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 with the National Health Insurance Scheme.

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

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

Result: Findings revealed that majority (99.3%) of the respondents were aware of the NHIS and less than half (48.9%) enrolled into the scheme, with majority (59.6%) accessing their services at University clinic. However about half (53%) of the respondents had poor knowledge of how the scheme works, with 60.4% of them agreeing that NHIS has provided easy access to healthcare while 79.1% agreed that it protects families from financial hardship of large medical bills. Out of 278 study sample 136 academic lecturers (48.9%) enrolled into the scheme, and 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:; Health; insurance; clients; perception; satisfaction;.

INTRODUCTION

Good health is essential to sustained economic and social development and poverty reduction. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care (WHO 2018). Nigeria has shown commitment to achieving universal health coverage

(UHC), but report from WHO (2014) shows progress has been slow. A recent review of health-system financing for UHC in Nigeria shows high out-of-pocket expenses for health care, a very low budget for health at all levels of government, and poor health insurance penetration (Awosusi 2014).

Less than 5% of Nigerians have health insurance coverage most enrollees are in the formal sector with very poor coverage in the informal sector (WHO 2002).The recently signed National Health Act is a viable framework, the implementation of which can fast-track progress towards UHC (Uzochukwu 2015). This act sets the background to earmark adequate public resources to health towards strengthening primary health care through the Basic Healthcare Provision Fund. 50% of the fund will be managed by the National Health Insurance Scheme to ensure access to a minimum package of health services for all Nigerians and 45% by the National Primary Healthcare Development Agency for primary health-care facility upgrade and maintenance, provision of essential drugs, and deployment of human resources to primary health-care facilities. The Federal Ministry of Health will manage the remaining 5% for national health emergency and response to epidemics.

In Africa, Algeria in 1949 adopted a statutory health insurance programme, followed by Libya in 1957, Tunisia in 1960 and Egypt in 1967. In 2003 the Government of Ghana established a National Health Insurance Scheme (NHIS) to make health care more affordable for the citizens (Mensa, Oppong & Bobi-Barima et al 2010). WHO has been involved in technical advisory work especially on assessing the feasibility of SHI in some African countries like Rwanda and Swaziland (Carrin et al, 2011). In Swaziland, because of the poor quality of care in the government sector, they adopted SHI as alternative options to the existing private medical aid

scheme. The aim of their adopting SHI was to ensure universal access to health care by mobilizing additional resources to financing quality improvements, as well as build up tertiary, specialized care within Swaziland (Carrin et al 2011). Similarly Rwanda has spearheaded the development of a number of schemes that together

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). 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. One's perception of a thing or an event is modulated by previous experiences. This is as a result of learning, 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, lead to more regulations and utilization, create more competition for health care providers and 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), 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 prior to the occurrence of sickness 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.

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. 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 addressed 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 which evaluated the impact of NHIS on healthcare consumers in Calabar metropolis, Southern Nigeria, documented that 54.0% respondents agreed that the quality of health care services rendered was better than before, while 38.5% respondents felt the quality of health services was the same as before. Only 7.5% 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) showed 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.

METHODOLOGY

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.

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 Presently, there are thirteen faculties and a postgraduate school in the

University, 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. University community have University Clinic for accessing Health care services and some people do visit UDUTH and Specialist Hospital Sokto.

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. Theriogenology. Surgery and Radiology	50
TOTAL		**976**

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 are inclusive in this study, while those that are on Study leave are not involve in this study meanwhile Non Academic Staff member were also excluded in this study

Sampling Procedure

(a) Sample size estimation and procedure

The minimum sample size was determined using the formula

$n= Z^2pq / d^2$ (Ibrahim, 2009) where:

n= Minimum sample size

z= Standard normal deviate at 95% confidence interval= 1.96

P= p = 65% (Proportion of enrollees who were satisfied with attitude of NHIS staff in a study on users' satisfaction

q= q= 1-P (1-0.65) = 0.35

d= Precision expected at 95% confidence limit (0.05) precision of tolerable alpha Error.

From $n= Z^2pq / d^2$

$n= (1.96)^2 \times (0.65) \times (0.35) / (0.05)^2$ Therefore **n= 349.5 ≈ 350**

Allowing for 10% non-respondent rate the optimum sample size will be **n/RR** (Ibrahim, 2009) where n=350, RR=90% (0.9) this gives **350/0.9= 388.8 ≈ 389.**

Therefore since the total population is less than 10,000 the study applies following formula

Np= n / 1+ (n/N)

Where N = 976 (Number of Academic staff present during the study)

n= 389

389 / 1 + (389/976) = 278 is the total number of the study sample size.

Therefore out of the 976 Academic staff lectures only 278 were enrolled in to the study

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.

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 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.

Ethical consideration

Ethical approval for the study was obtain from Usmanu Danfodiyo University Sokoto and informed consent were obtained from participants

RESULTS

Socio-demographic Characteristics of Respondents

Variables	n (%)
Age (Years)	
20-29	12 (4.3)
30-39	84 (12.9)
40-49	104 (37.4)
50-59	36 (30.2)
≥60	42 (15.2)
Mean Age= 28.6, ±7.03	
Sex	
Male	268 (96)
Female	10 (4)
Marital status	
Single	20 (7.1)
Married	256 (92.1)
Separated	2 (0.8)
Family size	
Less than 5	80 (28.8)
5-10	88 (31.7)
11-20	28 (10.1)
21 above	82 (29.4)
Highest qualification	
Degree	40 (14)
Masters	108 (39)
PhD	132 (47)

A total of 278 academic staff completed the self-administered questionnaire within three month of this study. There were 268 males representing 96% of the respondents. And ages of respondents ranged from 40 to 49 years, with mean age of 28.6 years and median of 29 years. Majority 256 (92.1%) were married with 88(31.7%) had 5-10 children.. About half 136 (48.9%)

of the respondents had been enrolled with the scheme and majority 81(59.6%) of them accessed services at University clinic and 36(27%) at UDUTH, Sokoto

Knowledge of the Scheme

Majority 246 (99.3%) of the respondents were aware of the NHIS, but over half 148 (53%) of the respondents had poor knowledge of the scheme (figure 1)

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

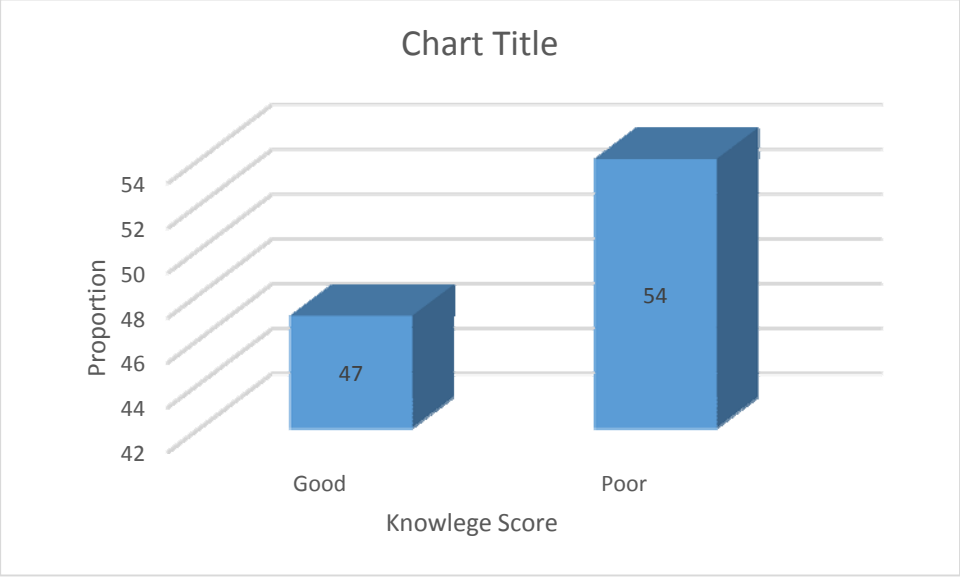

Table 1. Respondents' perception of National Health Insurance Scheme (NHIS)

Variables	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)
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 200 (71.9%) of the respondents' preferred NHIS services than the cash and carry system of health care, 220(79.1%) agreed that it protects families from financial hardship and 168 (60.4%) felt the services provide easy access to healthcare. However almost half representing about 136 (48.9%) 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 whenever needed	34 (25)	66 (48.5)	36(26.5)
Overall scheme service	26 (19.1)	98 (72.1)	12 (8.8)

A total of 278 Sample size of academic lecturer were use of which One hundred and thirty six academic lecturers representing 49.1% has 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.

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. 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

Knowledge about what the NHIS was generally poor. In this study 53% of the respondents did not know how the NHIS works. This is somehow different 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 South 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

Conclusions

Based on findings of this study, the 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 dissatisfaction in the process of enrollment with the NHIS. This implies that the administrative part of the scheme was very ineffective. Since registration is an administrative duty and the first process of enrolment into NHIS, giving the first impression about the Scheme, the NHIS should give it the attention needed towards ensuring enrollees' satisfaction, toward making the registration easier and available at any time the wish to accessed it.

Recommendations

The following recommendations were made:

(I) Removal of all bottlenecks encountered in the registration process (examples delay in getting identification cards for accessing NHIS service) in order to fast track registration of new and existing employees into the scheme, select Health Maintenance Officer (HMO) and engaged them fully in rendering service to the clients' at their convenience.

(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 their service providers and 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 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.

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