulnerable households and strengthen their role in implementing RSBY (Seshadri et al., 2014).

As a pioneering effort, this research explores the role and experiences of GR systems in GSHIS in providing a voice to the community in the Indian state of Gujarat. The Specific research questions were: a) What are the processes of collecting and responding to grievances in PMJAY? b) How is the awareness about the Grievance Redressal System among the beneficiaries? c) What is the experience of beneficiaries interacting with the Grievance Redressal System of PMJAY? Before turning to the methodology, a brief history of implementing GSHIS in Gujarat is presented below.

History of GSHIS in Gujarat

The RSBY, launched in Gujarat in 2008, covered hospitalization expenses up to INR 30,000 per family of five members per year. It expanded to include all districts and urban areas by 2011-2012. The scheme was implemented through an insurance model and was monitored through an interdepartmental task force comprising Labour, Health, and Rural Development departments. Gujarat launched the MA Scheme in 2012 to provide cashless medical and surgical treatment of specified conditions to poor families through a network of identified public and private hospitals. In 2014, the scheme was extended as the MA Vatsalya scheme to additional non-poor citizens. The coverage under the scheme was expanded from INR 2 lakhs to INR 3 lakhs per family per annum in 2018. Unlike RSBY, the MA scheme was operated through a 'trust model' in which the insurance functions were managed through an in-house trust. In 2018, when PMJAY was launched and subsumed existing schemes, the MA scheme was catering to around 3 lakh families. The PMJAY has been operating in a hybrid model wherein claims up to INR 50,000 are processed through an insurance company and the State Nodal Agency processes the claims above INR 50,000.

The RSBY implementation in Gujarat involved the creation of a GR system through coordination with the hospitals and insurance companies through performance reviews, medical audits, and periodic third-party evaluations. The pioneering system that Gujarat developed for RSBY continued under the MA and PMJAY scheme. This included a tiered system that involves the Taluka, District/Municipal Corporation, and the State-level GR committees.

2. Methodology

A cross-sectional descriptive study was conducted in Gujarat from January 2022 to August 2023. This was a mixed-method study with qualitative and quantitative data collection methods from different primary and secondary sources. These included 1) a desk review of relevant policy documents, guidelines, and reports, 2) an analysis of grievances collected by the web-enabled system - CGRMS portal developed by PMJAY, 3) a telephonic survey of patients who availed hospitalization under the scheme, and 4) in-depth interviews of key informants.

The desk review included guidelines for the GR system, details of committee members and their roles, and minutes of meetings of the district GR committee. The 9018 grievances received from all the districts of Gujarat on the CGRMS portal from November 2018 till 7 December 2022, were cleaned, sorted, and analysed in Microsoft Excel. This analysis aimed to understand the trend and nature of grievances based on stakeholders, channels, and districts.

The portal received the most grievances from Ahmedabad, followed by Surat and Vadodara district. The district of Vadodara, which had the highest rate of grievances per 10,000 Ayushman beneficiaries, was chosen for telephonic surveys and in-depth interviews. These details are available as supplementary material 1.

The study population for the telephonic survey included 1800 patients who availed of hospitalization under the scheme in the Vadodara district from October to December 2022. The State Health Agency (SHA), Gujarat, made this list available. The sample size of 260 patients was selected through a simple random sampling technique using a pseudo-random number generator. The determination of the sample size was made considering the constraints of feasibility, time, and resources, without making any statistical assumptions. This decision was based on the primary purpose of the research to explore awareness and utilisation of grievance redressal in the short period of February and March 2023. A structured questionnaire was created in English. It included questions on socio-demographic information, scheme utilization, awareness of the GR system, and the experience of registering a grievance. The questionnaire was pilot tested for content and flow. Patient satisfaction with the registration, treatment and after-treatment/payment process was calculated using the Likert scale. The questionnaire was reviewed internally by the research team (Mayur Trivedi and Yogita Chaudhary) and finalised after a series of iterations. A Computer-Assisted Personal Interviewing (CAPI) approach using KoBo toolbox software was adopted for digital data collection. The interviews were conducted by a team of eight investigators who were trained in clinical and para-clinical sciences. Before starting the telephonic interviews, respondents' verbal consent was taken. The anonymised raw data was cleaned, sorted and analysed using Microsoft Excel.

The key informant interviews comprised meetings with eight state and district officials, -namely, one district programme coordinator (DPC), one chief district health officer, one quality medical officer, one insurance coordinator, one hospital manager, one Ayushman Mitra, and two state-level officials from the SHA. Eleven patients who registered grievances on the CGRMS portal or had experience raising grievances from the telephonic survey were randomly selected for in-depth interviews until saturation. The interviews were conducted using in-depth interview guides developed after internal review. The interviews were audio-recorded when permission was given; otherwise, notes were taken. The interviews were transcribed verbatim by a member of the research team (Yogita Chaudhary) and subsequently reviewed by another team member (Mayur Trivedi) to ensure accuracy. The researchers read the transcripts and field notes reflexively, i.e. remaining mindful of their own orientation shaping the interpretations, to identify variables that affected the GR mechanism.

The study received ethical clearance from the Institutional Ethics Committees of the Indian Institute of Public Health Gandhinagar vide TRC-IEC No. 09/2020-21 and Institute of Public Health Bangalore vide IPH/20-21/E/86.

3. Results

Channels for registering grievances in the MA-PMJAY Gujarat

There are multiple channels for beneficiaries to register complaints after their hospitalization: online portals of the government of India and of specific states, interpersonal channels like call centres, and feedback or follow-up calls to patients. The different channels that beneficiaries can access to register grievances related to the PMJAY scheme are described below.

The CGRMS is an online system for registering, processing, managing, monitoring and redressing all grievances from any of the aggrieved stakeholders under the PMJAY. The 3-tier system includes district, state, and national level officers and committees. They receive, scrutinize, and act on grievances that are tracked through a unique registration number for quick resolution. The Centralised Public Grievance Redress and Monitoring System (CPGRAMS) is a single-window online platform that allows individuals to lodge grievances about any scheme with public authorities in India. It covers all ministries/departments at the national and state levels. The state-level portals in Gujarat include 1) the Performance Monitoring and Control Centre (PMCC) portal, an initiative of the Commissioner of Health, Gujarat, for real-time performance monitoring and reporting of various health programmes and schemes,[1] 2) the Chief Minister (CM) Dashboard, an online platform where beneficiaries can register their grievances about any issue related to any department of the Government of Gujarat, and 3) the State-Wide Attention on Grievances by Application of Technology (SWAGAT) portal, the Chief Minister's online grievance redressal system for all public

1 Please see https://pmccgujarat.weebly.com/about-pmcc.html

issues[2]. Besides the online systems, a national call centre (14555/1800 111 565) is integrated with the CGRMS portal to collect feedback from the patient after discharge[3]. A similar state-level toll-free number (1800 233 1022) and health helpline number 104 are also available for beneficiaries to register their grievances. Jan Samvad (Real Time Citizen Feedback System) is a questionnaire-based feedback system to seek feedback from beneficiaries of various government schemes/ projects, including PMJAY[4]. Last, the district officials undertake audit visits to hospitals and interact with hospitalized patients to seek their feedback and grievances. The beneficiaries can register their grievances through phone calls, letters, emails, or through in-person visits to the DPC of PMJAY. All empanelled hospitals in PMJAY have a dedicated helpdesk at a prominent location in the hospital to support patients' engagements throughout the hospitalization. A dedicated hospital staff, Ayushman Mitra (AM), manages the helpdesk and liaises between patients, doctors, hospital administration, and scheme managers. The patients also report their complaints to AM during the hospitalization.

Some key informants highlighted that the CGRMS portal receives a very insignificant proportion of the overall grievances; most are received through calls and the CM dashboard. However, data from these channels are neither being compiled nor used to strengthen the scheme. The data received through offline channels, like calls or messages to DPCs, are not compiled and merged with online data on grievances. The data on resolved grievances are neither compiled to understand the trend nor used as training or campaign materials.

"Maximum grievances are received through calls and the CM Dashboard; most of these are related to (issues) during and after hospitalization. The pre-hospitalization grievances are mostly received from the toll-free number, SWAGAT portal, and CGRMS portal. The complaints received on the CGRMS portal are around 0.1% of total grievances." - Policymaker 1

"No Action Taken Report (ATR) is prepared for complaints other than those in CGRMS. These ATRs are not used for decision-making and planning. This portal (CGRMS) is not used as a databank of cases for disseminating success stories for patients' awareness or capacity-building efforts as training service providers." - Policymaker 2

"Stakeholders such as Ayushman Mitra reach out to the DPC directly through WhatsApp in case of any technical issues in making cards. When the beneficiaries register the grievances directly to the DPC, they are resolved by them, but these grievances are not fed into the CGRMS portal." – Policymaker 3

2 Please see https://pib.gov.in/PressReleasePage.aspx?PRID=1919513
3 https://nha.gov.in/PM-JAY.html
4 https://informatics.nic.in/uploads/pdfs/9ba61178_2227.pdf

4. Details of grievances received at the CGRMS

In the absence of a compilation of all grievances, the CGRMS is the only data available for comprehensive analysis. The analysis of the 9018 CGRMS entries indicated that 55% were general enquires and not grievances. These general enquiries were excluded from the analysis, as they were irrelevant to the purpose of the study. The remaining 4028 grievances were analysed for this study. Most of these grievances were registered directly by the beneficiaries (70%), followed by hospitals (12%), and beneficiaries through the common service centres (11%). Grievances related to PMJAY cards accounted for around one-third (33%) of the total. Requests for enrolment in the scheme made up over a quarter (28%) of the grievances. One-fifth (20%) of the grievances were about demands for money while availing benefits under the scheme. The remaining grievances were related to the unavailability of support services, claims and empanelment of facilities, and denial of treatment coverage. Beneficiaries use the CGRMS mostly for pre-hospitalization grievances, that is, issues related to enrolment in the scheme or receipt of Ayushman cards. The details can be found in Table 1.

Table 1: Details of Gujarat-based grievances registered in CGRMS: a comparison by type of grievances and stakeholders who registered them (n=4028, In %)

Type of Grievances/ Stakeholder	Benefi-ciary	Common Service Centre	Hospital	Implementa-tion Support Agency	Insur-ance Company	PMAM	Others	Total
Related to enrol-ment card	29.7	3.6	0.0	0.0	0.0	0.0	0.0	33.4
Request for enrolment	15.1	4.2	4.4	0.6	0.1	1.5	1.6	27.5
Money demanded	18.0	0.9	0.8	0.1	0.0	0.3	0.4	20.4
Support services	4.6	2.0	2.0	0.3	0.1	1.8	0.0	10.9
Related to claims/ empanelment	0.0	0.0	5.0	0.0	0.0	0.0	0.0	5.0
Treatment denial	2.7	0.0	0.0	0.0	0.0	0.0	0.0	2.7
Total	**70.1**	**10.7**	**12.2**	**1.0**	**0.3**	**3.6**	**2.1**	**100.0**

The key informants highlighted that the pre-hospitalization grievances were because of glitches in the TMS or BIS. Common Service Centre staff or Ayushman Mitra can support beneficiaries during registration. Similarly, the beneficiaries would need to rely on hospital staff or reach out to district or state programme coordinators for information or complaints during hospitalization. To ensure the successful implementation of the scheme and the proper handling of grievances, it is imperative that beneficiaries, scheme officials, and intermediaries possess a thorough understanding of the scheme's design, entitlements, procedures for accessing entitlements, as well as processes for identifying and addressing grievances. Inadequate coordination between internal (district, state and central officials), intermediary (empanelled hospitals, common service centres, and insurance companies/insurance service agencies) and external stakeholders (beneficiaries) were also a source of grievance for beneficiaries. An example of such lack of coordination is explained below.

"These (card-related grievance) issues are mostly related to the BIS system, in which a beneficiary uploads information, but it is not visible to the authority to approve it and process the card." - Policymaker 4

"Lack of coordination between BIS and TMS. Patients are registered in the BIS but not shown in TMS". - Hospital manager 1

"I was talking to Dr ABC in XYZ Hospital. He was handling everything related to the Ayushman scheme. I had registered complaints in customer care (the number given behind the Ayushman card) many times, and even registered live complaints. I also saw this scheme's website to find more numbers and links. I called those numbers; some were reachable, and some were unreachable. A friend of mine who works in a hospital sent me a few email IDs. I sent mail to them as well. But nobody gave a reply. After that, I registered my grievance on the portal." - Patient 1

"If there are changes in rules or policies, these changes are not communicated to the district-level officials. If an insurance company changes, they change the processes, these changes are communicated after everything has been done at their level. Due to this district-level officials, hospitals and patients have to suffer as they are not aware of the changes." - Policymaker 2

5. Insights from telephonic survey

The sampled patients included an equal representation of men and women. Most of them were Hindus (85%), married (82%), almost half were in the age group of 41-60 years (47%), and one-third (34%) were non-working groups of students or elderly. Most patients belonged to the general category (39%), followed by the Other Backward Class (29%), and the Scheduled Tribe (14%). (Table 2)

Most patients (58%) preferred private facilities for their hospitalization, followed by government hospitals (23%) and not-for-profit hospitals (19%). The proportion who received treatment from the private sector was higher for the general category (66%) as compared to socially disadvantaged groups like Scheduled Caste (40%) and Scheduled Tribe (47%). Approximately 55% were admitted to hospitals for surgical procedures, 34% for day-care procedures, and the remaining 10% for medical hospitalization. Approximately 43% of patients were treated for cancer-related ailments. The other two common reasons for admission were kidney ailments and cardiovascular illnesses, at 15% each. While 94% of patients were satisfied with the services they received, the unsatisfied patients were from the 'General Category' who received treatment from private hospitals. Six out of sixteen individuals expressed dissatisfaction because of delays in registration or treatment, while five out of sixteen reported denial of treatment or demand for money. This aligns with the findings of the secondary analysis of the CGRMS portal, which showed that post-hospitalization complaints were primarily regarding financial demands and denial of treatment.

Table 2: Socio-demographic profile of the participants for the survey

Category	No. of Patients	Percent (%)
Gender		
Male	145	56
Female	115	44
Age (in completed years)		
Below 18	6	2
18-40	60	23
41-60	120	46
61 and above	74	28
Marital status		
Single	23	9
Married	214	82
Divorced/Separated	2	1
Widowed	21	8
Religion		
Hinduism	222	85.4
Islam	35	13.5
Christianity	2	0.8
Jainism	1	0.4
Education		
Illiterate	45	17
Literate but no formal school	7	3
1-8 standards	86	33
9-12 standards	89	34
Some college but no graduate/ Diploma	7	3
Graduate/post-graduate/ PhD	24	9
Not Applicable	2	1
Occupation		
Student/Elderly	88	34
Housewife	60	23
Farmer	28	11
Shop/business	21	8
Unskilled worker	19	7
Unemployed	18	7
Skilled worker	16	6
Private sector employee	8	3
Not applicable	2	1

Social group		
General Category	101	39
Other Backward Caste	76	29
Scheduled tribe	36	14
Scheduled Caste	20	8
Do not know	21	8
Prefer not to say	6	2
Total	**260**	**100**

Most of the participants (85%) were not aware of any system for raising a scheme-related grievance. The low level of awareness varied by social gradient; while 19% of respondents from general categories (that is, upper caste beneficiaries) knew about the GR system, only 6% (that is, 2 out of 36 beneficiaries) of the Scheduled Tribe category (that is, Adivasi beneficiaries) were aware of it. Out of the 38 respondents (15%) who were aware of the GR system, the majority (55%) got information from formal sources like hospital staff, health workers, doctors, and AMs. Interpersonal sources such as friends and relatives accounted for 27% of the information. Only three respondents mentioned text messages, and one indicated hoarding as a source of information for GR. These findings corroborated well with the insights from key informant interviews, which revealed an absence of targeted Information, Education, and Communication (IEC) for the grievance redressal system. The scheme only provides for a toll-free number on the card and a phone number of district-level officials on the hoardings at the empanelled hospitals. There are no other efforts to increase beneficiaries' awareness of entitlements regarding grievance redressal.

> *"Awareness related to the grievance system is generated (as) the toll-free number on the back of the card. Other channels are not at the centre of these awareness campaigns." - Policymaker 4*
>
> *"IEC of toll-free numbers is done through posters and banners. It is also available on the Ayushman card. But there is no IEC for the CGRMS portal." - Policymaker 2*

Nearly half of the respondents who claimed to be aware of ways to register grievances knew about telephonic formal channels such as call centre or toll-free numbers (49%). Another one-third of the respondents indicated that AM or other staff could be used as a channel for registering grievances (33%). Very few participants were aware of the internet-based formal channels like the official website/portals like CGRMS, CPGRAMS, and SWAGAT portal (7%) and writing a letter/email to various government offices (7%). No participant knew about all the channels for raising grievances. The key informant interviews also highlighted the three common modes of grievance registration: 1) through AM at the hospitals, 2) through phone calls to DPCs, and 3) through toll-free numbers. However, the aggrieved patients expressed a lack of awareness about the grievance redressal system and channels, including that of the dedicated portal. The key informants mentioned that

beneficiaries with ties to local politicians preferred an informal system for registering grievances, such as contacting the scheme staff directly.

> *"The informal system of receiving grievances is powerful at the district level. These are for the beneficiaries, especially from rural areas. Calls are received from politicians like the sarpanch and members of the legislative assembly." - Policymaker 2*
>
> *"People do not know about any such site, application or process. No such information is shared through newspapers." - Patient 3*
>
> *"We asked a neta or karyakarta in the corporation to call them, and after that we got approval." - Patient 9*
>
> *"I thought that there must be a way of filing grievances, and I found out about the toll number because it was on the card. I filed my complaint on the phone only; I do not know about any other channels for filing a grievance in the scheme." - Patient 2*

As per the patients who were aware of the scheme, the two most common reasons for which grievance can be raised were denial of treatment (41%) and demand for money for treatment under the scheme (34%). Only a few participants knew they could file complaints for various issues, such as denial of non-clinical entitlements like food and transport, staff behaviour, delays in receiving the Ayushman card, and denial of emergency treatment. However, half of these participants, too, were unaware of the Turn Around Time (TAT) for grievance redressal. Only one participant correctly guessed that the TAT was 15 days. Only 6 out of 38 participants knew they could refile a grievance if they were not satisfied with the grievance resolution. No patients mentioned that they re-filed grievances and one indicated the processes could be cumbersome and thus, they avoided refiling despite remaining unsatisfied with the resolution. The district and state authorities also indicated that they have registered no case of the refiling of grievances.

> *"If I refile the complaint, then I will have to manage everything and run around for it. I work in a private job, so I do not have time to run around for these things." - Patient 11*

Fourteen participants (5%) had some complaints regarding the scheme. Only two of the fourteen participants registered and raised their grievances, one each at the hospital and through a telephonic formal channel. The grievance registered through a formal telephonic channel was followed up by the system and resolved satisfactorily. However, the one registered at the hospital did not receive any follow-up and was unresolved. Among those who did not file complaints, the most frequently cited reason was a lack of knowledge on where or how to register grievances. Additional reasons included the lack of trust in the grievance redressal (GR) system, lack of time and the perception that it would not be helpful.

The system's efforts are restricted to the provision of limited information and do not extend to building the capacity of patients. Aggrieved patients experienced a lack of hand holding at the hospital level, delays in registration through the centralized system, and a resolution of grievances owing to centralized management of the system. They needed to call multiple times before their calls were answered on the toll-free numbers/call centres.

> *"I called and registered my complaint by calling the customer care number I found online. They picked up the call only after I had called 2-4 times." - Patient 8*
>
> *"I filed my grievance in the scheme on the toll number, which is on the card when they (the hospital staff) demanded money. We called 3-4 times on the toll number. The problem was resolved, and my treatment was approved after two days." - Patient 9*
>
> *"I kept calling, but they kept saying that we have got no support from Delhi. He said that you keep trying to make this card in a gap of 10-15 days. When this issue is resolved from Delhi, then you will get a new card. Then after 1-1.5 years, I got a new card." – Patient 3*

6. Discussion

This research used a mixed-method approach of data collection to explore the grievance redressal system of the PMJAY in Gujarat, India. The research findings suggest that, although there are various channels available for registering and reporting complaints, there is room for enhancing the collection and coordination among these channels. Currently, the complaints from various sources are addressed and answered individually. The lack of cohesion in the grievance redressal system creates obstacles for beneficiaries, making it hard for them to access and navigate the system. Delays in resolving grievances cause frustration among beneficiaries.

Most patients were aware of the cashless hospitalization benefit of the scheme; however, the awareness about other non-clinical entitlements, emergency care, and the right to register a grievance was limited. These are similar to the observations made by the research on RSBY and MA schemes in Gujarat (Patel & Unadkat, 2018; Thakur, 2016; Thomas et al., 2021).

The low awareness of the channels of grievance registration and entitlements could have prevented patients from registering their grievances. Beneficiaries are often unaware of their rights, the grievance redressal channels, and the process for filing a grievance. Awareness of the service standards is crucial for individuals to feel empowered in expressing their grievances if they are unsatisfied (Schlesinger et al., 2002; Stojisavljević et al., 2022). The lack of awareness highlighted the existing information asymmetry as an important roadblock for consumers to build trust in the system. In this scenario, the study re-emphasized the role of an effective Grievance Redressal System in providing positive reinforcement to the beneficiaries (Goda, 2015). This lack of awareness leads to grievances not being registered or resolved, creating a cycle of negative experiences and hindering the overall effectiveness of the scheme.

Besides low awareness about the GR system, the lack of trust in the system's ability to resolve grievances and the perceived high opportunity cost deterred patients from filing grievances, despite being aggrieved. These results are similar to a study conducted by the Care Quality Commission in the United Kingdom. The study found that individuals who believed complaining would not make a difference and struggled to identify where to raise concerns were afraid to voice their concerns (ICM & Care Quality Commission, 2013).

The most common sources of information about the GR system were hospital staff and friends or relatives. This suggests inadequate dissemination of information by the system and the potential for worsening the patient-provider power imbalance. Informal channels, such as administrative and political connections, benefit only certain beneficiaries with high social and financial capital. It has been documented elsewhere that higher-income groups have a higher ability to voice dissatisfaction and raise complaints effectively (Schlesinger et al., 2002). Given that PMJAY primarily serves low-income beneficiaries, there is an urgent need for the scheme to acknowledge the diversity within this socio-economic group and identify the most vulnerable and socially marginalized beneficiaries from within the wider beneficiaries. To raise awareness and build trust among these subgroups, the system should focus on proactive outreach – through handholding through civic and community support - to capture their experiences, encourage formal grievance submission, and ensure resolution of their concerns (Pande & Hossain, 2022; Parliamentary and Health Service & Ombudsman, 2015).

The findings call for targeted campaigns for awareness generation on nuances of entitlements and grievance redressal mechanisms through various information channels beyond hoardings and banners. Attempts need to be made to build the beneficiaries' trust in the grievance redressal system through disseminating successful resolutions to enable and encourage more aggrieved beneficiaries to register their grievances. While this study highlights the challenges beneficiaries face in accessing the grievance redressal system, it does not address the system's perspective in responding to and resolving these grievances, which is a noted limitation. Further research is needed to bridge this gap and provide a comprehensive understanding of the grievance redressal process.

7. Conclusion

If implemented effectively, grievance redressal mechanisms play a crucial role in ensuring that beneficiaries of social welfare schemes have access to fair treatment. Although India's GSHIS have made remarkable progress, there is a dearth of research on grievance redressal mechanisms in these schemes. This first-of-its-kind research documents the grievance redressal mechanism in India's GSHIS using the case study of Gujarat. The learnings from this study would be useful to strengthen the grievance redressal system and implementation of the PMJAY scheme. More research into the complex reality in which the PMJAY scheme and its GR system operate may facilitate evidence-informed program planning and policymaking.

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Supplementary material 1: Details of the districts by card holders and grievances received

District	No. of grievances registered	Beneficiaries with the Ayush-man card	Grievance/10,000 beneficiaries with the card in a district
Vadodara	767	662626	11.6
Ahmedabad	1578	1435202	11.0
Surat	1087	1231667	8.8
Kachchh	264	347704	7.6
Bhavnagar	295	431823	6.8
Jamnagar	230	347735	6.6
Anand	276	425193	6.5
Valsad	300	480765	6.2
Bharuch	298	502060	5.9
Morbi	112	203260	5.5
Narmada	115	246651	4.7
Banas Kantha	285	619134	4.6
Gandhinagar	195	420339	4.6
Gir Somnath	139	340214	4.1
Kheda	203	513644	4.0
Rajkot	429	1061326	4.0
Porbandar	56	166844	3.4
Devbhumi Dwarka	41	122652	3.3
Dohad	176	526820	3.3
Surendranagar	136	415579	3.3
Panchmahal	104	326138	3.2
Mahesana	228	754722	3.0
Botad	45	154501	2.9
Aravalli	78	275036	2.8
Patan	128	500478	2.6
Junagadh	156	615296	2.5
Chhotaudepur	66	271528	2.4
Dang	21	87935	2.4
Mahisagar	72	296395	2.4
Navsari	124	508923	2.4
Sabarkantha	130	596354	2.2
Tapi	64	318788	2.0
Amreli	101	590482	1.7
Grand Total	**9018**	**15797814**	**5.7**

About the Authors

Mayur Trivedi (Corresponding author)
Professor
Azim Premji University, Bhopal
Email ID - mayur.trivedi@apu.edu.in
Mobile - 9099148177
ORCID 0000-0002-4532-2340

Yogita Chaudhary Consultant (Epidemiology)
National Institute of Epidemiology
Indian Council of Medical Research, Chennai
Email ID – yatichaudhary2@gmail.com
Mobile – 9971034395
ORCID 0009-0000-8329-7361

About Azim Premji University

Azim Premji University was established in Karnataka by the Azim Premji University Act 2010 as a not-for-profit University and is recognized by The University Grants Commission (UGC) under Section 22F. The University has a clearly stated social purpose. As an institution, it exists to make significant contributions through education towards the building of a just, equitable, humane and sustainable society. This is an explicit commitment to the idea that education contributes to social change. The beginnings of the University are in the learning and experience of a decade of work in school education by the Azim Premji Foundation. The University is a part of the Foundation and integral to its vision. The University currently offers Postgraduate Programmes in Education, Development and Public Policy and Governance, Undergraduate Programmes in Sciences, Social Sciences and Humanities, and a range of Continuing Education Programmes.

Azim Premji University
Survey No. 66
Burugunte Village
Bikkanahalli Main Road
Sarjapura, Bengaluru - 562125

Website: azimpremjiuniversity.edu.in