CUSTOMER SATISFACTION SURVEY REPORT

NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

NHIMA
Leaving No One Behind

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LIST OF ACRONYMS

7NDP	Seventh National Development Plan
ERB	Ethics Review Board
FGD	Focus Group Discussion
HCPs	Health Care Providers
IDI	Indepth Interviews
KII	Key Informant Interviews
MoH	Ministry of Health
NHIMA	National Health Insurance Management Authority
NHIS	National Health Insurance Scheme
OPD	Outpatient Department
R-SNDP	Revised Sixth National Development Plan
SDG3	Sustainable Development Goal 3
UHC	Universal Health Coverage
WHO	United Nations World Health Organisation

EXECUTIVE SUMMARY

Introduction and Background

Universal Health Coverage (UHC) is among the targets under the United Nations Sustainable Development Goals, and is specifically encapsulated in Goal Number 3 (WHO, 2016). Target 3.8 requires countries like Zambia to achieve UHC, including financial risk protection, access to quality essential healthcare services and safe, effective, quality and affordable essential medicines and vaccines for all.

To contribute towards this goal, Zambia introduced a compulsory national health insurance scheme through an Act of Parliament called "National Health Insurance Act No. 2 of 2018". The Scheme is designed to address health financing challenges and ensure an increase in access to quality health services, thereby contributing to the country's economic agenda by providing a healthy and productive workforce. The compulsory National Health Insurance Scheme operates on a solidarity principle by allowing the pooling of resources and risk across a group of people. This promotes equity and universal access based on clinical need as a principal objective.

Since 2019, the National Health Insurance Management Authority (NHIMA) has seen its membership grow to an estimated 6.7 million people covered by the Scheme and eligible to access the National Health Insurance Benefit Package through the over 1 million contributing members as of June 30th 2021. The Scheme also boasts of 240 accredited health facilities where members can access services across the ten provinces of Zambia. Notwithstanding this growth in terms of services being provided and the increase in the number of beneficiaries, NHIMA has never conducted a survey to understand and appreciate how the Scheme has fared among the general populace of Zambia.

It is against this background that NHIMA commissioned this study to, among others, assess clients' satisfaction regarding using insured health services under the National Health Insurance Scheme, identify gaps and generate valuable and consistent customer feedback that will provide input to initiate strategies to retain customers and improve health care delivery on the National Health Insurance Scheme.

Study design, methodology and Data analysis

This study employed a descriptive cross-sectional survey design with a mixed-methods approach targeting health facilities accredited with NHIMA, clients accessing services under NHIMA and those on the NHIMA registry but never accessing any services so far. The data collection involved the use of qualitative approaches where Focus Group Discussions (FGDs) and Key Informant Interview (KII) Guides were used to collect data of a narrative nature. A structured closed ended tool was also designed to collect quantitative data. Questionnaire interviews, FGDs and KII were carried out by trained Research Assistants between August and October 2022. Data analysis involved the use of Nvivo for qualitative data and SPSS and Stata for quantitative data. Through a well-designed sampling process, a total of 988 questionnaires, 100 interviews with NHIMA members who have never claimed, 24 KII and 5 Provincial FGDs were conducted.

Results

Demographic and Social Economic Characteristics of Respondents

Results on demographic and socio-characteristics of respondents show that Lusaka province had the highest number of respondents (39.8 percent) followed by Copperbelt province (24.2 percent). Muchinga province (1 percent) had the lowest proportion of respondents just below Northern province (2 percent). Paid NHIMA public sector employees constituted about 42.7 percent while paid NHIMA private sector employees were at 24.1 percent of the total sample. The unemployed and self-employed together accounted for 24.9 percent of the total sample.

Of the total number of respondents, about 9.5 percent were aged 65 years and above while 4.8 percent were aged between 15-24 years. Majority of respondents were aged between 35-44 years accounting for about 31.2 percent of all respondents. There were more female respondents (59.4 percent) compared with male

respondents (40.6 percent). Approximately 69.6 percent of respondents reported that they were married while 15.8 percent said that they had never been married before. On education attainment, about 63.4 percent of the total sample had at least higher/tertiary education qualification while about 25.4 percent had secondary school level education.

Membership with NHIMA and other Health Insurance

NHIMA membership is drawn from the public sector with 63.5 percent registered through workplaces. Only 18 percent reported to have self-registered while fewer than four percent were registered through MCDSS under the vulnerable category and NHIMA agents. Generally, there is a wide information gap among members regarding the scheme, benefit package and the registration process. Largely, the employer (46.9 percent) has remained the major source of information about NHIMA, followed by friends/family/community at 17.8 percent. Other sources of information (radio, internet, and print media) accounted for less than 15 percent. NHIMA continues being favourable in meeting health costs compared to out-of-pocket health expenditures. Majority (93.5 percent) of respondents felt the monthly contributions were affordable.

Perception of Quality of Health Care in NHIMA Accredited HCPs

As part of establishing whether or not NHIMA accredited HCPs were conforming to quality health care provision, this study was also designed to investigate the perception of quality of health care as observed by clients in relation to several health care outcomes including registration, vital checks, consultations, diagnostics, pharmacy and admissions. With respect to registration, all clients have to go through registration even in cases of emergencies although emergency cases are given priority. About 9 in 10 respondents (90.5 percent) mentioned that they were satisfied with the registration process with only about 1 in 10 (9.5 percent) who said they were dissatisfied/unsatisfied.

In terms of vital checks, over 95 percent mentioned that their vitals were taken. On overall satisfaction with the consultation process, majority (76 percent) of respondents were satisfied. As for diagnostics, slightly over 9 in 10 (93 percent) of respondents were satisfied with the process, only 7 percent expressed dissatisfaction. On admissions, results show that about 38 percent of clients were allocated NHIMA wards: 29.2 percent were admitted in low-cost wards with 20.8 percent admitted in high cost wards.

Results on whether a client got all drugs prescribed by a health personnel from the pharmacy at the HCP shows that slightly above half (57.3 percent) of respondents said that they did; and on whether a client was given a prescription to buy drugs or some drugs elsewhere, about 64.3 percent of clients were affirmative in the response indicating that not all drugs are found in pharmacies at hospitals. On the question of overall satisfaction with services at NHIMA accredited HCPs, results show that close to 8 in 10 (79.1 percent) were satisfied with about 20.9 percent not satisfied.

Notwithstanding the above, there were specific gaps noticed in the way services were provided under NHIMA. On a broad range of issues, results show that about 73 percent of NHIMA clients did encounter an unspecified problem as they sought services while 27 percent of respondents said they didn't. Noticeable gaps included unavailability of medical commodities (46.3 percent), services provided were of poor quality (29.4 percent) and HCPs lack equipment (11.4 percent). In order of ranking, the top three problems encountered by clients were (1) shortage of drugs (32.5 percent), (2) poor service delivery from NHIMA agents and HCPs (19.8 percent) and (3) approval processes taking too long (10.8 percent). Clients were also expressive on items they thought could be included in the NHIMA service package. Topping the list was pharmaceuticals and blood products (15.2 percent), oncology services and investigations (8.5 percent) and diagnostic services (8.2 percent).

Perception of Quality of NHIMA Health Insurance and Information

On NHIMA member's perception of quality of the insurance and information, majority of members were generally satisfied (79 percent). However, 42 percent reported that they did indeed spend some (extra) money despite being NHIMA clients, with majority (62 percent) spending it on expenses due to apparent lack of drugs, medical supplies, and equipment at accredited Healthcare Providers (HCPs). Topping the expenditure list was payment for pharmaceuticals and blood products (54 percent) comparatively.

Knowledge of the complaints procedure system was very low (8 percent). The feedback rate was average (50 percent) with satisfaction of the response mechanism being at only 64 percent. In the same vein, receipt of information from NHIMA on available services was

also low (11 percent) with accessibility to the NHIMA website being relatively low as well. Of the 10 percent respondents who had visited the website, a number of them expressed mixed reactions on the adequacy, relevance, and helpfulness of the information it provided.

5As *Principles Scores*

For each of the 5As principles, clients scored them differently and were largely dependent on the number of questions and the question type with binary responses involving a yes/no or scale measurement involving agree/disagree). Almost half of the respondents indicated that they were very satisfied with NHIMA services (4/5). The highly scored principle was availability (4/4) as indicated by 74 percent of respondents.

The least scored principle was acceptability at (4/14 or 2/7). Accessibility (3/5) was indicated by 46 percent of the respondents and affordability scored (3/4) as indicated by less than 50 percent of respodents. The principle of accommodation scored (6/8) and was indicated by 37 percent of respondents. Table 1 provides the 5As index score.

Table 1: *5As index score*

Index score	An overall score (Total score for indicator)	The score of each indicator	Highest number of respondents from 5As	Interpretation
Overall NHIMA customer satisfaction	5	4/5*100=80% represents High satisfaction	43%	43 percent of NHIMA clients were very satisfied with NHIMA services
Availability	4	4/4*100=100% Represents High satisfaction	74%	74 percent of NHIMA clients were very satisfied with services availability
Accessibility	5	3/5*100=60% Represents Moderate satisfaction	43%	43 percent of NHIMA clients were moderately satisfied with service accessibility
Affordability	4	3/4*100=75% Represents High satisfaction	46%	46 percent of NHIMA clients were very satisfied with service affordability
Accommodation	8	6/8*100=75% Represents high satisfaction	37%	37 percent of NHIMA clients were very satisfied with service being accommodative
Acceptability	14	4/14*100=28% Low satisfaction	35%	35 percent of NHIMA clients had low satisfaction with service acceptability

Conclusion and Recommendations

This study has demonstrated that while NHIMA and the services provided alike is a relatively new phenomenon to the provision of universal health insurance coverage, it is a mechanism with high potential to improve access to affordable, quality and responsive medical health care for all Zambians and thereby contributing to the attainment of the United Nations Sustainable Development Goal Number 3, target 3.8 where Universal Health Coverage is highly emphasized and expected of among UN member countries.

Not only is this platform convenient for individuals and persons on official government or private sector "pay rolls", our study has shown that even those not formerly employed will be served adequately with minimal contributions thus setting potential and adequate momentum to achieve health outcome dictates as outlined in the 8th National Development Plan and Vision 2030.

Based on the findings of this study, the following are recommendations for NHIMA to work on to improve service delivery and client satisfaction:

1. Owing to the lack of or limited availability of information about NHIMA and the services provided under the National Health Insurance Scheme, NHIMA must restrategise information sharing by designing effective and varied communication platforms to inform different target groups, including the vulnerable groups and the informal sector, on all aspects of the scheme, particularly the benefit package and registration;

2. Due to generalized complaints and observations, and also a finding from this study on the time it takes to serve clients, NHIMA and HCPs are required to quickly work on a model that would speed up service delivery in all accredited HCPs; this should first require interrogation of why there is this delay, and thereafter, model a response to that effect;

3. Considering that some NHIMA members end up paying for services that are in the benefits package, NHIMA should ensure that the accredited HCPs have the capacity to deliver the desired quality healthcare services, especially regarding drugs, medical supplies, and medical equipment;

4. In view of the low use of the website by NHIMA members, NHIMA should make it more user-friendly and develop a USSD code that could easily accommodate most clients countrywide given the internet challenges that most rural parts of Zambia currently face. NHIMA members could have the option to either use the website or the USSD code to access vital information about the scheme;

5. For specific items relating to perception of healthcare quality service provision relative to registration, vitals, consultations, diagnostics, pharmacy and admissions, NHIMA needs to engage accredited HCPs on the following:

    a. Where patients report not being checked for vitals, NHIMA should engage HCPs to ensure all machinery for vital checks are available and functioning effectively and well serviced all the time;

    b. The study found that in a number of sections of complaints of delayed health service delivery for NHIMA clients, through the HCPs, NHIMA needs to monitor that accredited facilities have enough health officials to provide satisfactory services to clients;

    c. Majority of clients talked to were of the view that since some pharmacies in hospitals lacked drugs, and some NHIMA accredited pharmacies are located distances away such that some NHIMA clients end up going home without accessing drugs, there is therefore need for NHIMA to work on a model that will ensure well stocked pharmacies are in close proximity to the hospitals for ease of access by clients; and,

    d. With regard to concerns from NHIMA clients on admissions where patients (NHIMA or not) are sometimes mixed up with those from general admissions, NHIMA needs to engage HCPs to find a solution on how admission wards can be remodeled for NHIMA clients only, and separated from general admissions.

6. In the "case study" on clients who contribute but have never accessed services under NHIMA, where such clients have negative perceptions which they have heard regarding the quality of health packages under NHIMA, it is imperative for NHIMA to communicate and disseminate correct information across the country using suitable channels for this particular target group;

7. It is clear that NHIMA is not yet capacitated to provide all the services required by its members such that there are NHIMA clients who have never accessed any of its services. These members rather prefer to use other medical services with capacity to offer the needed services. This means they make double medical aid payments - to their preferred service providers and to NHIMA, a mandatory statutory requirement.

    It is in this vein that NHIMA should explore the possibility of collaborating with other service providers by way of sharing shortfalls encountered by either party. Furthermore, working in collaboration with other service providers will ensure the attainment of Zambia's health vision which is ***'To provide equitable access to cost-effective, quality healthcare services as close to the family as possible'***; and,

8. In order to increase service delivery by the accredited facilities, NHIMA should consider coming up with graduated payments system for the facilities based on the scores they accrued in the past assessmnet. This assessment should be done by an independent organisation.

SECTION 1
INTRODUCTION AND BACKGROUND

1.0 Introduction and Background

The 2030 Global Agenda for Sustainable Development on health requires countries to make firm political commitments to public health. Governments must 'promote physical and mental health and well-being, extend life expectancy for all' and 'achieve Universal Health Coverage and access to quality healthcare' without 'leaving anyone behind.' This commitment is outlined under Sustainable Dev elopment Goal Number 3 (SDG3) and target 3.8.

Universal Health Coverage (UHC) is one of the targets of Sustainable Development Goal Number 3 (WHO, 2016). This target (target 3.8) requires countries like Zambia to achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and safe, effective, quality and affordable essential medicines and vaccines for all.

As guided by the global UHC agenda and Zambia's Vision 2030 of becoming a 'prosperous middle-income country by 2030', the National Health Insurance Act No. 2 of 2018 introduced a compulsory national health insurance scheme. The Scheme is designed to address health financing challenges and ensure an increase in access to quality healthcare services, thereby contributing to the country's economic agenda by providing a healthy and productive workforce.

Unlike most private health insurance, the compulsory National Health Insurance Scheme operates on a solidarity principle as it allows the pooling of resources and risk across a group of people. Further, it promotes equity and universal access based on clinical need as a principal objective and a major benefit is that contributions are not related to risk but to one's ability to contribute to the Scheme. There is cross-subsidisation among; the rich and poor, healthy and sick and the young and old.

Further, the National Health Policy of 2012 underscores the government's commitment to 'providing equitable access to cost-effective and quality health services as close to the family as possible in a caring, competent and clean environment' (Ministry of Health, 2012). The Ministry of Health's transformative agenda, as stipulated in the National Health Strategic Plan 2017-2021, has been aligned toward attaining Universal Health Coverage (UHC). Pivotal to achieving UHC is designing and implementing an innovative, predictable and sustainable mechanism to finance health care that will increase access to quality health services and contribute to the country's economic agenda by providing a healthy and productive workforce.

Health financing is a crucial component of a health system concerned with the accumulation, mobilisation and allocation of funds to cover the health needs of the people collectively and individually. It is a component of a health system that affects the production, delivery, and consumption of health services. Further, health financing impacts the coverage of the poor against financial risks and the magnitude of health outcomes and equity (WHO et al., 2008).

A review of Zambia's health financing mechanism, as evidenced in the Health Financing Strategy 2017-2027, indicated some functional challenges under revenue collection, pooling funds and purchasing. According to the WHO et al. (2008), a suitable health financing mechanism should be able to raise adequate health funds to ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. It should also provide incentives for providers and make users more efficient. It was envisioned that a compulsory National Health Insurance Scheme (NHIS) would help address some of the challenges, hence its introduction.

However, the journey towards introducing compulsory NHIS in Zambia has been a long thought-through process starting as far back as the health reforms of the 1990s to the Vision 2030. The different National Development Plans, namely the Fifth National Development Plan (FNDP, 2006), Revised Sixth National Development Plan (R-SNDP, 2011) and the Seventh National Development Plan (7NDP, 2017).

Before the health reforms of the 1990s, health services in Zambia were provided for free. However, the economic challenges the country started experiencing

in the 1980s affected the quality of health services offered by the existing hospitals and health centres. After 1991, Zambia's health system was reformed to provide health services that were responsive to the local needs through decentralising decision-making to the districts. The reforms introduced in 1993 aimed to revitalise Primary Health Care through a cost-sharing mechanism as a key principle of community participation and sustainability.

The Zambia Vision 2030, launched in 2006, identified inadequate financing and human resources as some of the health sector's major challenges. These challenges were further interrogated by developing strategic documents such as the Fifth National Development Plan, which proposed elaborate options for community health insurance schemes. The Revised Sixth National Development Plan of 2011 proposed the establishment of the National Social Health Insurance Scheme, and the Seventh National Development Plan of 2017 proposed introducing the Social Health Insurance Scheme and health care financing improvements.

The National Health Insurance Scheme (NHIS) is being managed, operated and implemented by a corporate body called the National Health Insurance Management Authority (NHIMA), established under the National Health Insurance Act No. 2 of 2018, which was assented to in 2018. Statutory Instrument No. 63 of 2019, also known as the National Health Insurance (General) Regulations, 2019, operationalised the implementation of the NHIS and outlined the health benefits (National Health Insurance Benefits Package) that the members of the Scheme could access from the accredited health facilities.

Since 2019, NHIMA has seen its membership grow to an estimated 6.7 million people being covered by the Scheme and eligible to access the NHI Benefit Package through its over 1 million contributing members as of June 30th 2021. The Scheme also boasts about 165 accredited health facilities which as at 2022 has grown to approximately 240 facilities, where members can access services across the ten provinces of Zambia. The services covered include registration or consultation fees, investigations, pharmaceuticals, inpatient services, surgical services, annual medical checkups, mental health, maternal and paediatric services, and dental and vision care.

The National Health Insurance Management Authority has seen a continued rise in the number of members utilising the Scheme. The number of members accessing health care under the Scheme has now exceeded 120,000. According to the NHIMA Press Release of 2021, the first quarter (Q1) of 2021 saw 60,148 claims processed compared to 28,062 in the fourth quarter (Q4) of 2020, representing an increase of 114 percent. The value of health insurance products needs to be measured, monitored and explained clearly to the members to ensure the availability of funds to the health sector for improved services. Against this background, the Authority wished to carry out a Customer Satisfaction Survey to establish the Customer Satisfaction Index for its customers. It also expected to determine the percentage of the Zambian population with access to efficient and quality health services.

a. Objectives

The assignment's main objective was to assess clients' satisfaction regarding using insured health services under the National Health Insurance Scheme, identify gaps and generate valuable and consistent customer feedback that would provide input to initiate strategies that would retain customers and improve health care delivery on the National Health Insurance Scheme.

b. Scope

i. To determine the level of Customer Satisfaction concerning the following service attributes:

- Speed of service/product;
- Quality of service/product;
- Affordability;
- Information on services/product;
- Courteousness, competence, and satisfaction of clinicians/patient;
- Communication;
- Physical attributes (ambience of waiting area and wards etc.);
- Accessibility of the Authority's services through telephone, information dissemination and physical premises;
- Responsiveness to customer feedback; and,
- Any other relevant dimension of service as perceived by the Authority's customers.

ii. To identify critical gaps in the service delivery system and recommend interventions.

iii. Satisfaction with adherence to the Commitments set out in the service agreements with the HPCs.

iv. To determine the level of satisfaction

concerning the Authority's Complaints Management System.

v. To determine the effectiveness of customer feedback mechanisms.
vi. To determine the adequacy, relevance and access to information provided by the Authority through website, telephone, and Emails.
vii. To determine an overall external customer satisfaction index.

c. Expected Output

The Consultants were expected to provide three detailed reports to be presented to the NHIMA Management as follows:

1. Customer Satisfaction Survey report.
2. Identified gaps and recommendations in quality service delivery.
3. Survey on percentage of Zambia population accessing efficient and quality Health Care service report.

SECTION 2
LITERATURE REVIEW

2.0 Literature Review

According to Abuosi et al. (2016), the available literature on health insurance and quality of care is limited. Abuosi et al. (2016) further categorised the literature on health insurance and quality care into five categories being:

1. Those indicating a positive association between health insurance and quality care;

2. Those indicating a negative association between health insurance and quality care;

3. Those indicating a difference between insured and uninsured in the same facilities depending on the type of service and attitude of the provider;
4. those indicating no difference at all; and,

5. Those that show poor quality of care affects both insured and uninsured clients and provides no incentive to renew membership or join the Scheme.

One way to explore the effectiveness of a health insurance scheme is from a health provider's perspective and/or from a beneficiary's perspective. A mixed research method using in-depth interviews, focused group discussions, and document analysis showed that referrals, effective monitoring, timeliness, efficiency, reimbursement compliance, and accreditation affected implementers' perception of the quality of health care services. Factors such as consultation, diagnostic services and drug supplies were highlighted from a beneficiary's perspective (Kipo-Sunyehzi, 2021).

Another way of exploring the effectiveness of a health insurance scheme is by making comparisons of the different perceptions of members and non-members of a health insurance scheme. In comparing these perceptions of quality healthcare in Ghana's hospitals with the use of convenience sampling in a cross-sectional study conducted by Abuosi et al. (2016), the results of the study revealed no significant difference between the outpatient members and non-members of the health insurance scheme with regards to waiting time, fairness of care, adequacy of resources and services. However, the study further showed that improved financial access to care and better laboratory and diagnostic services seemed to favour members of the health insurance scheme the most (Abuosi et al., 2016).

In a published report by the Institute of Medicine (IOM, 2001), six aims for quality health care are set out: safety, effectiveness, equitable, patient-centred, timely and efficient. Prakash (2010) observed that patient-centeredness, timeliness and efficiency could be associated with patient satisfaction from these six aims listed. Prakash (2010) further noted that hospitals treated patients as consumers. Measuring quality health care through patient satisfaction could assist them in realising a higher patient satisfaction rating and hence enjoy the benefits of improved patient loyalty and patient retention, among others.

And as alluded to by Al-Abri & Al-Balushi (2014), patient satisfaction surveys have become an essential source of information for health care providers in identifying gaps and coming up with effective plans of action for quality improvement. A literature review also identifies areas and practices within the hospital that impede patient satisfaction. These include physician-patient communication, waiting time, laboratory and diagnostics services, and pharmacy and drug availability, among others (Adhikari et al., 2021; Kebede et al., 2017; Almatrafi et al., 2018; Phuong et al., 2019; Yurizali & Adhyka, 2022; Abera et al., 2017; Alelign et al., 2019).

According to a study by Bertakis et al. (1991), effective doctor-patient communication was central to patient satisfaction. In explaining the reasons for medical tests, physicians communicated effectively, and the more time they spent with patients showed increased patient satisfaction (Adhikari et al., 2021). A mixed-method cross-sectional study in Fiji by Chandra et al. (2019) showed that a doctor's interpersonal skills and how they communicated with patients affected patient satisfaction.

Similarly, Bertakis et al.'s study showed that when

patients were motivated to discuss physiological issues where there was less dominance by the doctor, patient satisfaction was high (Bertakis et al., 1991). And the results yielded in a study done in Tanzania by Tancred et al. (2016) showed that most patients were dissatisfied with the hospital staff and described them as disrespectful, rude, or unhelpful.

Waiting time is the other issue for patients and can vary from one health provider to another. Waiting time can be the time taken to register as a patient, see a physician, have laboratory/diagnostic tests taken and results provided (Osundina & Opeke, 2017; Abera et al., 2017), as well as the time it takes to get medication from a pharmacy (Bader et al., 2021). In Ghana, long waiting times caused patient dissatisfaction among the insured in a study conducted by Abuosi et al. (2016).

Cross-sectional studies by Yurizali & Adhyka (2022) showed a direct impact of the fast track and waiting time on patient satisfaction and Sanclemente-Ansó et al. (2015), using a questionnaire adaptated from a patient satisfaction survey, also showed that a shorter waiting time for diagnosis services increased patient satisfaction. Interestingly, time of arrival and date of the visit were identified as associated factors, as was seen in the results of a cross-sectional study by Biya et al. (2022) conducted in eight Ethiopian zonal hospitals where exit interviews were administered to a systematic randomly selected sample. It showed that patients spent longer waiting times on Mondays than on Fridays, and those who came in the morning were likely to spend more time than those who visited the facility in the afternoon.

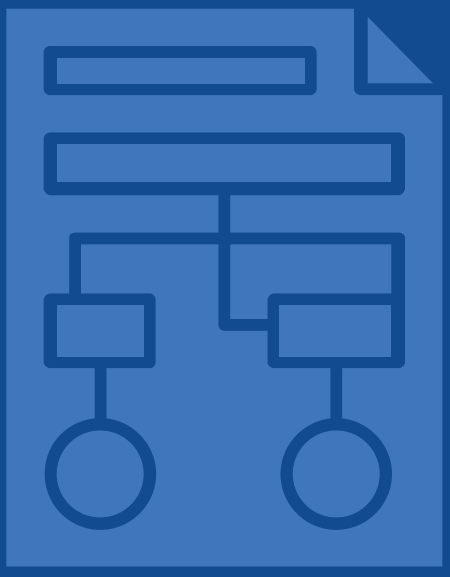
Laboratory and diagnostic services are considered critical to a quality health care system and patient satisfaction. Availability of laboratory services (Almatrafi et al., 2018), vital information on specimen collection, cleanliness and location of the laboratory and availability of required diagnostic tests). Studies have shown (Abera et al., 2017; Alelign & Belay, 2019) contribute to patients' satisfaction with diagnostic services.

In exploring patient's satisfaction with a new tele-radiology facility being offered in Ameland (a municipality and one of the West Frisian Islands off the north coast of the Netherlands), patient satisfaction questionnaires were administered to all patients who received an x-ray and tele-radiology service in a cross-sectional study conducted which revealed a high rate of satisfaction with the technical and interpersonal skills during the diagnostic phase, especially among the elderly (Jacobs et al., 2016).

In a cross-sectional study by Hailu et al. (2020) where structured questionnaires were used to collect data, patient dissatisfaction at public facilities in Ethiopia was attributed to the location of the laboratory sites, inadequate waiting area, unhygienic latrines, missing results, unavailability of the requested tests, poor communication and the cost of tests. Similarly, by using exit interview structured questionnaires, the results in Mindaye & Taye's (2012) cross-sectional study conducted in Ethiopia showed that patients were satisfied with Anti-Retroviral Therapy (ART) monitoring laboratory facilities but bemoaned its accessibility and unavailability of toilets.

Drug unavailability in any health facility will have adverse clinical and health outcomes, as observed in a study by Phuong et al. (2019), where several research documents reporting on patient outcomes related to drug shortages were reviewed. For example, in a cross-sectional study conducted by Kebede et al. (2017), who used pharmacy exit interviews through self-reporting questionnaires, a low patient satisfaction rate in the outpatient pharmacy was observed because of drug unavailability and the uncomfortable waiting area at public hospitals in Ethiopia.

In a cross-sectional study conducted in Malaysia that aimed at assessing patient satisfaction and factors associated with it, a newly developed questionnaire was administered to some systematic randomly selected patients in public clinics, and the results showed a high rate of satisfaction on account of administrative and technical competencies as well as the location of the site (Ismail, Gan & Ahmad, 2020). Ismail, Gan & Ahmad (2020) also identified age, education, frequency of visits, self-perceived health status, and pharmacist knowledge as some of the associated factors.



SECTION 3
RESEARCH METHODOLOGY

3.0 Research Design

In this assignment, NHIMA expected a measure of levels of satisfaction by individual members (policy contributors) and the effectiveness with which they manage the Scheme using accredited health care providers (more than 240). NHIMA, therefore, wished to know client individual member satisfaction using specific areas of interest, namely:

i. ***Availability*** (the relationship of the volume and type of existing services (and resources) to the clients' volume and types of needs. This entails the adequacy of the supply of physicians, dentists and other service providers, supply of facilities such as clinics and hospitals, and specialised programs and services such as mental health and emergency care);

ii. ***Accessibility*** (the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost);

iii. ***Affordability*** (the relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay and existing health insurance). The clients' perception of worth relative to total cost is a concern here, as is their knowledge of prices, total cost and possible credit arrangements;

iv. ***Accommodation*** (the relationship between the manner in which the supply resources are organised to accept clients including appointment systems, hours of operation, walk-in facilities, telephone services);and,

v. ***Acceptability*** (the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients). In the literature, the term acceptability appears to be used most often to refer to the specific consumer reaction to such provider attributes as age, sex, ethnicity, type of facility, neighborhood of the facility, or religious affiliation of the facility or provider. In turn, providers have attitudes about the preferred attributes of clients or their financing mechanisms. Providers either may be unwilling to serve certain types of clients (e.g. welfare patients) or through accommodation (relationship between NHIMA facility and individual members), may make themselves more or less available).

Given this expectation, the study used a descriptive cross-sectional survey design with a mixed-methods approach targeting health facilities accredited with NHIMA, clients accessing services under NHIMA and those on the NHIMA registry but never accessing any services so far. The following are the attributes of survey design:

a. Survey Specific Questions

Regarding survey questions, the Consultant mainly used the assignment objectives and scope of the assignment and other relevant documents to develop the survey tools. Tool development was a consultative activity; hence, the Consultant involved the client throughout the process, from designing to approval.

b. Tools

Since the study employed a mixed-methods approach which included qualitative and quantitative data elements, the consultants collected quantitative data through a questionnaire targeting NHIMA beneficiaries, that is, policyholders or one of their dependants. As for qualitative data, the consultants used in-depth interviews with Health Facility personnel and those clients who had never accessed services under NHIMA.

c. Sampling Frame

The sampling frame included all NHIMA members (men, women and youth) in districts where NHIMA has accredited healthcare facilities. We used probability and non-probability sampling techniques to sample NHIMA health facilities and clients accessing these facilities as

well as those not accessing them. A sampling frame was generated through coordination with NHIMA, contacts with healthcare facilities and community leadership in selected districts to understand population estimates and geographical distribution of households.

Renavatio, the Consultant, used a multistage cluster sampling method. Districts with accredited healthcare facilities were purposively identified. The healthcare facilities were then divided into public and private owned facilities. NHIMA currently has 240 accredited facilities, majority of which are public healthcare providers. Facilities were stratified by level and ownership and randomly selected for the survey. The inclusion and exclusion criteria of the target participants were as follows;

Inclusion Criteria:

i. NHIMA clients who have attended the Outpatient Department (OPD) or Inpatient Department (IPD) of an accredited facility in the last 12 months and are willing to participate in the study; and,
ii. Parents of beneficiaries above 18 years of age.

Exclusion Criteria:

i. The NHIMA patients who were not willing to participate;
ii. NHIMA Patients who had previously been interviewed in the survey; and,
iii. Beneficiaries less than 18 years of age.

Key informants included health care providers and other stakeholders identified in consultation with the client. The Consultant used purposive sampling to select key informants who participated in the survey.

d. Sample Size Estimation

The sample size for this survey was estimated using the 2020 Labour Force Survey. Our settlement for the Labour Force survey is guided by the fact that NHIMA has made it compulsory (through Law) for all individuals in formal employment to contribute to NHIMA. To estimate the proportion of successes in utilization and satisfaction of NHIMA services, we generated a sample size guided by parameters appropriate for a single population of (NHIMA) clients. According to the 2020 Zambia Labour Force Survey Report, formal employment was estimated at 26.2 percent.

Formal employment is the type of employment in which employees are entitled to social security coverage and contract in addition to annual paid leave, or any such entitlement and any legal registration for own account workers/employers. NHIMA ensures deductions of 1 percent of earnings of formal employees and is matched by a 1 per cent employer contribution. Therefore, to estimate the sample size, we assumed that p is the number of people in formal employment; Z is the value from the standard normal distribution reflecting the confidence level to be used (e.g. Z=1.96 for 95%), and E is the desired margin of error. The following formula, therefore, was used to determine the sample size required:

$$n = p(1 - p)(Z/E)^2$$

$$= 0.262(1 - 0.262)(1.96/0.4)^2 = 465$$

Where:

n = is the sample size

Zα = 1.96 at 95 percent

The confidence interval is the value from the standard normal distribution reflecting the confidence level as required (e.g., Z = 1.96 for 95 percent)

P = 26 percent of the population in formal employment making contributions towards the Scheme.

E = 4 percent margin of error/precision (E is the desired margin of error).

The sample size required, therefore, was 490, factoring in the 5 percent non-response rate due to unavailability to take part in the survey (i.e. mortality, ill health, etc.); as shown in the formula below:

n +(5 percent non-response rate) =465/.95=490

A sample size of 490 policyholders with at least one corresponding beneficiary was used. As such, there was approximately 980 respondents where 490 represent

policyholders while another 490 other beneficiaries in the policyholder's household. This sample size ensured that the 95 percent confidence interval estimate of the proportion of NHIMA clients satisfied (or unsatisfied) with the services is within 5 percent of the true proportion.

e. Sampling Technique Assignment

NHIMA has approximately 240 accredited health facilities that have provided services to NHIMA policyholders. In this study, we selected 10 percent (24 health facilities) of NHIMA accredited health facilities with known claims.

We also chose health facilities by province and volume of claims/clients utilising services using the NHIMA scheme. Therefore, we selected 28 health facilities (considering round-offs) weighted by provincial volumes in this case.

In places such as Lusaka and the Copperbelt, where volumes are higher, or in provinces where our sample has two or more facilities, conveniently ensured to include both high and low-volume facilities to balance the views associated with both. The respondents to the individual questionnaire and participants in focus group discussion were all picked either in the Out-Patient Department or In-Patient Department within the sampled facilities. Table 2 is a summary of the sampling technique assignment.

Table 2: *Sampling Technique Assignment*

Province	Sum of No. Claims	% of Claims	% of 24 HF	Policy Beneficiary
Central	55, 625	6	2	60
Copperbelt	214, 020	25	6	246
Eastern	41, 129	5	2	50
Luapula	30, 474	4	1	40
Lusaka	352, 451	41	10	402
Muchinga	8, 075	1	1	10
Northern	13, 863	2	1	20
North-Western	37, 801	4	1	40
Southern	89, 076	10	3	98
Western	24, 142	3	1	30
Grand Total	**866, 656**	**100**	**28**	**996**

f. Application of Sample Size per Facility

Table 3 shows the sampling distribution by province, the sum of claims, percentage of claims, percentage of health facility, and beneficiaries volume. Out of all the claims (866, 656), 41 percent were from Lusaka province and a quarter (25 percent) were from Copperbelt province. Muchinga province had the least claims (1 percent).

Using probability proportional to size to allocate the sampled health facilities, the proportion of provincial claim volume was proportional to the sampled twenty-four health facilities (10 percent of 240). Therefore, Lusaka province having the highest claim volume (41 percent * 24), has a proportion of 10 health facilities that were selected and sampled. Copperbelt province having the second-highest claim volume (25 percent * 24), had a ratio of 6 health facilities selected and sampled.

Further, the percentage of claim volume in each province was proportional to the beneficiaries' sample size. Similarly, based on the proportion of provincial claims, the sample size of 490 was distributed proportionately. Therefore, Lusaka province having the highest proportion, the sample was (41 percent * 490) 402 beneficieries followed by Copperbelt province with (25 percent * 490) 246 beneficieries.

Table 3: *Percentage distribution of type of health facilities by province and by claim volume*

Province	Number of Claims by HF				Percentage of Claims by HF				Sample of HF by type		
	Mission	Private	Public	Total HF Claim volume	Mission	Private	Public	Total Sampled HF	Mission	Private	Public
Central	1, 049	5, 554	49, 022	55, 625	1.9	10.0	88.1	2	0	0	2
Copperbelt	6, 580	67, 619	139, 821	214, 020	3.1	31.6	65.3	6	0	2	4
Eastern	12, 678	5, 961	22, 490	41, 129	30.8	14.5	54.7	2	1	0	1
Luapula	6, 503	16, 400	7, 571	30, 474	21.3	53.8	24.8	1	0	1	0
Lusaka	11, 408	195,857	145, 186	352, 451	3.2	55.6	41.2	10	0	6	4
Muchinga	1, 420		6, 655	8, 075	17.6	0.0	82.4	1	0	0	1
Northern	779	100	12, 984	13, 863	5.6	0.7	93.7	1	0	0	1
North-Western	7, 363	1, 982	28, 456	37, 801	19.5	5.2	75.3	1	0	0	1
Southern	34, 157	8, 246	46, 673	89, 076	38.3	9.3	52.4	3	0	0	2
Western	5, 384	104	18, 654	24, 142	22.3	0.4	77.3	1	0	0	1
Grand Total	**87, 321**	**301, 823**	**477, 512**	**866, 656**	**10.1**	**34.8**	**55.1**	**28**	**1**	**10**	**15**

Table 3 above shows the percentage distribution of type of health facilities by province and by claim volume. Therefore the sampling proportion was guided by the volume of claims of each type of health facility. In Lusaka province, 56% of health facilities were private, and 41 percent were public facilities. Therefore, 6 private health facilities and 4 public facilities were sampled. In Copperbelt province, 2 private health facilities and 4 public health facilities were sampled

g. Purposive Sampling and Sample Allocation

As alluded to, this assignment was based on a mixed-methods design. The second part of sampling employed a qualitative component where data was collected from purposively selected individuals. This data was critical for programming and improving the execution of national insurance. We conducted in-depth interviews to gauge the functionality of NHIMA from the management point of view and client facilities.

For purposes of collecting qualitative data and ensuring strengthening programming in terms of access and reasons thereof, we identified those clients who are contributing to NHIMA but have never accessed or made any claims using their Scheme in the last year. The data for this purpose was collected using interviews from a list of 100 respondents countrywide. From each high-volume provincial facility and using employer information, we selected ten policyholders to investigate why they may not have accessed any services although they are active and paid-up members of the Scheme. Table 4 summarises all individuals selected purposively for this assignment.

Table 4: *Purposive sample size*

National/Province	NHIMA Employees	Health Facility	Policyholder Not Claimed
National	3	0	0
Central	1	1	10
Copperbelt	1	1	10
Eastern	1	1	10
Luapula	1	1	10
Lusaka	1	1	10
Muchinga	1	1	10
Northern	1	1	10
North-Western	1	1	10
Southern	1	1	10
Western	1	1	10
Grand Total	13	10	100

h. Focus Group Discussions

A total of 7 FGDs were held in five targeted provinces. These provinces had been sampled purposively. They have the most number in terms of claims, according to the data provided by NHIMA. Then the facilities were randomly sampled, and the final individuals to participate were conveniently sampled. These were sampled as they exit the facility and after accessing the NHIMA services. Below is Table 5 showing the sampled facilities and target groups.

Table 5: *Disaggregated FGDs per province*

Province	Facility Name	Target Group
Lusaka	• University Teaching Hospital - Adults hospital • University Teaching Hospital – Children hospital • Chilenje Level One Hospital	• Men • Female Youths
Copperbelt	• Ndola Teaching Hospital	• Female Youths • Male Youths
Southern	• Choma General Hospital	• Women • Mixed group
Central	• Kabwe General Hospital	• Female Youths • Men
Eastern	• St Francis Mission Hospital	• Male Youths • Women

As noted, the disaggregation and designation of the FGDs was aimed at both providing safe spaces for voices and opinions of women, girls and other vulnerable populations whilst also ensuring that people of a similar age group (old vs youth) have their own safe spaces to share their experiences and perspectives. This assisted in responding directly to the need for gender disaggregated data and information thus "All data collected should be disaggregated by sex, and location".

i. Key Informant Interviews

A total of 15 KIIs were adequate to provide the richness to augment the statistical analysis. Meetings and interviews with the key informants were scheduled in advance, noting that most officials have busy schedules and are not easy to access. Our strategy was to have this negotiated, agreed and communicated during the inception phase.

j. Primary Data Collection

Primary data collection at the field level was done through a survey questionnaire and semi-structured interview guides. The data for the survey questionnaire was collected electronically using KoboCollect with cloud storage. The Consultant selected research assistants, all university graduates with experience in survey data collection. The research assistant were trained in using KoboCollect for data collection. This was then followed by a field pre-test to test the research instruments before fieldwork.

k. Quality Assurance

Multiple quality checks were built into the data collection process to ensure that high-quality data was collected at every design stage, training, supervision, and checking stage. The teams were provided with a standard manual detailing how to conduct themselves in the field and instructions on data collection. The approach was to allow for standardization during the exercise. The data collection tools for the different respondents were pre-tested in an initial pilot study to ensure they are valid and reliable.

Regular supervision of the data collection teams as they conducted the exercise was done which promoted accountability. Regular fieldwork meetings were held to track progress, evaluate work accomplished, identify any problems encountered and their solutions, and address any emerging issues. The data was reviewed at the end of each day to check for completeness and accuracy.

l. Data Cleaning

During and after data collection, the Consultant had set up validation rules or input masks in data entry software for data sets. The Consultant used SPSS and Microsoft Excel for data organisation, management, and analysis. The Consultant checked against all variables for collected data and ensure that all recorded names and variables have detailed labels. If such is missing, data labels were created.

The Consultant further designed a purpose-built database structure to organise data and files. This data organisation was to be accompanied by notes and documentation about the data. After that, the Consultant cleaned, verified, cross-checked and validated the data for analysis.

This was accomplished by checking for data completeness, adding variable and value labels where appropriate, verifying random samples of the collected data, and checking for double entry of data. We performed statistical analyses such as frequencies, means, ranges or clustering before analysis to detect errors and outlier values.

SECTION 4

DATA ANALYSIS AND REPORTING

4.0 Data Analysis and Reporting

a. Quantitative Data Analysis

Quantitative data was summarised into proportions and absolute numbers for the outcomes and demographic characteristics based on the project's indicators of interest. Categorical variables were presented as percentages. The final results were presented as tables and graphs.

b. Qualitative Data Analysis

Content and thematic analysis was used in analyzing qualitative data. Audio files, notes from the KIIs and document reviews were transcribed, coded, and imported into NVivo for qualitative analysis and management. This analysis involved categorizing and bundling information to explore and identify patterns within the data.

Further, cross-case comparisons around major themes were made to ensure differences and similarities are detected and examined in detail to explore any arising contextual issues. These data sets were supported with various quotes from the participants. The report's writing was preceded by a discussion on the format of the report. Thus, the Consultant prepared this report with the client's agreed-upon format.

c. Accountability and Ethics

Renavatio Consultants recognizes the sensitivity of the topic and nature of the study. Therefore, Renavatio Consultants submitted the protocol for ethical approval to the ethics committee of the private Ethics Review Board (ERB) called ERES CONVERGE and submitted the Clearance Certificate to NHIMA. In addition, the Consultant showed commitment to safeguarding and promoting the welfare of the respondents during the course of the study.

Hence, all research team members were trained to meet the highest ethical data collection and analysis standards throughout the survey. Additionally, the research team was trained on maintaining confidentiality, seeking for informed choice before embarking on data collection, ensuring freedom of participation, respect for local customs and tradition, among other aspects related to accountability and ethics.

d. Covid-19 Contingencies

Renavatio Consultants took additional precautions to minimize staff and respondents' exposure to COVID-19.. For instance, during training, the Consultant conducted training in an area conducive to reducing infection risks. The training was conducted in a COVID-safe environment following prevention guidelines and training the research assistants on safety behaviours. The Consultant also followed the Covid-19 guidelines prescribed by the Ministry of Health.

e. STATA Index Process

Question responses identified to measure a certain principle were transformed to YES/NO.

Creating an index score requires that all questions have uniform responses.

In case of a question based on a four Likert scale response (agree, strongly agree, disagree and strongly disagree), the strong disagree and disagree responses were recoded to "NO" while strongly agree and agree were recoded as "YES" responses.

Example, a question on who attended to you on your last visit to a health facility; this question was recoded as whether the NHIMA client was being attended to by trained personnel "Yes" and "No" represented being attended to by untrained personnel.

STATA SYNTAX:

Creating measure of availability to have same responses

recode satisfaction_registration (1/2=1 "Yes")(3/4=0 "No"), gen(q7_3A)
recode Satisfaction_Vital_taking (1=.)(2/3=1 "Yes") (4/5=0 "No"), gen(q9_3B)
recode Satisfaction_Consul_process (1/2=1 "Yes")

(3/4=0 "No"), gen(q10_3C)
recode Attened_to (1=.)(1=0 "No")(2/4=1 "Yes") (5/6=0), gen(Q15_2A)

Creating an Availability score
gen Availability = (q7_3A+q9_3B+q10_3C+Q15_2A)

f. Interpretation of Index Scores

If a respondent answered "yes" to all of the four questions (on availability), his or her index score would be four, meaning that satisfaction with service availability is very high (4/4 *100=100%).

If a respondent answered "no" to all four questions, his or her availability score would be 0, indicating satisfaction with service availability is very low (0/4*100= 0%).

Score closer to Zero is deemed very low while a score closer to hundred is considered very high.

0-25% Very Low Satisfaction
26- 49% Low Satisfaction
50-64% Moderate Satisfaction
65-74% High Satisfaction
75-100% Very High Satisfaction

SECTION 5

CLIENT SATISFACTION SURVEY FINDING

Table 6: *Respondents by age*

Age groups	Frequency	Percent	Cumulative Percent
15-24	47	4.8	4.8
25-34	270	27.3	32.1
35-44	308	31.2	63.3
45-59	240	24.3	87.6
60-64	29	2.9	90.5
65+	94	9.5	100.0
Total	**988**	**100.0**	

The study targeted respondents above the age of 18 years. From the total number of respondents, about 9.5 percent were above 65 years of age and about 4.8 percent of respondents were between 15-24 years of age. The survey had most of the respondents aged between 35-44 years of age, accounting for about 31.2 percent of all respondents.

Table 7: *Respondents by sex*

Sex	Frequency	Percent
Female	587	59.4
Male	401	40.6
	988	**100.0**

The study surveyed a total of 988 respondents across the country using the individual questionnaire. There were a total of 587 female respondents representing about 59.4 percent. Males were 401 representing about 40.6 percent. There were more females because sampling was using exit interviews and poor health seeking behaviour on the part of the males resulted in few males been surveyed.

Table 8: *Marital status*

Marital Status	Frequency	Percent	Cumulative Percent
1. Never married	156	15.8	15.8
2. Married	688	69.6	85.4
3. Separated	12	1.2	86.6
4. Divorced	46	4.7	91.3
5. Widowed	82	8.3	99.6
6. Cohabiting	4	.4	
Total	**988**	**100.0**	**100.0**

Of the 988 respondents interviewed, 688 respondents (approximately 69.6 percent) reported being married. Furthermore, there were 156 respondents representing about 15.8 percent of the respondents who said that they have never been married before.

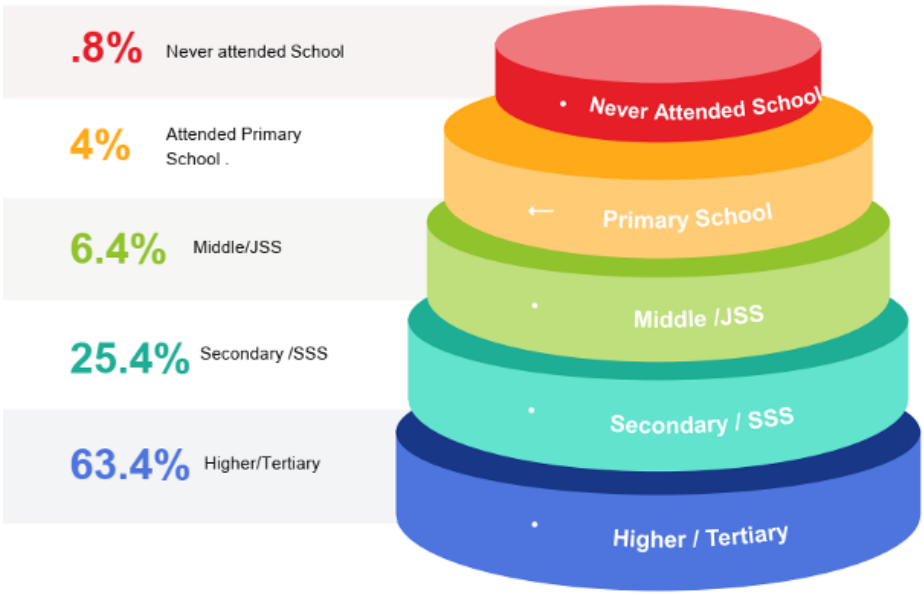


Figure 1: *Education status*

The survey collected data from individuals that are literate. The survey had about 63.4 percent of the total sample who had at least attained higher/tertiary education. Also there were about 25.4 percent who had at least reached secondary school level of education. Then a paltry of 0.8 percent of the respondent had never been to school.

Table 9: *Total individual respondents*

Province	Frequency	Percent
Central	62	6.3
Copperbelt	239	24.2
Eastern	55	5.6
Luapula	40	4.0
Lusaka	393	39.8
Muchinga	10	1.0
North Western	45	4.6
Northern	20	2.0
Southern	94	9.5
Western	30	3.0
Total	**988**	**100.0**

The study had planned to administer a total of 996 respondents. After cleaning the data and dropping outliers the total number of respondents is now 988. Lusaka province had the highest number of respondents representing about 39.8 percent followed by Copperbelt province representing about 24.2 percent. Muchinga province had the lowest proportion followed by Northern province which stood at 1 percent and 2 percent, respectively.

Table 10: *Respondents employment sector*

Employment Sector	Frequency	Percent
1. Paid Public Sector Employee	422	42.7
2. Paid Private Sector Employee	238	24.1
3. Paid apprentice	3	.3
4. Paid intern	1	.1
5. Volunteer (unpaid)	4	.4
6. Retiree / Pensioner	74	7.5
7. Unemployed	119	12.0
8. Self employed	127	12.9
Total	**988**	**100.0**

The sample was dominated by the paid public sector employees who were 422 representing about 42.7 percent. The paid private sector employees were 238 representing 24.1 percent of the total sample. This distribution is to be expected because NHIMA started first with the public sector and followed up with the private sector in terms of enrolling members on the Scheme. The unemployed and self-employed together accounted for 24.9 percent of the total sample.

SECTION 6
MEMBERSHIP WITH NHIMA

6.1 Introduction

By law, membership with NHIMA is mandatory. It has registered members from all walks of life irrespective of the social and economic status of people. Initially, the bulk of the membership was drawn from the formal sector, largely the public service institutions, and extended to private firms and institutions. Members were registered and mandated through payroll deductions of premiums at workplaces.

In addition, self-registration and other registration methods are available to all groups, particularly in the informal sector and vulnerable groups. Different categories of membership status exist to provide access to quality healthcare services to everyone without catastrophic out-of-pocket health expenditures.

6.2 Source of Information about the NHIMA Scheme

Various sources provided information to the respondents about the NHIMA scheme. When asked about their primary source of information regarding the Scheme, the source with the highest response rate was from employers with 595 out of 1270 cases representing 46.9 percent.

Other information sources included: family and friends at 226 (17.8 percent), television at 152 (12 percent), and NHIMA agents at 113 (8.9 percent) of the total cases. The rest of the information sources (radio, internet, and print media) accounted for less than 15 percent combined. The least source being print media at 23 represented 2 percent of the cases.

Table 11: *Source of information about the NHIMA Scheme*

Source	Number of responses	As a Proportion of Total Responses
TV	152	12.0
Radio	84	6.6
Print Media	26	2.0
Internet	43	3.4
Friend/Family/Community	226	17.8
Employer	595	46.9
NHIMA Agent	113	8.9
Other (Specify...)	31	2.4
Total	1270	100.0
Western	30	3.0
Total	**988**	**100.0**

6.3 Registration under NHIMA

Regarding membership registration for the NHI scheme, the majority of members, 623 out of 988 respondents, were registered through their employers at places of work accounting for 63 percent of the total respondents. 177 respondents were self-registered, which included registration through the NHIMA desk, NHIMA agent, or online platforms, accounting for 17.9 percent, and 147 respondents registered through a contributing member accounting for 14.9 percent. Other modes of registration accounted for 3.7 percent (37 respondents) as shown in Table 12.

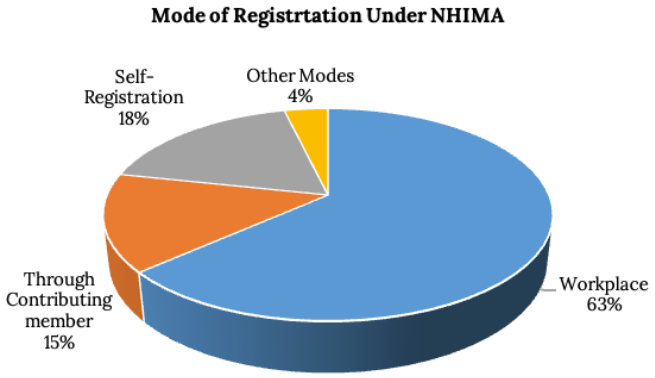


Figure 2: *Mode of Registration under NHIMA*

Table 12: *Mode of Registration under NHIMA*

Mode	Frequency	Percent
1. Workplace	627	63.46
2. Through contributing member	147	14.88
3. Self-Registration	177	17.91
4. Other Modes	37	3.74
Total	**988**	**100**

For the 3.7 percent representing other modes of registration, MCDSS accounted for 10.8 percent (4 out of 988 respondents) and NHIMA agents accounted for 89.2 percent (33 out of 988 respondents) as shown in Figure 3 and Table 13 below.

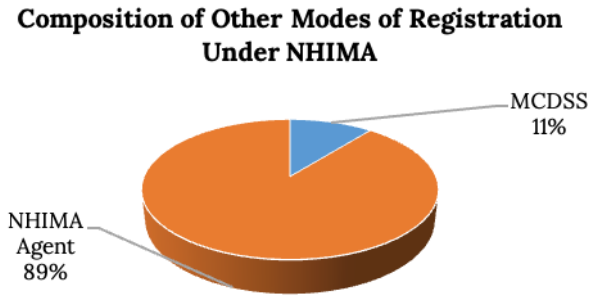


Figure 3: *Other Modes of Registration under NHIMA*

Table 13: *Other Registration Modes*

Registration Mode	Frequency	Percent
1. MCDSS	4	10.81
2. NHIMA Agent	33	89.19
Total	**37**	**100**

6.4 Length of Registered Membership with NHIMA

NHIMA has been in existence since October 2019. Members have been registering with the scheme over the years and incremental growth in membership has been recorded. Regarding the length of registration period with NHIMA, the majority of respondents, 383 out of 988 (38.8 percent), had been registered members with NHIMA for over two years, whilst 34 respondents (35 percent) had been members for two years, and 259 respondentss (26.2 percent) for less than a year. See Table 14 below.

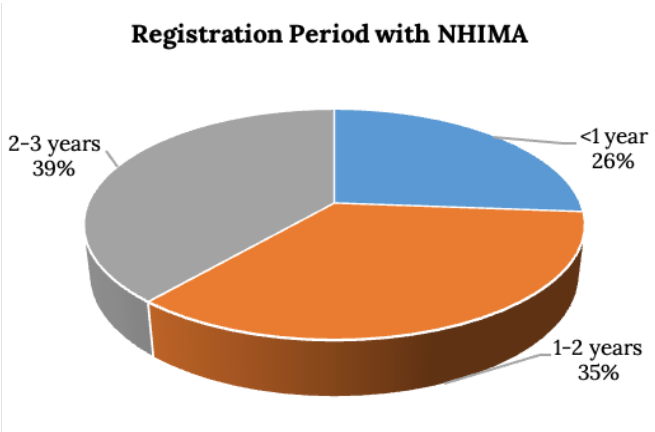


Figure 4: *Registration Period with NHIMA*

Table 14: *Registration Period with NHIMA*

Period	Frequency	Percent
<1 year	259	26.2
1-2 years	346	35.0
2-3 years	383	38.8
Total	**988**	**100**

6.5 NHIMA Membership Status

Regarding the membership status of the respondents, the majority of the respondents, 718 out of 988 (72.6 percent), were contributing members, followed by a beneficiary spouse at 161 (16.3 percent). The rest of the membership statuses accounted for less than 10 percent with retirees and the vulnerable at 62 (6.3 percent) and 25 (2.5 percent) respondents respectively as shown in Figure 5. Senior citizens constituted the other membership status.

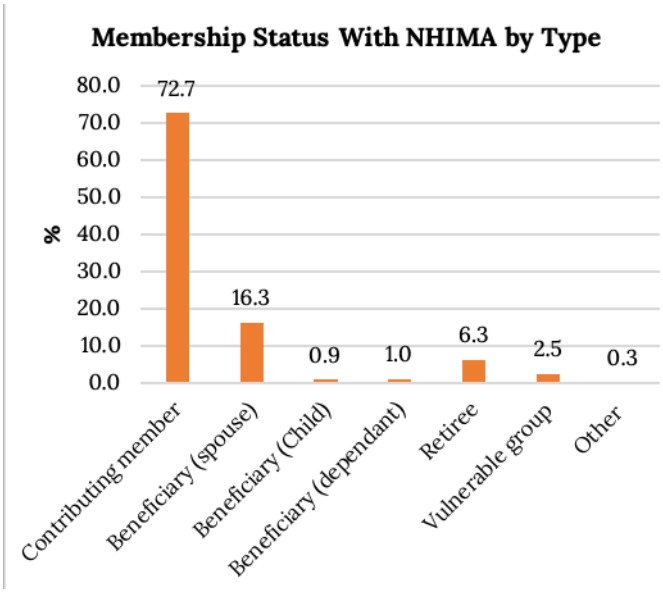


Figure 5: *Membership Status With NHIMA by Type*

Table 15: *Membership Status With NHIMA*

Type	Frequency	Percent
1. Contributing Member	718	72.67
2. Beneficiary (spouse)	161	16.3
3. Beneficiary (Child)	9	0.91
4. Beneficiary (dependant)	10	1.01
5. Retiree	62	6.28
6. Vulnerable group	25	2.53
7. Other	3	0.3
Total	**988**	**100**

6.6 Awareness of MCDSS NHIMA Registration Recommendation Under Vulnerable Category

Out of the 988 total respondents, 597 (58.6 percent) indicated that they were not aware of the recommendation from MCDSS to register with NHIMA under the vulnerable group category. 409 respondents (41.1 percent) responded in the affirmative that they were aware of the recommendation. This could explain the low membership to NHIMA under the vulnerable group membership status.

Table 16: *Awareness of MCDSS NHIMA Registration Recommendation under Vulnerable Category*

	Number of responses	As a Proportion of Total Responses
No	579	58.6
Yes	409	41.4
Total	**988**	**100**

6.7 Capping of Beneficiaries to only those under 18 years

Concerning the respondent's views on the capping of beneficiaries to only those under 18 years, 568 (57.5 percent) of the total respondents agreed with the capping whilst 420 (42.5 percent) did not agree to the restriction of 18 years and below for the beneficiary age other than the spouse as shown in Table 17. The main reason given for the negative response was the financial constraints on the part of the beneficiary child or dependant who was no longer covered by the principal beneficiary.

Table 17: *Capping beneficiaries to only those under 18 years*

	Number of responses	As a Proportion of Total Responses
No	420	42.51
Yes	568	57.49
Total	**988**	**100**

6.8 Affordability of NHIMA Monthly Contributions

Regarding the monthly NHIMA contributions, 730 (93.5 percent) of the total 781 respondents agreed that the NHIMA monthly contributions were affordable and eased the financial difficulties of health expenditure as stated by 732 (93.7 percent) compared to 57.2 percent of the respondents who were able to afford financial access to health care services before registering with NHIMA. They stated that NHIMA was a better means of settling healthcare costs than an out-of-pocket payment. Data showed that the average NHIMA monthly contribution was ZMW 57.12.

"...Secondly, I appreciate NHIMA and I advise them to register. So, yesterday I was encouraging young people to register for NHIMA because it is just K40" ***FGD participant, Kabwe Central Hospital***

"...NHIMA is helping us because we know that from the deductions we are getting help and those deductions are not even felt, it's like we don't pay anything" ***FGD participant, Ndola Teaching Hospital***

However, about 49 (6.2 percent) of the total respondents indicated experiencing financial difficulties even after registering for the NHIMA scheme and that the contributions were not affordable as shown in Table 18.

Table 18: *Analysis of Affordability of NHIMA Contributions and Financial Access to Healthcare Services*

Question Type	Number of responses	Those that said 'NO' as a proportion of total responses	Those That said 'YES' as a proportion of total responses
1. Is the NHIMA monthly contribution affordable to you and your household?	781	51 (6.53%)	730 (93.47%)
2. Do you experience any financial difficulties as a result of spending on Health care after registering for NHIMA?	781	732 (93.73%)	49 (6.27%)
3. Were you able to afford financial access to healthcare services before registering with NHIMA?	781	334 (42.77%)	447 (57.23%)

6.9 Knowledge about the NHIMA Benefit Package

Regarding the NHIMA benefit package, 365 (81.7 percent) of the 447 respondents stated that they did not know the benefits package despite being on the scheme. The respondents did not even understand what was contained in the benefits package. However, when probed further, they could generally state some of the services received at the health facilities. Only 82 (18.3 percent) of the respondents indicated knowing the benefits package. See Table 19 below.

"We lack information and we do not know the benefit package" ***FGD participant, UTH new born hospital***

"...I don't know what is under NHIMA and what is not under NHIMA because sometimes it happens that you are given prescription for medicines and when you go there you are just told that this medication is not under NHIMA" ***FGD participant, Chilenje Level1 Hospital***

Table 19: *Knowledge about the NHIMA benefit package*

	Number of responses	As a Proportion of Total Responses
No	365	81.7
Yes	82	18.3
Total	447	100

Two provinces stood out with less than 10 percent of respondents expressing knowledge about the NHIMA benefit package at 3.7 percent for North Western and 5.6 percent for Western province as shown in Table 20.

Table 20: *Knowledge about NHIMA Benefit Package by Province*

Knowledge about	Name of province										
NHIMA benefit package	Central	Copperbelt	Eastern	Luapula	Lusaka	Muchinga	North Western	Northern	Southern	Western	Total
No	81.5	71.1	76.9	62.5	86.5	75.0	96.3	75.0	88.6	94.4	81.7
Yes	18.5	28.9	23.1	37.5	13.5	25.0	3.7	25.0	11.4	5.6	18.3
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

The benefits packages mentioned by 18.3 percent of respondents, included the following breakdown of services with pharmaceuticals and blood products (13.5%), OPD and consultations 72 (12.7%), and Vision care services (10.4%) the most mentioned services as shown in Table 21.

Table 21: *Benefit packages known*

	Number of responses	As a Proportion of Total Responses
1. OPD registration and consultation	72	12.7
2. Pharmaceuticals and Blood products	76	13.5
3. Investigations and diagnostic services	55	9.7
4. Medical and surgical services	53	9.4
5. Maternal, new-born care and pediatric services	48	8.5
6. Oncology services	22	3.9
7. Vision care services	59	10.4
8. Mental health services	20	3.5
9. Dental and oral health services	48	8.5
10. Orthopaedic appliances and prosthesis	23	4.1
11. Services that require pre-authorisation approval	21	3.7
12. In-patient care services	33	5.8
13. Physiotherapy and rehabilitation services	35	6.2
Total	565	100.0

SECTION 7
HEALTH INSURANCE SCHEMES

7.1 Subscription to other Health Insurance Schemes

In addition to being a beneficiary of the NHIMA scheme, 112 (11.3 percent) out of the 988 respondents said they had subscriptions with other health insurance schemes whilst 876 (88.7 percent) did not subscribe to any other insurance scheme and relied on NHIMA for their health insurance. Proportionally, more male respondents had subscribed to other health insurance schemes than female respondents. See Table 22 below:

Table 22: *Analysis of Subscription with Other Health Insurance Schemes & restrictions*

Question Type	Number of responses	Those that said 'NO' as a proportion of total responses	Those That said 'YES' as a proportion of total responses
1. Do you subscribe to any other health Insurance scheme apart from NHIMA?	988	876 (88.66%)	112 (11.34%)
2. Does your other health insurance restrict who can be a beneficiary?	112	48 (42.9%)	64 (57.14%)

In terms of subscription to other health insurance schemes by beneficiary type, contributing members accounted for the majority (91.1 percent) of members contributing to other schemes followed by the beneficiary spouse at 7.8 percent. Table 23 shows the membership status of beneficiaries subscribing to other schemes

Table 23: *Analysis of Subscription With Other Health Insurance Schemes by Beneficiary Type*

Membership status with NHIMA	Subscription to other health Insurance schemes apart from NHIMA		
	Yes	No	Total
1. Contributing Member	616	102	718
2. Beneficiary (spouse)	153	8	161
3. Beneficiary (Child)	9	0	9
4. Beneficiary (dependant)	9	1	10
5. Retiree	61	1	62
6. Vulnerable group	25	0	25
7. Other	3	0	3
Total	876	112	988

7.2 Affordability of Contribution to Other Health Insurance Scheme compared to NHIMA

Of the 112 respondents subscribing to other schemes, 59 (52.7 percent) did not agree that the contributions to other health insurance scheme were more affordable than NHIMA whilst 44 (39.3 percent) respondents said that contributions to other schemes were more affordable.

Nine (8 percent) of the respondents did not know whether other schemes were more affordable than NHIMA or not. This could be attributed to some employers paying for health insurance for their staff which doesn't affect their incomes. See Table 24.

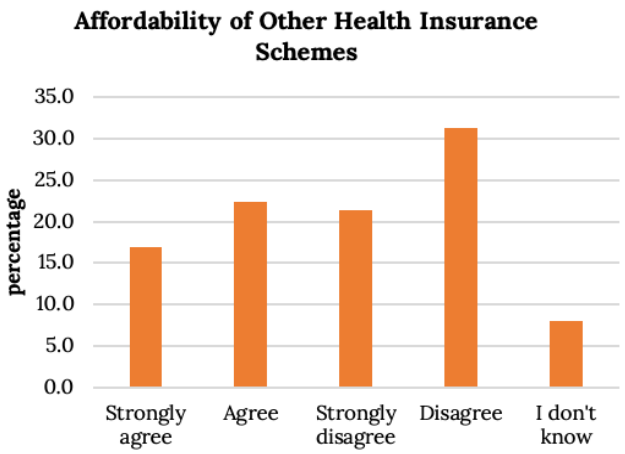


Figure 6: *Affordability of Other Health Insurance Schemes*

Table 24*: Affordability of Other Health Insurance*

Rank	Frequency	Percent
1. Strongly agree	19	17.0
2. Agree	25	22.3
3. Strongly disagree	24	21.4
4. Disagree	35	31.3
5. I don't know	9	8.0
Total	**112**	**100**

7.3 Overall Service Provision for Other Health Insurance Schemes

The overall rating of service provision for the other health insurance schemes was moderately satisfactory. 43.8 percent of respondents indicated service provision was good whilst 23.2 percent said service was excellent. In contrast, 9.8 percent of respondents rated service provision by other health insurance schemes as poor and 23.2 percent as average. This was expressed by the contributing members to NHIMA and other health insurance schemes. See Table 25 below.

Table 25: *Rating the overall service provision for the other health insurance schemes*

	Number of responses	As a Proportion of Total Responses
1. Poor	11	9.82
2. Average	26	23.21
3. Good	49	43.75
4. Excellent	26	23.21
Total	112	100

SECTION 8

HEALTHCARE UTILIZATION BY CLIENT

SECTION 8
HEALTHCARE UTILIZATION BY CLIENT

8.0 Introduction

NHIMA was formed in October 2019 through an Act of Parliament. Over the years, NHIMA has seen an increase in the number of clients using the services provided through accredited health care providers. The value of a health insurance scheme is in its ability to offer quality health care services to its members. This section of the client satisfaction study looks at the utilisation of the health care services under NHIMA.

The section also discusses accessibility challenges related to whether the Health Care Provider (HCP) is a public or private institution, distance to the facility, cost of transport to and from the facility, operational hours and whether clients have opportunities to present some of their challenges to the HCP, among other issues.

8.1 Accessibility

Among the sampled respondents, 75.7 percent (n=748) confirmed having accessed health care services in the past 12 months while the other 24.3 percent (n=240) were accessing the services for the first time. For those confirming to have accessed health care services in the past 12 months, 26.3 percent indicated they had accessed services more than three times while those accessing the services once in 12 months stood at 22.1 percent (n=165). The majority of the respondents had accessed health care services at least twice in the last 12 months. See below Table 26 for more information.

Table 26: *Frequency of Accessing Health Care Services in the last 12 Months*

Frequency of Accessing Health Care Services	Frequency	Percent
1. One time	165	22.1
2. Two times	279	37.3
3. Three times	107	14.3
4. More than 3 times	197	26.3
Total	**748**	**100.0**

When asked on when they last used NHIMA insurance to access health care services, the majority represented by 74.1 percent (n=554) indicated that they used the services in the last three months while those indicating to have used the services between four and six months stood at 19.7 percent (n=147), those indicating between seven and nine months were 4.3 percent, between ten and twelve months were at 1.9 percent with only one respondent indicating to have used the NHIMA insurance in more than 12 months. See Table 27 for details.

Table 27: *Period of last usage of the NHIMA Insurance*

Period of last usage	Frequency	Percent
1. 0-3 months ago	554	74.1
2. 4-6 months ago	147	19.7
3. 7-9 months ago	32	4.3
4. 10-12 months ago	14	1.9
5. More than 12 months ago	1	0.1
Total	748	100

Although most contributors are utilising the NHIMA scheme to access health care services, most of the utilisation is concentrated in the Lusaka province at 43.4 percent (n=325) followed by Copperbelt province at 22.3 percent (n=167) with Muchinga province having the least number of members utilising NHIMA scheme at 1.7 percent.

The finding is consistent with the data shared by NHIMA which shows that the majority of accredited health care providers are in Lusaka followed by the Copperbelt province and the utilisation of services is mainly done in public health facilities at 76.9 percent (n=575) with the remaining 23.1 percent (n=173) indicating to have utilised health care services from private health care providers.

On the hours of operation, 81.1 percent (n=607) indicated that the health care providers operate through out the day while those indicating not to operate on a 24/7 basis were 18.9 percent (n=141). However, the facilities indicated to be operating on a 24/7 basis are mostly hospitals with some laboratories. Some pharmacies were also operating on a 24-hour basis.

One of the issues raised by members was that the NHIMA desk staff only work from 08 to 17 hours from Monday to Friday. In some cases, the NHIMA staff come late for work. Some reporting as late as 10 hours while in some public facilities, they indicated that the assigned NHIMA staff were removed from the facilities and no replacements have been done.

> *"...We try to make a time table; the goal is so that we work the whole night. But we had a challenge with the desk. The problem is the staffing. So initially, when we started, we were given two members of staff, directly employed by NHIMA itself in Lusaka were posted here. After a short time, after about six months, one lady left, she was given a higher position I think at NHIMA headquarters and left one and after a year and some months, the one who remained left. So, we had to start training these other ones. But one of the reasons why at the moment, we are still working the normal working hours up to 17hrs, its because at night there's a reduction, then on the clinical side, they start and the nurses, they know how to carry out those processes and then they try to normalize them during the working hours. But eventually we want the service to be open over the weekends and after hours..."* ***KII Kabwe Central Hospital.***

On whether the HCP has different patient flows for NHIMA and other health insurance schemes, 58.4 percent (n=437) said yes while the other 41.6 percent (n=311) said no. It should be mentioned here that from observation, differentiated patient flows were only observed at registration and consultation for OPD patients while diagnostics/laboratories, treatment and at pharmacies, there was no differentiation. As for IPD patients, in some facilities, dedicated NHIMA wards were available while others only had designated beds in the same ward as NHIMA beds.

> *"...The admission parts where we keep them, I don't think it's satisfactory we don't have proper NHIMA wards, so they still get mixed with ordinary patients but on the outpatient department I think that one they should be happy..."* ***KII Chipata Central Hospital***

In terms of distance from the respondent's residence to the health care provider facility, the majority 42.4 percent (n=317) indicated that they fall within a radius of less than 5km with an average walking time of less than 30 minutes. Those falling between 5km and 10km were 41.7 percent (n=312) while the remaining 15.9 percent resided in places which were more than 10km from the health facility and had average walking times of between 30 to 60 minutes and above 60 minutes, respectively.

Table 28: *Distance covered by the client to the nearest health facility*

Average Distance to the nearest health facility	Frequency	Percent
1. Less than 5km	317	42.4
2. Above 5km but less than 10km	312	41.7
3. Above 10km	119	15.9
Total	**748**	**100.0**

Although the distances and walking times fall within the acceptable range of 5km to the nearest health facility, 26.2 percent of the respondents indicated having challenges in accessing the health care facilities nearer to their homes. Some of the challenges cited were that the facilities were far from their homes (40 percent), transport to and from the health care facility was expensive (42 percent), the nearest facility does not offer the required health services (11.9 percent) and 6.1 percent of the respondents saying that fuel to get to the health care facility was expensive.

Most of the NHIMA accredited facilities are Level 1 to Level 3 hospitals. These are referral facilities who receive clients from health centers and district hospitals. As such, the issue of transport is most of the time involved whenever one wants to seek medical attention. The costs vary depending on where one is coming from.

8.2 Affordability

On the costs of transport paid by the respondents to get to the nearest health care facility from the residencies, the mean cost was calculated at K50.47 while the mode or most paid amount was K30. In terms of percentiles, K12 was paid by the 25th percentile, K30 by 50th percentile and K60 was paid by the 75th percentile of respondents. On whether these transport costs were affordable by the respondents, 73.6 percent (n=727) said that they could afford while those not able to afford stood at 26.4 percent (n=261).

The majority of those confirming to afford the cost of transport from their homes to the health care facilities are either employed as paid public sector employees 48.3 percent (n=351) or paid private sector employees at 25.7 percent (n=187). However, even with the paid public sector and private sector employees, there were other people who could not afford the transport costs.

Those confirming to afford the transport with the paid public sector employees were 83.2 percent (n=351) compared to 16.8 percent (n=71) who said that they could not afford. Those in the private sector employee category who confirmed to affording the transport costs stood at 78.6 percent (n=187) while the remaining 21.4 percent (n=51) said that they could not afford.

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Table 29: *Affordability of Transport Costs by Employment Status*

Employment status	No	Yes
1. Paid Public Sector Employee	71, 27.2%	351, 48.3%
2. Paid Private Sector Employee	51, 19.5%	187, 25.7%
3. Paid apprentice	0, 0%	3, 0.4%
4. Paid intern	0, 0%	1, 0.1%
5. Volunteer (unpaid)	0, 0%	4, 0.6%
6. Retiree / Pensioner	43, 16.5%	31, 4.3%
7. Unemployed	53, 20.3%	66, 9.1%
8. Self employed	43, 16.5%	84, 11.6%
Total	**261, 100%**	**727, 100%**

As earlier mentioned, the costs associated with clients accessing medical services vary from area to area. As an example, clients accessing services from Chipata Central come from areas across the Eastern province and the transport costs range between K100 and K150 from the furthest points in Chipata district.

> *"...It will cost you a minimum of about 100 to 150 Kwacha, that's within Chipata district. That is reaching the hospital, one way, that is from the furthest point, from the furthest point, would be, say, just before Katete, so a patient there would pay K80 to about K100 depending on the time of the day, coming just to the hospital, so the other point would be... I would say look at the border, so in the border area, some would pay about a K50 go come would be about K100, next place would be probably going as far as Lundazi area, you will spend about K120 just one way, coming just to the hospital.*
>
> *So, it's not cheap and depending on the mode of transport, if its taxi, it becomes more expensive, motor bike, it becomes cheaper but it's not safe, in terms of... helmets and whatever is required to move during the night..."* **KII Chipata Central Hospital.**

8.3 Service Provision by the Health Care Provider

On the awareness of health care services offered by the respective health care providers. Respondents were asked to mentioned the services offered by the health care facility they have visited before. The responses were totaled up based on the number of times a particular service was mentioned and percentages of these responses were computed. The table below shows the level of awareness of the different services offered at the sampled accredited health care facilities.

Table 30: *Affordability of Transport Costs by Employment Status*

Service	N	Percent
1. OPD registration and consultation	815	15.9%
2. Pharmaceuticals and Blood products	747	14.6%
3. Investigations and diagnostic services	646	12.6%
4. Medical and surgical services	458	9.0%
5. Maternal, new born care and pediatric services	432	8.4%
6. Oncology services	127	2.5%
7. Vision care services	420	8.2%
8. Mental health services	181	3.5%
9. Dental and oral health services	380	7.4%
10. Orthopedic appliances and prosthesis	188	3.7%
11. Services that require pre authorization approval	136	2.7%
12. In patient care services	329	6.4%
13. Physiotherapy and rehabilitation services	253	4.9%
14. Ambulance Service	1	0.0%
Total		**100%**

The service which most respondents knew about was OPD registration and consultation at 15.9 percent followed by pharmaceuticals and blood products at 14.6 percent with investigations and diagnostic services coming in third at 12.6 percent. The least services to be mentioned were ambulance and oncology services which were at 0 and 2.5 percent, respectively.

On the question of whether the member visited any other facility besides the one they last visited for health care services, the majority 65.2 percent (n=644) said no while the other 34.8 percent said yes. No reasons were provided as to the change or preference in the use of a specified facility.

Clients visiting the health care facilities are attended to by different medical cadres. Most of the clients are attended to by medical doctor's (50.6 percent) followed by nurses at 38.7 percent. Other clients reported to have been attended to a student nurse and laboratory technician at 0.3 percent.

Table 31: *Professionals attending to clients at NHIMA accredited health care facilities*

Medical Cadre who attended to the Client	Frequency	Percent
Community Health assistant	9	2.6
Nurse	133	38.7
Midwife	5	1.5
Medical doctor (including any specialist)	174	50.6
Clinical Officer	6	1.7
Laboratory Technician	1	0.3
Pharmacist	11	3.2
Registry clerk	4	1.2
Student nurse	1	0.3
Total	**344**	**100.0**

8.4 Level of Satisfaction with the service received

Generally, most clients which includes NHIMA members and their beneficiaries were satisfied with the service they last received from an accredited health care facility. Those indicating to be very satisfied stood 16.6 percent while those who were just satisfied was at 70.6 percent. Those reporting not to be satisfied with the service stood at 12.8 percent. This number of unsatisfied clients included those stating to be unsatisfied at 11.9 percent while the very dissatisfied stood at 0.9 percent

Table 32: *Level of satisfaction with the last service received*

Level of Satisfaction	Frequency	Percent
1. Very satisfied	57	16.6
2. Satisfied	243	70.6
3. Unsatisfied	41	11.9
4. Very dissatisfied	3	0.9
Total	**344**	**100.0**

Although most members are generally happy with the service received at accredited health care facilities, there are incidences where they expressed dissatisfaction by both the providers and clients. The shortage of drugs in most health facilities is one of the areas the members are not satisfied with.

> *"...They are not satisfied, especially the out-patients when they go back with prescriptions to buy medicine. So that's the issue. They are not happy because whatever we have had with NHIMA, the stock status of drugs has not been good. So, there are still patients who go out with prescriptions and that they are not happy. Yes, when they get admitted in the hospital, they are given a nice bed, they are given good room which is well done, things like that, so that area they are satisfied..."* ***Chilenje Level One, KII***

The areas members were not satisfied with are the absence of certain services such as pharmacy, diagnostics, that is, laboratory and ultra sound as well as the absence of NHIMA wards at accredited health care facilities.

8.5 Availability of an internal complaint's procedure

The majority 78 percent of the respondents indicated that they were not aware of the presence and procedure for placing any grievances they may have with the health care facility. Only 22 percent of the respondents indicated knowing about the procedures.

Table 33: *Availability of internal complaints procedure*

Availability of Internal Complaints Procedure	Frequency	Percent
No	583	78.0
Yes	164	22.0
Total	747	100.0

Some reports of favouritism on who accesses the service first were heard from some of the respondents during focus groups discussions, and others indicated having experienced unpleasant attitude of health care workers, use of inappropriate language and refusal to provide them with treatment.

Nevertheless, very few people reported having been discriminated against on the basis of age (5), disability (1), health status (8), ethnicity (3), gender (3) or social status (14). The above numbers are absolute based on responses recorded from 988 respondents.

SECTION 9

PERCEPTIONS OF QUALITY OF CARE

9.0 Introduction

There were mixed reactions regarding the time that respondents took to be served in the queue. Some respondents noted that they spent a long time in the queue because at times there is only one clinician available who has to attend to various patients with different complaints. Respondents mentioned that they are served on a first come first serve basis unless it's an emergency. Emergencies are a priority at most stations but because of the long queues, some hospitals end up practicing favoritism where a known patient/ person is attended to earlier than others regardless of their condition (urgent or non urgent). An example is Kabwe Central Hospital which is almost always full such that they end up favouring those that they know. This results in some patients going back home without receiving any treatment.

About 78.9 percent, (N=988) mentioned that they find long queues when they visit the NHIMA accredited health facilities. Analysis by province shows that many/ long queues in NHIMA accredited health facilities were prevalent in Northwestern province (88.9 percent), followed by Luapula (82.5 percent) and Copperbelt (81.6 percent). However, the association was not statistically significant (p=.495). About 30 percent of respondents mentioned that they wait 15–30 minutes before they are attended to at the accredited health facilities followed by 25.4 percent who mentioned less than 15 minutes and around 17 percent mentioned more than 60 minutes (Figure 8 and 9).

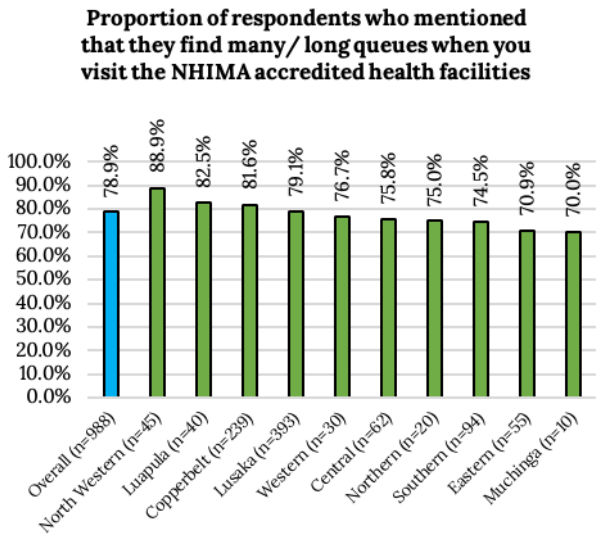


Figure 7: *Many or Long queues found at Accredited NHIMA health facilities*

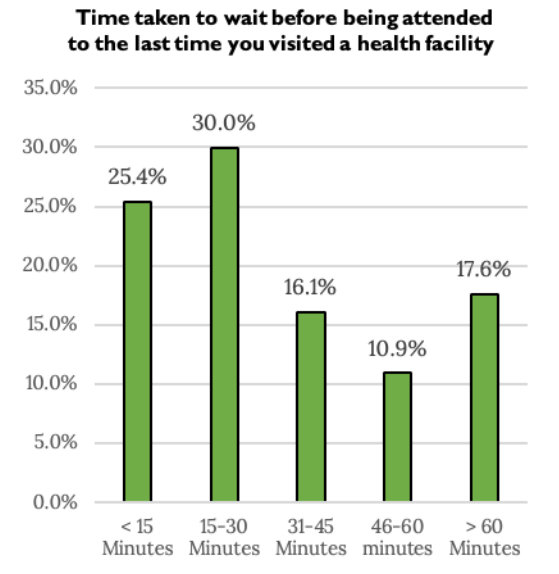


Figure 8: *Time taken before being attended to the last time you visited a health facility*

There are also mixed reactions regarding the attitudes of health care workers. Some respondents mentioned that the workers' attitude was accommodating. Respondents noted that there is a lot of care from the doctors, and they look after patients well. On the other hand however, it was reported that a few doctors and nurses are frustrated because they are overwhelmed with work. As a result, they can be rude to patients and even shout at them. Additionally, some doctors go for urgent meetings without notifying the patients queuing to be served. Patients end up waiting without knowledge as to when they will be served.

Respondents were asked if the health facility staff greeted them, around 47 percent of them mentioned that some of the health facility staff greeted them whilst 44.4 percent mentioned that all the health facility staff greeted them. It is worth noting that around 8 percent mentioned that the health facility staff did not greet them. Analysis of data by gender of respondents who mentioned that all health facility staff greeted them were males (47.1 percent) as compared to females (42.6 percent). However, those who mentioned that some of the health facility staff greeted them were females (48.4 percent) when compared to males (44.9 percent).

Respondents were further asked on how they would then describe the behaviour of health care workers towards patients. Slightly over half of them (52 percent) mentioned that health staff members were helpful, 23 percent mentioned that they were courteous and accommodating and 15 percent mentioned that health workers were empathetic. It is worth noting that 5 percent and 4 percent of the respondents mentioned that health workers were not sensitive and rude respectively as shown below.

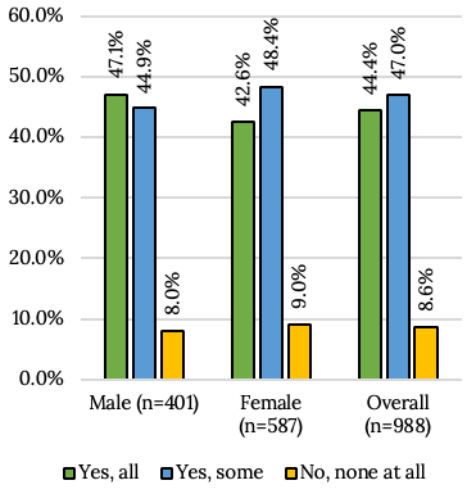


Figure 9: *Respondents greeted by staff from the NHIMA accredited facilities*

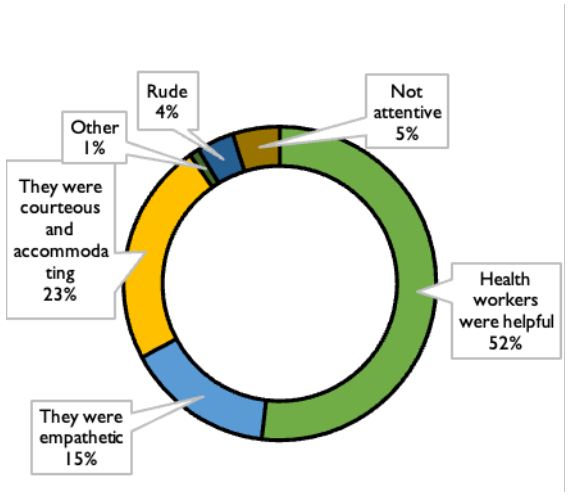


Figure 10: *Behaviour of health care workers towards patients*

Further, respondents were asked if the health care workers are quick to attend to patients, about (51.5 percent) mentioned that some of them are quick to attend to patients, 38.8 percent mentioned that all of them are quick to attend to patients whilst around 9 percent of the respondents mentioned that none of the health workers are quick to attend to patients, see Figure 12 below.

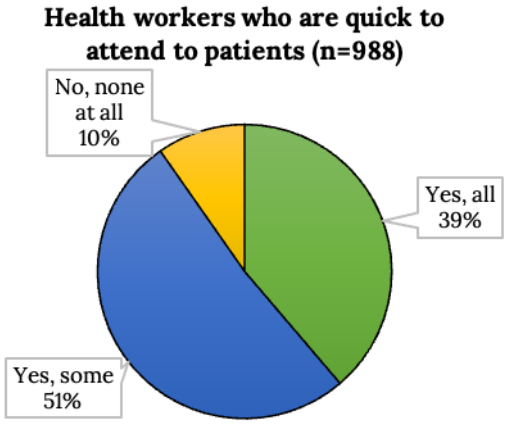


Figure 11: *Health workers who are quick to attend to patients*

Respondents were also asked about the cleanliness of the environment and on availability of hand washing and hand sanitization services to prevent COVID-19 at the health facilities. Responses from the FGDs revealed that the health facilities were mostly clean. There were some health facilities where respondents raised concerns. For instance, the sanitation situation at St Francis Mission Hospital is reported to be in a bad condition especially in the wards. The ablution blocks are also said to be dirty as well as the lockers. The respondents have suggested that the lack of cleanliness is due to shortage of workers.

Additionally, it emerged from the FGDs that the University Teaching Hospital (UTH) was also in a bad space with old paint on the walls and old floors. Moreover, the wards sometimes do not have water hence making it difficult to practice the recommended hygiene and sanitation standards. More specifically, respondents were asked if the health care workers

keep the place/environment clean or neat. The results show that more than 90 percent of the respondents were affirmative. About 68 percent of the respondents mentioned that health facilities have hand washing/ sanitizing place at the entrance, however only 33.3 percent of the respondents mentioned that they were asked to wash their hands or sanitize to prevent COVID-19 as shown by the figure below.

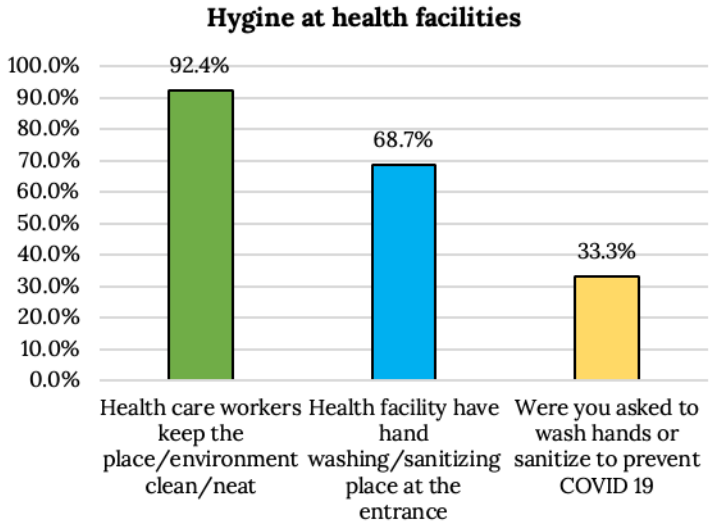


Figure 12: *Hygiene at health facilities*

The registration process for most respondents seems to be a simple and less cumbersome process. The majority of the respondents noted that the registration process did not take long although very few respondents found the registration process burdensome for them. About 14.3 percent of the respondents cited that they were asked to buy a new registration book during their registration and the rest (85.7 percent) mentioned that they were not asked to buy a new book during registration process. Regarding the length of time taken for registration, 41.1 percent said the process took less than 15 minutes, 33.8 percent mentioned that it took them 15–30 minutes and 12.6percent mentioned that it took them 31–45 minutes. Furthermore, they were asked if they were satisfied with the registration process, a greater proportion of (73.2 percent) mentioned that they were satisfied and 17.3 percent mentioned that they were very satisfied with the registration process. It is worth noting that less than 1 percent mentioned that they were very dissatisfied and 8.6 percent mentioned that they were unsatisfied with the registration process as shown in the figures below.

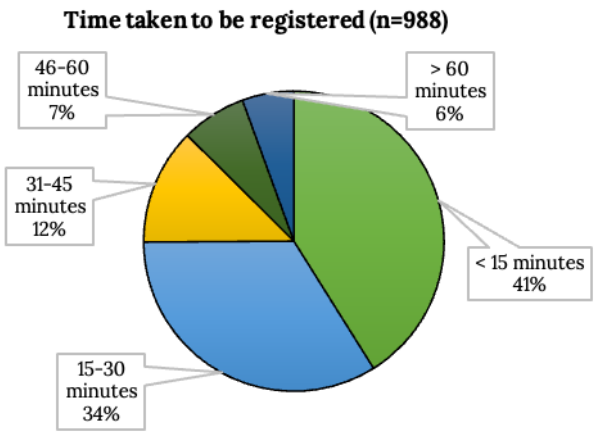


Figure 13: *Time taken to be registered*

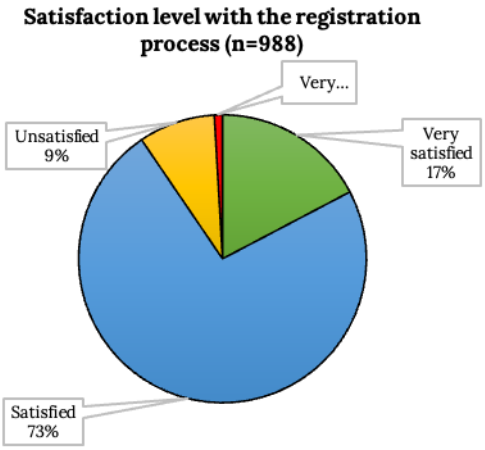


Figure 14: *Satisfaction level with the registration process*

9.1 Description

Respondents were asked if they were required to have vitals like temperature, blood pressure or weight to be checked during their last visit to the health facility. Most of the respondents mentioned that they had their vitals checked although a few noted that they only had BP checked but not temperature. One respondent revealed that one of the facilities did not have a BP machine.

The results show that 89.4 percent were affirmative and, these sentiments were common among male respondents (90 percent) when compared to female respondents (88.9 percent). Those who mentioned that vitals were taken, were further asked on how long they waited before they were attended to and results show that it took less time, more than half of the respondents (53.5 percent) mentioned less than 15 minutes, followed by 30.5 percent who mentioned 15–30 minutes and 10.1 percent who mentioned 31–45 minutes.

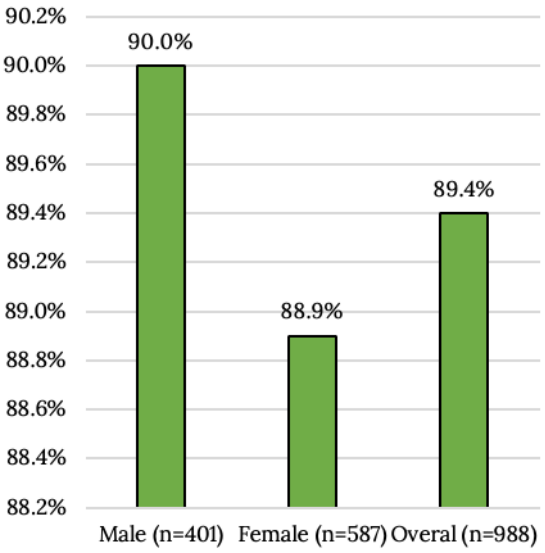
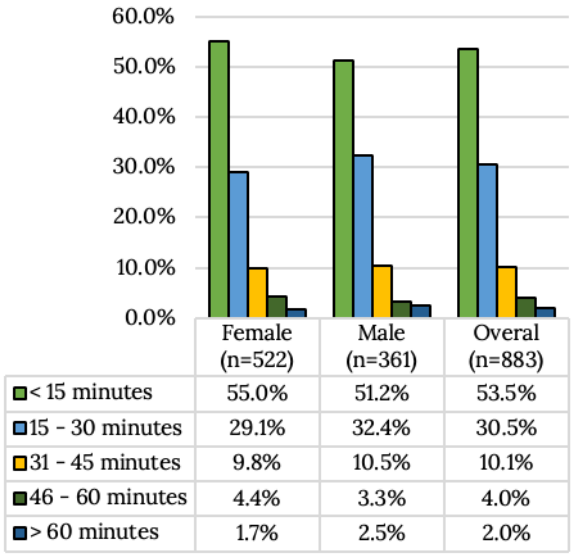


Figure 15: *Proportion of respondents who mentioned that they were required to have vitals like temperature, Blood Pressure or Weight checked during the last visit to the health facility*



	Female (n=522)	Male (n=361)	Overal (n=883)
< 15 minutes	55.0%	51.2%	53.5%
15 - 30 minutes	29.1%	32.4%	30.5%
31 - 45 minutes	9.8%	10.5%	10.1%
46 - 60 minutes	4.4%	3.3%	4.0%
> 60 minutes	1.7%	2.5%	2.0%

Figure 16: *Waiting time for vitals capturing*

Further, they were asked if there were waiting bays with seats available at vitals capturing stations. Around (93 percent, n=883) mentioned in affirmation to availability of bays with seats. Respondents were asked if the health care workers checked their vitals including blood pressure, temperature, weight, pulse, and respiratory rate.

Over 95 percent mentioned that their vitals were taken and, 66 percent of them mentioned that health care workers explained the readings to them after checking the vitals.

When asked if there was anything unusual about their vitals (such as raised or low BP, heart rate or temperature), only 31 percent were affirmative, 54 percent mentioned there was nothing unusual, and 15 percent mentioned that they did not know.

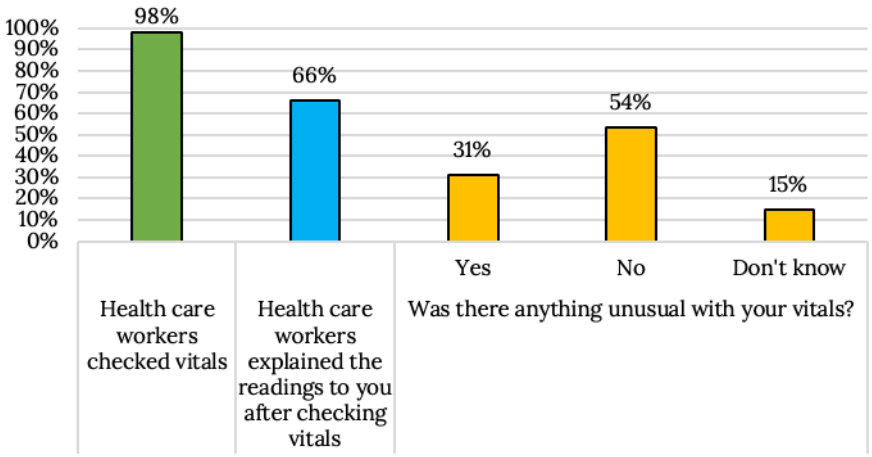


Figure 17: *Vitals taken when visiting the health facility*

Generally, the majority of respondents showed satisfaction regarding the process of vital readings. Respondents from the FGDs cited that they were in a position to ask questions about their readings and the nurses were happy to explain to them.

Most respondents also stated that the process of vital readings was generally within a reasonable timeline with the majority of respondents mentioning that the process usually lasted 30 minutes or less. Around (60 percent, n=883) mentioned that they were allowed to ask questions concerning vital readings.

Additionally, respondents were asked on how long it would take for the whole vitals checking process to be done, most of them mentioned less than 15 minutes (62 percent), followed by 26 percent who mentioned 15–30 minutes and 8 percent who mentioned 31-45 minutes.

Further, they were asked on how they were satisfied with vitals taking process, 80 percent were satisfied, 17 percent were very satisfied and only 3 percent mentioned that they were unsatisfied, see figure below.

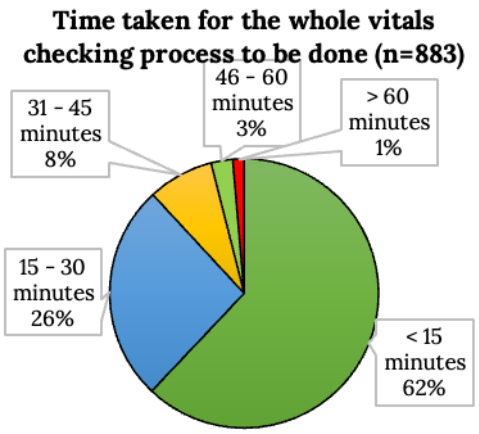


Figure 18: *Time taken for the whole vitals checking process to be done*

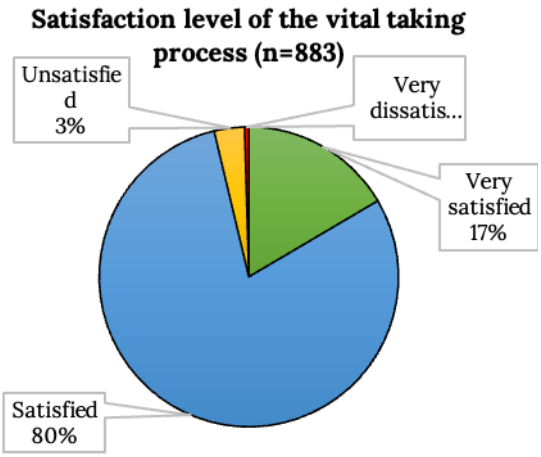


Figure 19: *Satisfaction level of the vital taking process*

9.2 Description

The consultation process is said to be reasonable by most respondents. The majority of respondents from the FGDs stated that consultation did not exceed an hour although in some cases there are respondents that noted that consultation could go for more than an hour. These were however very few. The majority of respondents were attended to within reasonable time. During consultation, the majority of doctors took time to respond to questions that patients might raise during consultation. They were also examined to their satisfaction with some being referred for further investigation after examination. For most respondents, privacy was maintained during consultation. About 31.3 percent mentioned that they took 15-30 minutes, followed by 30.4 percent who mentioned less than 15 minutes and 14.2 percent who mentioned more than 1 hour. When it comes to the whole consultation process around 42 percent mentioned less than 15 minutes, 34.8 percent mentioned 15–30 minutes and 11.9 percent mentioned 31-45 minutes. Around 95 percent mentioned that there were benches or chairs for clients to wait from in the consultation room.

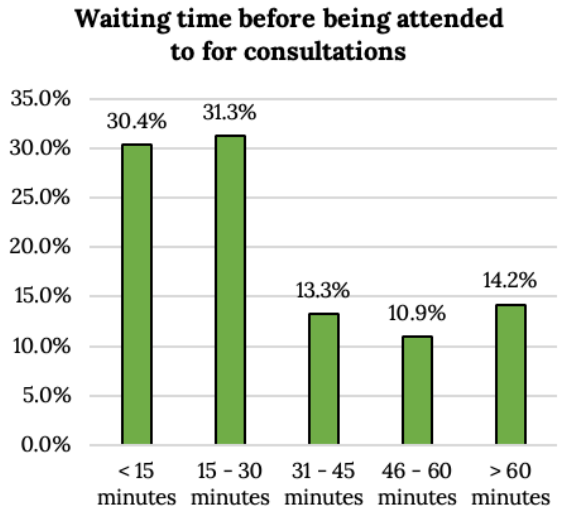


Figure 20: *Waiting time before being attended to for consultations*

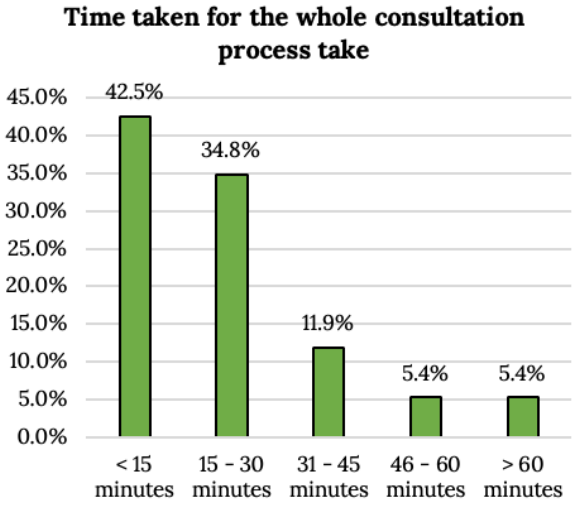


Figure 21: *Time taken for the whole consultation process take*

Around 95 percent mentioned that health workers took time to listen and examine them to their satisfaction during consultation. About 45 percent mentioned that they were referred for investigation after being examined for example, radiology, blood tests, ultrasound, MRI, CT scan etc. Respondents were also asked if the health workers explained the diagnosis, the result of the diagnosis as well as the course of treatment and the results show that 80.6 percent were affirmative. Around 90 percent of the respondents mentioned that the doctors or nurses prescribed drugs for them. When asked about privacy in the consultation rooms, 94.7 percent mentioned that there was privacy for their comfort during the consultation. Respondents were also asked if in the past year, if they had any member of their family admitted in the hospital after the consultation process and results show that only 17 percent were affirmative. Respondents were asked on their overall satisfaction with the consultation process, most of them (76 percent) were satisfied with the consultation process and only 7 percent were unsatisfied.

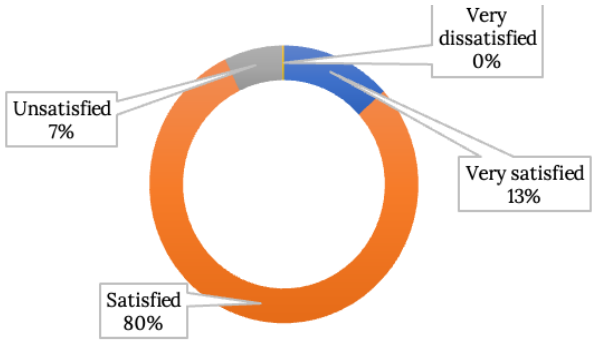


Figure 22: *Satisfaction level with the consultation process*

Description

Most health facilities gave results of tests conducted to respondents within a turnaround time of two to three weeks and by all means these results are explained to patients to their satisfaction.

Respondents were asked if the health facility staff carried out ordered investigations/tests on respondents, 95 percent were affirmative and around 92 percent of them mentioned that health facility staff gave them the results for the tests conducted in their last visit. In addition, 81 percent mentioned that health facility staff explained the test results to them in detail.

Respondents were asked on the actual tests that were done on them, the results show that the tests which were common are blood tests (45 percent), followed by X-ray (23 percent) and ultra-sound (10 percent), see figure below:

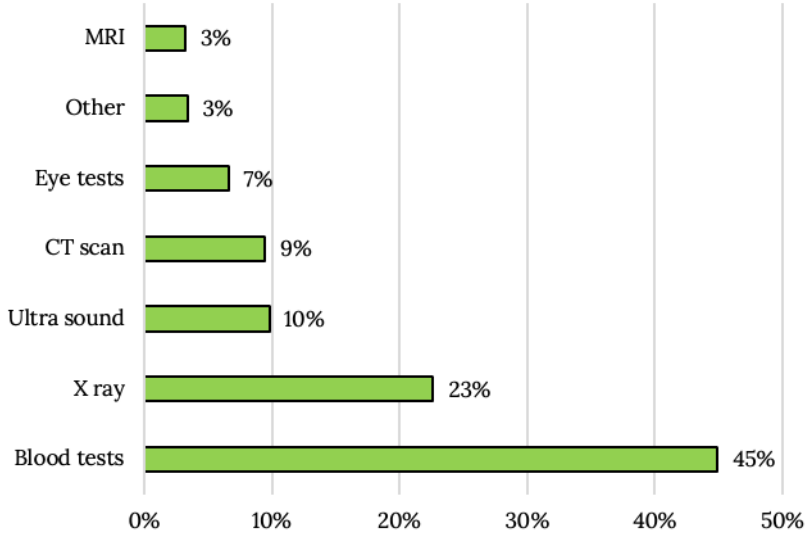


Figure 23: *Tests conducted*

Most health workers took care to follow infection prevention measures when conducting various tests and also ensured that patients received privacy when undergoing tests as well as when disclosing results. Results show that 84.8 percent mentioned that health workers attending to them follow infection prevention measures when conducting tests e.g. changing gloves, sanitizing/hand washing.

Respondents were further asked if they paid for any tests which were conducted with 4.4 percent, (n=447)) mentioning that they paid for the test. The common test which was paid for is blood tests. In terms of privacy during disclosing of results, 92 percent of the respondents mentioned that there was privacy during disclosure of results.

In general, respondents were asked on how long they waited before being attended to for diagnostic tests and 39 percent mentioned 15–30 minutes, followed by 33 percent who mentioned less than 15 minutes and 10 percent who mentioned 31–45 minutes. Additionally, respondents were asked on how long they spent doing investigation tests during their last visit.

The results show that 35 percent mentioned 15–30 minutes, followed by 34 percent who mentioned less than 15 minutes and 14 percent who mentioned 31-45 minutes. The results also show that 96.6 percent of the respondents mentioned that they are benches or chairs for clients to wait from.

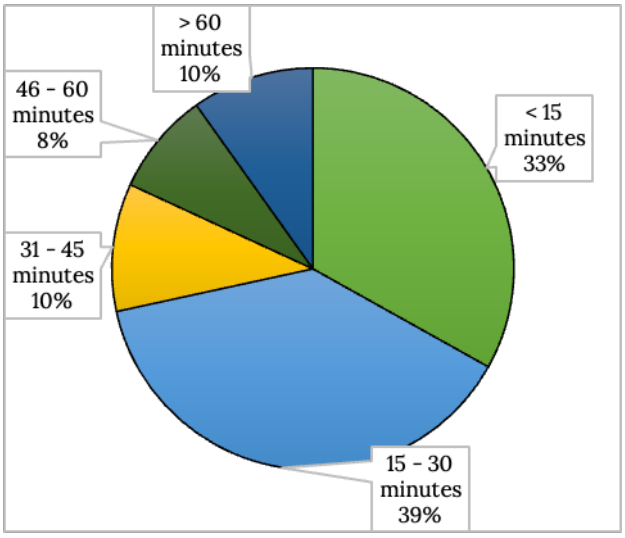


Figure 24: *Waiting time before being attended to for diagnostic tests*

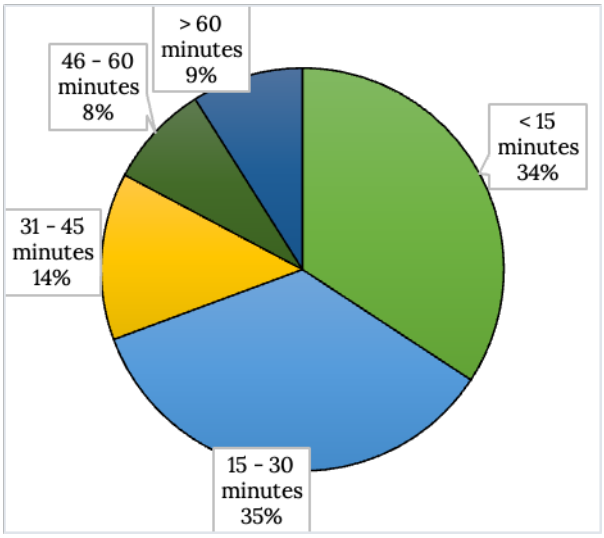


Figure 25: *Time spent doing investigation tests*

Respondents were asked if they felt that the personnel in the diagnostic departments are competent enough to their satisfaction and 81.7 percent were affirmative. Respondents were also asked on their level of satisfaction with the whole process of investigation/testing. The results show that, 76 percent of the respondents were satisfied while 17 percent mentioned that they were very satisfied, and 6 percent mentioned that they were unsatisfied as shown below.

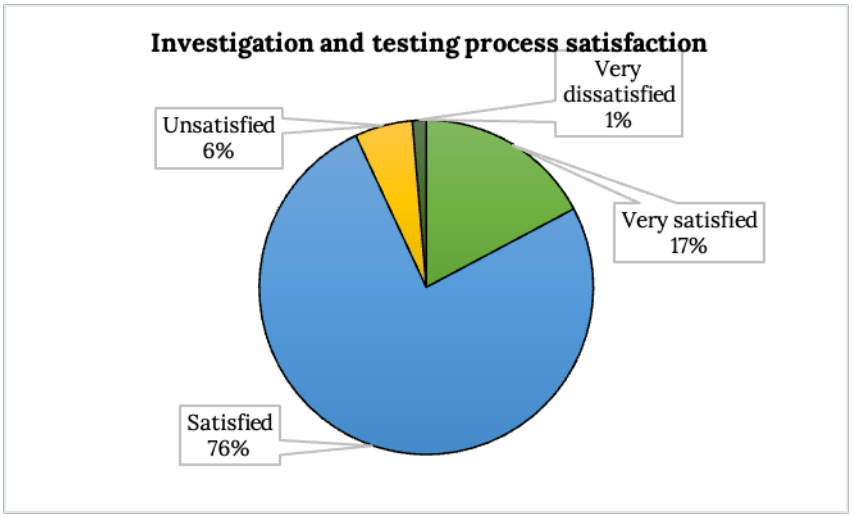


Figure 26: *Investigation and testing process satisfaction*

Description

With regard to pharmacy services, some respondents from FGDs expressed positive sentiments asserting that they have access to all the medication they need from the NHIMA pharmacies without paying for them. However, there were others that expressed complaints regarding the distances travelled to nearest pharmacies. In some areas there is only one NHIMA accredited pharmacy which becomes a problem for most patients when that particular pharmacy does not have the required drugs.

Some pharmacies are also not well stocked such that they are always having shortages. FGDs with respondents from Chilenje level 1 hospital complained of its lack of drugs with one respondent stating that they have on several occasions only got Panadol as the other drugs were unavailable.

Perception on the quality of pharmacy services was also assessed and respondents were asked on the duration they waited in the pharmacy before being served. The results show that it takes 15 minutes for 63 percent of the respondents before being attended to at the pharmacy. In general, it takes less time being at a pharmacy.

On the other hand around 65 percent of the respondents mentioned that it takes less than 15 minutes at the pharmacy with only 1 percent taking more than an hour. See figures below for detailed analysis.

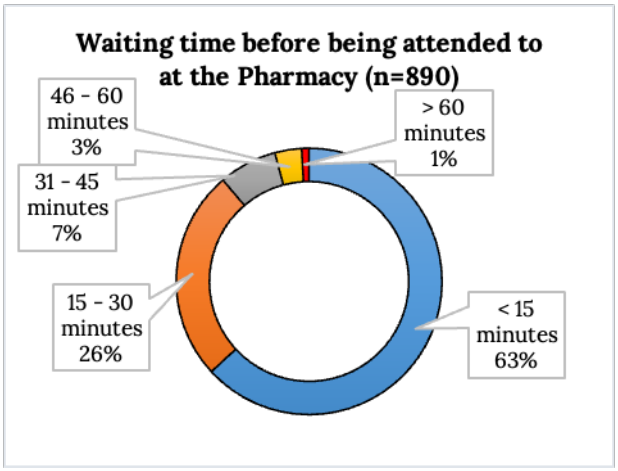


Figure 27: *Waiting time before being attended to at the Pharmacy*

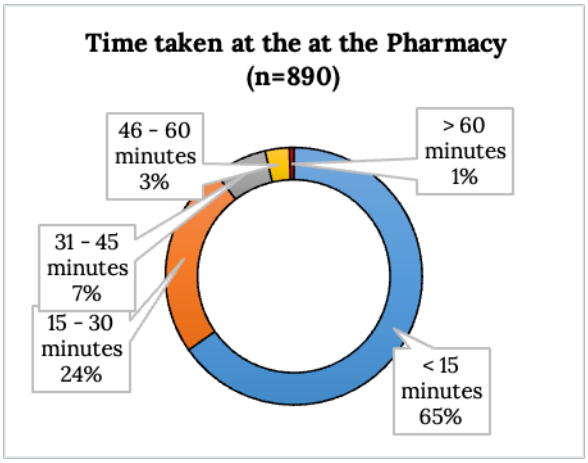


Figure 28: *Time taken at the at the Pharmacy*

When asked if they got all the drugs from the pharmacy, the results show that 57.3 percent of the respondents mentioned that they got all the drugs from the pharmacy. A proportion of 64.3 percent of the respondents mentioned that they were given a prescription to buy some drugs. This show that not all the drugs are found at the pharmacy.

Respondents who got the drugs were asked if the staff at the pharmacy explained the drug usage to them in detail to their satisfaction, around 93 percent were affirmative. Their experience at the Pharmacy was shown by the results in the figures below with 42.8 percent mentioning that it was good during their last visit. About 41 percent rated the experience as average. When it comes to overall satisfaction, respondents were asked how satisfied they were with the whole process of collecting drugs from the pharmacy.

The result show that overall satisfaction was better with most of the respondents (69.3 percent) reporting that they were satisfied, see Figure 30 for detailed results.

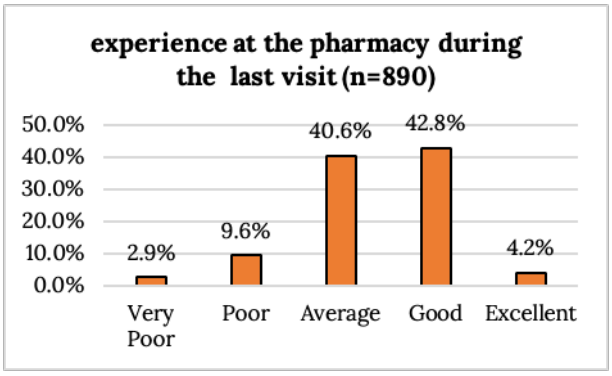


Figure 29: *Experience at the pharmacy during the last*

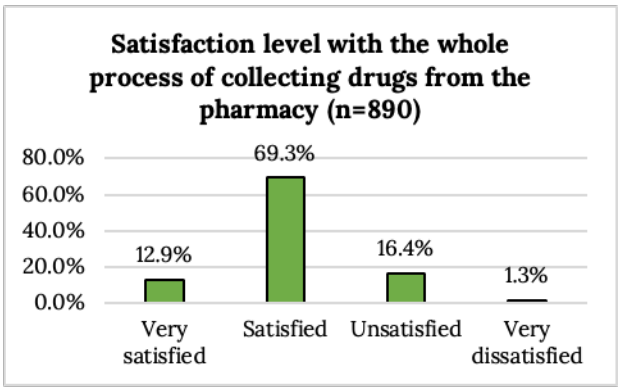


Figure 30: *Satisfaction level with the whole process of collecting drugs from the pharmacy*

Description

There are mixed reactions from respondents regarding admission services. While most respondents expressed positive sentiments regarding admission in wards; other respondents were unhappy about admission services. Those that viewed admission positively were happy about allocation of beds, the state of the wards and the services that they received while they were admitted. For those that showed dissatisfaction regarding admissions, it was mainly due to general ward placement, expenditure on medical consumables etc. For instance, one respondent from the FGDs mentioned that when he was admitted at Copperbelt hospital under NHIMA, he was placed under general wards due to the hospital's congestion. The medicine that he needed was also not available and so was issued with a prescription to buy the medicine elsewhere.

Other respondents also expressed the same sentiments about being admitted together with the general patients. They feel that they pay enough money to be admitted in private wards. Another disgruntled patient who was involved in an accident and was admitted at St Francis Mission Hospital had to have his hospital expenses paid by his company and yet he had been contributing to NHIMA. Moreover, he had to buy the medicines he needed because NHIMA had failed to provide.

A proportion of 17 percent of the respondents mentioned that they were either admitted or had a member of their family admitted in the hospital after consultation process. Most of them were females (17.5 percent) as compared to males (16.2 percent). According to age disaggregation, results show 20.2 percent of respondents were between 55–64 years, followed by 19.1 percent (65+ years) and 18.4 percent (45–54 years), see below.

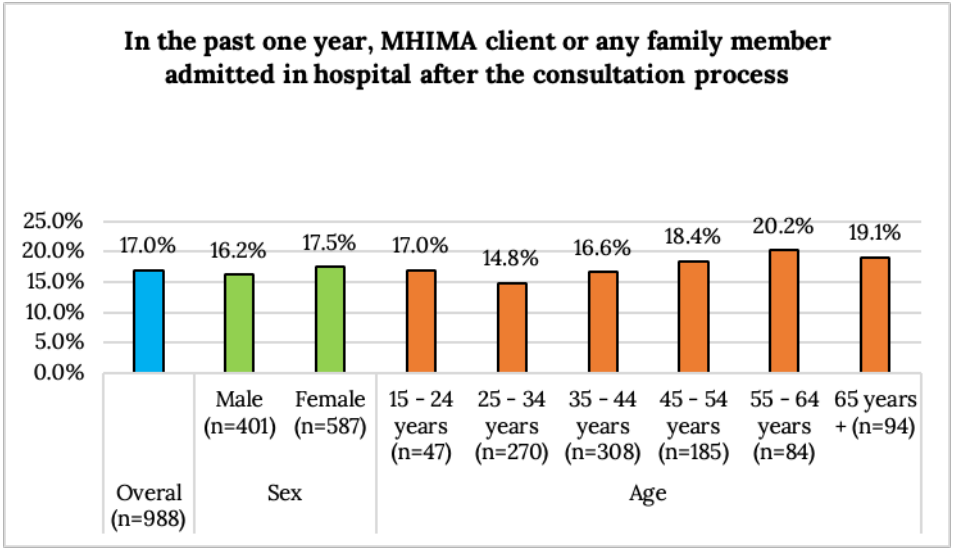


Figure 31: *In the past one year, NHIMA client or any family member admitted in hospital after the consultation process*

Respondents who mentioned that they were admitted, were also asked the length of time for their admission. Half of the respondents (50 percent) mentioned that they were admitted for one to three days, 19.6 percent mentioned for four to six days, 15.5 percent mentioned above 10 days and 14.9 percent mentioned 7 to 10 days.

When it comes to queues, 35.1 percent mentioned that there were long queues of patients waiting to be admitted. They were further asked on the length of the waiting period before being attended to by a nurse at the ward. Most of the respondents mentioned that they waited less than 15 minutes (49 percent), followed by 30 percent who mentioned 15–30 minutes and 8 percent mentioned greater than 60 minutes.

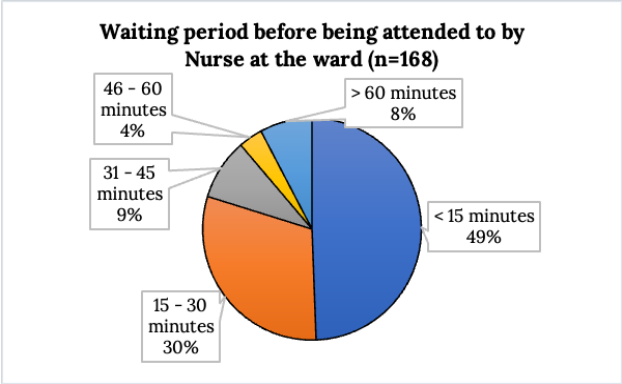


Figure 32: *Waiting period before being attended to by Nurse at the ward*

In terms of bed spaces, respondents were asked if they were enough bed spaces, 74.8 percent were affirmative. Further, it shows that the bedding in the wards are clean with 75 percent of the respondents in affirmative. Respondents were also asked if the bed net had mosquito nets and only about 21.4 percent were in agreement. Respondents were also asked about the time taken for them to be allocated a bed space and more than half (55 percent) mentioned that it took them less than 15 minutes as shown below.

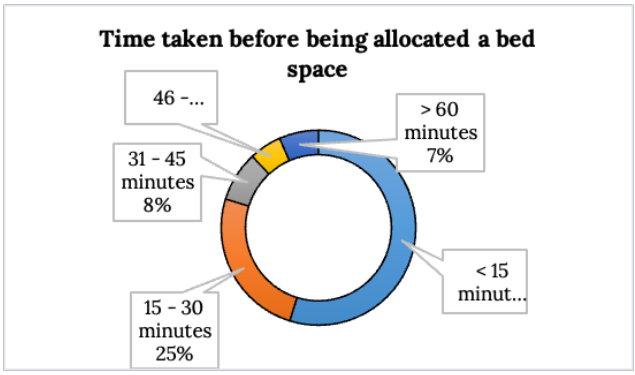


Figure 33: *Time taken before being allocated a bed space*

Respondents were asked if they were accommodated in a low cost or high-cost ward and results show that most respondents (38.1 percent) were allocated NHIMA wards, followed by 29.2 percent who mentioned that they were allocated to low-cost wards and 20.8 percent mentioned being allocated to high-cost wards as shown in Figure 34 below.

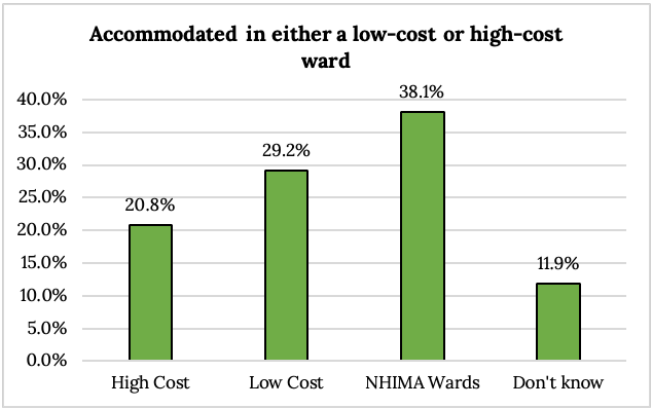


Figure 34: *Accommodated in either a low-cost or high-cost ward*

When asked if hospitals allow a relative/anyone to be by the patient bedside, 89.3 percent were affirmative. The results also show that there is provision of meals for the admitted patients with 68.5 percent mentioning that they were given meals when they were admitted. The inclusion of people with disabilities was also assessed where about 13.7 percent of the respondents interviewed mentioned that they have some activity limitation. They were further asked if the facility had wheelchair ramps and 65.5 percent were affirmative with only 25.6 percent saying the facility they went to had handicap toilets.

Description

Key to this section is the perception of the quality of the services provided by NHIMA looking at access, Value for Money (VFM) principles, the effectiveness of the customer feedback mechanisms as well as providing an overall satisfaction rate on the quality of health care services under NHIMA.

Locality for all provinces was taken to be the district while for Lusaka province, it was understood from the sub-district levels of Lusaka district which are Chawama, Chelstone, Chilenje, Chipata, Kanyama and Matero. The majority of the respondents, that is, 61.1 percent (n=604) indicated that they know an NHIMA facility in their locality while the other 38.9 percent said that they didn't know. Although not all the people indicated knowing an NHIMA facility in their locality, they still felt that an NHIMA-accredited healthcare provider in their area was able to sufficiently meet the quality of healthcare services needed.

Perception of quality of NHIMA insurance was assessed with some gaps identified. Most respondents expressed concerns regarding the quality of NHIMA insurance. Gaps that emerged from the FGDs included that NHIMA was at times unable to cover a number of processes such as getting medicine from their accredited pharmacies, admissions and at times even consultation. In accessing the services in question, there are instances when respondents were asked to use their own cash for these services that could not be accessed under the NHIMA scheme. The summary of some of the verbatims are as follows:

> *"NHIMA services they're not that okay at the moment because for you to come here you've to go in a queue. Then also as she was saying the drugs are not available there's a payment linked to NHIMA for you to have that medication but when you go there even they don't have it, so meaning you've to go and buy. So let NHIMA improve on medication where they're saying this chemist is linked to NHIMA let them buy a lot of drugs so that we can enjoy the services".* **FDG, Choma General Hospital, Choma**

> *"You have to do more on the coverage of medicines, there are certain times when they keep on referring you. So, you have to do more because sickness comes at any time, whether you have money or not. That is why we are saying, certain services are not covered under NHIMA. For example, in certain laboratories where the NHIMA does not cover certain tests, now where do you get the money and you are already sick?*
>
> *For example from Solwezi, I was referred to Lusaka and I couldn't just come alone, and the fact that I depend on my monthly salary, because we have other people we need to support and coming here, we need to lodge and then been told that we need to pay for certain services. Help us so that we are able to understand because we all leave our families home and we fund that we need to travel to the lab and pharmacies and be told there is no medicine".* **FDG, University Teaching Hospital Lusaka**

> *"The challenge we have is a lack of medicines and when I go to their pharmacies, last time I passed through all the pharmacies accredited by NHIMA in Cairo Road and there was no medicine in all the pharmacies, so that is the problem. When you go back for review, you find there are no medicines".* **FDG, University Teaching Hospital Lusaka**

Table 34: *Analysis of Responses on Service Satisfaction, VFM, OOPs, and Sufficiency of NHIMA Services, 2022*

Question Type	Number of responses	NO' as a proportion of total responses	YES' as a proportion of total responses
1. Do you feel you get satisfaction and value for your money in the way NHIMA provides health care insurance services to its clients?	988	206 (21%)	782 (79%)
2. Is the named facility or those on the list of NHIMA-accredited facilities sufficient to meet the quality health care services needed?	988	275 (28%)	713 (72%)
3. In the last 12 months, did you spend money directly or indirectly to access health care services/ treatment despite being on NHIMA?	988	573 (58%)	415 (42%)
4. Does NHIMA sufficiently cover medical services or medicines that you access at a health care facility/provider?	988	300 (30%)	688 (70%)

Table 34 shows that out of the total sample of 988 respondents that accessed services under NHIMA, 79 percent (n=782) indicated that they are satisfied and get value for money in the way that NHIMA provides services to them. Further, 72 percent (n=713) of the total respondents agreed that the listed NHIMA-accredited facilities meet the quality health care services needed. However, for those that accessed health care services in the last 12 months 42 percent (n=415) of the respondents indicated that they spent some money despite being NHIMA clients This being said, there are also clients on the other hand that spoke positively regarding NHIMA insurance for it was able to cover the services that they needed (n=688, 70%).

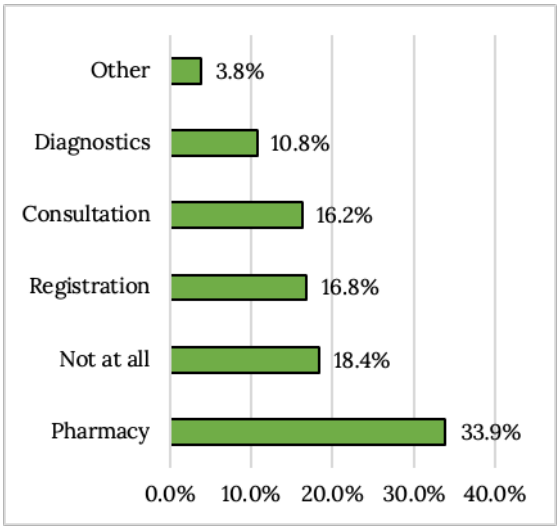


Figure 35: *Line of service delivery where gaps were noticed*

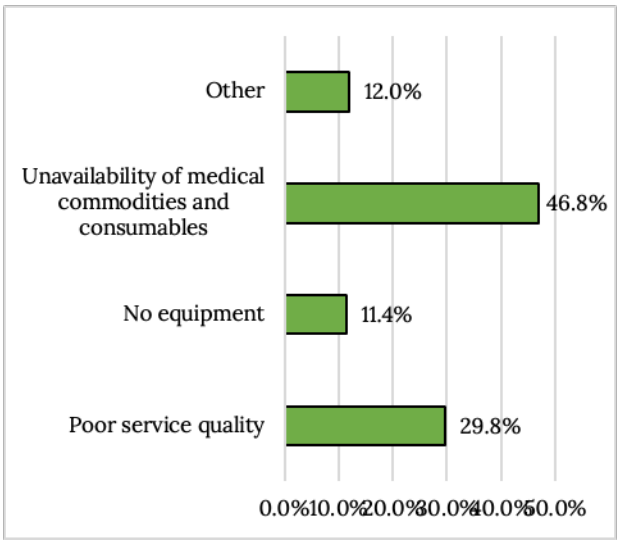


Figure 36: *Gaps noticed in the way services are provided under NHIMA*

The responses also showed gaps in the following areas: in pharmacy (33.9 percent), registration (16.8 percent) and consultation (16.2 percent). Upon asked on the specific gaps noticed in the way services were provided under NHIMA, 46.3 percent mentioned the unavailability of medical commodities, 29.4 percent mentioned poor service and 11.4 percent mentioned lack of equipment, see Figures 35 and 36 above.

For the 415 (42 percent) respondents who had in the last 12 months spent money directly or indirectly to access health care services or treatment despite being on NHIMA, more than half (62 percent) of the responses cited a lack of drugs, medical supplies, and equipment at the accredited facility. 12 percent was due to accessing a service that was not in the benefits package, 10 percent was because they could not find service or expertise at the facility, 8 percent due to lack of information, 4 percent due to long distances to the facility, and others 4 percent was mainly due to long queues at facility, long approval processes, being given only substitute drugs, services unavailability on weekends, see Table 35.

Table 35: *Analysis of the Reasons for Spending Money, 2022*

Question Type	Number of responses	As a proportion of total responses
1. Lack of drugs, medical supplies and equipment	348	62%
2. Accessed a service beyond benefits package	69	12%
3. Could not find service or expertise at the facility	56	10%
4. Lack of information	44	8%
5. Long distance to the facility	24	4%
6. Others (long queues, long approvals process, only substitute drugs, services unavailable on weekends)	22	4%
Total	563	100%

The three top service areas that were paid for by NHIMA clients were; pharmaceuticals and blood products (54 percent), investigations and diagnostic services (12 percent), and medical and surgical services (8 percent) as seen in table 36 below.

Table 36: *Analysis of what services money was spent on, 2022*

Question Type	Number of responses	As a proportion of total responses
1. Pharmaceuticals and Blood products	317	54%
2. Investigations and diagnostic services	71	12%
3. Medical and surgical services	45	8%
4. OPD registration and consultation	38	6%
5. Vision care services	25	4%
6. Dental and oral health services	22	4%
7. Maternal, newborn care and paediatric service	15	3%
8. In patient care services	14	2%
9. Physiotherapy and rehabilitation services	13	2%
10. Services that require pre-authorization on approval	9	2%
11. Orthopaedic appliance and prosthesis	7	1%
12. Mental health services	7	1%
13. Others (Oncology services, P.O.P, Kidney stone, Pregnancy scan, and blood test)	7	1%
Total	590	100%

While NHIMA has been helpful to most respondents, some respondents have faced challenges as the scheme has failed to cover for the services they medically needed to access. About 72.9 percent mentioned that they did not encounter any problems during the time they sought services under NHIMA, however, 27.1 percent mentioned that they encountered some problems, see table 37 below.

Table 37: *Analysis of what services money was spent on, 2022*

Question Type	Number of responses	'NO' as a proportion of total responses	'YES' as a proportion of total responses
Did you encounter any problem(s) during the time you were seeking the service under NHIMA?	988	720 (72.9%)	268 (27.1%)

They were further asked on the problems they encountered and the top three problems encountered were shortage of drugs (32.5 percent), followed by poor service delivery from NHIMA agents and the HCP (19.8 percent) and approval process taking long (10.8 percent), see Figure 37.

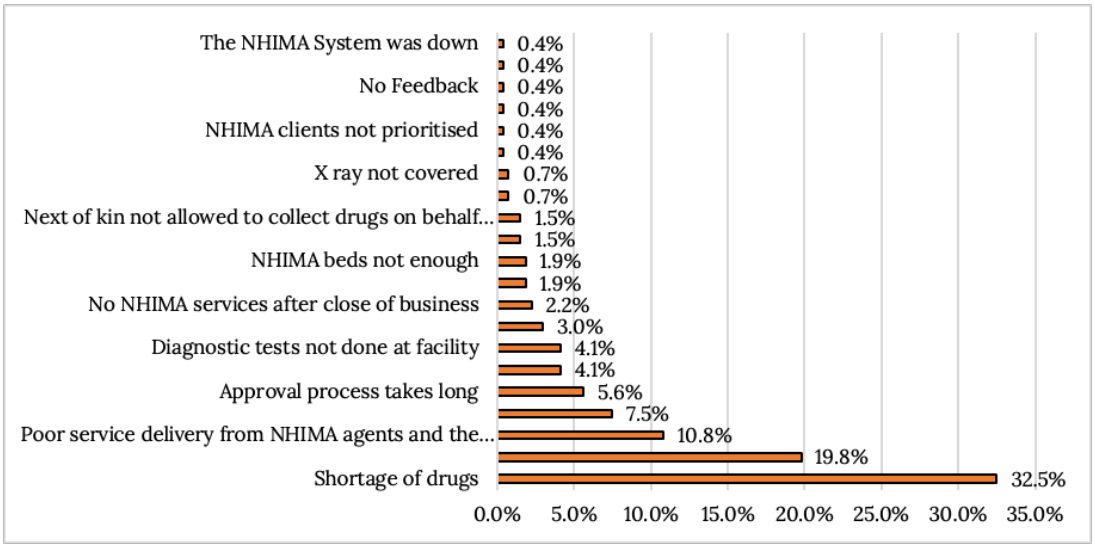


Figure 37: *Problems encountered when accessing NHIMA services*

When it comes to satisfaction, respondents were asked if they feel they get satisfaction and value for their money in the way NHIMA provides health care insurance services to its clients. Most of them (79.1 percent) expressed satisfaction and only 20.9 percent did not express satisfaction. Respondents were also asked on some of the services that they would want to be included in the service package. The top three most mentioned services were pharmaceuticals and blood products (15.2 percent), followed by Oncology services and investigations (8.5 percent) and diagnostic services (8.2 percent) as shown in Figure 38 below.

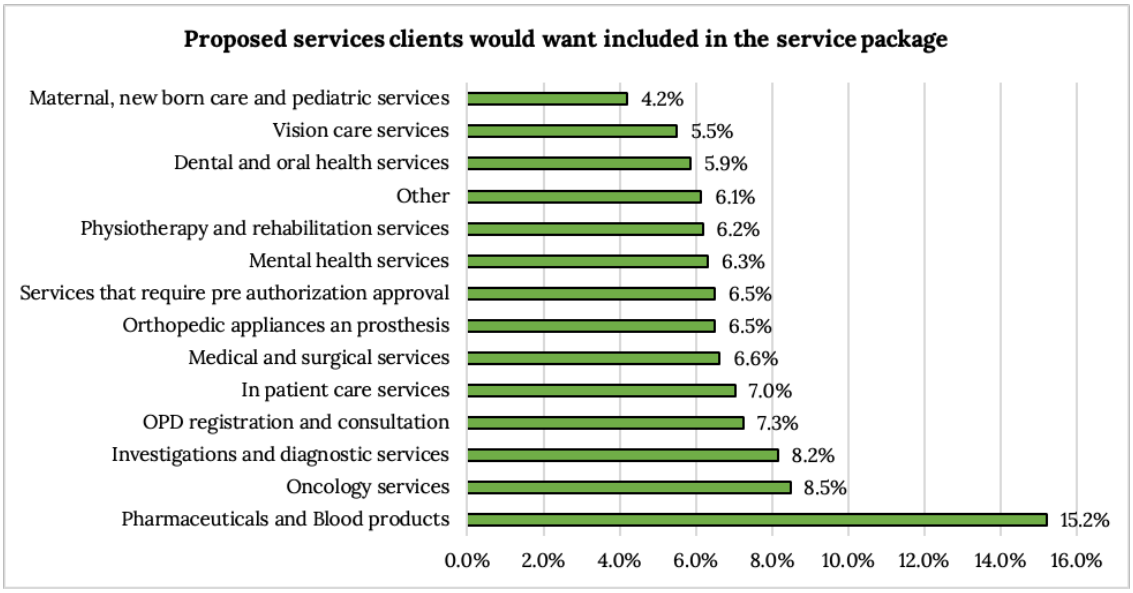


Figure 38: *Proposed services clients would want included in the service package*

Some respondents indicated that they lodge complaints to NHIMA even though they have no faith in the system. Their complaints have not been addressed, a reason they point as the cause of lost confidence. Some noted that they had no idea where to lodge their complaint as revealed during FGDs. Below are summaries verbatims:

> *"That is difficult, we do not know whom to complain to, that is why people label hospitals on social media's because they do not know where to complain to. Just like here, we just die with those complaints in our hearts, we do not know where to take our complaints to".* ***FDG, Kabwe Central Hospital, Kabwe***

> *"The problem is that when you report a complaint, like to the office for NHIMA it is like even them they get stuck you might find that the challenges that they are found with concern NHIMA and they look like they don't even have where to start from helping you but this one time I complained to the administrator and I was helped".* ***FDG, Kabwe Central Hospital, Kabwe***

Study results also show that only about (7.3 percent, N=988) had lodged complaints. They were further asked if they received any feedback, and 50 percent mentioned that they received feedback and 63.9 percent of them were satisfied with feedback the got from NHIMA as shown by the figure 39 below.

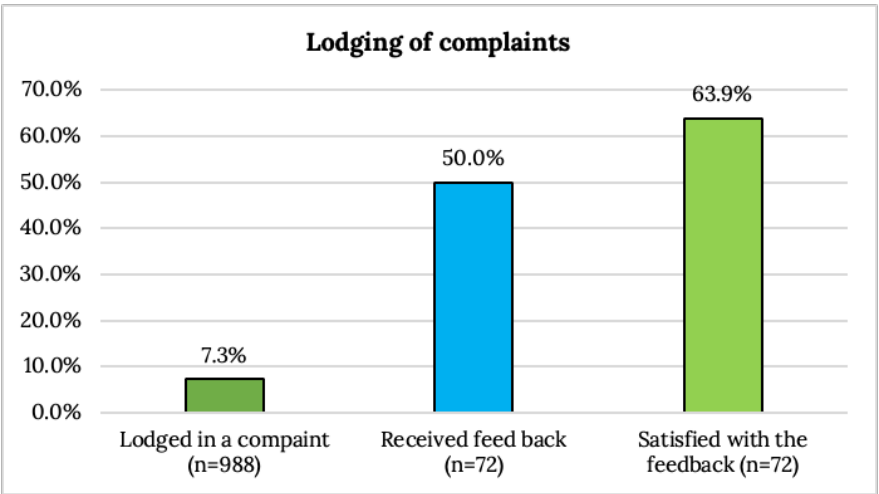


Figure 39: *Lodging of complaints*

Further, respondents were asked on some the things they feel NHIMA should improve upon in terms of customer feedback. Though feedback is rated generally good, there are some areas mentioned that respondents felt needed some adjustments. The most mentioned things are service delivery (28.5 percent), followed by provide timely feedback (18.7 percent) and provide more information on NHIMA and benefits package (14 percent), see figure 40 below.

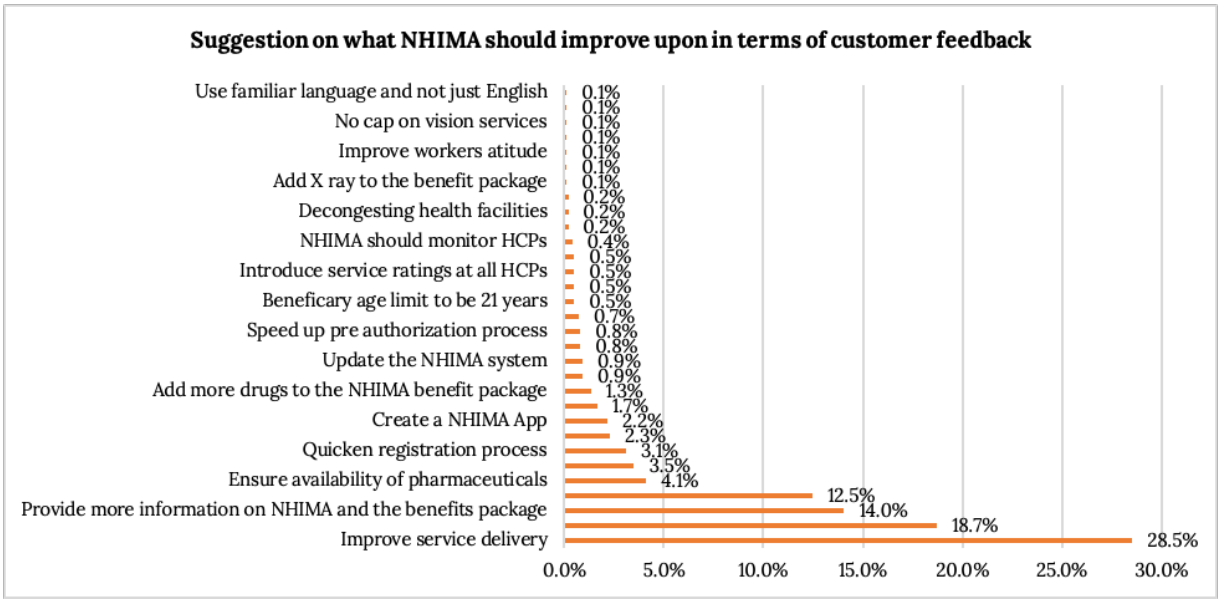


Figure 40: *Suggestions on what NHIMA should improve upon in terms of customer feedback*

Respondents were asked to provide some recommendations on what NHIMA should do to improve the provision of health care insurance to its clients. Many areas were mentioned as needing improvement. Others mentioned the need to have pharmacies located in close proximity to the hospital.

Some mentioned the need for NHIMA to improve their cover to a minimum of ten people so that they can also cater for the extended families like grandparents. Overall, the top three most mentioned recommendations were to improve service delivery (36.7 percent), followed by ensuring availability of pharmaceutical products (18.9 percent) and accredit more facilities (12.6 percent), as shown in Figure 41.

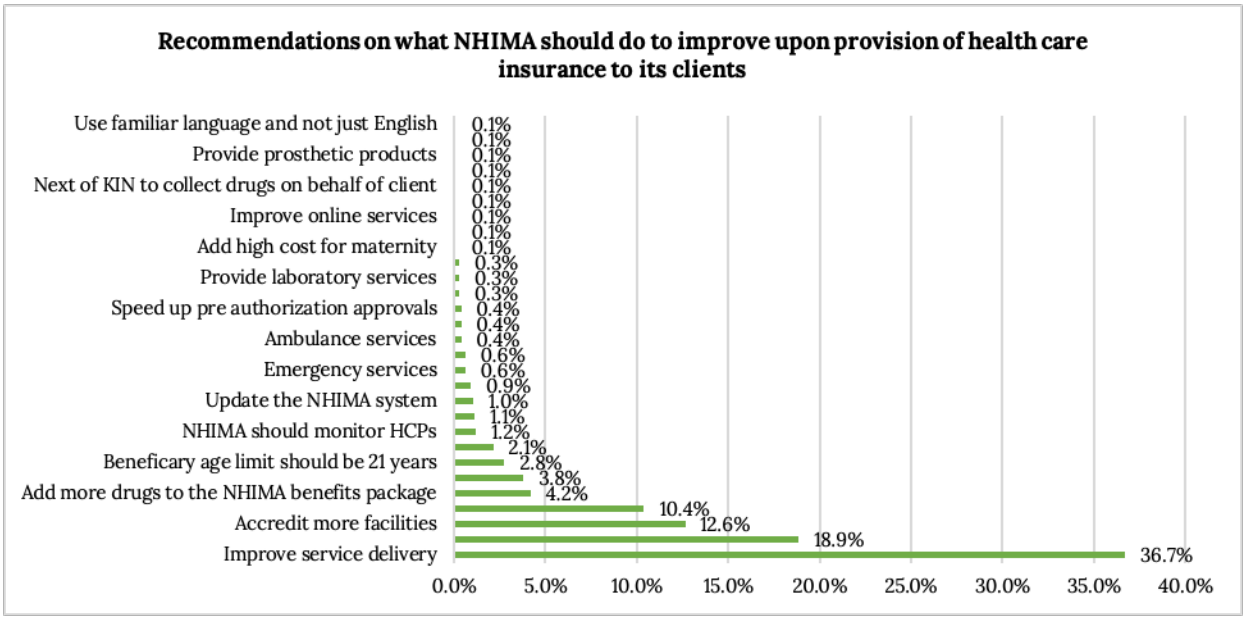


Figure 41: *Recommendations on what NHIMA should do to improve upon provision of health care insurance to its clients*

Description

Key to this section is the adequacy, relevance and ease of access to information that is provided by NHIMA. Service provision requires that the provider and the customers can communicate whenever there is a need. This fosters mutual understanding and it helps to provide feedback on the service provision to both parties. There are several ways in which communication can be done and it includes walk-ins to the providers' premises.

On the number of clients confirming to know where the nearest NHIMA office is physically located, only 38.5 percent (n=380) answered in the affirmative while the remaining 61.5 percent did not know and 22.3 percent (n=223) of the clients confirmed having visited an NHIMA office while the other 77.4 percent (n=765) have never. Of those confirmed to have visited the nearest NHIMA office, only 48.4 percent (n=108) indicated that the offices are disability user-friendly.

When asked whether they have contacted NHIMA in the past 12 months, only 18.5 percent (n=185) of the respondents confirmed having done that and the majority of them were between the age bracket of 25 to 59 years. Most of the contact was made through phone calls at 45.5 percent (n=95) followed by walk-ins at 39.7 percent (n=83) and through NHIMA agents at hospitals was 7.2 percent (n=15) while the combined e-contact such as Facebook, WhatsApp, and Website was just below 8 percent.

The reasons for contacting NHIMA were mainly to do with registration status 26.9 percent, beneficiary update 24.0 percent, membership update 22.3 percent, accessing health service (pre-authorization services) 15.3 percent, registering a complaint 6.2 percent, deduction clarification 3.3 percent and employment status update at 2.1 percent.

It is worth noting that 73 percent of those indicating to have contacted NHIMA said that they were successful. Of those who were successful in contacting NHIMA, 56.2 percent said that it was easy while 16.8 percent said that it was difficult with 27 percent not confirming it to be either easy or difficult.

Table 38: *Analysis of Information Shared by NHIMA, 2022*

Question Type	Number of responses	NO' as a proportion of total responses	YES' as a proportion of total responses
1. Do you receive any information from NHIMA on available services?	988	89%	95 (11%)
2. Has NHIMA provided or shared information on healthcare packages to you?	988	94%	6%
3. Have you ever visited the NHIMA website?	988	90%	10%

Table 38 above shows that out of the total sample of 988 respondents that accessed services under NHIMA, only 11 percent (95) indicated that they had received information from NHIMA on the available services. When probed about how they had received information from NHIMA on the available services, 29 percent (n=48) received via SMS, 17 percent (n=27) through Television, and 13 percent (n= 20) by phone calls. 12 percent each (n=20) was through radio and online platforms such as Facebook and the website while 10 percent (n=16) was through physical meetings with NHIMA agents and 6 percent (n=10) through emails, see Table 39.

Table 39: *Percentage distribution on how the information on Services was received, 2022*

Channel of Communication	Number of responses	As a Proportion of Total Responses
SMS	48	29%
Television	27	17%
Phone call	21	13%
Radio	20	12%
Online Platforms (Website, Facebook)	20	12%
Physical meeting with NHIMA agents	16	10%
Email	10	6%
Other (specify)	1	1%

Table 40: *Percentage distribution on how information on the Benefits Package was received, 2022*

Channel of Communication	As a Proportion of Total Responses
NHIMA Agent	24%
Employer	18%
TV	15%
Internet	12%
Radio	11%
Facebook including Phone/SMS	8%
Print Media	7%
Friends/family/community	5%

When inquired on whether NHIMA had shared or provided any information on the health benefits package that the clients are entitled to, only 63 out of 988 respondents (6 percent) answered in the affirmative whilst 94% (925) said they had not been provided with information on the benefits package (Table 39). Further, of the 63 respondents that had received information on the benefits package, 24 percent received it through a NHIMA agent, 18 percent through employers, 15 percent from TV, 12 percent from the internet, 11 percent from the radio, 8 percent from the NHIMA Facebook including Phone/SMS, 7 percent from the print media and lastly 5 percent from a peer (friends/family/community) as seen in Table 40 above.

Table 41: *Percentage distribution on how the information on Services was received, 2022*

Channel of Communication	Number of responses	As a Proportion of Total Responses
SMS	755	31%
Phone call	473	20%
Email	377	14%
Television	262	11%
Online Platforms (Website, Facebook)	213	9%
Radio	194	8%
Physical meeting with NHIMA agents	164	7%
Other (specify)	1	1%

With regards to preferred channels of receiving vital information from NHIMA, Table 40 shows that 31 percent (n=755) of respondents indicated that SMS was ideal whereas 20 percent (n=473) of them preferred phone call, 14 percent (n=377) emails, 11 percent (n=262) TV, 9 percent (n=213) online platforms such as the website, Facebook and Twitter and lastly 7 (n=164) percent opted for a physical meeting with NHIMA agents.

Description

The NHIMA website has a dashboard with full contact details, toll free number and an email address. It has various options which include; eNHIMA and update of details for members, access to publications, forms for membership, list of accredited health facilities, media and press releases as well as an icon for procedures of making a complaint (which did not include online complaints but required someone to download a form), the registration process among others.

Further, multiple documents under the benefit package were listed such as operational manual for optical health facilities, banefit package for private standalone pharmacies, private sector tariff and benefit package, seond and third level hospital DRG tariff, benefit package package for private standalone pharmacies, and a benefit package brochure which were difficult to follow and undersand.

Table 42: *Analysis of Information Shared by NHIMA, 2022*

Question Type	Number of responses	NO' as a proportion of total responses	YES' as a proportion of total responses
1. Is the information provided through their website adequate?	96	27 (39%)	59 (61%)
2. Is the information provided through their website relevant?	96	22 (23%)	74 (77%)
3. Is the information provided through their website easy to understand and helpful?	96	28 (29%)	68 (71%)
4. Are there any gaps in the information provided through their website?	96	52 (54%)	44 (46%)

With regards to access to the NHIMA website, results of the study showed that only 96 out of the 988 sampled respondents (10 percent) had indicated that they had ever visited the NHIMA website (refer to Table 42). An analysis of those that ever visited the NHIMA website in table 42 below shows that 61 percent found the information adequate and 39 percent did not. A majority of them (77 percent) found it relevant whilst a few (23 percent) did not. Regarding it being easy to understand and helpful, 71 percent said it was while only 29 percent said it wasn't, 46 percent indicated that there were gaps in the information and 54 percent said there were not.

Of the 44 respondants that indicated gaps existed in the information provided by NHIMA as seen in table 42, over 50 percent of them cited gaps around the website as potential gaps. They indicated issues such as it being complicated and outdated, failing to capture or provide information on beneficiaries, lacking a proper complaint procedure and customer feedback mechanism, and others felt that information should be made available in other local languages and not just English. The other gaps outlined by the respondents also stood out; (i) inadequate information on a benefits package, (iii) unclear utilization procedures, (iv) unclear instructions on how to update beneficiaries, and (v) the website not being user friendly.

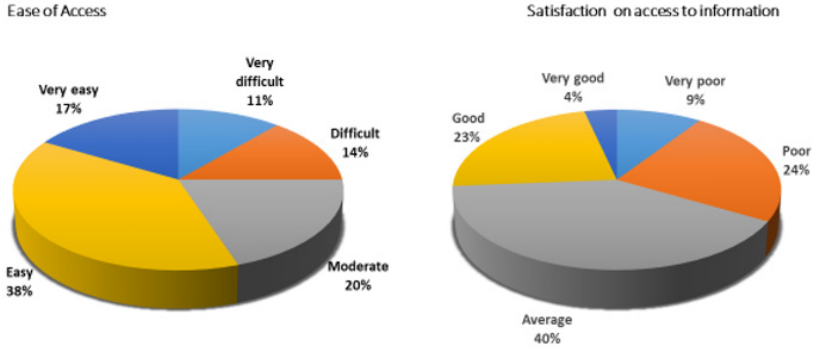


Figure 42: *Ease of NHIMA Website and Overall Rating on Access to Information on Available Health Care Services*

The majority of those that ever visited the NHIMA website found it either easy (n=37, 39 percent), or very easy (n=16, 17 percent). 20 percent (n= 19) found it moderate, 14 percent (n= 13) difficult and 11 percent (n=11) very difficult as seen in figure 44. Further, the figure also shows the rating of how access to information on available health care services (i.e. list of accredited providers and available services in benefit packages) is from NHIMA. The data shows that of the 941 out of the 988 who responded, 4 percent (n= 34) rated it very good, 23 percent (n=213) as good, 40 percent (n= 381) as average, 24 percent (n=224) as poor, and 9 percent (n=89) as very poor.

Description

The study showed that 79 percent of the respondents were satisfied and believed that they got value for money in the way that NHIMA provides services to them. Further, 72 percent agreed that the listed NHIMA-accredited facilities sufficiently met the quality health care services that are needed. Suffice it to say, however, 42 percent of those that had accessed health care services in the last 12 months spent some money despite being NHIMA clients with more than half of them (62 percent) spending money because of an apparent lack of drugs, medical supplies, and equipment at the accredited facility. And the top of the expenditure list was payment for pharmaceuticals and blood products at 54 percent.

Further analysis showed that nearly 17 percent of the total respondents that visited the health facilities had experienced some problem during the time they went to seek services under NHIMA with shortages of drugs topping the list at 35 percent. What is not surprising, was that the majority of those that indicated existing gaps in NHIMA services felt that pharmaceuticals and blood products were not sufficiently provided.

With regards to ease of access to needed health care services after becoming a NHIMA member, very few of the respondents had difficulties, with a total of 95 percent responding either very easy, moderate or easy. Further, a combined total of 94 percent rated their satisfaction with NHIMA's way of service provision as either excellent, good or moderate with only 6 percent saying it was poor or very poor. However, there was a low rate of awareness of the NHIMA complaints procedure among the respondents as only 8 percent knew about it. Suffice to say that only half of the complaints lodged in with NHIMA were responded to by NHIMA with about 64 percent of the feedback provided by NHIMA being considered satisfactory, while 36 percent was

Description

Receipt of information from NHIMA on the available services was low as only 11 percent indicated that they had received this information. And most of information was received through SMS (29 percent), while 17 percent received through Television, 13 percent by phone calls. 12 percent each was through radio and online platforms such as Facebook and the website while 10 percent was through physical meetings with NHIMA agents and a further 6 percent through emails.

Furthermore, high number of respondents (94 percent) indicated that they had not received any information specifically on the benefit package. For the 6 percent that had received any information about the benefit package, a majority (24 percent) of them had received through a NHIMA agent, 18 percent through their employers, 15 percent from TV, 12 percent from the internet, 11 percent from the radio, 8 percent from the NHIMA Facebook including Phone/SMS, 7 percent from the print media and lastly 5 percent from a peer (friends/family/community).

Receiving information from NHIMA agents only meant that NHIMA clients only get to know about the benefit package at the point of seeking services. On the preferred channel of receiving information from NHIMA, 31 percent preferred SMS followed by 20 percent through phone calls, 14 percent emails, 11 percent TV, 9 percent online platforms such as the NHIMA website and Facebook and lastly 7 percent opted for physical meetings with NHIMA agents.

Finally, very few of the total respondents (10 percent) had ever visited the NHIMA website. There were also mixed reactions about the adequacy, relevance and helpfulness of the information on the NHIMA website among the respondents that had ever visited the NHIMA website. More than half (61 percent) found the information adequate and 39 percent did not.

Further, 77 percent found it relevant whilst a 23 percent did not. With regards to it being easy to understand and helpful, 71 percent said it was easy to understand and helpful while only 29 percent said it wasn't, and furthermore, 46 percent indicated that there were certain gaps in the information and 54 percent said there were not. The major gaps cited were this the website is too complicated and outdated; its failure to capture or provide information on beneficiaries; its lack of a complaint procedure and customer feedback mechanism, and others felt that information should be made available in other local languages.

With regards to the user-friendliness of the NHIMA Website, 39 percent found it easy, 17 percent very easy, 20 percent moderate, 14 percent difficult and 11 percent very difficult. Overall rating of access to information on available survives such as follows, 4 percent rated it very good, 23 percent as good, 40 percent as average, 24 percent and poor, and 9 percent as very poor.

SECTION 10:
5As Principles Framework

SECTION 10
5As PRINCIPLES FRAMEWORK

10.0 Introduction

The National Health Insurance Authority operates a delivery and customer satisfaction framework anchored on five principles also known as "5As". These health access principles include; Availability, Accessibility, Affordability, Accommodation and Acceptability. Definitions and items of assessment of these access principles are explained in Section 3.0, page 13.

The current client satisfaction survey endeavoured to measure customer satisfaction within the 5As principles lens. In fact, the 5As access principles guided the formulation and design of both the tools and the structural model design of the survey to ensure measurement of client satisfaction was laid within the ambit of the 5As. Each of the definitions as well as the items of assessment of the access principles were operationalised through the questionnaire and other tools used to collect data and information during the study.

While all the 5As form the core of this report and are reflected throughout its contents, this section was framed to show, using scores, how NHIMA is performing on the main focal principles in terms of customer satisfaction. In order to arrive at this score, a process was adopted to first of all, show responses and results on specific questions designed to directly measure the 5As and secondly, to also show condensed composites of each of the 5As by scoring them using indexing principles. Each of the questions that measured, for example, availability, was collapsed into one index score of satisfaction.

10.1 Availability Score

In order to measure availability, we transformed the availability definition and indicators into operational items which included: whether or not services met clients' needs and whether they were satisfied with a number of processes including registration, vitals, consultations, among others, and whether or not clients were served by and found specifically qualified health personnel to address their specific needs including but not limited to mental health. Variables used to measure the availability score index are presented in Table 42 while the actual score is presented in Figure 47.

Table 43 shows that the overall number of NHIMA clients stated that they were satisfied with registration process. Table 42 further shows almost 100 percent of NHIMA clients were satisfied with vitals taking, 9 out of 10 of every NHIMA clients were satisfied with the consultation process. In addition, ninety-one percent of NHIMA clients were attended to by trained personnel.

Figure 43 shows the composited overall score for the principle of "availability", where zero meant not satisfied and 4 meant very satisfied. Overall, majority of NHIMA clients in this study scored availability with a 4, very satisfied (as indicated by 74 percent of respondents).

Table 43: *Percent distribution of availability measures by background characteristics*

Variables	Satisfaction with the registration process	Satisfaction with vital taking	Satisfaction with the consultation process	Attended to by trained personnel
	%	%	%	
Age				
15-24	95.75	100	95.74	94.44
25-34	93.33	94.21	93.33	87.36
35-44	88.96	96.75	91.88	91.96
45-59	89.17	97.63	93.33	90.8
60-64	86.21	92.86	93.1	77.78
65+	89.36	96.63	94.68	96.77
Gender				
Male	91.27	95.57	95.26	92.65
Female	89.95	96.74	91.65	89.42
Marital Status				
Never Married	92.31	95.56	93.59	85.71
Married/cohabitating	90.46	96.3	93.06	91.43
Separated/Divorced	86.21	96.08	91.38	90.91
Divorced	90.24	97.33	93.9	92.86
Education				
Never attended school	75	100	87.5	100
Primary	92.23	96.77	96.12	100
Secondary	92.43	96	93.23	90.91
Higher/Tertiary	89.62	96.23	92.65	89.27
Total	**90.49**	**96.26**	**93.12**	**90.7**

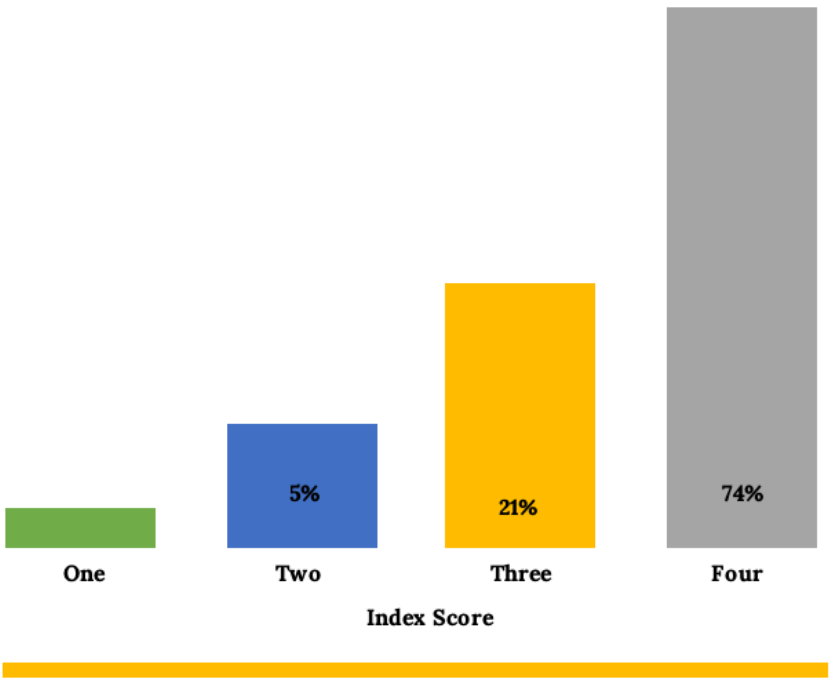


Figure 43: *Availability Index Score*

10.2 Accessibility Score

The principle of accessibility was operationalised by asking NHIMA clients to respond to questions such as: how long it took for clients to access a NHIMA accredited facility; whether or not they paid to access a HCP and how much they spent to get to such a premise. The variables and selected background characteristics used to measure accessibility score are presented in Table 44 while the overall score is presented in Figure 44.

Table 44 shows that 81 percent of NHIMA clients stated that health facilities operate 24/7. Only 26 percent reported that they encounter difficulties getting to the nearest health facility. Results in table 2 further show that about 42 percent of clients spend direct or indirect costs as they access health services even if they are on NHIMA, 74 percent were able to afford transport costs to the nearest health facility. Accessibility score is presented in figure 2. Less than half of NHIMA clients scored three out of 5 which shows NHIMA clients are moderately satisfied with service accessibility.

Table 44: *Percent distribution of Accessibility measures by background characteristics*

Variables	Health facility operate 24/7	Difficulties getting to the nearest health facility	Spend on health indirectly of directly	Know any health facility apart from where you seek medical care	Afford transport cost to the nearest health facility
	%	%	%		
Age					
15-24	75.76	21.21	29.79	57.45	78.72
25-34	83.84	24.24	43.33	57.78	82.96
35-44	82.63	22.46	42.53	65.58	76.62
45-59	81.05	28.42	42.92	67.08	71.25
60-64	69.57	17.39	68.97	48.28	75.25
65+	75	44.12	31.91	46.81	39.36
Gender					
Male	79.14	23.84	42.39	57.36	75.06
Female	82.51	27.8	41.74	63.71	72.57
Marital Status					
Never Married	80.7	13.16	41.67	62.82	85.26
Married/cohabitating	80.7	28.17	42.92	61.13	72.83
Separated/Divorced	86.05	30.23	46.55	72.41	70.69
Divorced	83.64	30.91	31.71	50	59.76
Education					
Never attended school	83.3	33.33	25	50	37.5
Primary	74.65	32.62	38.83	46.6	48.54
Secondary	83.15	29.78	35.86	54.18	66.14
Higher/Tertiary	81.34	23.33	45.21	66.45	81.15
Total	**81.15**	**26.2**	**42**	**61.13**	**73.58**

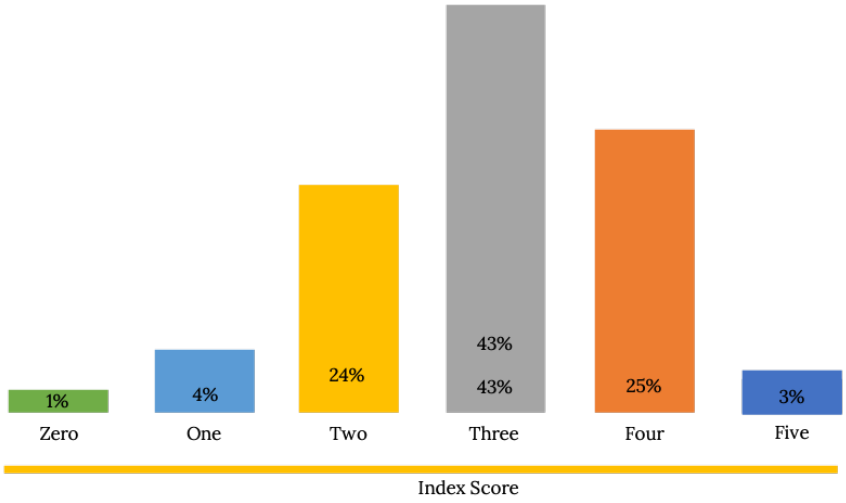


Figure 44: *Accessibility index score*

10.3 Affordability Score

Affordability hinges around the relationship of prices of services and providers' insurance or deposit requirements to the clients' income. And it was required for respondents in the survey to provide information on whether or not they were able to pay for the services within the capitations provided; whether or not clients had value for their money for the services provided; whether or not they had to spend some money outside what is provided for by NHIMA. The variables that were used to measure affordability score are presented in table 3 by background characteristics. Note that one variable used to score the affordability score was also used to score the accessibility score.

Table 44 shows that overall, 9 out of 10 clients stated that NHIMA contributions were affordable (93

Table 45: *Percent distribution of Affordability measures by background characteristics*

Variables	Affordability of NHIMA contribution	NHIMA sufficiently cover medical bill	Afford health care access before NHIMA	Spend on health indirectly of directly
	%	%	%	
Age				
15-24	93.1	87.23	55.17	29.79
25-34	95.48	72.96	59.28	43.33
35-44	93.38	66.56	59.56	42.53
45-59	93.36	66.67	56.4	42.92
60-64	94.74	55.17	57.89	68.97
65+	79.31	73.4	27.59	31.91
Gender				
Male	93.59	71.32	59.48	42.39
Female	93.38	68.48	55.48	41.74
Marital Status				
Never Married	94.33	79.49	60.99	41.67
Married/cohabitating	93.11	68.21	58.1	42.92
Separated/Divorced	96.15	60.34	44.23	46.55
Divorced	92.16	69.51	50.98	31.71
Education				
Never attended school	60	62.5	60	25
Primary	86.21	70.87	34.48	38.83
Secondary	90.45	75.3	41.57	35.86
Higher/Tertiary	95.56	67.25	64.81	45.21
Total	**93.47**	**69.64**	**57.23**	**42**

percent); about 70 percent of NHIMA clients were of the view that NHIMA sufficiently cover their medical bills. Further, it shows that more than half of NHIMA members were able to afford health care access before NHIMA (57 percent) while about 42 percent stated that they incur costs indirectly on health services even when on NHIMA. In terms of the overall affordability score, figure 3 shows that a score of three out of 4 was the highest score indcating that 46 percent of NHIMA clients were very satisfied with service affordability.

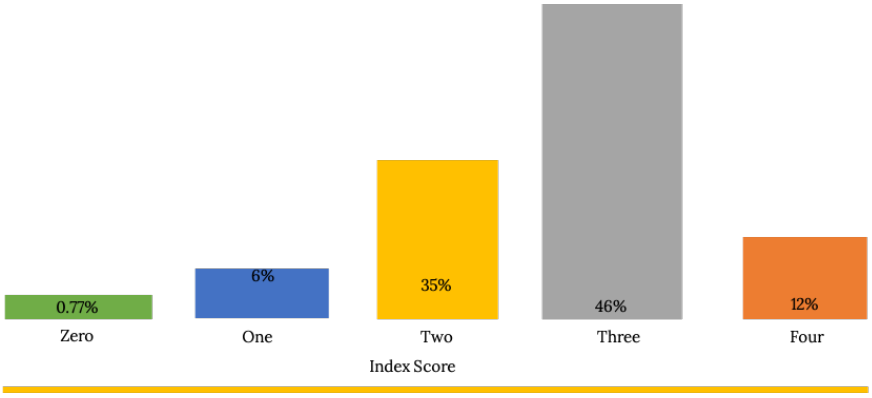


Figure 45: *Affordability index score*

10.4 Accommodation Score

A number of variables (Table 44) were selected to present the accommodation score and they included among others: whether or not HCP has waiting bay, whether or not clients given more information after vitals, diagnosis or whether or not the HCPs has an internal complaints system, hours of operation,

Table 46: *Percent distribution of Accommodation measures by background characteristics*

Variables	Health facility have waiting bay with seats	Health worker explain the vital reading	Health worker explain diagnosis results	Privacy during consultation	Pharmacy explain the drug	Facilities have NHIMA dedicated wards	Are there chairs and waiting benches	Health facility have internal complaint
	%	%	%					
Age								
15-24	100	66.67	63.83	95.74	85.37	45.45	93.62	9.09
25-34	95.87	66.12	82.22	94.81	91.77	58.08	92.59	25.89
35-44	91.7	65.34	82.14	95.45	95.22	58.05	89.94	25.85
45-59	92.42	66.82	78.75	93.33	92.34	58.95	90.83	19.47
60-64	89.29	67.86	82.76	96.55	84.62	60.87	93.1	21.74
65+	95.51	67.42	82.98	94.68	96.51	64.71	89.36	10.29
Gender								
Male	93.63	69.81	82.04	95.26	94.23	52.65	89.28	21.52
Female	93.68	63.79	79.56	94.38	92.02	62.33	92.33	22.25
Marital Status								
Never Married	93.33	64.44	77.56	97.44	92.14	58.77	91.03	23.01
Married/cohabitating	93.41	67.2	81.65	94.51	93	55.78	91.76	21.27
Separated/Divorced	88.24	66.67	74.14	89.66	95.83	65.12	81.03	32.56
Divorced	100	61.33	81.71	95.12	91.78	78.18	92.68	18.18
Education								
Never attended school	100	62.5	75	100	75	66.67	87.5	16.67
Primary	93.55	70.97	78.64	93.2	96.84	56.34	91.26	12.68
Secondary	96.89	67.11	82.87	95.22	96.2	57.87	92.43	19.66
Higher/Tertiary	92.28	65.17	80.03	94.73	91.09	58.82	90.58	24.19
Total	**93.66**	**66.25**	**80.57**	**94.74**	**92.92**	**58.42**	**91.09**	**21.95**

walk-in facilities, telephone services; whether or not these services were appropriate to their needs and expectations.

About 9 in 10 NHIMA clients observed that the health facility they went to in the last 12 months has a waiting bay with seats. Two-thirds said that health workers that attended to them explained the vital reading, while 8 out of 10 clients said that health workers explained diagnosis results to them.

Ninety-five percent of NHIMA clients stated that there was privacy during consultation while 9 out of 10 stated that the pharmacy personnel explained the usage and dosage of the drugs given to them. Fifty-eight percent stated that Facilities have NHIMA dedicated wards while 9 out of 10 persons stated that health facilities have chairs and waiting benches.

Only 1 in 5 (22 percent) clients were able to state that the Health facility had an internal complaint system. Figure 4 shows the overall accommodation score of 6 out of 8 indicating that 37 percent of NHIMA clients were very satisfied with accomodation.out of the 8 items used to compute the score.

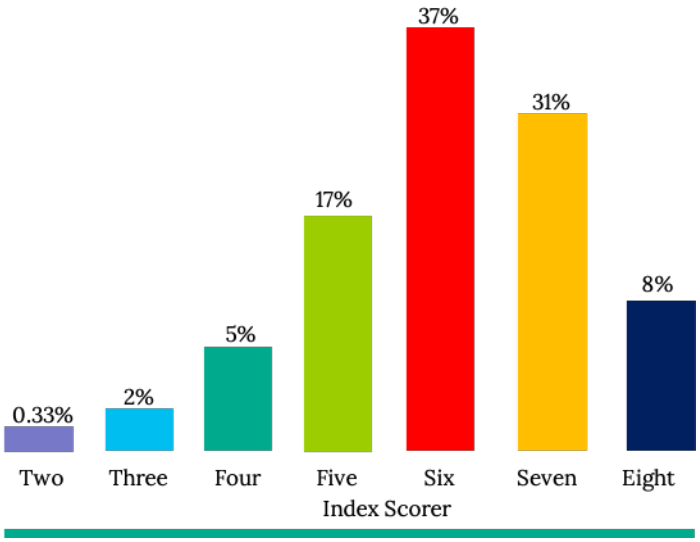


Figure 46: *Accommodation index score*

10.5 Acceptability Score

A number of indicators, some of them cross-cutting the other 5As already presented, were designed to measure accommodation. Acceptability is a principle built around the perception on services provided as seen by clients and also views held by service providers towards service provision and towards clients; it is a two pronged measure.

Some questions included the following: whether or not clients felt HCP personnel had good or bad attitude towards them; whether they were kind or rude; whether they were compassionate or indifferent.

Similarly, providers were also required to mirror their clients in terms of whether or not they graciously accepted/accommodated and appreciated them; whether clients were or have been hostile to them. Table 46 and 47 constitute variables used to measure acceptability presented by background characteristics.

Table 47: *Percent distribution of acceptability measures by background characteristics.*

Variables	Did health worker greet you	Stigmatized due to age	Stigmatized due to disabilities	Stigmatized due to chronic conditions	Stigmatized due to Ethnicity	Stigmatized due to Gender	Stigmatized due to social status
	%	%	%				
Age							
15-24	97.87	0	0	0	0	0	0
25-34	93.7	0.37	0	1.13	0	0.75	2.26
35-44	88.64	0.32	0	0.33	0.32	0	0.65
45-59	92.5	0.83	0.42	1.68	0.84	0.44	2.17
60-64	82.76	0	0	0	0	0	0
65+	90.43	1.06	0	0	0	0	1.09
Gender							
Male	92.02	0.5	0.25	1.01	0.25	0.25	1.25
Female	90.97	0.51	0	0.69	0.34	0.35	1.58
Marital Status							
Never Married	94.23	0	0	0.65	0	0.65	0
Married/cohabitating	91.18	0.58	0.15	0.73	0.44	0.29	1.77
Separated/Divorced	79.31	1.72	0	1.75	0	0	1.79
Divorced	96.34	0	0	1.22	0	0	1.23
Education							
Never attended school	100	0	0	0	0	0	0
Primary	93.2	0.97	0	0.99	0	0	3.03
Secondary	91.24	0.4	0	0.41	0.4	0.41	1.23
Higher/Tertiary	91.05	0.48	0.16	0.96	0.32	0.32	1.29
Total	**91.4**	**0.51**	**0.1**	**0.82**	**0.31**	**0.31**	**1.44**

Table 46 shows that 9 in 10 of NHIMA clients were greeted by health workers; only less than one percent felt stigmatized due to their social status, chronic condition (0.82 percent), age (0.5 percent), ethnicity (0.31 percent), gender (0.31 percent) and disability (0.1 percent).

Table 47 shows that 60 percent of NHIMA clients were allowed to ask questions; 95 percent stated that health workers took time to listen to them (clients). With regards to the attitude of health workers, 36 percent of clients said health workers were courteous and accommodating and were empathetic (24 perdent). On the flip side, about six percent of respondents said some health workers were not attentive and were rude (7.6 percent).

The acceptability score index had 14 items and only about 6 were responsive with an actual score while the rest had a zero score and therefore are not shown in Figure 10.5. On a scale of 14, the highest acceptability score was 4 out of 14 as indicated by 35 percent of respondent exhibiting favourable overall attitude towards health workers.

Table 48: *Percent distribution of acceptability measures by background characteristics*

Variables	Allowed to ask question concerning vitals	Health workers take time to listen	Health workers were helpful	They were empathetic	They were courteous and accommodating	Other (specify)	Rude	Not attentive
	%	%	%					
Age								
15-24	61.11	91.49	80.85	17.02	29.79	2.13	14.89	10.64
25-34	60.33	94.44	82.22	22.22	36.67	0.74	7.41	7.78
35-44	60.29	95.78	79.22	23.05	34.42	2.27	4.22	6.49
45-59	58.77	94.58	81.67	25.83	40.83	0.83	6.25	7.92
60-64	57.14	93.1	89.66	25.83	31.03	0	6.9	6.9
65+	58.14	95.74	88.3	34.48	36.17	4.26	3.19	9.57
Gender								
Male	58.17	96.76	85.29	25.19	34.41	1	6.64	5.74
Female	60.73	93.53	79.56	23.51	37.82	2.04	5.24	9.03
Marital Status								
Never Married	64.44	92.31	77.56	28.21	42.31	1.28	10.26	8.33
Married/cohabitating	59.81	95.38	83.09	22.25	34.97	1.58	5.2	7.08
Separated/Divorced	49.02	93.1	74.14	25.86	31.03	5.17	6.9	13.79
Divorced	57.33	96.34	85.37	31.71	41.46	0	4.88	7.32
Education								
Never attended school	50	87.5	87.5	12.5	25	0	12.5	12.5
Primary	58.06	95.15	84.47	25.24	40.78	0.97	5.83	5.83
Secondary	61.78	95.22	84.86	24.3	36.25	0.8	6.77	8.76
Higher/Tertiary	59.25	94.73	80.19	24.12	35.94	2.08	5.75	7.51
Total	**59.68**	**94.84**	**81.88**	**24.19**	**36.44**	**1.62**	**6.07**	**7.69**

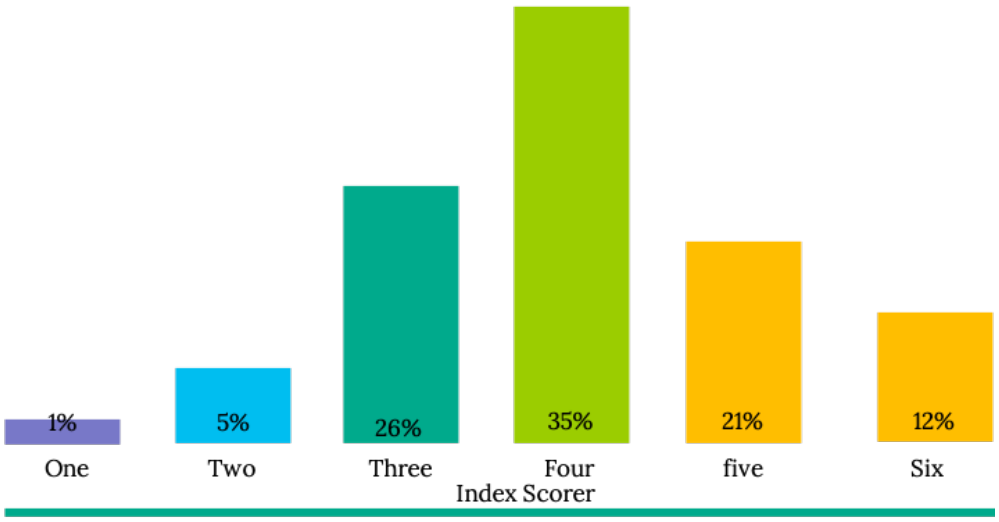


Figure 47: *Acceptability index score*

For each of the 5As principles, clients scored them differently. The highly scored principle was availability at 74 percent (4/6) and the least scored principle was Acceptability at 35 percent (4/14 or 4/6). Accesibility (46 percent) and Affordability scored below 50 percent overall while Accomodation scored 37 percent (6/8).

10.6 NHIMA Overall customer satisfaction

NHIMA Overall customer satisfaction was created based on the 5As. This was accomplished by simply creating a single variable for each of the 5As, and then combined all single variables for 5As to come up with the overall customer satisfaction index score shown in Figure 48 results show that 43 percent of NHIMA clients were very satisfied with overall NHIMA services.

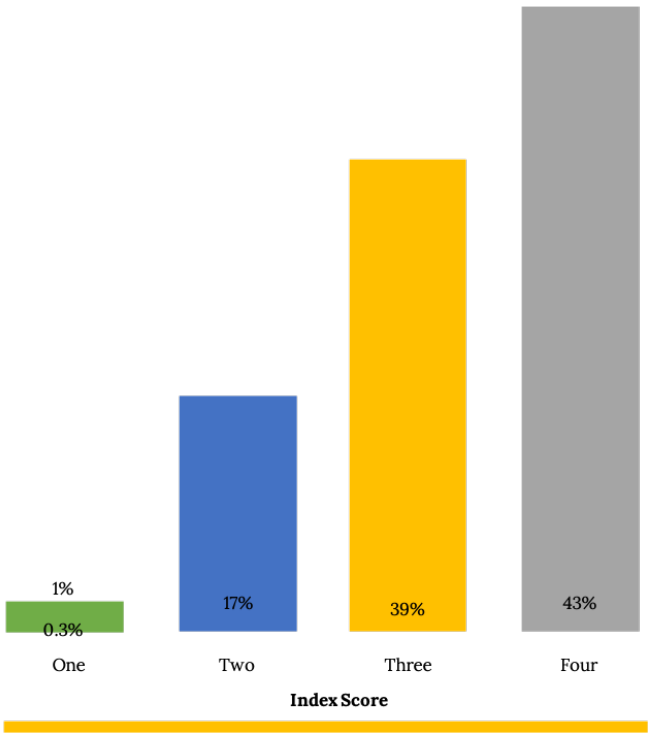


Figure 48: *Overall NHIMA customer satisfaction*

SECTION 11

NEVER ACCESSED NHIMA SERVICES

11.1 Description

A lot of people have never accessed NHIMA services even though they are registered clients due to a number of reasons. Some lack knowledge about the specific products offered by NHIMA. Others have wrong or little information about the services of NHIMA. There are also people who even though money is deducted from their salaries do not know how to go about accessing NHIMA services. The word-of-mouth phenomenon is vital as it helps one get a better idea about a service and is key in decision making. For example, some Medical Aid schemes are notorious for delaying payments, and most practitioners avoid them – leaving members on the lurch.

With regards to NHIMA, lack of information has contributed in NHIMA not being the best service provider in Zambia. For instance, some respondents mentioned that in terms of interaction, people know where to easily find other service providers like Prudential, they know who to talk to, who to call and if they have challenges know where exactly to go. This was said to be in contrast with NHIMA services and yet it is mandatory to be a member even though one is receiving the services elsewhere. Additionally, issues of orientation to their products were reportedly still in their infancy stages.

Information about NHIMA is still scanty, respondents who have not accessed the services indicated that they heard of it through the radio, Facebook and through grape vine. Moreso, some have heard negative information on the services provided by NHIMA with others saying it does not cater for all medicals but rather one has to do top-ups when it comes to issues like surgeries and spectacles. The packages must be fully explained such that clients gain access to a wider variety of services including out-patient, in-patient (hospitalisation), acute and chronic medicines, and the dread disease benefit which ensures access to medical assistance for specified diseases and or medical conditions.

Additionally, it is crucial to have information on which NHIMA accredited health facilities provide specific services. Further, others are not happy that NHIMA medical aid scheme is covering for only certain conditions. It was recommended that NHIMA must provide healthcare cover for a variety of conditions across healthcare disciplines. Broadly, it must cater hospital and out-patient cover. Respondents suggested that the scheme must give a client the right to choose a service provider of choice. Accessibility to high-quality healthcare must be guaranteed to any holder of the NHIMA card.

Since it is a government driven scheme, it is imperative that information is widely available even to the remote parts of country so that clients get to know what kind of services they are eligible for and where they can access the services. It emerged that knowledge on which medication that is provided under NHIMA is not clear for most respondents hence they end up opting for other service providers. The issue of long queues is another reason as to why people have never accessed NHIMA services as they shy away from the accredited health facilities. Some people prefer to go to private hospitals where they pay cash and receive quick services. Even though private hospitals are a bit expensive, it was cited that at least they are guaranteed of getting the medication prescribed whereas with NHIMA, some prescribed medications might not be readily available in their accredited pharmacies.

While some people are willing to recommend others to NHIMA especially considering its affordability, they have inadequate knowledge to the specific products offered. As such, people are suspicious about NHIMA services because it's a government institution and many people cited that they generally have negative perceptions with government run institutions. Furthermore, some people feel disenchanted in the way NHIMA was implemented as such schemes tend to be optional. It emerged that when NHIMA came, other competitors were already offering better services and because of the mandatory approach of NHIMA, people now queue for services. NHIMA is also viewed as a preserve of the medium and high-class citizens, those in rural areas are somewhat sidelined by NHIMA.

Respondents suggested that the medication that can

be accessed under NHIMA should be highlighted and the workforce reinforced, instead of queuing up and still not get the prescribed medication. They should supplement on the services and simplify the system to make it easy even for some people who are illiterate. In terms of its services, NHIMA must stretch its borders so that it starts to operate in private hospitals as well rather than limiting itself to public hospitals and mine hospitals. Even though NHIMA medical aid packages are affordable, there is need to offer a new range of medical aid packages.

The majority of the people did not join NHIMA willingly. Rather, it came as a requirement from their authorities at work. Others received the NHIMA forms together with contract forms such that it appeared as if joining NHIMA is a pre-requisite for one to be employed. Complaints about NHIMA are that many people are not fully aware of it, how it operates yet many people see deductions on their payslips and monies going to NHIMA. Many people stated that they were just given forms to sign without even fully understanding what they were signing for.

In the Western Province, information was said to be scanty with regards to NHIMA's coverage of hospital bills and purchasing of some drugs in pharmacies. However, the challenge is that not many facilities around some areas are accredited with NHIMA. This is made worse by the fact that proper contact details of NHIMA that are operational 24/7 are difficult to access. Complaints of age limit for beneficiaries were discussed and it was suggested that they be moved from 18 years to 25 years.

SECTION 12
CONCLUSION AND RECOMMENDATIONS

12.1 Conclusions

This study was commissioned to investigate NHIMA client satisfaction regarding utilisation of insured health services, identify gaps, and generate valid and consistent customer feedback to provide input to strategies to retain customers and improve health care delivery on the National Health Insurance Scheme. A country wide survey was designed to respond to this call and included, among others, the collection and analysis of data as well as producing a report detailing the main objective and specific objectives. This study informs NHIMA and the government in general of a number of aspects the authority needs to improve general health service delivery.

The levels of customer satisfaction with respect to various services provided were found to be varied. There were situations where clients were satisfied while in others, they clearly expressed need for improvement. For example, while the speed and quality of services provided were attributes clients found generally satisfying, it is also true that they were less happy with such attributes as communication, responsiveness to customer feedback and certain physical attributes such as ambience.

In this regard, NHIMA has a duty to interrogate its clients on prospects of improving aspects projected as "less satisfactory". One major complaint from almost all data collection procedures was the time it takes for clients to be served, and also, availability of medicines. In most instances than not, NHIMA clients feel the time it takes to receive a service is extremely long and this was indicated in almost all sampled areas. It was also found that lack of medicines is one such big lacuna in the provision of adequate, quality health services. The summary of the verbatim is as follows:

> *"What I have seen is that this project has a lot of challenges. The process is too long. Because, honestly speaking, we came a long time ago. Up to now we have not been attended to. They keep telling us, 'go to that office, then to that one,' and so on. We are patients. You never know, one may die in a queue while awaiting to be attended to. They need to improve in terms of speed of service".* **FGD, St Francis, Katete**

> *"I think everything in terms of services needs to be found at one place. Hmm. That's all I can say. Everything should be located in one place. Not that you go to that and that office. You move from one office to another. Whereby, Ok, even medicine must be found right here in one place. Medicine should be available here. Not that you go looking for it in some other location. That is a bit far off".* **FGD, Chelenje Level 1, Lusaka**

This study found that the operations of the scheme has had some identifiable gaps that require NHIMA and the government to pursue and hopefully minimise. For example, from the client's perspective, there is substantial information gaps; where results from this study clearly suggest that a number of people on NHIMA have quite very little information on the operations, complaint procedures, services available etc

.

On the part of HCPs, some gaps were observed bordering more on their ability to provide the services as prescribed by NHIMA. For example, results in this study show that some HCPs lack machinery to conduct detailed investigations for lab referrals, radiology etc, which equipment is needed to satisfy service delivery to clients. Lack of these attributes is a clear mismatch between what NHIMA says it does for clients and what clients find at HCPs. This again does not reflect well on adherence to commitments set out in the service agreements which NHIMA has with HCPs.

Some HCPs also felt that certain decisions which required NHIMA response and authority took too much time to be responded to or never get responded to at all. Notwithstanding, it must be mentioned that some of these observations were not universal as some HCPs were generally conversant and never expressed such lacunas emphatically. In a number of instances, HCPs are quite elated with the improved funding from NHIMA which accordingly has "improved greatly" in recent times compared to the past few years.

The complaint management system is a very critical

component in service delivery. NHIMA, through this study, endeavoured to investigate how this process is satisfactory to both clients and HCPs. Connected to the complaint management system is also the effectiveness of the customer feedback mechanism. In this study, while some clients do have some knowledge of both systems, majority do not have; and these aspects were also highlighted by some HCPs who indicated that NHIMA clients do not seem to know how to channel their complaints to NHIMA and even when they do, they feel the response time is too long and in some instances, they never get any satisfactory response at all. For Example, a client in a FGD process said:

> *"I've used the toll free before; again there was another instance when I used both instances and I never got any feedback. I have not tried to lodge in any complaint because I never get feedback"* **FGD, *Choma***

NHIMA, as a brand and a health insurance authority, has been advertised extensively. Much of the information prescribed for clients is generally adequate and relevant. The authority has gone miles to ensure information sharing platforms such as the website, adverts in the media are stocked and updated frequently. The purpose of this process has been well articulated and a number of clients and HCPs appreciate these avenues. This study found that while this has been outstanding, some HCPs suggested as follows (verbatim):

> *"NHIMA has to help us with advertising the package as well; of course the package is self-advertising but it's good to have a deliberate advertising kind of program both in local language and English in all the networks; be it radio and TV, so that people can be educated, and also do some campaigns of some kind which can be supported; am not sure as to whether NHIMA can support campaigns where health staff can actually go into the community under public health, and advocate for the NHIMA package, that is what we would love"* **HCP – *Eastern Province***

Among the many objectives this study aimed to measure and achieve was to determine an overall customer satisfaction index. This component was measured by compositing a number of indicators which included the consummation and collation of outcomes that directly or indirectly spoke to the 5As principles. It is our understanding that to measure overall client satisfaction, one needed to ensure the foci of NHIMA as anchored on the 5As principles was adequately amplified and reflected. It is also notetaking that the 5As interrogate satisfaction from both the service providers (HCPs) and the clients. For each of the five principles, results show variations in levels of satisfaction. For example, out of a score of 5 for accessibility, NHIMA clients and HCPs scored 4 (or 80%). However, on the principle of accommodation, the score was 3 out of 7 (or 45%) which is indicative of the need to improve on the delivery of attributes that form this particular principle.

This study has demonstrated that while NHIMA and services providers alike are relatively a new phenomenon to the provision of universal health insurance coverage, it is a mechanism with high potential to improve access to affordable, quality and responsive medical health care for all Zambians and thereby contribute greatly to the United Nations Sustainable Development Goal Number 3, target 3.8 where Universal Health Coverage is highly emphasized and expected of among UN member countries. Not only is this platform convenient for individuals and persons on official government or private sector "pay rolls", our study has shown that even those not formerly employed will be served adequately with minimal contributions thereby setting potential and adequate momentum to achieve health outcome dictates as outlined through the 8th National Development Plan and Vision 2030.

12.2 Recommendations

The following are recommendations for NHIMA to work around to improve service delivery and client satisfaction:

1. Owing to the lack of or limited availability of information about NHIMA and the services provided under the National Health Insurance Scheme, NHIMA must restrategise information sharing by designing effective and varied communication platforms to inform different target groups, including the vulnerable groups and the informal sector, on all aspects of the scheme, particularly the benefit package and registration;

2. Due to generalized complaints and observations, and also a finding from this study on the time it takes to serve clients, NHIMA and HCPs are required to quickly work on a model that would speed up service delivery in all accredited HCPs; this should first require interrogation of why there is this delay, and thereafter, model a response to that effect;

3. Considering that some NHIMA members end up paying for services that are in the benefits package, NHIMA should ensure that the accredited HCPs have the capacity to deliver the desired quality healthcare services, especially regarding drugs, medical supplies, and medical equipment;

4. In view of the low use of the website by NHIMA members, NHIMA should make it more user-friendly and develop a USSD code that could easily accommodate most clients countrywide given the internet challenges that most rural parts of Zambia currently face. NHIMA members could have the option to either use the website or the USSD code to access vital information about the scheme;

5. For specific items relating to perception of healthcare quality service provision relative to registration, vitals, consultations, diagnostics, pharmacy and admissions, NHIMA needs to engage accredited HCPs on the following:

    a. Where patients report not being checked for vitals, NHIMA should engage HCPs to ensure all machinery for vital checks are available and functioning effectively and well serviced all the time;

    b. The study found that in a number of sections of complaints of delayed health service delivery for NHIMA clients, through the HCPs, NHIMA needs to monitor that accredited facilities have enough health officials to provide satisfactory services to clients;

    c. Majority of clients talked to were of the view that since some pharmacies in hospitals lacked drugs, and some NHIMA accredited pharmacies are located distances away such that some NHIMA clients end up going home without accessing drugs, there is therefore need for NHIMA to work on a model that will ensure well stocked pharmacies are in close proximity to the hospitals for ease of access by clients; and,

    d. With regard to concerns from NHIMA clients on admissions where patients (NHIMA or not) are sometimes mixed up with those from general admissions, NHIMA needs to engage HCPs to find a solution on how admission wards can be remodeled for NHIMA clients only, and separated from general admissions.

6. In the "case study" on clients who contribute but have never accessed services under NHIMA, where such clients have negative perceptions which they have heard regarding the quality of health packages under NHIMA, it is imperative for NHIMA to communicate and disseminate correct information across the country using suitable channels for this particular target group;

7. It is clear that NHIMA is not yet capacitated to provide all the services required by its members such that there are NHIMA clients who have never accessed any of its services. These members rather prefer to use other medical services with capacity to offer the needed services. This means they make double medical aid payments - to their preferred service providers and to NHIMA, a mandatory statutory requirement.

    It is in this vein that NHIMA should explore the possibility of collaborating with other service providers by way of sharing shortfalls encountered by either party. Furthermore, working in collaboration with other service providers will ensure the attainment of Zambia's health vision which is ***'To provide equitable access to cost-effective, quality healthcare services as close to the family as possible'***; and,

8. In order to increase service delivery by the accredited facilities, NHIMA should consider coming up with graduated payments system for the facilities based on the scores they accrued in the past assessmnet. This assessment should be done by an independent organisation.

NEXT STEPS – Research Agenda

In order to keep up with all or most service delivery indicators inclusive of service satisfaction, NHIMA should institute an annual satisfaction survey, or where this is not possible, a two-year satisfaction survey should be considered in order to keep truck as well as a vital source of M&E data for service delivery improvement and for effective planning.

SECTION 13
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