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# ORGANIZATIONAL AND DIGITAL BARRIERS IN PATIENT SUPPORT AND INTERNAL EXPERTISE SERVICES: A CROSS–SECTIONAL SURVEY OF HEALTHCARE WORKERS IN KAZAKHSTAN

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**Abstract**

**Introduction.** Patient Support and Internal Expertise Services play a central role in translating patient complaints into managerial decisions. In practice, day–to–day work may be constrained by high workloads, multiple intake channels, and fragmented information systems.

**Aim.** To assess organizational and digital barriers perceived by Patient Support and Internal Expertise Services specialists, and to evaluate the association between root–cause recording and accounting for repeated complaints.

**Materials and Methods.** A cross–sectional empirical observational descriptive–analytical study was conducted using an online questionnaire (Google Forms). Data were collected between November 26, 2025, and January 21, 2026. A 16–item questionnaire was used. The sample comprised 35 employees of medical organizations performing Patient Support and Internal Expertise functions. Descriptive statistics were calculated; associations were assessed using Fisher's exact test ($p<0.05$).

**Results.** The main complaint channels were telephone and walk–in complaints, each accounting for 37.1%. Working across multiple information systems was considered inconvenient by 97.1% of respondents. The most common difficulties were the lack of data export functions for reporting (42.9%) and overload due to task concentration on a single specialist (34.3%). Recording the root cause of a complaint in the system was noted in 97.1% of responses (predominantly in free–text form), while accounting for repeated complaints in reporting was noted in 65.7%. An association was identified between recording the root cause and accounting for repeated complaints (OR=6.67, p=0.038).

**Conclusion.** Digital barriers, high workload, and limited standardization in complaint analytics were identified as key perceived constraints on the work of Patient Support and Internal Expertise Services specialists. A unified approach to recording root causes and monitoring recurrence together with improved data export and analytics functions may strengthen the operational capacity of these services, while training needs were also identified by respondents as an area requiring further attention.

**Key words:** Patient satisfaction, Quality of health Care, Health services administration, Cross–sectional studies, Health information systems, Digital health.

**Introduction.** The quality of healthcare is increasingly assessed not only through clinical outcomes and safety indicators, but also through patient experience, or the patient's ability to report a problem lucidly and get back a response that is equally intelligible. In international methodologies, forms of feedback and complaints are considered indicators of system failures: when patients describe experiences such as being treated unfairly, receiving confusing information, encountering rude behavior, or experiencing delays, these situations often coincide

ISSN 2524 – 0684 e-ISSN 2524 – 0692

with risk points such as gaps in communication, routing pathways, continuity of care, organizational processes, and expectation management [1–4].

However, the potential of complaints as a source for managerial decision–making is not automatically realized. Systematic reviews show that even when complaints are aggregated within medical organizations, they are often analyzed on a «case–by–case» basis without comparing recurrence, causality, or process bottlenecks, and therefore complaint data rarely feeds back into systematic process improvements [5–7].

A separate body of research examines how medical organizations use patient feedback. Qualitative hospital–based studies have identified a recurring problem: feedback is formally collected but often does not reach the decision–making level and is not translated into changes in processes. Barriers encompass time pressure and competing metrics combined with weak internal communications plus lack of a defined process owner [8]. Reviews of staff behavior in response to complaints show that complaint outcomes are largely shaped by staff behavior and the organizational context in which they work, including leadership support, clear procedures, training, feedback mechanisms, and psychological safety [9].

In this framework, these units at the interface between patients and systems serve as primary points for coordinating feedback and routing appeals. These units are referred to as Patient Support and Internal Expertise Services (PS and IE) in this paper. These services receive patient appeals, select the routing channel, record the root cause, track recurrence, and coordinate communication with departments, management, and commission decisions. When such services operate under high workload on multiple disconnected platforms without adequate resources or authority, regulatory requirements may be formally met while systematic improvements do not occur [8–11].

Although researchers write about patients' complaints and how they signal quality and safety of healthcare, most studies are either restricted to complaint typologies or to policy analysis. Relatively little empirical literature details how complaint–handling organizations operate in everyday organizational life, especially from the perspective of specialists whose job it is to process patient appeals and generate report analyses.

At the same time, the managerial reality of recent years is multi–channel communication. In Kazakhstan, complaints and appeals can arrive simultaneously through internal organizational channels and external platforms (including electronic government appeals), increasing the burden on the primary processing circuit and complicating consolidation and analytics. International practice is also moving in this direction: government and insurance platforms, social networks, and public services form a "distributed" feedback loop, thereby increasing the importance of a unified approach to classification, causal analysis, and recurrence management [5, 8, 11, 12, 13–14].

From a managerial perspective, the work of PS and IE can be considered through three interrelated components: (1) process (speed, routing, completeness of cause recording, handling of repeated appeals), (2) resources and environment (training, authority, staffing, digital tools, data access), and (3) use of results for improvement (real corrective actions based on reporting, feedback to departments, reduction of recurrence for the same reason) [1, 5–11]. The concept of the root cause is particularly important here: if the cause is recorded in «free text» without a unified approach or is not recorded at all, recurrence becomes invisible, and reporting becomes merely formal.

Scientific literature suggests that structured causal analysis and systematic follow–up of complaints are more feasible where unified categories, transparent coding rules, and adequate data export capabilities exist. In this context, examining the organizational and digital barriers

ISSN 2524 – 0684 e-ISSN 2524 – 0692

encountered by services that process complaints may provide useful empirical input for healthcare management practice [5–8].

The present study aims to describe the organizational and digital barriers that PS and IE specialists identify as most significant in their day–to–day work: departmental execution discipline, workload and resources, training, authority, and digital infrastructure.

To situate this study in the context of what is already known, targeted literature searches were conducted in the PubMed database for research published from January 2010 to October 2025, using combinations of the terms «patient complaints», «complaint management», «patient support services», «internal audit» and «healthcare quality improvement». The searches identified studies of empirical work on organizational attributes relevant to complaint–handling units.

No studies were found that specifically examined operational barriers and practices within PS and IE using survey data from frontline specialists charged with processing complaints, reinforcing the rationale for the present study.

Thus, studying organizational and digital barriers encountered in the day–to–day work of PS and IE specialists may contribute empirical evidence that is currently limited in this area.

Objective of the study: To describe organizational and digital barriers perceived by PS and IE specialists in their day–to–day work, and to evaluate the association between approaches to recording root causes of complaints and the practice of accounting for repeated appeals.

Tasks:

1. Respondents described the work context (workload, intake channels, reporting frequency, decision–making on routing), then rated the organizational and digital barriers they perceived in PS and IE work;

2. Evaluate the prevalence of key managerial practices (recording the root cause, accounting for repeated complaints, implementation of improvement measures);

In addition, it was tested how recording root causes relates to accounting repeated complaints.

The study was designed as a hypothesis–informed exploratory analysis intended to generate empirical evidence for further organizational research.

**Materials and Methods.**

*Ethical issues*

The study was considered and approved by the Local Ethics Commission NJSC «AMU», Republic of Kazakhstan (Protocol No.2 dated 25.11.2025). Voluntary participation with an anonymous questionnaire: Informed consent shall be deemed given by completing and submitting the online questionnaire. The preamble in Google forms stated the goals and objectives of this study, described the nature of participation as well as guarantees on confidentiality. The main principles applied in conducting this study were based on ethical standards for science practice and the Declaration of Helsinki [19].

*Study Design*

The study was designed as a cross–sectional observational survey in the form of an Anonymous Online Employee Survey on PS and IE. The manuscript was prepared following the IMRaD structure in accordance with ICMJE recommendations [15].

In Kazakhstan, the Patient Support and Internal Expertise Service (PS and IE; Kazakhstani term: Служба поддержки пациента и внутренней экспертизы) is a specialized unit within a medical organization responsible for receiving, registering, and reviewing patient appeals and complaints, as well as for conducting internal review of healthcare quality. The establishment of this service is mandated by the Code of the Republic of Kazakhstan «On Public Health and Healthcare System», which requires medical organizations to create such a service

ISSN 2524 – 0684 e-ISSN 2524 – 0692

for internal expertise and assigns it responsibility for the ongoing analysis of care delivery, identification of deficiencies in healthcare quality, and consideration of patient appeals [16]. Its functions, structure, and role in the organization of internal expert review are further specified in the Order of the Minister of Healthcare of the Republic of Kazakhstan dated 3 December 2020 No. KR DSM–230/2020 [17]. In practice, the work of PS and IE specialists is also carried out within the broader legal framework governing the consideration of appeals, including the Administrative Procedure and Process Code of the Republic of Kazakhstan [18].

Period and Conditions. The survey was conducted from November 2025 to January 2026. Distribution of the questionnaire was carried out using a targeted recruitment method via professional work chats of PS and IE specialists.

*Inclusion criteria:*

Participants were healthcare workers performing PS and IE functions who were 18 years of age or older and who voluntarily consented to complete the questionnaire during the data collection period. Participation was voluntary and anonymous. No personally identifiable information was collected, and informed consent was obtained electronically prior to questionnaire completion.

*Exclusion criteria:*

Questionnaires with missing key items as well as duplicate submissions with identical timestamps and response patterns were excluded from the analysis. Duplicate submissions caused by technical issues were handled conservatively: only the earliest complete response was retained, while subsequent entries were removed during the data–cleaning procedure.

Recruitment flow was documented according to recommendations for reporting internet–based surveys. The link to the questionnaire was distributed in professional thematic chats uniting specialists of PS and IE (specialists of the service and managerial staff).

Prior to distribution, the questionnaire was reviewed by several specialists in healthcare management, who assessed the clarity, content relevance, and interpretability of the items in relation to real organizational practices of complaint management. Based on this review, minor wording adjustments were introduced before distribution. No formal psychometric validation or systematic pilot testing was conducted; this represents a limitation of the instrument that should be considered when interpreting the findings.

The approximate population pool is 129 registered members of the professional chat at the time the survey was distributed. There were originally 37 responses collected. There were 2 participants who indicated that they had internet connectivity issues and thus had submitted the questionnaire twice; for those 2 participants, the first ‘valid’ questionnaire administered was used and duplicates were removed from the data prior to analysis.

After data cleaning, 35 questionnaires were retained for analysis. All 35 were used for descriptive analyses. Where individual items relevant to the primary associative analysis were missing, the affected respondents were excluded from that specific inferential test only.

Because recruitment was conducted through professional chats, selection bias cannot be excluded, as more professionally active or motivated specialists may have been more likely to participate.

*Research Instrument*

An original author's questionnaire consisting of 16 questions developed to assess organizational and digital aspects of PS and IE work: work experience, average workload, main channels for receiving appeals, reporting frequency, routing mechanism, recording of root causes, accounting for repeated complaints, performance limitations, comfort of working across multiple platforms, availability of training, implementation of improvement measures, sources

ISSN 2524 – 0684 e-ISSN 2524 – 0692

of difficulties in information systems, list of platforms used, and an open question for suggestions.

*Confidentiality and Data Disclosure Risk Management.*

Personal identifiers (full name, individual identification number, place of work with the exact name of the medical organization, contact details) were not collected. Only the researchers had access to the raw data. Data were exported in anonymized form, stored in a secure account, and used exclusively in aggregated form. Possible risks of re–identification were assessed as minimal (absence of direct identifiers). To further reduce risk when presenting results, small subgroups were combined (aggregation of categories for experience and workload where necessary), and free–text responses were not published verbatim if they could contain unique details.

*Statistical Analysis.*

Data were analyzed in Microsoft Excel (Microsoft 365) using descriptive statistics and contingency–table methods. Statistical significance was set at $p<0.05$.

Binary associations between categorical variables were evaluated using contingency tables (2×2). Odds ratios (OR) with 95% confidence intervals (95% CI) were calculated to estimate the strength of associations. Due to the relatively small sample size, statistical significance was assessed using Fisher's exact test.

All analyses were performed using standard spreadsheet–based statistical calculations, and results were independently verified through repeated computation.

For analytical purposes, response categories were consolidated into binary variables (e.g., 'yes' vs 'no/partial'). Responses indicating uncertainty or partial implementation were grouped with negative responses for the purposes of exploratory comparison.

The association between root–cause recording and accounting for repeated complaints was defined a priori as the key comparison; other analyses were descriptive/exploratory.

**Results.** A total of 35 specialists performing PS and IE functions in medical organizations participated in the survey. Table 1 displays their professional characteristics and workload indicators. Overall, the sample was dominated by PS and IE specialists. A significant proportion of participants had 1–7 years of work experience in PS and IE, and the most common workload was a flow of 11–20 appeals per shift (Table 1).

**Table 1.** Respondent Professional Characteristics and Workload

| **Indicator** | **n** | **%** |
|---|---|---|
| **Position in PS and IE** | | |
| Specialist | 22 | 62.9 |
| Physician–Expert | 10 | 28.6 |
| Head of Department | 3 | 8.6 |
| **Work Experience in PS and IE** | | |
| 6–11 months | 3 | 8.6 |
| 1–3 years | 17 | 48.6 |
| 4–7 years | 13 | 37.1 |
| More than 7 years | 2 | 5.7 |
| **Average Volume of Appeals per Shift** | | |
| Up to 4 | 1 | 2.9 |
| 5–10 | 4 | 11.4 |
| 11–14 | 10 | 28.6 |

ISSN 2524 – 0684 e-ISSN 2524 – 0692

| | | |
|---|---|---|
| 15–20 | 18 | 51.4 |
| More than 20 | 2 | 5.7 |

*Main Channel for Receiving Appeals*

The structure of the most frequent (primary) channel for receiving appeals is shown in Figure 1. Most often, respondents reported in–person visits and telephone calls as the primary intake channel.

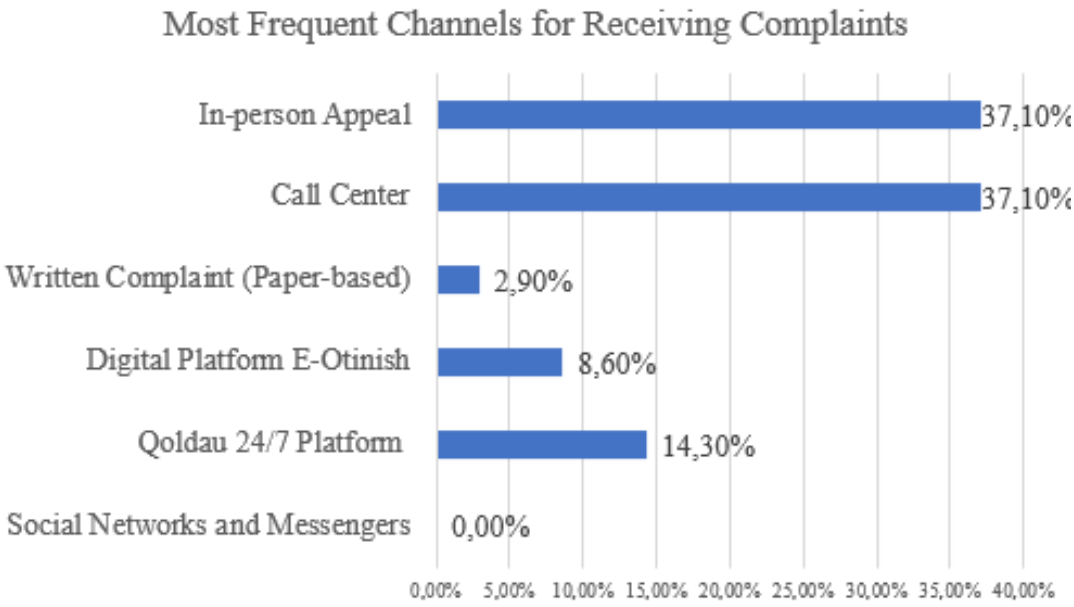
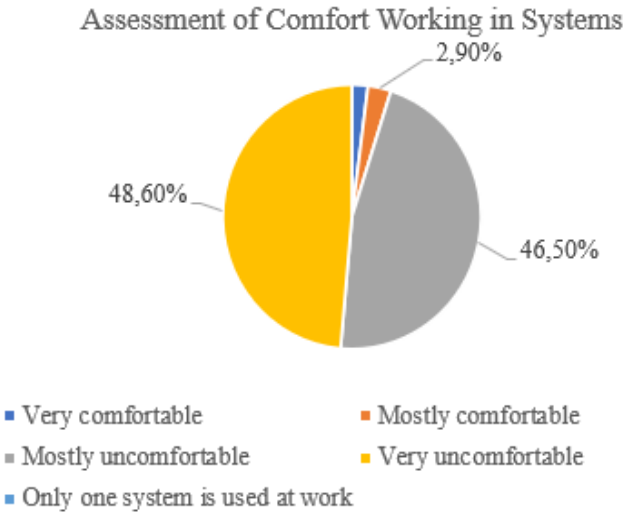



**Figure 1.** The most frequent channel for receiving patient appeals, according to PS and IE specialists, in percentages

*Digital Environment and Challenges of Working in Multiple Systems*

The assessment of comfort when it is necessary to use several information systems and channels in parallel is presented in Figure 2. Most participants (97.1%) reported that using multiple information systems and channels in parallel is perceived as inconvenient (Figure 2).



ISSN 2524 – 0684 e-ISSN 2524 – 0692

**Figure 2.** Assessment of comfort when simultaneously using multiple information systems and channels for processing appeals, in percentages

Difficulties when working with complaints and appeals in information systems are shown in Figure 3. Leading positions were occupied by the lack of data export capabilities for reports and high workload associated with the concentration of tasks on a single specialist. Issues related to access (logins, passwords) and technical failures were noted less frequently (Figure 3).

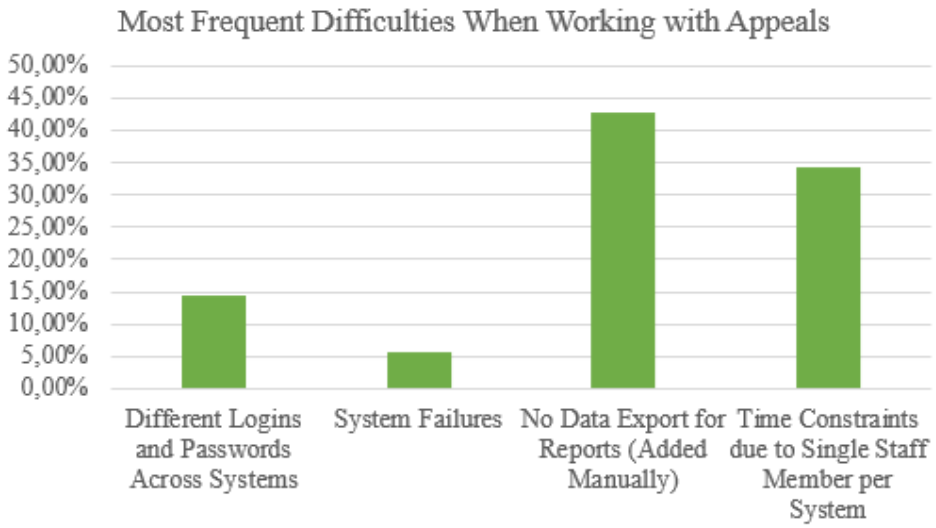



**Figure 3.** Most frequent difficulties when working with appeals in information systems, in percentages (multiple choice, n=35)

*Organizational Practices and Managerial Decisions*

Features of organizing work with appeals and key managerial practices are presented in Table 2. Respondents indicated that a substantial share of appeals appears to be resolved at the PS and IE level without reaching commission review, with predominant reporting frequency being quarterly. In respect of complaint routing, respondents most often indicated the organization's director (34.3%) and the head of the PS and IE service (28.6%) as the persons responsible for routing decisions (Table 2).

Table 2 also presents data on root–cause recording and accounting for repeated complaints. Root causes were reported as recorded predominantly in free–text form (Table 2). Accounting for repeated complaints in reporting was noted by 65.7% of respondents, while 34.3% either did not follow this practice or were uncertain whether it was applied.

*Staff training and perceived work–related barriers*

Table 2 also summarizes staff training and perceived work–related barriers. Most respondents reported that they had not undertaken any specific training in complaints handling. The most frequently reported barriers were poor execution discipline across departments, lack of training in complaints handling, psycho–emotional burden on specialists, insufficient authority of PS and IE, and an insufficient number of specialists (Table 2).

**Table 2.** Organizational Practices and Managerial Conditions of PS and IE Work

| **Indicator** | **n** | **%** |
|---|---|---|
| **Share of appeals resolved at the PS and IE level (without** | | |

ISSN 2524 – 0684 e-ISSN 2524 – 0692

| | | |
|---|---|---|
| **commission/management)** | | |
| 40–60% | 17 | 48.6 |
| 20–40% | 13 | 37.1 |
| 10–20% | 2 | 5.7 |
| More than 60% | 2 | 5.7 |
| Less than 10% | 1 | 2.9 |
| **Frequency of Reporting on Complaints** | | |
| Every quarter | 28 | 80.0 |
| Every month | 5 | 14.3 |
| Every year | 1 | 2.9 |
| Irregularly | 1 | 2.9 |
| **Decision–Making on Complaint Routing** | | |
| Director (Head) of your organization | 12 | 34.3 |
| Head of PS and IE | 10 | 28.6 |
| Deputy Head | 7 | 20.0 |
| Specialist of PS and IE | 6 | 17.1 |
| **Recording of Root Cause of Complaints in the System** | | |
| Yes, in free form | 25 | 71.4 |
| Partially | 8 | 22.9 |
| Yes, according to approved list | 1 | 2.9 |
| No | 1 | 2.9 |
| **Accounting for Repeated Complaints in the Report** | | |
| Yes | 23 | 65.7 |
| No | 7 | 20.0 |
| Difficult to answer | 5 | 14.3 |
| **Completion of Training on Handling Complaints** | | |
| No | 29 | 82.9 |
| Difficult to answer | 5 | 14.3 |
| Completed training on internal audit | 1 | 2.9 |
| **Main Perceived Limiting Factor in PS and IE Work** | | |
| No discipline in departments regarding execution | 13 | 37.1 |
| Lack of training on complaints | 8 | 22.9 |
| Psycho–emotional load on specialists | 7 | 20.0 |
| Insufficient authority of PS and IE | 4 | 11.4 |
| Insufficient number of PS and IE specialists | 3 | 8.6 |
| **Are Improvement Measures Conducted Based on Report Results?** | | |
| Difficult to give an answer | 20 | 57.1 |
| Yes | 9 | 25.7 |
| No | 5 | 14.3 |
| Assistance from higher authorities is needed | 1 | 2.9 |

* [1] Odds ratios were calculated from 2×2 contingency tables. Statistical significance was assessed using Fisher's exact test. Confidence intervals are reported at the 95% CI.

*Association of Managerial Practices*

The association between these two variables was analyzed to evaluate potential links between different stages of the complaint handling process.

ISSN 2524 – 0684 e-ISSN 2524 – 0692

To assess the consistency of managerial practices, an analysis of the relationship between recording the root cause of the complaint and accounting for repeated complaints in reporting was performed. A statistically significant association was identified: where the root cause is recorded, repeated complaints tend to be noted in reports more frequently (Table 3). This pattern indicates that respondents who recorded root causes also more frequently reported accounting for repeated complaints.

The observed association should be interpreted cautiously given the wide confidence interval, reflecting uncertainty related to the exploratory sample size. Therefore, the observed relationship should be interpreted as a preliminary empirical indication rather than evidence of a stable organizational relationship.

**Table 3.** Association between Root Cause Recording and Accounting for Repeated Complaints (2×2)

| | **Repeated Complaints: Yes** | **Repeated Complaints: No** |
|---|---|---|
| Root Cause Recorded: Yes | 20 | 6 |
| Root Cause Recorded: No/Unsure | 3 | 6 |

* [2] Fisher's exact test, OR=6.67, 95% CI 1.27–35.04, p=0.038.

**Discussion.** In daily work, PS and IE activity appears to rely largely on fast, familiar channels such as telephone calls and face–to–face visits (Figure 1). These findings indicate that, despite the availability of digital platforms, direct interaction remains the preferred mode of first contact in complaint routing.

However, this approach also has limitations. Although rapid responses are valuable, communication through unstructured channels increases the risk of incomplete records, which may complicate subsequent analysis.

The respondents' general feeling of 'inconvenience' when working across multiple information systems is consistent with evidence from international studies linking digital fragmentation to the administrative burden of multiple systems in healthcare organizations. Earlier qualitative studies also warn that fragmented platforms and duplicative systems may increase cognitive burden and reduce the time available for analysis and improvement activities. These findings suggest that working across multiple disconnected systems may create additional operational constraints for specialists responsible for complaint processing.

Studies using structured complaint taxonomies suggest that systematic use of complaint data depends not on the volume of complaints per se, but on whether information is coded and grouped rather than recorded in free–text form. This is relevant to the present findings: respondents mostly reported free–text documentation of cause, which may reflect the absence of standardized classification frameworks in the information systems used, rather than broader system–level differences in digital infrastructure. In this context, the limitation appears to lie not in the collection of complaints itself, but in the absence of structured approaches to categorizing and aggregating complaint data for reporting purposes [1, 10].

An interesting relationship was noted between recording the root cause of complaint and reporting on repeated complaints (Table 3). This pattern may reflect differences in documentation practices rather than a definitive indicator of broader organizational characteristics: where the root cause is fixed, monitoring of problem recurrence appears more often. This finding may be considered as exploratory support for the need to standardize approaches to causal analysis and minimally unify categories of root causes (even if allowing

ISSN 2524 – 0684 e-ISSN 2524 – 0692

for a free–text field), though confirmation in larger studies is needed. Such approaches may improve the analytical usability of complaint data for internal reporting and monitoring.

The originality of this research lies in examining complaint management processes from the perspective of specialists who directly process patient appeals. Where earlier research focused primarily on complaints in policy or administrative settings, this study offers empirical descriptions of everyday organizational and digital constraints in complaint–handling, allowing practical barriers to be understood that are arguably hidden from administrative reporting data.

The issue of staff training deserves separate attention. A significant proportion of respondents had not undergone specialized training in handling appeals and complaints (Table 2), while poor execution discipline across departments and psycho–emotional burden were also frequently reported as barriers in day–to–day work. Work with appeals requires not only knowledge of regulatory deadlines and procedures, but also communication skills and effective coordination with departments responsible for corrective actions. Although the present study did not assess whether training improves work outcomes, the high proportion of respondents without specialized training suggests that training needs in this area warrant further investigation.

From a practical and managerial perspective, the findings are consistent with broader approaches to healthcare quality management that emphasize structured complaint handling, standardized documentation, use of feedback for improvement, and system–level analytical capacity [20–24]. In this context, improving complaint handling may involve greater standardization of root–cause recording, better interoperability and data export functions in health information systems, and further attention to training needs among specialists responsible for complaint processing.

*Study limitations*

The study has several methodological limitations. First, the sample was collected through convenience recruitment in professional chats and cannot be considered representative of all regions or types of medical organizations. Second, data are based on self–reports and reflect individual perceptions that may vary across organizations. Third, the author–designed questionnaire underwent expert review for content clarity but was not subjected to formal psychometric validation or systematic pilot testing, which limits the assessment of instrument reliability. Fourth, the small sample size (n=35) limits the statistical precision and generalizability of the findings. Nevertheless, the study provides a practical “map” of the key PS and IE difficulties and helps identify directions for improvement that can be examined in future studies: unification of root–cause recording, tracking recurrence, training needs, and digital solutions for data export and analytics. Given the exploratory design and context–specific organizational environment, the findings should be interpreted primarily as indicative of operational patterns rather than directly generalizable to all healthcare systems.

**Conclusion.** The findings of this exploratory survey suggest that PS and IE specialists perceive their work environment as characterized by digital fragmentation and high workload, with limited standardization in complaint analytics.

We found a statistically significant association between recording the root cause of a complaint and accounting for repeat appeals in reporting; given the cross–sectional design and our small sample size, we treat this as an association as opposed to evidence of causality. These results suggest that more systematic documentation of complaint causes may be relevant to the development of recurrence–monitoring practices, although this interpretation requires confirmation in larger studies.

From a managerial perspective, these results suggest the potential value of standardizing complaint classification and strengthening the analytical capabilities of information systems.

ISSN 2524 – 0684 e-ISSN 2524 – 0692

Specialists also frequently cited lack of training as a limiting factor, which warrants attention in future organizational interventions, though the current study did not measure the effect of training on performance outcomes.

Improvements in these components may support the more structured use of patient feedback in internal monitoring and improvement activities.

Future studies with larger and more varied samples and across organizations are needed to assess how digital infrastructure and organizational practices affect the success of complaint management systems.

**Conflict of interest.** The authors declare no conflict of interest.

**Authors' contribution.** Concept, I.G. and S.I.; methodology, S.I.; software, I.G.; validation, I.G. and S.I.; formal analysis S.I.; investigation, I.G. and S.I.; resources, I.G.; data management, S.I.; writing–preparation of the original manuscript, I.G.; writing – review and editing, S.I.; visualization, I.G.; supervision, S.I.; project administration, S.I. All authors have read and agreed to the published version of the manuscript. The authors declare that this material has not been previously published and is not under consideration by other publishers.

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**Data availability statement.** The data supporting the findings of this study are contained within the article. Additional data are available from the corresponding author upon reasonable request.

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# ПАЦИЕНТТЕРДІ ҚОЛДАУ ЖӘНЕ ІШКІ САРАПТАМА ҚЫЗМЕТТЕРІНДЕГІ ҰЙЫМДАСТЫРУШЫЛЫҚ ЖӘНЕ ЦИФРЛЫҚ КЕДЕРГІЛЕР: ҚАЗАҚСТАНДАҒЫ МЕДИЦИНА ҚЫЗМЕТКЕРЛЕРІ АРАСЫНДА ЖҮРГІЗІЛГЕН КӨЛДЕНЕҢ САУАЛНАМАЛЫҚ ЗЕРТТЕУ

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**Түйіндеме**

**Кіріспе.** Пациенттерді қолдау және ішкі сараптама қызметі пациенттердің өтініштерін басқарушылық шешімдерге айналдыруда маңызды рөл атқарады. Іс жүзінде жоғары жүктеме, өтініштерді қабылдаудың көптеген арналары және ақпараттық жүйелердің фрагменттілігі қызметтің күнделікті жұмысын қиындатуы мүмкін.

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**Мақсаты.** Пациенттерді қолдау және ішкі сараптама қызметі мамандарының ұйымдастырушылық және цифрлық кедергілерді қалай қабылдайтынын бағалау, сондай–ақ шағымның бастапқы себебін тіркеу мен қайталама өтініштерді есепке алу арасындағы байланысты бағалау.

**Материалдар мен әдістер.** 2025 жылғы 26 қараша мен 2026 жылғы 21 қаңтар аралығында онлайн–анкета (Google Forms) қолдану арқылы эмпирикалық сипаттамалы–аналитикалық көлденең зерттеу жүргізілді. 16 сұрақтан тұратын авторлық анкета пайдаланылды. Іріктемеге пациенттерді қолдау және ішкі сараптама қызметтерінің функцияларын орындайтын медициналық ұйымдардың 35 қызметкері енгізілді. Сипаттамалық статистика жүргізілді, ассоциациялар Фишердің дәл критерийі арқылы бағаланды ($p<0,05$).

**Нәтижелер.** Байланыс арналарының ең кең таралған түрлері азаматтардың жеке келуі және телефон арқылы байланыс болды (37,1%). Жағдайлардың 97,1%–ында бірнеше жүйемен жұмыс істеу қолайсыз деп бағаланды. Ақпараттық жүйелермен жұмыс істеудегі негізгі қиындықтар есептілік үшін деректердің жеткіліксіздігі және міндеттердің бір маманға шоғырлануына байланысты шамадан тыс жүктеме болды. Бұл факторлар тиісінше 42,9% және 34,3% жағдайда бағаланды. Жүйеде шағымның бастапқы себебін тіркеу жауаптардың 97,1%–ында (негізінен еркін түрде) көрсетілді, есептілікте қайталама шағымдарды есепке алу – 65,7% жағдайда. Бастапқы себепті тіркеу мен қайталама шағымдарды есепке алу арасында ассоциация анықталды (OR=6,67, p=0,038). Зерттеудің көлденең дизайнын ескере отырып, алынған нәтижелер себеп–салдарлық байланыс ретінде емес, ассоциациялар ретінде түсіндірілуі тиіс.

**Қорытынды.** Цифрлық кедергілер, жоғары жүктеме және шағымдар аналитикасының шектеулі стандартизациясы пациенттерді қолдау және ішкі сараптама қызметі мамандарының жұмысындағы негізгі кедергілер ретінде анықталды. Түпкі себептерді тіркеуге және қайталанатын өтініштерді мониторингілеуге бірыңғай тәсіл, деректерді экспорттау мен талдау функцияларын жетілдірумен қатар, осы қызметтердің операциялық мүмкіндіктерін күшейтуі мүмкін, ал оқытуға деген қажеттілік те респонденттер тарапынан қосымша назар аударуды талап ететін бағыт ретінде аталды.

**Түйінді сөздер:** пациенттердің қанағаттануы, медициналық көмектің сапасы, денсаулық сақтау қызметтерін басқару, көлденең зерттеулер, денсаулық сақтау ақпараттық жүйелері, цифрлық денсаулық сақтау.

# ОРГАНИЗАЦИОННЫЕ И ЦИФРОВЫЕ БАРЬЕРЫ В РАБОТЕ СЛУЖБ ПОДДЕРЖКИ ПАЦИЕНТОВ И ВНУТРЕННЕЙ ЭКСПЕРТИЗЫ: ПОПЕРЕЧНОЕ АНКЕТНОЕ ИССЛЕДОВАНИЕ МЕДИЦИНСКИХ РАБОТНИКОВ В КАЗАХСТАНЕ

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**Аннотация**

**Введение.** Служба поддержки пациентов и внутренней экспертизы играет ключевую роль в преобразовании обращений пациентов в управленческие решения. На практике существенными барьерами могут быть высокая нагрузка, множество каналов приема обращений и фрагментированность информационных систем.

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**Цель.** Оценка организационных и цифровых барьеров, воспринимаемых сотрудниками служб поддержки пациентов и внутренней экспертизы, а также изучение связи между фиксацией первопричины жалобы и учетом повторных обращений.

**Материалы и методы.** В период с 26.11.2025 по 21.01.2026 года было проведено эмпирическое описательно–аналитическое поперечное исследование с использованием онлайн–анкеты (Google Forms) из 16 вопросов. В выборку включены 35 сотрудников медицинских организаций, выполняющих функции службы поддержки пациентов и внутренней экспертизы. Проведена описательная статистика, анализ ассоциаций выполнен с применением точного критерия Фишера ($p<0,05$).

**Результаты.** Наиболее распространенными каналами поступления обращений были личные визиты граждан и телефонные звонки (37,1%). В 97,1% случаев – работа с несколькими системами была оценена как неудобная. Основными трудностями были нехватка функций выгрузки данных для отчетности (42,9%) и перегрузка вследствие концентрации задач на одном специалисте (34,3%). Фиксация первопричины жалобы в системе отмечалась в 97,1% ответов (преимущественно в свободной форме), учет повторных жалоб в отчетности – в 65,7%. Выявлена ассоциация между фиксацией первопричины и учетом повторных жалоб (OR=6,67, p=0,038). С учетом поперечного дизайна исследования полученные результаты следует интерпретировать как выявленные ассоциации, а не как причинно–следственные связи.

**Заключение.** Цифровые барьеры, высокая нагрузка и ограниченная стандартизация аналитики жалоб определены как ключевые ограничения в работе специалистов службы. Единый подход к фиксации первопричин, мониторингу повторных обращений, наряду с улучшением функций выгрузки данных и аналитики, может усилить операционный потенциал этих служб, тогда как потребности в обучении также были обозначены респондентами как область, требующая внимания.

**Ключевые слова:** удовлетворенность пациентов, качество медицинской помощи, управление службами здравоохранения, поперечные исследования, информационные системы здравоохранения, цифровое здравоохранение.