

1 **Knowledge, experiences and perceptions of the Ghana**

2 **National Health Insurance Scheme in three districts**

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18 **Abstract**

19 **Background**

20 Ghana's National Health Insurance Scheme is a demand side programme where the
21 governing authority registers clients and purchases health care services for them from public
22 and private providers. Access of services is high across a broad Benefits Package with no
23 parallel enrolment necessary for any type of service at the point of access. Nonetheless,
24 there is evidence of difficulty in acquiring and use of the NHIS card to access health care
25 services.

26 **Objective**

27 While studies had been conducted into general awareness, there was no linkage between
28 awareness, uptake and experiences with registration and use of the card. This study fills this
29 gap.

30 **Methods**

31 This is a descriptive study. A mix of qualitative (39 Focus Group Discussions) and quantitative
32 (625 household interviews) methods were used to collect the data. Qualitative data was
33 analysed manually using a thematic approach while a frequency analysis was done for the
34 quantitative data.

35 **Results**

36 Knowledge about the Scheme was near universal. Enrolment was lower among FGD
37 discussants, 38.7% had valid cards, than for household respondents, 62.9% valid cards. While
38 mixed experiences with the registration process was observed among FGD discussants, 74%

39 of the households' ranked attitudes of Scheme staff as positive. The study found the NHIS
40 card facilitates access to facility based health care. Satisfaction levels with use of the card
41 were mixed and contextual among discussants. However, 90% of households reported their
42 cards were readily accepted at health facilities. Expired card (51.4%) and health facility had
43 stopped accepting NHIS cards (14.3%) were mentioned as reasons for non-acceptance.

44 **Conclusion**

45 People's experience during registration and use of the NHIS card to access health care has
46 lasting effect on their perceptions of the Scheme. This can be harnessed to manage the high
47 expectations, grow membership, discourage frivolous use and address artificial barriers of
48 access.

49 **Introduction**

50 From 1957, health care in Ghana was free until 1969 when the Hospital Fees Decree (NLCD
51 360) was passed, and subsequently amended as Hospital Fees Act 387 of 1970, to introduce
52 user fee for consultation [1-4]. In the ensuing years, laboratory, and diagnostic services,
53 invasive procedures and a select group of drugs were added to the chargeable list. Later,
54 fixed fee charges for designated services and a 15% charge of the actual cost for general
55 services was introduced with the enactment of The Hospitals Fees Legislative Instrument, LI
56 1313, in 1985 [3,4]. A list of exemptible services and conditions were specified in the
57 legislation [1,3,4]. As the country sunk deeper into economic crisis, government funding for
58 the health sector was reduced substantially, full cost recovery or what in Ghanaian parlance
59 is referred to as 'cash and carry' came into effect in 1992 [4-8].

60 User fees persisted until 2005 when the National Health Insurance Scheme (NHIS) was fully
61 rolled-out nationwide [9-13]. Building up to this roll-out was the passage in 2003 of Act 650 –
62 the legal backing – which has since been replaced by Act 852 of 2012. The NHIS was a direct
63 social response to the adverse effects of financial inaccessibility to health care services [5,11-
64 13] for the over sixty-eight percent of the population at the time [14-15]. Act 650 established
65 the National Health Insurance Authority (NHIA) – which has 10 regional offices and 159
66 District Mutual Health Insurance Schemes (DMHISs) – as the implementer of the NHIS. The
67 DMHISs act as agency offices and are responsible for registration, card processing, revenue
68 generation through premium collection, reimbursement of service providers and community
69 engagement [9,16,17]. The Scheme is now widely recognised as a good pro-poor Social
70 Health Insurance scheme [14,18].

71 About thirty-six percent (10,576,542 members) of the population is actively enrolled [19].
72 Designed as a demand-side programme, the NHIS run all year-round registration systems for
73 clients and participating service providers [3]. Membership is compulsory for all persons
74 living in Ghana based on an annual renewable system. This is however currently not being
75 enforced [6,17,20,21]. At the point of registration, potential enrolees provide biometric
76 information, which then serves as their identification within the system [16]. Enrolees are
77 either premium-exempted or premium-paying. The premiums are set by the DMHISs, usually
78 higher for urban and lower for rural populations, but within a range determined by the NHIA
79 [6,17, 20,21]. An inclusion list of inpatient, outpatient and emergency services is covered at
80 full cost by the curatively-inclined NHIS Benefits Package with no prior authorization before
81 member access [3,22,23].

82 The NHIS has impacted positively on utilisation of outpatient (increased by more than forty-
83 fold) and inpatient (increased by more than thirty-fold) services from the pre-NHIS era
84 [24,25]. Whereas average per capita health care utilisation rate for NHIS cardholders is 3,
85 that for general utilisation for Ghana is 1.7 [26,27]. Reports however shows of an ineffective
86 registration system and unavailability of services to NHIS card holders [4,8,28]. Challenges of
87 access to registration are related to both supply and demand side factors. While the supply
88 side challenges are partly attributable to the switch from magnetic to biometric registration
89 which has resulted in centralisation of the registration process at the district scheme offices,
90 the demand side challenges are context specific [16-18,22,24]. Challenges of unavailability of
91 services to cardholders can be categorised as NHIS systems-related failures, client abuse due
92 to a lack of utilisation cap and general health system-wide failures. The NHIS systems-related
93 failures though chronic, peaks and fluctuates. When normally otherwise NHIS clients are
94 reported not to be receiving the full Benefits Package of services, at the peak of the
95 Scheme's challenges, service providers – mainly private and faith-based facilities – withhold
96 all services to clients trying to access care with NHIS cards [4,8,18,29,30].

97 The effects of systemic challenges are easily describable from a technical angle. Their effects,
98 however, from the populations view point are less clear and complicated. This necessitates
99 the study of knowledge, experiences and perceptions that are context specific [31,32]. This
100 study therefore aims to adduce and validate evidence that unpack issues that are reflective
101 and necessary for gauging the perceived state of the Scheme by the population to improve
102 its implementation. This study was undertaken as a baseline survey for the African Health
103 Markets for Equity Programme (AHME). The NHIA had operated for over a decade. While
104 studies had been conducted into general awareness, there was no linkage between
105 awareness, uptake and experiences with registration and use of the card. This study set out

106 to find; level of awareness; experiences with registration; usage after registration; and
107 experiences with access to services.

108 **Methods**

109 ***Study Setting:***

110 The study was conducted in three districts: Ashaiman, Adaklu and Kassena-Nankana (divided
111 as East and West). The districts were selected to represent the southern and northern
112 sectors of the country and also the rural-urban divide.

113 Ashaiman, with an even sex distribution has a predominantly youthful population - 31.9%
114 are between the ages 0-14 years - of 190,972 residents. The municipality is a bustling urban
115 settlement in the Greater Accra region with 92% of the population economically active [33].
116 Accordingly, poverty prevalence is comparatively low at 4.4% [34]. 109,870 people were
117 actively subscribed onto the Ashaiman Municipal Scheme [35].

118 Thirty-six percent of the 36,391 residents in the Adaklu district are below 15 years. Located
119 in the Volta Region, this district exhibits features of rurality; 63.1% of the economically active
120 population are engage in agriculture [36] resulting in 89.7% of the population living below
121 the poverty line [34]. Sixty-seven percent active subscriptions were recorded by the district
122 Scheme [35].

123 Split as East and West, Kassena-Nankana district is mainly rural (72.7%) and located in the
124 Upper East Region. The population is 109,944 people. There are 19,790 households in the
125 district averaging 5.4 persons per household [37]. Poverty prevalence is 37.3% [34]. A total
126 of 93,965 people were actively subscribed onto the district scheme [35].

127 ***Study Design***

128 This is a descriptive study. Data was collected using a mix of qualitative and quantitative
129 techniques. The study was in two parts; Focus Group Discussions (FGDs) using a semi
130 structured open ended questionnaire to collect qualitative data and household survey using
131 a structured tool to collect quantitative data. Earlier empirical studies exploring perceptions
132 and experiences about the NHIS in Ghana used similar study design and methods [4-
133 7,11,13,18,20].

134 ***Sampling and Data Collection***

135 Communities for the AHME project in each district were determined based on consultations
136 with Staffs of the District Department of Social Welfare and DMHISs. Both the FGDs and
137 household surveys were conducted in the same communities in each district except for
138 Kassena-Nankana where only FGDs were conducted. These communities were purposively
139 selected based on distance from the community - within the same community, less than 20
140 minutes travel time and more than 20 minutes travel time - to an NHIS registration centre
141 and an NHIS accredited health facility. Five communities each in Ashaiman municipality, and
142 Kassena-Nankan districts and ten in the Adaklu district were selected for the study. The
143 sample, for both FGDs and household survey, was dependent on the availability of
144 respondents. FGD discussants were selected based on the following criteria: women with
145 Children Under 5; men 20 years and above who are decision makers in their homes; mixed
146 group of opinion and traditional leaders; and a mixed group of adolescents. Criteria for
147 inclusion into the household survey included: not previously a discussant in the FGDs; being
148 the head or nominated by the head of household to respond; and age 18 years and above.

149 For the household survey, a household sampling interval of ten was observed in Ashaiman
150 municipality and that for Adaklu district was four.

151 A group of experienced consultants with expertise in health systems research, health
152 insurance and public health were assembled to develop the study guides for both the FGDs
153 and the household survey based on findings from a literature review. The FGDs were
154 conducted by these same experts while data collection at the household level was done by
155 researchers with experience in conducting national level surveys. The researchers were
156 fluent in at least one of the dominant languages spoken in one of the study districts. The
157 study in each district was preceded by a week of intensive communication and community
158 durbars on the AHME programme. On the days of data collection, the town criers went
159 round to mobilise the people.

160 Information was collected on respondents' socio-demographic information, knowledge,
161 experiences in acquiring and using the NHIS card to access health care services and attitudes
162 of NHIS staff and health workers at registration centres and health facilities. Thirty-nine
163 FGDs, thirteen in each district, involving 336 participants were conducted in all the three
164 districts - 103 discussants in Ashaiman, 109 in Adaklu and 124 in Kassena-Nankana districts.
165 On average, there were 12 discussants in each FGD session. Method for recording the FGDs
166 was note taking and tape recording. Two household surveys were conducted in Ashaiman
167 and Adaklu involving a total of 625 respondents, 309 and 316 respectively.

168 ***Data Analysis***

169 The qualitative data was analysed according to predetermined themes identified during the
170 literature review. The actual analysis involved reading and manual coding of transcripts. The

171 initial stages involved comparison of transcripts and field notes of FGD researchers to ensure
172 validity of responses. After initial independent readings of the transcripts, the authors
173 including two other researchers convened for the final analysis. The findings are presented
174 as expressed quotes.

175 The quantitative data was analysed using the Frequency Analysis method. The data was first
176 entered in Microsoft Excel and to control for data entry errors, there were three rounds of
177 data entry verification and validation. Findings are presented as percentages in tables.

178 ***Characteristics of Survey Respondents***

179 There were more male FGDs discussants, 53.6%, than females. On the other hand, there
180 were more female household survey respondents, 56.5%. More than half of both the FGD
181 discussants and household survey respondents were between the age ranges 31-60 years
182 and 26-60 years respectively. Whereas majority of FGD discussants, 43%, were engaged in
183 agriculture and other agriculture-related businesses, majority of the household respondents
184 were traders, 26.6%. About thirty percent each of FGD discussants and household
185 respondents were educated to the Senior High School and Junior High School and levels.

186 **Results**

187 ***Membership***

188 Seventy-two percent of the FGD discussants had ever enrolled onto the Scheme with 38.7%
189 holding valid cards. The discussants who had never enrolled mentioned reasons to include
190 lack of money to pay the premium, and registration fees and perceptions of poor attitude
191 towards NHIS card holders by health care workers. Others narrated graphic examples of
192 experiences that informed their decisions not to enrol as shown below:

193 *“.....I went to hospital with my father and there were a lot of people. The nurse came and*
194 *asked for those who did not have the NHIS card, called them out and treated them first. My*
195 *father was treated later but he died. So I reasoned that if my father had not had the card, but*
196 *had had money in his pocket, he would have been alive. So I decided not to have the card”.*

197 [Adaklu FGD discussant].

198 *“I do not even think that there is any compelling reason for me to go get an NHIS Card. My*
199 *wife went to the Hospital last month with her card and had to pay for her folder, spent a long*
200 *time to get attended to, then was given a prescription that we had to struggle to buy the*
201 *medicines.....it’s no longer attractive, and I think the challenges the NHIS faces in Bongo is*
202 *too much”.* [Kassena-Nankana FGD discussant]

203 Two-fifth of the discussants who had the card had never renewed and some examples of the
204 reasons for non-renewal are as below:

205 *“I was a valid card holder and went to the hospital but the machine could not read the card*
206 *and I had to pay. When I compared access to health care with the card, I realized that not*
207 *holding the card gives me better and faster access to health services”.* [Ashaiman FGD
208 discussant]

209 *“When I fell sick and went to the hospital, I was asked to buy my own drugs, even though I*
210 *had the card. So I bought all my medicines. I also hear other people with the same story. I felt*
211 *it was not necessary to have the card. After all, health insurance does not cover all the*
212 *drugs”.* [Adaklu FGD discussant]

213 *“I went to Bongo to get my NHIS card renewed, but the queue was too long; I spent three*
214 *days and it was never my turn to be attended to.....they said the registration machine had*

215 *broken down and there was no network, so I left in anger and never returned!*". [Kassena-
216 Nankana FGD discussant]

217 Seventy-eight percent of the household respondents had ever enrolled onto the Scheme and
218 majority of them, 62.9%, had valid cards. As Table 1 shows, of the 22% that had never
219 enrolled 56.1% stated they have not had the time to go register.

220 **[Insert] Table 1: Reasons for never enrolling onto the NHIS among household respondents**

221 ***Knowledge about the NHIS***

222 Knowledge about the existence of the NHIS was universal among the FGD discussants. They
223 commonly understood and stated that the NHIS was implemented to facilitate the provision
224 of *'free health care'*. Some noted that the card facilitated access to hospital care without
225 paying for the treatment. Others expressed how fee for service used to be catastrophic
226 health expenditure for the household. A discussant at Kassena-Nankana indicated: "*we used*
227 *to sell our cows and other food products to pay for the cost of hospitalization of our children*
228 *when they get sick, but now with the NHIS card, we do not have to do that. You are taken*
229 *care of free-of-charge*". This sentiment was echoed severally and in different forms by
230 discussants in all the districts.

231 The discussants mentioned both formal and informal channels as the sources through which
232 they got information about the NHIS. Most indicated they get their information about the
233 NHIS through the television and radio and from local announcements at the lorry station. For
234 some, their knowledge and sources of information was based on their experiences with the
235 Scheme. Interestingly, these discussants stated that they heard about the NHIS at the point
236 of sickness as shown in the quote below:

237 “...Me, I got to hear about the NHIS when I got sick in 2008 and was to be hospitalized; the
238 doctor in Bongo Hospital asked me to go for the NHIS card so that I would not have to pay
239 from my own pocket any time I got sick. He (the doctor) educated me about the NHIS, (and)
240 then asked me to see a person who was in-charge of NHIS in the hospital to help me get
241 enrolled”. [Kassena—Nankana FGD discussant]

242 Among the households surveyed, knowledge of the existence of the NHIS was 98.2%.
243 Respondents were presented with result statements in relation to membership and the
244 exemptions package and were required to assess their validity or otherwise as shown in
245 Table 2. Ninety percent (90%) correctly stated that renewal of membership onto the Scheme
246 is on annual basis. Further, 54.7% correctly stated that pregnant women are enrolled onto
247 the Scheme for free. Respondents’ knowledge about the Scheme’s benefit package was
248 equally high. Over 80% of all respondents stated services covered by the Scheme included
249 consultations and medicines. Respondents also mentioned picking a consultation card
250 (69.1%), out-patient care (54.2%), admissions (50.6%) and laboratory investigation (37%) as
251 the other services covered by the Scheme.

252 **[Insert] Table 2: Household respondents’ knowledge about the NHIS**

253 ***Experiences with the NHIS Registration and Card Processing***

254 Responses of the FGD discussants provide insight into reasons for delays in registration and
255 card processing. Discussants expressed frustration in the registration process. Some recalled
256 experiences three days prior to the discussion to include persistent network failure and poor
257 organisation of services at the district scheme offices. Two quotes from Kassena-Nankana
258 below epitomise the general experience as narrated by the discussants.

259 *“Now all of us have to go to Kassena-Nankana in order to register for (the) NHIS card or*
260 *renew our cards; it take(s) up to 5 days sometimes before you get to be attended to in*
261 *Kassena-Nankana”.*

262 *“When I went to register, the queue was so long that I had to sleep over there for 3 days*
263 *before I got my NHIS card. I slept on a bench the first day and on the bare floor the second*
264 *day. Getting food to eat was very difficult. They (DMHIS) did not even provide us with water*
265 *to drink”.*

266 However, majority of the household respondents got their cards the same day (56.3%) of
267 registering. Others mentioned 2-5 days (12%), 1-2 weeks (9.1%), 2-4 weeks (4.1%), 1-3
268 months (17.7%) and three months and above (0.8%). DMHISs have autonomy in setting the
269 fees for enrolment. Most of the enrolled respondents (87.8%) reported paying a fee of which
270 67.1% knew the fee amount before they went to register. Forty-one percent (40.9%) of
271 these fee-paying registrants reported paying between – the exchange rate at the time –
272 US\$4.93-US\$11.50 and 37.1% reported paying between US\$2.58-US\$4.69. Other amounts
273 reported to have been paid before registration include less than US\$1.04 (6.4%), US\$1.04-
274 US\$2.35 (12.1%), US\$11.74-US\$18.78 (3.1%) and above US\$18.78 (0.4%). Respondents
275 ranked their impressions about the fees they paid as affordable (54.1%), moderately
276 affordable (35.4%), high (8%) and too high (2.5%). Majority, 73.1%, thought the fees they
277 paid were legal; 2.1% reported to have paid illegal fees and 20.8% stated they paid both legal
278 and illegal fees to register. Of the respondents who did not pay a fee at the time of
279 registering, 28.8% stated they had benefited from one of the exemptions policies.

280 ***NHIS Staff Attitudes***

281 FGD discussants that reported positive NHIS staff attitudes at registration centres were in
282 the minority and from the Adaklu district. Discussants in the Ashaiman and Kassena-Nankana
283 districts were unhappy with attitudes of some Scheme staff. The following quotes represent
284 these sentiments:

285 *“The workers, especially those on attachment do not talk politely to clients at all. It is a very*
286 *poor attitude. At times we go in to settle quarrels when commotion erupts during the*
287 *registration process”*. [Ashaiman FGD discussant]

288 *“The NHIS staffs were disrespectful to us when we went to get registered in Kassena-*
289 *Nankana. They insulted us by calling us animals. When we complained about the way they*
290 *treated us unfairly by helping their friends and rich people to skip the queue they became*
291 *angry and further insulted us....”*. [Kassena-Nankana FGD discussant]

292 Seventy-four percent (74%) of households' surveyed ranked attitudes of NHIS staff at the
293 point of registration as either very good or good and a further 17.1% ranked staff attitude as
294 excellent. Eighty-three percent of respondents stated NHIS staff were patient and guided
295 them through the registration process. However, 9% ranked the NHIS staff attitude as either
296 poor or very poor. Reasons for the ranking of NHIS staff attitudes are presented in Table 3.

297 **[Insert] Table 3: Household respondents' reasons for ranking of NHIS staff attitudes**

298 ***Access of Services and Experiences with Use of the NHIS Card at Health Facilities***

299 Findings from the FGDs show that though the NHIS card is used for varied purposes, its
300 common use is to access health care. Reasons mentioned by card holding discussants for
301 their inability to use their NHIS cards to access health care are similar to that of the

302 household respondents as presented below. Discussants who were satisfied with use of the
303 card stated they did not pay for medicines and beds while on admission. They were given
304 equal attention as the fee paying clients by health workers with some stating preferential
305 treatment was rather given to card holders. In contrast, some stated that presenting the
306 card at some health facilities was the reason for the poor quality of services that they
307 received. Others also stated that use of the card was associated with some level of
308 humiliation as shown in the following sentiments:

309 *“When you show up with the card at the hospital, the nurses look at you and complain that*
310 *who is that poor person coming to disturb them”*. [Ashaiman FGD discussant]

311 *“My experience is that with the NHIS card you will not have attention compared with when*
312 *you go without the card. I was the first to go and expected that I should be treated first*
313 *before those who came after me. But non-cardholders who came after me were treated*
314 *first”*. [Adaklu FGD discussant]

315 Seventy-three percent of household respondents that had used their NHIS cards reported
316 using it to access health care. The frequency of use of the card ranged from less than 2
317 weeks (6.1%), 2-3 weeks (10.7%), 1-3 months (26.8%), 4-6 months (20.5%) and, 6 months or
318 more prior to the survey (36%). The other common use of the card as found in this survey is
319 as an Identity Card at the bank, Police station and to access mobile money services. On the
320 other hand, majority of respondents who did not use their cards stated they had not fallen
321 sick (88%) whilst holding a valid card. A quarter stated they had lost their cards. Other
322 responses are provided in Table 4.

323 **[Insert] Table 4: Reasons for which household respondents had not used their NHIS cards**
324 **to access care**

325 Seventy-two percent of the household respondents who had accessed care with their NHIS
326 cards reported using it at a government health facility. Forty-six percent had used their cards
327 at a private health facility. A further 14.8% had used the card at a pharmacy and the
328 remaining 10.7% used their cards at faith-based, laboratory, and traditional (herbal)
329 facilities. Private clinics (27.6%), district (18.8%) and regional (17.5%) hospitals were
330 mentioned as the main places of last use of the card. On the last use, 37.6% of the
331 household respondents stated they used it to access outpatient services. Thirty-three
332 percent had used it to access pharmacy services. Respondents also mentioned having last
333 used the card for admission (22.4%), laboratory (6.2%) and other services (0.9%). Ninety
334 percent of the card holders who had used their cards stated health facilities easily and
335 readily accepted their cards. Respondents whose cards were not easily and readily accepted
336 mentioned the following reasons: card had expired (51.4%); health facility not NHIS
337 accredited (25.7%); health facility had stopped accepting NHIS cards (14.3%); and others
338 reasons (8.6%).

339 Majority, 53.6%, of the respondents whose cards were easily and readily accepted stated not
340 all the services they required were covered by the NHIS card. Medicines (81.7%), laboratory
341 services (57.5%), consultation (17.7%) and registration (17.2%) were mainly mentioned as
342 not covered by the card. As a result, 53% reported paying additional money. Amounts
343 mentioned to have been paid as additional fees included – exchange rate at the time –
344 US\$1.17-US\$4.69 (35.3%), US\$4.93-11.74 935.3%), US\$11.97-US\$23.47 (23.3%), US\$23.71-
345 35.21 (4.7%) and more than US\$35.21 (5.3%). For those household respondents who

346 reportedly paid additional monies, not all of them knew why they were charged the extra
347 fees. The 83.9% of respondents who knew why they were charged extra fees mentioned the
348 additional fees were mainly for medicines (38.2%) and laboratory services (36.9%). Further,
349 30% of the household respondents who had sought care stated they were referred to other
350 facilities. Majority, 46.7%, stated they were referred to buy medicine. Other services
351 mentioned for which respondents were referred included laboratory (26.7%), scan (15.6%),
352 X-ray (10.4%) and other services (0.7%). Most of the respondents, 97%, who reported to
353 have been referred stated they did not pay for services when they brought the results back.

354 Experiences with the use of the NHIS card to access health care among household
355 respondents were mainly positive. Close to three-quarters of the about 77% of respondents
356 that were either satisfied or very satisfied with use of their cards stated the health workers
357 were friendly towards them. Despite the positive responses, there was some amount of
358 dissatisfaction among some respondents with the services associated with the NHIS card as
359 shown in Table 5.

360 **[Insert] Table 5: Reasons for household respondents ranking of their experiences of the**
361 **use of the NHIS care to access care**

362 ***Health Worker Attitudes towards NHIS Card Holders***

363 Positive health worker attitudes toward card holders at the FGD level were mainly in the
364 Adaklu district. *“The nurses insult the patients and their family for bringing people to the*
365 *clinic if they are holding the NHIS card.....”* was a sentiment echoed severally and in different
366 forms by most aggrieved discussants in Ashaiman and Kassena-Nankana districts as they
367 recounted their negative experiences with health workers.

368 On the other hand, most household respondents (90.3%) reported of good, very good and
369 excellent attitudes of health workers. Ten percent reported poor and very poor attitudes.
370 Reasons for the respondents ranking of NHIS staff attitudes are presented in Table 6.
371 Overall, 90.8% of respondents expressed a willingness to renew their cards. Reasons for
372 renewal and non-renewal are shown in Table 7.

373 **[Insert] Table 6: Reasons for ranking of health worker attitudes by household respondents**
374 **at health facilities**

375 **[Insert] Table 7: Reasons for which household respondents will either renew or not renew**
376 **their NHIS cards**

377 ***Improving the NHIS***

378 FGD discussants shared some ideas on how the NHIS could be improved and the changes
379 they would like to see at the district scheme offices. Most discussants in all three districts
380 would like to see the annual renewal of membership scrapped. They advocated for more
381 flexible terms of membership beyond a year. Discussants also stated that card holders who
382 had not used their cards before expiry should be given a discount on renewal. Others
383 advocated for further decentralization of the registration process. They suggested district
384 Scheme offices should open more registration centres to decongest the main offices to
385 speed up the registration process. Majority of discussants also suggested that the district
386 Scheme offices purchase more biometric registration equipment and find lasting solutions to
387 the frequent system down-time and network failures. Others suggested as below:

388 *“The strategy applied to SSNIT (social security contributions) contributors should be*
389 *expanded to include petty traders. Devise a mechanism to collect small amount of money*

390 *periodically from them and register them onto the NHIS at very low tariffs*". [Adaklu FGD
391 discussant]

392 *"There is a need to increase the list of medicines that the NHIS covers especially for pain relief*
393 *of women in labour. For now, as midwives working at the Health Centres and CHPS*
394 *(Compounds), the patients and their relatives have to buy Pethidine or Diclofenac*
395 *suppositories for pregnant women in labour or who are due for procedures such as*
396 *episiotomy, post evacuation of the uterus, et cetera*". [Kassena-Nankana FGD discussant]

397 **Discussion**

398 This study sought to ascertain the knowledge, experiences and perceptions of the NHIS from
399 the general populations' perspective. An interesting finding was that over 70% of the study
400 respondents had ever enrolled onto the Scheme. Enrolment was higher in Adaklu and
401 Kassena-Nankana districts. These districts have high incidence of rural poverty. We therefore
402 infer that respondents in these districts perceived the NHIS as protection from catastrophic
403 health expenditures implying that the Scheme is fulfilling its core mandate [4,10,20,32,34].
404 Valid subscription was however 38.7% and 62.9% among FGD and household respondents.
405 There appears to be high leakage or non-uptake of the Scheme. Solving this challenge of
406 non-uptake and low renewal of membership has operational implications at the district
407 Schemes level to invest resources to understand the causes and take remedial actions. Good
408 social marketing of the Scheme at the community level in the meanwhile may contribute to
409 membership growth and retention [6,8,29].

410 We observed that respondents had high knowledge of the NHIS. All FGD discussants and
411 98.2% of households surveyed were aware of the Scheme, and fairly informed on

412 membership and the benefits package. This seemingly high knowledge may be attributable
413 to the vigorous marketing in the early years [20] and the high political commitment
414 exhibited towards the Scheme by successive governments [2,20,23]. Notwithstanding, the
415 evidence was also indicative of some level of misunderstanding and misrepresentation of
416 the Scheme. These findings are consistent with that reported by Gobah and Liang in a rural
417 district of Ghana and Nelson et al in a metropolitan area in Southern Nigeria [20,38].
418 Continues engagement and communication between DMHISs and district level stakeholders
419 will serve as a channel to disseminate timely, correct and critical information about the
420 Scheme to communities. This will also serve to nurture a relationship of discourse and
421 dialogue between district schemes and communities where some of these challenges faced
422 by the Scheme can be addressed [29,32].

423 FGDs, as it is generally known, allows for greater self-expression hence the sharp contrasts in
424 the narratives of experiences in obtaining the NHIS card. The introduction of a biometric
425 system centralized the NHIS registration process. This has resulted in challenges of
426 inadequate staff numbers, machines, and supplies and exacerbated by persistent system
427 downtime and network failure. These are administrative bottlenecks that impact client
428 experiences. However, for particular Schemes the challenge is mostly related to negative
429 staff attitudes which were mostly referred to as poor. These challenges consequently affect
430 enrolment and renewals. This brings into perspective the question on operational guidelines
431 and efficiency of the card processing system at the district scheme offices [6,20]. The
432 negative experiences associated with the NHIS on account of staff attitudes confirm earlier
433 findings by Gobah and Liang and Jehu-Appiah et al [6,20]. This will require extensive training
434 in crowd management and customer relations to solve [4,20,34].

435 From a methodological perspective, experiences with the NHIS registration process and
436 attitude among the survey sample were mixed. We observed less favourable experiences
437 among the FGD participants compared to the household respondents. Reflective discussions
438 tend to draw from people narratives and higher levels of embellishment of lived
439 experiences. As a result, experiences may become biased and exaggerated. To address this
440 inherent bias, we tried to focus the groups on the issues as personal experiences rather than
441 emphasising hypothetical sympathies with other participant experiences. This does not
442 mean bias is totally eliminated. Human emotions once shared can become a power opinion
443 manipulator and more so when the shared experience has a negative impact. We observed
444 this in the FGD groups leading to discussants sharing their negative experiences more readily
445 than in household individual surveys. Though contrasting, our interactions were more
446 towards understanding all aspects of the lived experiences rather than finding a dominant
447 pattern. Thus, as a descriptive study, the subjective opinions are as relevant as the
448 perspective they bring to bear on the success of the health insurance scheme.

449 Once the NHIS card is acquired, it facilitated access to facility based care. This is evident in
450 the high proportion of respondents who had used their cards when sick. These findings are
451 therefore suggestive that not only does possession of a valid card reduce the barrier of
452 financial access, it also promotes good health care seeking behaviour [6,9,10,20]. This does
453 not mean that service experience was always satisfying as some had difficulty appreciating
454 the quality they received. Dalingjong and Laar, Jehu-Appiah et al and Alfors observed similar
455 experiences [6,7,23]. Though satisfaction levels with the use of the card were generally high,
456 the negative experiences were symptomatic of the inefficiencies and deficiencies of the
457 health system of Ghana [3,4,20]. These striking reactions in differences in the use of the

458 card, we reiterate, provides a depth of evidence of what is working and what is not. Alhassan
459 et al suggested that such negative reactions to services under the Scheme are attributable to
460 the high expectations, which sometimes are unrealistic, that translate into demand [31].

461 At the provider level, increased utilization of health services in the aftermath of the
462 introduction of the NHIS brought to the fore systemic challenges and the unpreparedness of
463 the health service to implement such a policy. This resulted in overload of work at health
464 facilities as health workers were not adequately trained to interact and process NHIS claims
465 [3,6,23,]. The use of the NHIS card, however, among both sets of respondents depends on
466 the individual need and acceptability. The primary use among all is to access care. It is the
467 secondary use that shows variations.

468 We note some limitations of our study. An inherent limitation is that the sample size and
469 sampling process for the household survey was not scientifically predetermined. Since we
470 did not also focus on triangulating responses, there is the possibility of respondent recall
471 bias. We note that strong views by vocal discussants during the FGDs may have influenced or
472 drowned the views of the less vocal discussants. We do not also exclude the possibility of
473 study respondents providing socially desirable answers when interviewed. That said, the use
474 of both qualitative and quantitative methods allowed us to capture in the true words and
475 weigh the knowledge, experiences and perceptions of the population [39] about the NHIS.

476 **Conclusion**

477 This study has demonstrated that awareness and knowledge about the NHIS is universal. Re-
478 enrolment onto the Scheme is however faltering. The use of the NHIS card to access health
479 care is high. People's experience during registration and use of the card has lasting effect on

480 their perceptions of the Scheme. Formation of these perceptions is also dependent on the
481 design of the Scheme, staff attitude and health system related factors. The Scheme factors
482 relate to personnel, machines and supplies for registration. The service factors are mainly
483 attitudinal, and the general organisation and service availability. That said, there are some
484 immediate things that can be done to help. At its basic, the NHIA can ensure they have
485 strong presence in communities by developing and maintaining communication channels for
486 information dissemination and feedback. Secondly, District Offices should improve on their
487 mobile registration centres and develop strategies to ease the long delays in registration.
488 Staff should be trained in crowd management and SMS systems on information notification
489 can help in prompting expiry dates and times of registration.

490 Overall, the experiences from this study about the Ghana NHIS contribute to improving the
491 Scheme. The positive knowledge, experiences and perceptions can be harnessed by district
492 schemes to manage the high expectations, grow membership and to discourage frivolous
493 use of the card at service points. The negative experiences and reactions, on the other hand,
494 if not sufficiently addressed can undermine the gains achieved and create artificial barriers
495 of access to services under the Scheme.

496 **Abbreviations**

497 AHME: African Health Markets for Equity DMHIS: District Mutual Health Insurance Scheme
498 FGDs: Focus Group Discussion NHIA: National Health Insurance Authority NHIS: National
499 Health Insurance Scheme

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505 **Availability of data and materials**

506 Data used in this analysis has been deposited at the African Health Markets for Equity
507 (AHME) project data repository at <https://ahmesocialdevtools.com/app/>. Access can be
508 granted upon request.

509 **Authors' Contribution**

510 All authors (SA & SF) conceptualized the study, collected, and analysed the data and drafted
511 the manuscript. All authors read and approved the manuscript.

512 **Competing Interests**

513 The authors declare none.

514 **Ethical Approval**

515 The Research Divisions of the Ministry of Gender Children and Social Protection and the
516 NHIA waived ethical approval for the AHME baseline survey as it was part of a larger piloted
517 social intervention programme on identifying and registering poor people onto the NHIS for
518 free. Informed consent, verbal, was obtained from all study participants. All identifiable
519 traces linking respondents to statements have been removed.

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631 **List of Figures**

632 **Figure 1:** NHIS membership status of survey respondents

633 **List of Tables**

634 **Table 1:** Reasons for never enrolling onto the NHIS among household respondents

Reasons	Frequency (%) (N=132)
Have not had time to register	56.1
Have not heard about the registration	12.1
Can pay for health care myself	11.4
Can't afford – too expensive	12.9

Insurance does not cover services I need	16.7
Hospitals don't respect the card	3.8
Processing procedures for card holders too long	7.6
Poor attitude of health workers towards card holders	3.8
Cheap medicines given to card holders	7.6

635

636

637 **Table 2:** Household respondents' knowledge about the NHIS

Item	Statement	True %	False %	Do not know %	Status
(N = 625)					
1	Foreigners who want to join NHIS have to pay in dollars	12.2	34.8	53	False
2	All children under 18 years do not need to register	10.9	81	8.1	False
3	Children under 18 are covered under the NHIS	83.3	9.9	6.2	True
4	Only the father is required to pay for NHIS	6.7	85.6	7.7	False
5	Pregnant women also pay to join the NHIS	24.8	54.7	20.5	False
6	Children who are not in school are required to pay for NHIS	26.2	57.6	16.2	False
7	The elderly, 70 years and above, are exempted from contributions	77.1	10.1	12.8	True
8	Only women above 70 years are exempted from contributions	27.4	55.8	16.8	False
9	NHIS is for a political party	4.2	82.2	13.6	False
10	The very poor (indigents) are covered for free under the NHIS	42.2	35.2	22.6	True
11	Cocoa farmers do not pay for NHIS	5.5	48.4	46.1	False
12	Rich people do not pay for NHIS	3.8	86.7	9.4	False
13	You renew your NHIS card every year	89.9	2.1	8	True
14	NHIS card is valid for five years	81.6	5.9	12.5	True

638

639 **Table 3:** Household respondents' reasons for ranking of NHIS staff attitudes

Reasons	Frequency (%) (N=493)
Patience and provided guidelines	83.1
Impatience and provided no guideline	19.6
No education of what NHIS is	15.2
Did not speak my language	8
Unfriendly and rude to me	8.6
Friendly and nice to me	50.3
Biased and favoured people they like	11.6
Allowed people to jump queue	34.3
They respected the queue	36.8
They have people to interpret and understood my language	32.6
They considered the elderly	10.9
They considered the poor	3.4
They discriminate against the poor	0.8

640

641

642

643 **Table 4:** Reasons for which household respondents had not used their NHIS cards to access
644 care

Reasons	Frequency (%) (N=100)
Never fallen sick	88
Lost the old card	25
Prefer Alternative and Traditional medicine	20
Can pay for health care myself	15
Insurance does not cover services I need	2
Card holders are treated last at the hospital	4
Hospitals don't respect the card	1
Waiting time to see the doctor too long	3
Processing procedures for card holders in the facility too long	3
Poor attitude of the health workers towards card holders	3
Cheap medicines given to card holders	5
Preference given to those who pay out-of-pocket	1
Card holders are asked to co-pay for health services	8
Others	14

645

646 **Table 5:** Reasons for household respondents ranking of their experiences with the use of the
647 NHIS card to access care

Reasons	Frequency (%) (N=365)
Positive experiences	
Assurance that government will pay	65.7
Confident that I don't need to pay out-of-pocket to use services	75.9
As an NHIS card holder I was given preferential treatment	59.4
Staff attitude towards me (an NHIS card holder) was very friendly	73.7
Quality medication was made available to me (NHIS card holder)	41.7
Laboratory services was offered to me (NHIS card holder) freely	5.3
Others	1.9
Negative experiences	
Waiting time to see the doctor too long	51.4
Processing procedures for card holders too long	21.4
Long queues at the OPD	35.7
Poor attitude of health workers	40
Doctor not present in the consulting room	30
No medicine available in the pharmacy	28.6
Laboratory services not working	10
Preference given to those who pay out-of-pocket	21.4
Staff attitude towards NHIS card holders is unfriendly	25.7
NHIS card holders are issued prescriptions to buy their own drugs	42.9
Card holders are asked to co-pay for health services	37.1
Others	8.6

648

649

650 **Table 6:** Reasons for ranking of health worker attitudes towards household respondents at
651 health facilities

Reasons	Frequency (%) (N=347)
Patience and provided guidelines	64.4
Impatience and provided no guideline	11.2
No education of what NHIS is	2.7
Did not speak my language	6.4
Unfriendly and rude to me	26.4
Friendly and nice to me	52.7
Biased and favoured people they like	9.4
Allowed people to jump queue	43
They respected the queue	38.5
They have people to interpret and understood my language	43
They considered the elderly	18.2
They considered the poor	8.8
They discriminate against the poor	2.7
They discriminate against the disable	3.3

652

653 **Table 7:** Reasons for which household respondents will either renew or not renew their NHIS
654 cards

Reasons for renewal (N=435)	Frequency (%)
Assurance that government will pay for the service	20
Confident that I don't need to pay out of pocket to use services	25.3
As an NHIS card holder I was given preferential treatment	13.7
Staff attitude towards me (an NHIS card holder) was very friendly	15.3
Quality medication was made available to me (NHIS card holder)	12.7
Laboratory services were offered to me (NHIS card holder) freely	6.2
Other, specify	5.4
Reasons for non-renewal (N=44)	
Waiting time to see the doctor was too long	11.7
Processing procedures for card holders too long	14.9
Long queues at the OPD	8.5
Poor attitude of the health workers	6.4
Doctor not present in the consulting room	6.4
No medicines available in the pharmacy	4.3
Laboratory services not working	2.1
Preference given to those who pay out of pocket	11.7
Staff attitude towards NHIS card holders is unfriendly	7.4
NHIS card holders are issued prescriptions to buy their own drugs	8.5
Card holders are asked to co-pay for health services	14.9
Others, specify	3.2

655