Original Research Article

CLIENTS' PERCEPTION AND SATISFACTION WITH NATIONAL HEALTH INSURANCE SCHEME SERVICES: A STUDY OF ACADEMIC STAFF OF USMANU DANFODIYO UNIVERSITY, SOKOTO

Abstract

Aim: To assess clients' perception and satisfaction on with the National Health Insurance Scheme.

Study Design: This descriptive cross-sectional study conducted between Octobers to and December, 2017, focused on academic staff who were clients' of (NHIS) at the Usmanu Danfodiyo University, Sokoto, Sokoto state, Northwest, ern part of Nigeria.

Methodology 278 eligible academic staff completed a self-administered questionnaire, using systematic samplings

Result: Findings revealed that majority (99.3%) of the respondents were aware of the NHIS and less than half (48.9%) of the respondent enrolled into the scheme, with majority (59.6%) accessing their services at University clinic. However about half (53%) of the 278 respondents had poor knowledge of how the scheme works, but with 60.4% of them agreeingd that NHIS has provided easy access to healthcare and while 79.1% agreed that it protects families from financial hardship of large medical bills. Out of one hundred and thirty six 136 academic lecturers (48.9%) who enrolled into the scheme, 67.6% were dissatisfied with the process of enrolment while 68.4% were satisfied with the attitude of NHIS staff. With regards to the waiting time at NHIS clinic, 58.8% were dissatisfied, and majority 72.8% were not satisfied with the drugs received at the NHIS pharmacy. Finally, among the enrollees' majority 72.1% of the respondents rated the overall satisfaction as poor and would not recommend the facility for family members/friends.

Conclusions Based on the findings, it was concluded that the clients' overall satisfaction with service provision was poor. It is recommended that periodic survey of clients' satisfaction and factors influencing it should be carried out by health Institutions and findings used as guide in policy and decision making towards improving service deliver and client satisfaction.

*Keywords: **Employees**; Health; insurance; clients; perception; satisfaction; **scheme**.*

Comment [OD1]: The authors need to give correct and precise details of the sampling method.

Comment [OD2]: Why single out academic lecturers out of the respondents? This statement needs clarification and review.

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INTRODUCTION

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized more than 30 years ago by the Alma-Ata Declaration signatories, who noted that Health for All would contribute both to a better quality of life and

also to global peace and security. The World Health Assembly (WHA) resolution stated that, from 2005, everyone should be able to access health services **and not be** without being subjected to financial hardship in doing so. Till date, the world is still a long way from universal health coverage. In some countries, up to 11% of the population suffers this type of severe financial hardship each year, and up to 5% is forced into poverty. Globally, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line (WHO, 2010).

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Health financing is an important part of broader efforts to ensure social protection in health. As such, World Health Organization (WHO) is a joint lead agency with the International Labour Organization (ILO) in the United Nations initiative to help countries develop a comprehensive social protection floor terms as 'Social health insurance' (SHI) is one of the possible organizational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others. Typically, in the more **mature** developed European SHI system, workers **ing people** and their employers, as well as the self-employed, pay contributions that cover a package of services available to the insureds and their dependents. In most cases, they are obliged to make these contributions by law. Many governments also pay subsidies into these systems in order to ensure or improve their financial sustainability. **More recently.** WHO has also shown commitment**ted** to renewing primary health care, and health insurance is attracting more **and more** attention in low- and middle-income countries, as a means for improving health care utilization and protecting households against impoverishment from out-of-pocket expenditures. The health financing mechanism was developed to counteract the detrimental effects of user fees introduced in the 1980s, which now appear to inhibit healthcare utilization, particularly for marginalized

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populations, and to certain extent sometimes lead to catastrophic health expenditures. The World Health Organization (WHO) considers health insurance a promising means for achieving universal health-care coverage. Various types of health insurance scheme are available;. National or Ssocial Hhealth iInsurance (SHI) is based on individuals' mandatory enrolment. Several low- and middle-income countries, including the Philippines, Thailand and Vietnam, are establishing SHI. Voluntary insurance mechanisms include Private Health Insurance (PHI), which is implemented on a large scale in countries like Brazil, Chile, Namibia and South Africa. Community-Based Health Insurance (CBHI), is now available in countries like the Democratic Republic of the Congo, Ghana, Rwanda and Senegal. The various types of health insurance have different impacts on the populations they serve, . **For example,** i.e. PHI is said to mainly serve the affluent segments of a population, but CBHI is often put forward as a health financing mechanism that can especially benefit the poor. Hence cCountries wishing to introduce health insurance schemes into their health systems should be aware of how their impact varies. The impact of health insurance in low-and-middle-income countries has unfortunately been documented only partially. Previous reviews have evaluated the performance of CBHI in terms of enrolment, financial management and sustainability. A recent review by WHO provides an overview of the scope and origin of CHI in low- and middle-income countries, with a particular focus on China, Ghana, India, Mali, Rwanda and Senegal, and also assesses CHI's performance in terms of population coverage, range of services included and reimbursement rate.

Every country have different ways of its operation, **examples,** i.e. American Workers now pay an average of $1,318 out- of- pocket before health insurance coverage begins to cover part of their bills, up from $584 a decade ago. According to a new report from the Kaiser Family Foundation. That's after paying an average of $89 each month for health insurance (WHO,

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2010). Healthcare in England is mainly provided by England's Public Health Service, the National Health Service **that** provides healthcare to all permanent residents of the United Kingdom which **that** is free at the point of use and paid for from general taxation. Health care is provided by a single payer which is the British government and is funded by the taxpayer. All appointments and treatments are free to the patient (though paid for through taxes), as are almost all prescription drugs. The maximum cost of receiving any drug prescribed by the NHS is $12.

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Right now, health insurance in Africa constitutes a tale of two continents. The very affluent can take advantage of private insurance with top-tier doctors and hospitals. The World Health Organization (WHO) considers health insurance "a promising means for achieving universal healthcare coverage. "Africa has the highest burden of disease in the world but as recently as 2007, more than half of African countries spent less than $50 per person on health. Of the total health expenditure, 30 percent came from governments, 20 percent from donors, and 50 percent from private sources including patients themselves paying out-of-pocket. The burden of paying out-of-pocket is an important barrier for seeking health care in Sub-Saharan Africa and contributes to inequity in access to health care.

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Several African nations are slowly **"**moving towards the direction**"** of universal health coverage and national health insurance plans. But many African governments lack the political will to introduce plans, or the ability to design plans with innovative funding mechanisms to pay for them, only Rwanda and Ghana appear to have made significant progress toward providing universal health coverage through a National Health Insurance Scheme for the majority of their citizens. In countries **which have some manner** with some forms of non-national health insurance schemes whether community, private- or employer-based, their reach is typically very limited. **"**Many African countries, including Nigeria, Tanzania, Kenya, Uganda, and Cameroon

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have community-based health insurance schemes that offer protection for the poor but are unsustainable because poor people can't contribute enough premiums to maintain the schemes., Ghana is the only country in Sub-Saharan Africa that successfully implemented a social health insurance at national level. Other countries, including Uganda and South Africa, aim to implement national health insurance, with varying success (WHO, 2010)

Nigeria's ten year plan for development and welfare (1946-56) incorporated the first attempt at planning for Health services in Nigeria (Aderounmu 1992). Since 1st October 1960, successive Nigerian governments (Civilian and Military) have come up with the 2nd, 3rd and 4th National Development Plans, all of which have substantial portions dedicated to addressing issues related to national health care system. Today, the Nigerian health system is stratified into primary, secondary and tertiary health care levels with the primary level designed to take health care delivery literally to the doorstep of the populace and act as the gatekeeper to the health care system. Before the advent of the National Health Insurance Scheme (NHIS), heath care services to government officials, their dependents and students were supposed to be free while the general populace was expected to pay out of pocket (OOP) for health services received at all levels of the health care system. Health insurance as a complementary or alternative source of health care financing has become important in the developing world (McIntyre, 2007).

The rising cost of health care services, as well as the inability of the government health facilities to cope with the people's demand necessitated the establishment of National Health Insurance Scheme (NHIS, 2005). The history of the NHIS dates back to 1962 when the need for health insurance in the provision of health care to Nigerians was first recognized (Akande and Bello, 2002; Katibi and Akande, 2003). It was fully approved by the Federal Government in 1997,

signed into law in 1999 and launched officially on the 6th June 2005. The Scheme is designed to provide comprehensive health care delivery at affordable costs, covering employees of the formal sector, self-employed, as well as rural communities, the poor and the vulnerable groups. The NHIS in Nigeria seeks to provide health insurance, so that insured persons and their dependents are able to have access to good quality and cost-effective healthcare services (NHIS, 2005). **But, t**The formal sector programme of the NHIS specified that contributions made by or for an insured person qualifies him or her, a spouse and four biological children under the age of 18 years to a defined health benefits package (NHIS, 2005).

There is a general consensus that perception involves the process of selecting, organizing and interpreting information about a person, product, service or a situation and coming to a subjective or an objective conclusion about the thing or situation. Ifezue, (1997) indicated that perception is the meaning an individual attaches to a given situation and this is based on accumulated past experiences of the individual involved. Perception originated from the Latin words "perceptio" or "percipio" which means receiving or acquiring of sensory information. Perception is an active process responsible for organization of sensory information into simple, meaningful patterns, (Ornsterin & Carstensen, 1991).

Perceptions made of events or entities depend on how we interpret what we see, what we feel, what we smell and what sound we hear. **with our ears.** One's perception of a thing or an event is modulated by previous experiences. This is as a result of learning, **his** attitudes and interests, as well as current needs and the prevailing circumstance. Perception is also seen and described as the consciousness of an object or an event. Berelson and Steiner (1964) saw perception as the process involving selection, organization and interpretation of information

inputs to make a meaning out of the world. Our perception of an object or an event determines what our reactions will be.

Theories of Perception

Perception as a theme has impressed so much on many scholars that a significant number of theories have emanated over time. Some of these prominent theories are the ecological, and constructivist.

I. **Ecological theory of perception**: Ecological theory of perception emphasizes that perception is direct and that it functions like a radio interacting with definite stimuli emanating from the object or event of interest (Gibson 1979, Shepard, 1984). The belief of this theory is that the information for color-vision is present in the receptors. The theory emphasizes that all information about attributes of objects or events are present or available to the perceiver.

II. **Constructivist theory of perception:** The constructivist theory differs in that the proponents believe that perception is not receptive and that rather it is a construction of the mind which involves the perceiver's ability to make models of objects and events in the world. Here the creation of an image of what could have accounted for this sensation in the relevant organ must have been information inputs. But for completeness, these decomposed elements are once again assembled or composed into perceptions. They also attempt to develop a computational approach to visual perception.

Literature Review

Study by Alnaif, (2006) on physician's perception of Health Insurance in Saudi Arabia showed that health care service is a major concern for the respondents. Secondly, the respondents believed that "everyone in the Kingdom should have access to health care services". They also believed that SHI would improve access to health care, **would** lead to more regulations and

utilization, **and** create more competition for health care providers and **create** more jobs in the health sector. Another study on Perception and Demand for Mutual Health Insurance in the Kassena-Nanka District of Northern Ghana by Akazili et al (2005), **study** revealed the following findings: (1) existence of risk-sharing groups such as farmers groups, women groups and church groups whose members contribute money for funerals and other general needs; (2) 93% of household heads had knowledge of the cash and carry system (3) forty-four percent of those interviewed were aware of governments plan to replace the cash and carry system with a social health insurance scheme (4) About 93% of community members indicated interest in the scheme and were willing to contribute. On the contrary, a few people believed that contributing money **ahead of** prior to the occurrence of sickness **that will come** could attract such illness and that forcing the sick to pay before receiving care, instead of receiving care before payment, could constitute a major setback to the implementation of the scheme.

Patients' Perceptions of service quality in group versus solo practice clinics (Lin et al, 2004) the study objectives were to compare patients perceptions of service quality at solo and group practices, and to examine the association of perceptions with "potential patient loyalty" (PPL), clinics in Taiwan, the results showed that group practice patients perceived significantly higher service quality on all dimensions as against the outpatients registered with solo practitioners. It was also discovered that all service quality dimensions except assurance were significantly positively associated with PPL.

Perception of National Health Insurance Scheme (NHIS) by health care Consumers in Oyo State, (Awe and Sanusi, 2009), showed that (1) There is a relationship between socio-economic indices and perception of the programme, (2) 87% of the respondents were aware of the programme, (3) About 72% of the respondents indicated that there was delay in attending to

them for health care services and (4) 87% of respondents did not see any significant difference between the services provided under the cash and carry system and the NHIS.

Awareness and Perception of National Health Insurance Scheme (NHIS) among Radiographers in South East Nigeria, (Okaro, Ohagwu and Njoku, 2010). Shows: (1) there is a generally high level of awareness of the programme among the respondents; (2) seminars in hospitals are very important tools in sensitizing healthcare professionals, (3) participation in the scheme is low among the study population (4) there is paucity of knowledge of the operational principles of the scheme, (5) the study population was positively disposed towards the scheme.

A survey on perception of dentists in Lagos State by Adeniyi, (2010) reveals that 61% had only a fair knowledge of the NHIS but 76.6% believed it would expand access to dental care by improving affordability and availability of services**.,** **a**Another survey by Olugbenga (2010) on the knowledge and attitude of civil servants in Osun State, Southwestern Nigeria, showed that the NHIS documented that none had a good knowledge of the components of NHIS, 26.7% knew about its objectives, and 30% knew about who ideally should benefit from the scheme. Study by Sanusi, (2015), on assessment of awareness level of NHIS among health care consumers in Oyo State, Nigeria revealed that 72% of respondents claimed that they were not promptly attended to by their providers and hence wanted the program to discontinue. Another study which addresseds the issue of access constraints for government employees in Abakaliki, Ebonyi State, by Oyibo, (2011) found out that NHIS enrollees had little difficulty in accessing health care compared with those relying on OOP payments. A study to assess the impact of the NHIS in promoting access to healthcare by Ibiwoye, (2008) identifies the ineffectiveness of the scheme. Another study by Osuchukwu et al, 2013 **that** which evaluateds the impact of NHIS on healthcare consumers **among 200 participants** in Calabar metropolis, Southern Nigeria, documented that **108 (**54.0%**)** respondents agreed that the quality of health care services rendered was better than before, while**,** **77 (**38.5%**)** respondents felt the quality of health services was the same as before. Only **15 (**7.5%**) respondents** said that health services rendered is worse than before. A survey on users' satisfaction with services provided under NHIS in Southwestern Nigeria by Osungbade et al (2014) showeds that 60% of respondents encountered problems with their healthcare providers.

These included long-queues, poor reception from unfriendly health workers, inefficient treatment, and unclean environment. In another study by Shafi'u, 2010, among staff of Ahmadu Bello University (ABU) Zaria to assess client's satisfaction with the NHIS in Nigeria reports low Satisfaction which is attributed with longer duration of enrollment.

Comment [OD21]: Consider merging literature review with introduction. Review and shorten it.

METHODOLOGYS

Study Area

Sokoto is situated in the Northwestern part of Nigeria. The State was created from Old North-western in 1976; it assumed its present form after the creation of Kebbi State (in 1991) and Zamfara State (in 1996) It is bounded by Zamfara State to the South, Kebbi state to the west, Katsina State to the east and Niger Republic to the North. The State has 23 Local Governments with Sokoto Metropolis being the capital, and the capital comprises of the Sokoto North, Sokoto South and some part of Dange Shuni, Kware and Wamako Local Government Areas, The metropolis is the seat of government and popularly called the seat of caliphate. It lies between longitudes of 05. 11^0 to 13. 03^0 east, Latitude 13 00 North and covers area of 60, 33 square km. The average projected population of the state for 2015 is 4,886.888 (UNFPA, 2015) with the metropolitan having 425,969 (2006 census) Sokoto covers a total land area of 26,595,000m^2. The state has an average annual temperature of 28.3° C (82.9° F), it is one of the hottest cities in the country. The annual rainfall ranges between 500mm – 1,300mm and occurs between May and September with a peak in August. The dry season usually spans from November to March during which there is harmattan period that is characterized by the cold dusty wind between the months of November to February. The hot period starts from March and ends around May during which the recorded environmental temperatures are in the range of 38^0C – 42^0C with an average humidity of less than 20%.The people are mainly Hausa/Fulani; others are Zabarmawa, and other various tribes from different parts of the country while Islam is the predominant religion. The

vegetation is that of Savannah zone with grassland suitable for the cultivation of grains and animal husbandry. The people are mainly farmers. However, some engage in art work like shoe making, tanning, dying and other various kinds of trading

Usmanu Danfodiyo University, Sokoto (formerly University of Sokoto) is one of the four Universities established by the Federal Government of Nigeria in September 1975, at which time three University Colleges (now full-fledged Universities) were established. The development of the university started on a temporary site (now called City Campus), situated along Sultan Abubakar Road, Sokoto. Classes started in October 20th, 1977, with an initial enrolment of ninety-three undergraduate students for the degrees of Bachelor of Arts, Bachelor of Arts/Science in Education and Bachelor of Science; and an academic staff strength of thirty-three. In January, 1978, one hundred and two students enrolled for a two-year pre-Degree Programme in the Humanities and Basics Sciences. With this modest start, the Usmanu Danfodiyo University, Sokoto formally graduated a total of seventy-two students during its first convocation held in November 22nd, 1980. Presently, there are thirteen faculties and a postgraduate school in the University, as follows

1.Agriculture
2.Art and Islamic studies
3.Basic medical sciences
4.Clinical science
5.Education and Extension service
6.Engineering
7.Law
8.Management science
9.Medical laboratory
10.Pharmacy
11.Science
12.Social sciences
13.Veterinary medicine

The above faculties have various departments and units under them. The following table gives the distribution of the various departments and units in the university as at the time of this study that is October to December 2017.

Distribution by faculties, departments and number of lecturers

FACULTY	DEPARTMENTS AND UNITS	LECTURER
Agriculture	Animal sciences. Crop science. Fishery. Forestry	51
Art and Islamic Studies	Arabic. English. French. Islamic studies. Nigerian languages. Modern European languages and linguistic.	130
Basic Medical Sciences	Anatomy. Biochemistry. Chemical pathology. Microbiology. Hematology. Physiology and Pharmacology.	78
Clinical Sciences	Community Health. Medicine. Nursing sciences. Obstetrics and gynecology. Paediatric. Psychiatric. Radiology. Radiography. Surgery	125
Education and Extension Service	Adult Education and Extension services. Curriculum studies and Educational technology. Educational foundation. Science and Vocational Education.	71
Engineering	Civil engineering. Mechanical engineering and Electrical	24
Law	Public law and Jurisprudence. Islamic law. Private and business.	26
Management Sciences	Accounting. Business Administration and Public Admin	47
Medical Laboratory Sciences	Chemical pathology. Hematology. Histopathology. Immunology. And Microbiology	56
Pharmacy	Pharmacogenic and ethical medicine. Pharmacy and Toxicology. Pharmaceutics and Pharmacy microbiology. Pharmaceutics and medicine chemistry. Clinical pharmacy and Pharmacy practice	69
Science	Applied chemistry. Biochemistry. Biology. Pure chemistry. Microbiology. Geology. Physics. Mathematics. Computer science. Statistics.	175
Social Sciences	Economics. Geography. Political sciences and Sociology	74
Veterinary Medicine	Anatomy. Biochemistry. Medicine. Microbiology. Pathology. Parasitology. Pharmacology. Physiology. Public health.	50

	Theriogenology. Surgery and Radiology	
TOTAL		**976**

The University Statute established the center for Islamic Studies in 1982. Its aim, among others, is to promote the study of and research in Islam, Its instructions and related disciplines and its culture with special reference to the northern states of Nigeria. The center runs a diploma programme in Islamic Studies, which started in 1983, to assist in the manpower development of the locality and the country at large. The center also runs Certificate Courses in Arabic and Islamic Studies.

In November 1982, the Sokoto Energy Research Center was established at the instance of the Federal Government. The Center was created not only to execute research in solar energy, but also to train and develop manpower in that area.

The postgraduate school of the University was established in 1983 for the training of graduates in various disciplines at the Masters and Doctorate degree levels. At the convocation ceremony held in December, 1986, the school produced its first PhD graduate in Chemistry.

The University moved most of its faculties and Service Departments to the main campus in 1982. Phase 1 of Students' hostels had already been completed and occupied.

The City Campus now houses the Faculty of Veterinary Medicine, the College of Health Sciences, and Center for Islamic studies, Cibiyar Nazarin Hausa, the Department of Extension Services. Recently there were new building for faculties of law, social sciences and management science along Kware road in the university premises, a few services units and three Halls of Residence for students' accommodation. The university Catering Guest House, now named the University Guest Inn Limited, which runs on commercial basis, is located at Mabera layout.

Study Design

A descriptive cross sectional study design was used for this study. This design has been used by several authors that carried out studies related to this study (Osungbade et al, 2014; Dalinjong et al 2012; Iliyasu, et al, 2010 & Onyedibe, et al 2012). Therefore, it is deemed appropriate for this study because it collected the data in a natural setting of the respondent, it entails systematic collection of relevant data and the statistical analysis of the data so as to present a clear description of respondents' perception and satisfaction of NHIS service delivery in Usmanu Danfodiyo University Sokoto

Study population

The population comprised of Academic Staff Union members of Usmanu Danfodiyo University Sokoto, Nigeria. All academic staff members of Usmanu Danfodiyo University Sokoto that are on ground during the study period October to December 2017. Lecturer that are on Study Leave are not involve in this study, meanwhile Non Academic Staff member were also excluded in this study

Sampling Procedure

Respondents were selected using the simple random sampling technique. Academic lecturers in the University are divided into faculties. A faculty is made up of a department and units where lecturers are operating from in a given department. As at the time of the study, there were 976 academic staff in 13 faculties in Usmanu Danfodiyo University Sokoto. A list of these faculties was obtained from the University Data manager 2017, and all the faculties were selected. Proportional allocation was used to select 278 respondents from the faculties, then simple random sampling were done to select the respondent in each department.

Comment [OD22]: How was the sample size arrived at? Why was simple random using used? More Details needed.

Data Collection Procedures

For this study, primary data came from academic staff lecturer of Usmanu Danfodiyo University Sokoto (UDUS) who are present at the time of the study. Questionnaire was used as the means of collecting data. Thus, the study was structured, questionnaire administered to respondents as the principal method of data collection. The questionnaire probed into the following: demographic characteristics of respondents (age, sex, marital status, family size, and education), perception and satisfaction of clients' towards NHIS services. Questionnaire was chosen as the suitable instrument for data collection considering the fact that it is cost effective, ensures uniformity, avoids ambiguity, avoids errors, saves time and has a relatively high degree of standardization

Data Analysis

Data collected were **entered into the computer and** analysed using SPSS software version 20.0. Categorical data were presented as cross tabulations and test of significance was by Chi square at 95% confidence interval. The analyses were carried out using variables such as the socio-demographic background (independent variables) and dependent variables that included enrollees' perception of the health insurance scheme, satisfaction with access and quality of care provided by the Health Care Providers (HCPs) and, suggestions for improving the scheme.

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RESULTS

Socio-demographic Characteristics of Respondents

A total of 278 academic staffs completed the self-administered questionnaire within three month of this study. with There were x males representing 96% of the respondents. and. Aages of respondents ranged from 40 to 49 years, with mean age of 28.6 years and median of 29 years. Majority x (92.1%) of them were married with 5-10 children (31.7%). About half x (48.9%) of the respondents had been enrolled with the scheme and majority x (59.6%) of them accessed services at University clinic followed by and x (27%) at UDUTH, Sokoto

Knowledge of the Scheme

Majority x (99.3%) of the respondents were aware of the NHIS, but Oover half x (53%) of the respondents had poor knowledge of the scheme (figure 1)

Figure 1: Pie Chart showing overall knowledge scores of the respondents on how NHIS works

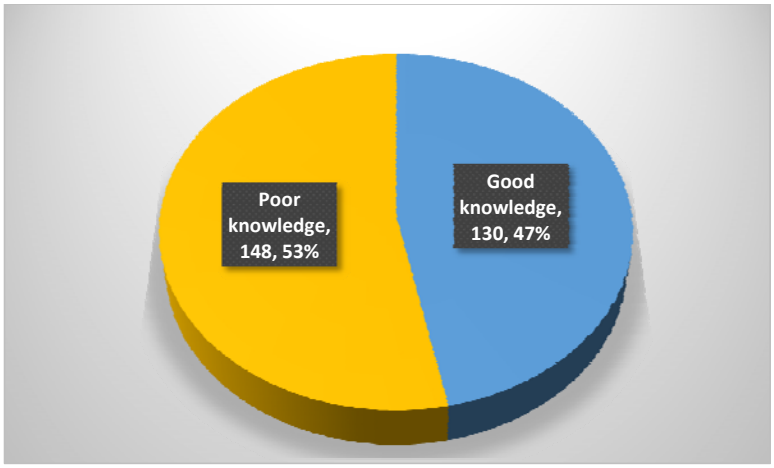

Table 1. Respondents' perception of National Health Insurance Scheme (NHIS)

Vvariables	Agree (%)	Disagree (%)	Undecided (%)
Do you Consider NHIS service provides up to date medical services	120 (43.2)	136 (48.9)	22 (7.9)
NHIS has provided easy access to healthcare	168 (60.4)	92 (33.1)	18 (6.5)

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I prefer NHIS services to the cash-and-carry system of healthcare	200 (71.9)	60 (21.6)	18(6.5)
Protect families from financial hardship of large medical bills.	220 (79.1)	52 (18.7)	6 (2.2)

Majority x 71.9% of the respondents preferred NHIS services than the cash and carry system of health care, x 79.1% agreed that it protects families from financial hardship and x 60.4% **perceives** felt the services provide easy access to healthcare. However majority representing about x 49.1% disagreed that NHIS provides up to date medical services

Table 2: Respondent satisfaction with the NHIS services

Variables	Satisfied (%)	Dissatisfied (%)	Undecided (%)
Process of enrolment/registration with NHIS	34 (25)	92 (67.6)	10 (7.4)
Waiting time at NHIS Clinic	52 (38.2)	80 (58.8)	4 (3)
Attitude of NHIS staff	93 (68.4)	26 (19.1)	17 (12.5)
Referral system	68 (50)	40 (29)	28 (21)
Drugs received	29 (21.3)	99 (72.8)	8 (5.9)
Investigation covered	68 (50)	60 (44.1)	8 (5.8)
Co-payment plan	40 (29.4)	43 (31.6)	53 (39)
Access to specialty care when ever needed	34 (25)	66 (48.5)	36(26.5)
Overall scheme service	26 (19.1)	98 (72.1)	12 (8.8)

Among One hundred and thirty six academic lecturers representing 49.1% who enrolled into the scheme, 67.6% indicated their dissatisfaction with the process of enrolment while (68.4%) were satisfied with the attitude of NHIS staff. With regards to the waiting time at NHIS clinic, 58.8% were dissatisfied, and majority 72.8% were not satisfied with the drugs received at the NHIS pharmacy. However, majority 72.1% of the respondents did not satisfied with the overall scheme service. Overall satisfaction of the program in this study shows 72% of the respondents dissatisfied with the scheme.

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DISCUSSION

Modal age of respondents was 40-49 years, while the mean age was 28.6.6±7.03. This falls within the work-force age. Findings revealed that NHIS program appears to be well patronized as majority of respondents were married, and whose family members are equally expected to register as well with the scheme. Awareness of NHIS by the respondents in this study might be due to the fact that almost all of respondents had tertiary education coupled with their working environment which might make them to be conversant with any National health policy such as NHIS in the country. This will enhance their awareness of the benefits of the scheme such as access to quality healthcare, prompt and adequate treatment of their ailments. The level of awareness regarding the NHIS in this study was very high 99.3%. This is similar to study done by Sanusi et al in 2009 to assess the awareness level of NHIS among healthcare consumers in Oyo state, the report showeds that 65% of the respondents are aware of NHIS. Evans and Shisana found that awareness of the NHI in South Africa was very high, with 90.8% of the respondents expressing that the NHIS should be a national priority and over 80% saying they would prefer it to the current healthcare system. Awareness about the NHI in South Africa exceeded that of Uganda, where only 40.7% had heard about the proposed Social Health Insurance scheme and more than a half of the respondents (57.3%) had never heard about it. This post-test level of awareness about NHIS might be attributed to the work of the Monash-Oxfam NHI project and their collaborating Partners who conducted community consultation processes to raise awareness about the NHIS in these areas. In this study, 53% of the respondents reported that they heard or became aware of the NHIS from friends and relatives, this is different from the study of Evans that found electronic media such as radio or television, as the main sources and 38.3% said they heard or got information from a community organization

Comment [OD40]: Fair. But author should provide a more robust implications of the results instead of just comparing with previous results. Consider Reviewing the entire discussion

Comment [OD41]: Which report?

Knowledge about what the NHIS was all about was generally poor. In this study 53% of the respondents did not know how the NHIS works. This is somehow differentce from finding of Iyabode et al (2017) that found 51.4% had good knowledge while 48.6% had poor knowledge about NHIS program and also to that of Salawudden (2011), in Kaduna found out that majority of the respondents 71.5% had good knowledge of what NHIS entailed and also similar to from finding of Study by Geoffrey, (2015) in sSouth Africa on Public awareness and knowledge of the NHIS among Client attending Hospital reveal that, 52.4% of the respondents had knowledge of the NHI modalities while 44.6% did not know but different with the finding of Olugbenga et al,(2010) on Knowledge and attitude of civil servants in Osun state, Southwestern Nigeria towards the national health insurance. Shows none had good knowledge of the components of NHIS, 26.7% knew about its objectives, and 30% knew about who ideally should benefit from the scheme

Study by Awe and Sanusi 2009, shows about 72% of the respondents indicated that there was delay in attending to them for health care services and 87% of respondents did not see any significant difference between the services provided under the cash and carry system and the NHIS. About half of the respondents perceived NHIS as a means to improve their health, some of them perceived NHIS as being capable of providing prescribed drugs. However, some respondents preferred to be given monthly medical allowance to take care of their health and that of their dependents than receiving treatment under NHIS Some 147 (42%) of the respondents rated NHIS services as good. In study by Alnaif, 2016 physician perception of health insurance in Saudi Arabia physicians believed that accessibility is a major policy concern and that SHI will have a positive effect on access to the health care system.

Among One hundred and thirty six academic lecturers representing 49.1% who enrolled into the scheme 67.6% indicated their dissatisfaction with the process of enrolment while (68.4%) were satisfied with the attitude of NHIS staff. With regards to the waiting time at NHIS clinic, 58.8% were dissatisfied, and majority 72.8% did not satisfied with the drugs received at the NHIS

pharmacy, however majority 72.1% of the respondents did not satisfied with the overall scheme service.

Overall satisfaction of the program in this study shows 72% of the respondents dissatisfied with the scheme this is similar to the finding of Salawudden (2011) that shows 66% dissatisfaction with the program and 38% respondent enrolled in the program. Study conducted by Iyabode and Esther also reveal only, 48.6% respondents were satisfied with the services of the scheme

Comment [OD42]: The specific areas of dissatisfaction that need to be addressed should be highlighted. The author should suggest specific ways these can be addressed instead of leaving it loose and open.

Conclusions

Based on findings of this study**, it indicate** thae**t** respondents agreed that NHIS service provided easy access to healthcare, protected families from financial hardship of large medical bills and preferred NHIS services than cash and carry system of healthcare, but showed**s** dissatisfaction in the process of enrollment with the NHIS. This implies that the administrative part of the scheme was**is** very ineffective. Since registration is an administrative duty and **is** the first process of enrolment into NHIS**, which should** giving**e** the first impression about the Scheme, the NHIS **scheme** should g**i**ave it **an** the attention **that made** needed towards ensuring enrollees' satisfaction**, the enrollees satisfied with it.**

Comment [OD43]: A more robust conclusion needed based on results.

Recommendations

The following recommendations were made:

(I) Removal of all bottlenecks encountered in the registration process in order to fast track registration of new and existing employees into the scheme, by introducing the National M**m**obile H**h**ealth i**I**nsurance p**P**rogram (NMHIP)**. it's** a novel concept, that provides mobile networks operators the platform to register, select HMO and provider and choose payment option and plans, all on their mobile phone, and at their convenience.

Comment [OD44]: NMHIP is a different program from the Formal sector programme of the NHIS. How does it provide solutions to the formal sector program?

(II) Compulsory enrolment into the scheme should be enforced by the employers at the onset of recruitment process for all working Nigerians, starting with those working in government organizations. This will improve our dismal health indices as most Nigerians will then have access to better healthcare services without the encumbrance of large out of pocket expenses.

(III) Health Maintenance Organizations and healthcare providers must realize that enrollees have the right to choose **who** their service providers **are** and **can** change to another when not satisfied with services rendered. Therefore, it is recommended that every provider strive to provide the best of services and the monitoring agencies (the clinic medical directors) should step up their monitoring antennae in order to curb the menace of dissatisfaction which is fast becoming common place in the scheme.

(IV) Several Nigerians are not fully enlightened in the components and structure of the NHIS. The researcher recommends a massive and far reaching enlightenment campaign in form of seminars, workshop and publications to educate the populace on the scheme.,

Comment [OD45]: Are the Medical Directors the monitoring agencies?

Comment [OD46]: What are the roles of NHIS, the regulatory agency and the HMOs in ensuring standards of service , patient satisfaction and advocacy?

REFERENCES

Adeniyi AA, Onajole AT. National health insurance scheme: A survey of knowledge and opinions of Nigerian dentists in Lagos. Nigeria. African Journal of Medical Science. 2010; 1(1)39:29–35.

Aderounmu A.O, 1992. National Health Insurance scheme in Nigeria, www.oauife.edu.ng accessed on 31st march 2017.

Akande TM, Bello O (2002) National Health Insurance Scheme in Nig. Medilor J. 7(1)

Alnaif, Muhammad S., (2005) "Physicians' Perception of Health Insurance in Saudi Arabia" Saudi Medical journal vol 27 pp. 693 – 699.

Berelson, B and Steiner, G.A, (1964) *Human Behaviour: An Inventory of Scientific findings*, New York: Harcourt

Dalinjong, P.A.& Alenxander, S.L. (2012). The National Health Insurance Scheme: perceptions and experiences of healthcare providers and clients in two districts of Ghana; Health Economics Review 2012 2(13) doi 10.1186/2191-1991-2-13 http://www.health economics review. Come/content/2/1/13

Ibiwoye A, Adeleke IA. Does national health insurance promote access to quality health care? Evidence from Nigeria. Nigeria. Geneva Papers on Risk and Insurance: Issues and Practice. 2008;33(1):219-233. DOI: 10.1057/gpp.2008.6

Iliyasu, Z., Abubakar, I.S., Abubakar, S., Lawan, U.M.& Gajida, A.U. (2010). Patients' satisfaction with services obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. Nigerian Journal of Clinical Practice 2010, 13, 371-8

Iyabode A, G. Esther O.F 2017. International journal of tropical diseases and health Perception and Satisfaction of Employees with National Health Insurance Scheme Services: A Descriptive Study at University College Hospital, Ibadan, Nigeria. 22(1). P 1-12

Katibi IA, Akande AA, Akande, TM, (2003). Awareness and Attitude of Medical practitioners in Ilorin towards National Health Insurance Scheme. Nig. Medical Practitioner Vol 43 No.2

McIntyre D. Learning from experience: Health care financing in low and middle income countries. Global Forum for Health Research, Geneva; 2007.

NHIS. National health insurance scheme operational guidelines. National Health Insurance Scheme Abuja, Nigeria; 2005.

Olugbenga-Bello AI, Adebimpe WO. Knowledge and attitude of civil servants in Osun State, Southwestern Nigeria towards national health insurance scheme. Nigeria: Nigerian Journal of Clinical Practice. 2010; 13(4):421-6.

Onyedibe, K. I, Goyit, M. G, Nnadi, N. E, 2012, An evaluation of the national health insurance scheme (NHIS) in Jos, a north-central Nigerian city, vol.(1) P005-012 Operational guideline- National health insurance scheme, June 2005, NHIS

Osuchukwu NC, Osonwa KO, Eko JE, Uwanede CC, Abeshi SE, Offiong DA. Evaluating the impact of national health insurance scheme on health care consumers in Calabar metropolis, Southern Nigeria. International Journal of Learning & Development. 2013;3(4):30. ISSN 2164-4063 Available:www.macrothink.org/ijld

Osungbade KO, Obembe TA, Oludoyi A. Users' satisfaction with services provided under national health insurance scheme in Southwestern Nigeria. International Journal of Tropical Disease & Health. 2014;4(5):595-607. Available: www.sciencedomain.org

Osungbade, K.O., Obembi, T.A. & Oludoyi, A. (2014).Users' satisfaction with services provided under national health Insurance scheme in fourth Western Nigeria; International Journal of Tropical disease & Health 4(5) 2014 www.sciencedomain.org

Oyibo PG. Out-of-pocket payment for health services: Constraints and implications for government employees in Abakaliki, Ebonyi State, Southeastern, Nigeria. Nigeria. African Health Science. 2011;11(3):481–5.

Salawudden S.A 2008. Assessment of clients' satisfaction and quality of outpatient care under the national health insurance scheme at Barau Dikko specialist hospital Kaduna, Kaduna state, MPH Project asses at www.kubanni.abu.edu.ng:8080

Sanusi A, Awe AT: An Assessment of awareness level of National Health Insurance among Healthcare consumers in Oyo state, Nigeria, 2009. Medwell Journals 4(2) 143- 148.

Sanusi RA, Awe AT. Perception of national health insurance scheme by health care consumers in Ibadan, Oyo State, Nigeria. Nigeria. Pakistan Journal of Social Sciences. 2015; 6(1):48-53.

Shafiu M, Sambo MN. Clients' satisfaction with health insurance scheme in Nigeria: The formal sector experience in the Northern Nigeria. Presentation at University of Heidelberg. Institute of Public Health, Germany; 2009.

Thinking of introducing social health insurance by WHO, 2010 acessed at http://www.who.int/healthsystems/topic/financing/healthreport/26_10Q.pdf on 4/01/2017

Comment [OD47]: -The references need thorough review.
-Many of the references are more than 10 years
-Pick a referencing style and be consistent.

Comment [OD48]: The paper needs a thorough **review to make it compendious and articulate.**