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Research Article

Perception of Quality of Healthcare Services among NHIS-HMO Enrollees Visiting Selected Hospitals in Lagos, Nigeria

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ABSTRACT

Background: Assessing and communicating healthcare services quality involves a detailed assessment of relevant and consensual variables that show the complex nature of health care. The Nigerian National Health Insurance Scheme (NHIS) is a government initiative aiming towards ensuring all citizens healthcare needs are provided for at a reasonable cost. This study objective was to examine how enrollees perceived the quality of healthcare services during visits to selected hospitals in Lagos, Nigeria.

Methods: Anchored on the structural functionalist theory, the study triangulated between quantitative (questionnaire) and qualitative (In-Depth Interview (IDIs)) method. Using simple random and convenient sampling technique, a total of 252 questionnaires and 9 in-depth interviews were used to elicit data from selected respondents across 9 healthcare facilities in 3 local government areas.

Results: 26.3% of the respondents disagreed to humane treatment, 29% confirmed lack of prompt attention; while 59.9% of the enrollees asserted that Healthcare Facility's (HCFs) were competent in providing healthcare services, unexplainable long waiting queues was lamented by 56.4%. While, 50.0% majority of the respondents had a positive perception rate, a significant 29% and 21% had a negative and average perception. Unlike tangible products which can be inspected for consistency during manufacturing process and subsequently, IDIs responses showed healthcare services is more often than not incorporeal objects that have no material existence. *Chi-square* result shows significant correlations from the group comparisons exists between quality of healthcare services and enrollees perception ($P<0.01$, $\chi^2(16)=32.051$) and the Spearman's correlation was positive at .183.

Conclusions: Enrollees provided insights into what they considered significant in quality service and how they perceive quality of such services accessed making for relevant recommendations like access to low quality services complaint and need to work to correct the grossly skewed allocation of enrollees across HCFs in order to limit the long waiting queue.

Keywords: Perception; Quality; Healthcare facility; NHIS-HMO; Enrollees; Healthcare service

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INTRODUCTION

Implications for policy makers

By examining the public-private partnership (NHIS-HMO), multiple HCFs and the two types of Medicare HCPs, the government and other stakeholders would discover significant aspects of health as perceived by the enrollees towards advancing the health outcome of patients as the study result revealed what significant aspects of healthcare service enrollees consider important in attaining their health outcomes as well as how they perceive and attach quality to aspect of healthcare services.

The government and other stakeholders need to work on correcting the grossly skewed allocation of enrollees to health care providers to ensure the issue of long waiting queue as well as lack of prompt attention discovered in the study is solved.

The study which aimed at bridging the knowledge gap by pushing back the frontier of focus from the enrollee and the scheme to the enrollee and the HCFs as it concerns their perception of healthcare service delivery can be used in formulating enrollee centered policies to make sure accredited HCPs deliver evidence based service for ensuring the desired healthcare result is achieved.

It is recommended to stir the establishment of constructive inspectorate division where enrollees can have access to reporting HCFs rendering services considered to be of low quality and actions such as warning to confiscation of license should be carried out or withdrawal of NHIS accreditation. This will ensure HCFs take the issue of quality into consideration while striving to provide the best of services and the enrollees will feel less fearful or doubtful about the quality of services as well as regrets for enrolment

Implications for public

This work is expected to inspire the conscience of the general populace to embrace and subscribe to the scheme whose aim is to provide access to quality healthcare in attaining their health desires and also aims to encourage enrollees to ensure they understand their rights and ensure the services given to them are such that improves their health status not to make payment for a relative medical service considered superior in quality at the HCFs, as this act dampens the faith in the quality of services given on the scheme's platform.

The subject of quality in healthcare is a subjective, dynamic and multidimensional term applicable to healthcare provision; however viewed it as the application of medical science and expertise ways that optimises health benefits without risk increment [1]. Related good health care quality to the provision of proper medical services in a clinically proficient way, involving excellent information dissemination, mutuality in the decision making process such that take into consideration the patient's cultural differences and similarities without personal prejudice [2].

Quality healthcare is one that involves consistency in delighting health consumers; this is done by delivering safe, reliable and efficient healthcare services that exceeds the consumer's explicit and implicit health desires in accordance with the current clinical guidelines and principles, without necessarily tampering with the providers' benefits [3].

In Nigeria, global health information systems, community policy collaboration, global studies and health care laws as part of the national health policy and strategy was put in place to achieve health for all Nigerians. The national health policy and strategy was put in place in 1988 and updated in 2004 the key policy thrust of the scheme involves medical infrastructure, regional health programs and service delivery; regional health information systems, community development partnership, research and healthcare policies [4]. Though, the National Health Insurance Scheme/Health Maintenance Organization (NHIS-HMO) is an approach meant to ensure healthcare is accessed by insured persons without making payments at the point of accessing such services, the federal ministry of health in considering the poor health state of citizens' adjudged the health services provided under the scheme's review incapable of meeting the populace health demands [5].

MATERIALS AND METHODS

The standard of health care is inherently a complex term that includes and depends on a variety of factors; unlike other sectors, features such as intangibility, heterogeneity and simultaneity complicate quality of healthcare service in terms of definition and measurement. Though, regarding definition and prioritization of quality issues, the various stakeholders contained in the health sector, beginning from the health care consumer to the health services providers holds different views. The identification and proper evaluation of essential health care service delivery dimensions is required for the improvement of quality in health services [6-8].

Several studies have been conducted to measure what areas of health care service are considered important and significant in building necessary cues in patient's experience. For example noted that a health consumer's quality perception may take into consideration their expected health outcome; access to and determining factor or factors in HCFs/HCPs preferences [9,10]. Quality healthcare features included ease of use, penetrability, inexpensiveness, tolerability, suitability, capability, aptness, anonymity, confidentiality, treatment, sensitivity, transparency, precision, reliability, comprehensiveness, consistency, equity, amenities and facilities [11,12]. Identified one hundred and eighty two quality healthcare characteristics and classified them into five categories; environment, empathy, competence, performance and efficacy [13].

Many quality characteristics in health care, such as timeliness, continuity and precision, are difficult to quantify outside the customer's subjective evaluation. Therefore, the main objective of this study is to evaluate how NHIS-HMO enrollees' perceive the quality of healthcare services at selected hospitals in Lagos, Nigeria.

The study method essentially triangulates in its methodology, hence, quantitative data was elicited using questionnaires and the qualitative data was captured using in-depth interviews (IDIs).

Evaluating healthcare service quality through the Donabedian's Structure, Process and Outcome (SPO model

In the comparison of consumers perception regarding quality of services among private and public health services providers in Nigeria, discovered that private hospital services were considered superior to public hospital services [14]. The standard of healthcare services has historically been measured in terms of structure, process and outcome indicators [15,16]. Whereas the systemic dimension considers, for example, the accessibility and relative efficiency of the many measurable healthcare elements, how transparent was the enrollee's care?; procedure considers, for example, the suitability of treatment, place and duration, was the care given to the enrollee appropriate for his/her ailment, was the care provided on time and was it provided for by the appropriate unit? Measurement of outcome examines the resultant effects of the care received and functionality, medical outcomes or scientific technologies may be included.

The triad of Structure, Process and Outcome (SPO) constructs is such that encompasses all aspect of healthcare services. Thus, the tangible aspects of equipment and physical structure emerged from the category structure; subcategories; access, care, work process and treatment emerged from the category process and subcategories; resoluteness and strategies to speed up health actions emerged from the outcomes category. Donabedian noted an existing association between the SPO set up based upon the assumption that a standardized structure ought to promote efficient process and efficient process ardently is supposed to lead to good health outcome (single direction). For him, structure is the professional and institutionalised ethos relating to healthcare provision (for example, the accessibility to equipment and medicines); process involves the procedures carried out on and for the health consumer (for example, HCFs/HCPs referrals as well as medical examinations) and outcome is the expected result considered necessary after receiving care from the health service provider (for example, health consumer's approval with the modus operandi in delivering the care).

Donabedian described seven elements of quality of medical care; efficacy, effectiveness, efficiency, equity, optimality, acceptability and legitimacy. Though, efficacy is difficult to quantify, it can be regarded as healthcare provided under optimum circumstances. The resultant effect from the health interventions is regarded as effectiveness; performances that does not compromise on the necessary health outcome despite it relatively low cost defines efficiency. While, equity is regarded as the ability to distribute health services to consumers without prejudice, optimality is the capacity to manage health services benefits as well as the attendant risks. Easy access to healthcare services as well as interpersonal relationship between healthcare consumers and the provider is regarded as acceptability. Legitimacy on the other hand deals with the social acceptability of the HCFs/HCPs with respect to the way it delivers health services. The option of which of these components as well as their relative importance should be prioritised in terms of quality should be guided according to the circumstance upon which the health care service is measured [17].

Evaluating healthcare service quality through patients' experience

Diverse scholars in countries throughout the world have deduced that there is a connection between patients' experiences and quality of healthcare delivery information. For example, corroborated that evaluating patient experiences as part of a systematic survey program in the United States as well as many other European countries, did more than provide knowledge regarding health consumers actual experiences [18]. It actually revealed the quality attribute consumers considered to be very essential. Similarly, assessed the experiences of older people and their relatives' in acute care settings [19].

Patient experiences has been identified as a pointer necessary for measuring and enhancing quality of healthcare service [20,21]. Other authors have also analysed the attributes considered to be important by health services users. For example, assessment of patients' and relatives' experiences and 'good' and 'not so good' perspectives of quality care; paid attention to patients' with breast care healthcare experiences using the new consumer quality index instrument [22,23].

In the context of primary care, patients' generated dimensions such as; quick access, trust in professional providing care, respect for patients' preferences, patients' involvement; information, education and support for self-care; attention to physical and environmental needs, emotional support, involvement of family and carers; continuity of care, smooth transition and coordination of care have been described as important to the provision of good quality care [24]. Therefore, the opinions of consumers in health services are important, as their perception of quality of delivery is one of the most important determinants in the success of any policy aimed at providing citizens with a fair, efficient and sustainable health care service [25].

The structure, objectives and scope of NHIS in assessing quality of healthcare service

The National Health Insurance Scheme (NHIS) scheme was designed to provide healthcare consumers in its adapted 2006 edition among others benefits:

- Access to good health care services.
- Protection from huge medical bills.
- Limiting rise in the cost of health care services.
- Equitable distribution of health care cost among different income groups.
- High standard of health care services delivery.
- Efficiency of health care services.
- Improve and harness private sector participation in the provision of health care services.
- Equitable distribution of HCFs within the federation.
- Appropriate patronage of all levels of health care.
- Funds availability to the health sector for improved services.

The National Health Insurance Scheme (NHIS) is a public-private partnership program involving the scheme, network or organizations (HMOs) which provides health insurance coverage for a monthly or annual fee and the privately or publicly managed institutions (HCPs/HCFs) providing nursing care,

medical and surgical treatment for sick or injured people with the comprehensive aim of ensuring health service coverage is easily accessible without the fear of exorbitant charging fees. The main goal is to ensure an improvement in the health indices in the country at the same time providing financial assistance to healthcare consumers. The mainstay of the program is to ensure that all the citizens have equal access to healthcare. The inscription on the scheme's logo "NHIS, easy access to healthcare for all" sums up the program core objective [26].

In addition to the benefit culled under the NHIS program, the HMOs are tasked with the responsibility of setting up efficient quality control programs to ensure services delivered to members enrolled under of the scheme is of good standard [27]. As provided for by the scheme, an enrolled member and the spouse with four legitimate offspring beneath the age of 18 are covered for Medicare accessibility in whichever HCFs/HCPs is accredited to provide services covered by the scheme. However, children above 18 years are excluded from the initial coverage but those in higher institute of learning are to be enrolled under the tertiary insurance scheme.

Patients referral owing to the need for investigations requiring specialised expatriates, such as surgical and or therapeutic care or other services demanding further intensive investigative diagnosis, rehabilitation etc. is from a primary to a secondary service provider or from secondary to tertiary level but with Prior Authorisation (PA) approval from the HMOs, with the exception of cases requiring an utmost immediate emergency care where delay can lead to complications or death and or contacting the HMO is futile; in such situations providers are required to provide care but the HMO is to be dully notified within a period of 48 hours.

The structural functionalist theory

The functionalist idea is one that equates solidarity and stability of the whole to the interdependence and interrelatedness of parts [28]. It connotes how society is a complex system whose parts work together to promote solidarity and stability. The early functionalist Spencer drew an analogy between society and the human body. The organismic model suggests that an understanding of any organ in the body, such as the heart or lungs, requires an understanding of its relationship with other organs and in particular its contribution to the organism's maintenance. Likewise, an understanding of every aspect of the society requires close examination of its interconnectedness with other aspects and specifically, its involvement towards the preservation and continuance of the larger society. Hence, social organisations such as family, health, government and religious systems are analysed as subsystems of the entire social system rather than different parts. Particularly, these subsystems are better understood with regard to the role they play in ensuring the survival of the entire system [29].

The National Health Insurance Scheme (NHIS) as an entity is made up of multiple stakeholders assembled to ensure that the system is revised. In consideration to parson's systemic functionality, each stakeholder is a subsystem that works towards the success of the NHIS's aim as well as the objectives. These subsystems must therefore be properly integrated to fit into the scheme for a balance in the quality of healthcare delivery system. The integration process is done through the internal harmonization of all the units. The stakeholders in NHIS programme include the government, HMOs, HCFs/HCPs, enrollees, company owners and Board of Trustees (BOTs). Similarly, all the parts (General Practitioners (GP), Community Health Extension Workers (CHEW), laboratory, diagnostic centres, etc.) in the health care facility must work together to ensure quality of services. Each of these parts must perform their respective functions for the success of the whole (quality service), failure of which can affect others.

The structural functionalist perspective provides a search light into understanding the role of the subsystems in the success of healthcare delivery. For instance what happens when the consultant does not carry out relevant laboratory tests before diagnosis or when there is lack of awareness to quality service at the HCFs by the enrollee or when the health care workers do not communicate the process of care to enrollees?

One important implication on how the principle of systemic functionalism is very applicable to the provision of healthcare services is noted in its assumption that quality healthcare delivery is a result of several parts working together to ensure the overall success or positive health outcomes of patients.

The relation between this research work and the theory of structural functionalism depends on the interdependence of all actors in ensuring quality health services is delivered. One important point of how systemic functionalist theory operates is that provision of quality healthcare services can be adjudicated as one where there is harmony and all stakeholders are involved in the process. The framework assumes that a combination of several quality factors is how enrollees' form an opinion about the HCFs services quality.

Study population

The population comprises of NHIS and HMO enrollees' between 18 years and 65 years visiting selected public and private hospitals in Eti-Osa, Ikeja and Ibeju-Lekki Local Government Areas (LGAs) within the three senatorial districts in Lagos, Nigeria. The accredited public and private HCFs included:

- St. Mary specialist hospital
- Awoyaya hospital
- Blue cross hospital
- Unity hospital
- The Eko hospital
- General hospital Akodo
- Budo specialist hospital
- Etta Atlantic memorial hospital
- St. Nicholas hospital

The selection of both public and private HCPs was to depict the two dominant healthcare facility systems in Nigeria.

Inclusion criteria

The study focuses specifically on the perception of quality of services among NHIS-HMO healthcare users visiting selected

hospitals in Lagos within the period of study. Consenting enrollees within 18 years of age and not exceeding 65 years. Enrollees who were consciously aware of their surrounding and could communicate verbally.

Sample size and sampling techniques

Multistage sampling technique was used to select the study participants. Simple random sampling was employed at each stage to reduce selection bias. The first stage involved clustering the twenty local governments into the three senatorial districts, selecting only one local government from each district through balloting. Stage two involved obtaining a list of all registered HCPs within the local governments and stratifying them into private and government administered. At this stage, convenience method was used to choose three HCFs accredited by NHIS to provide primary, secondary and or tertiary services to be sampled in the study.

Factor analyses of subjects variables ratio with a minimum of ten subjects per variable in the study instrument was utilised to choose a sample size of 240 enrollee respondents which was calculated (20 subjects per each of the 12 variables in the study instrument) [30,31]. The minimum sample size of approximately 266 (240/0.9) patients was reached after adjusting for 10% non-response to the questionnaire.

Data collection and analysis

A total of 252 copies of a structured questionnaire and 9 IDIs were used to elicit data from the respondents. The quantitative data collected was analysed using the normal descriptive statistics of frequencies and simple percentages with the help of the Statistical Package for Social Sciences version 20 (SPSS 20). The qualitative data was analyzed using inductive content analysis. To find the relationship between the variables and test of hypotheses, the contingency *chi-square* and the Spearman's correlation analysis was performed.

The quality indicator variables were presented on a five point likert scale: SA-Strongly Agree, A-Agree, U-Undecided, D-Disagree and SD-Strongly Disagree [32]. During hypotheses testing, these ordered categories were transformed, summated and the responses converted into five (5) categories termed as five (very good), four (good), three (undecided), two (bad) and one (very bad). The perception variables were measured using likert type items of five ordered categories, rated from five (very high in quality) to one (very low in quality).

Ethical issues: The study was approved by the ethics committee of the Lagos state government health service commission before the study commenced with an ethical clearance code of: LSHSC/88/S.3/II/257. Written informed consent was obtained from all HCFs/HCPs management as well as the participants.

RESULTS

Socio-demographic characteristics of the respondents

Table 1 shows that majority (67.5%) of the respondents were females. This percentage of the female respondents corresponds with the last census report. Again, a larger proportion (53.2%) of the respondents was married. The majority (36.0%) of the respondents fall within the age bracket of 31 and 40 which represents the active working population with a mean interval of 3.0278. Although more expensive, larger proportion of the respondents (81.3%) subscribed to the private HMO plan and 82.5% accessed care in private HCFs. This may be due to the fact that quality is mostly associated with price tag as discovered in a study on patients' satisfaction with access to public and private healthcare centers in London [33]. The results of the study showed that public patients, as opposed to private counterparts, were dissatisfied with the service climate factors.

Table 1: Socio-demographic characteristics of respondents.

Variable	Frequency (N=252)	Percentage (%)
Gender		
Male	82	32.5
Female	170	67.5
Age		
18-20	22	8.7
21-30	66	26.2
31-40	93	36.9
41-50	25	9.9
51-65	46	18.3

Marital status		
Single	70	27.8
Married	134	53.2
Others	48	19.0
Educational qualification		
No formal education	22	8.7
First leaving school certificate	15	6.0
Secondary school	34	13.5
OND/NCE	32	12.7
HND/B.Sc	101	40.1
M.Sc/MBA/M.Ed	38	15.1
Ph.D	10	4.0
Public-Private partnership		
Public/NHIS	47	18.7
Private/HMO	205	81.3
Public-Private HCFs		
Public HCFs	44	17.5
Private HCFs	208	82.5

Table 2 represents sample distribution on quality of health care services. A significant number (26.3%) combined weight of Strongly Disagree (SD) and Disagree (D) to being treated as humans. Similarly, 29% combined weight of Strongly Disagree (SD) and Disagree (D) confirmed lack of prompt attention. While 59.9% combined weight of Strongly Agree (SA) and Agree (A) asserted to HCF healthcare competency, majority (56.4%) combined weight of Strongly Agree (SA) and Agree (A) to unexplainable long queue.

Table 2: Distribution of respondents' on quality of healthcare service.

Questionnaire item	Responses					Total
	Strongly agree (%)	Agree (%)	Undecided (%)	Disagree (%)	Strongly disagree (%)	
I am treated as a human, not as a number (Respect)	85 (33.7%)	74 (29.4%)	26 (10.3%)	31 (12.3%)	36 (14.3%)	252 (100%)
Medical staffs of the HCF attends to patients promptly	57 (22.6%)	72 (28.6%)	50 (19.8%)	37 (14.7%)	36 (14.3%)	252 (100%)
The HCF is competent in	72 (28.6%)	79 (31.3%)	32 (12.7%)	33 (13.1%)	36 (14.3%)	252 (100%)

providing healthcare services						
The HCF is plagued with unexplainable long waiting queue	98 (38.9%)	44 (17.5%)	34 (13.5%)	42 (16.7%)	34 (13.5%)	252 (100%)

Compare to the 50.0% combined weight of very high and fairly high positive rating, combined weight of low and very low 29% and 21.0% average rating in Table 3, shows significant negative perception concerning quality of healthcare service.

Table 3: Distribution of Respondents' perception on quality of healthcare service.

Questionnaire item	Responses					Total
	Very High perception (%)	Fairly High perception (%)	Average perception (%)	Low perception (%)	Very Low perception (%)	
Respondents' rating of healthcare service quality	48 (19.0%)	78 (31.0%)	53 (21.0%)	40 (15.9%)	33 (13.1%)	252 (100%)

Test of hypothesis

H_0: There is no significant relationship between enrollees' perception and quality of healthcare services.

H_1: There is no significant relationship between enrollees' perception and quality of healthcare services.

Decision criterion: Reject H_0 if the calculated (observed value) of *chi-square* (χ^{2c}) is found to be greater than the critical value of *chi-square* χ^{2t} (0.01), if not, do not reject. Data from Tables 2 and 3 were cross tabulated and used in testing this hypothesis. The result is shown in Table 4.

Table 4: Cross tabulation of relationship between enrollees' perception and quality of healthcare services.

Variables	Very high perception (%)	Average perception (%)	Very low perception (%)	Total	χ^2
Very Good	11 (26.8)	19 (17.0)	20 (17.8)	112 (100.0)	χ^2=32.051
Good	16 (34.1)	14 (29.8)	17 (36.2)	47 (100.0)	r=0.183
Undecided	10 (38.4)	6 (23.1)	10 (38.4)	26 (100.0)	P=0.000
Bad	13 (39.4)	8 (24.2)	12 (36.4)	33 (100.0	df=16
Very bad	14 (41.2)	6 (17.6)	14 (41.1)	34 (100.0)	
Total	126 (50)	53 (21.0)	73 (29)	252 (100.0)	

Note: ** Correlation is significant at the 0.01 level

This shows the relationship between enrollees' perception and the quality of healthcare service. Empirically, respondents' views indicates some balancing where a total of twenty seven respondents' who are very high in perception saw the quality of healthcare service as very good and good and twenty seven who are also very high in perception saw the quality of healthcare service as very bad and bad.

Further group comparison shows a total of thirty seven respondents' who are very low in perception but saw the quality of healthcare service as very good and good is higher than those (26) who are very low in perception and saw the quality of healthcare service to be bad and very bad. Similarly, a total of thirty three respondents' who are average in perception who saw the quality of healthcare service to be good and very good is higher than those (14) who are average in perception but saw the quality of healthcare service to be bad and very bad. As we see from these group comparisons therefore, we can see empirically

that the relationship between perception and quality of healthcare service is significant but relatively weak.

Inferential statistics supports this empirical observation as shown in the calculated χ^2 (16)=32.051 is higher than the *chi-square* table (P<0.01). Therefore, the null hypothesis is rejected and the alternate hypothesis accepted. Also, the Spearman's correlation (r)=.183 shows a positive relation between perception and quality of healthcare service.

In-depth interview and observation report

Regarding healthcare services quality, an interviewee asserted thus: The service is good, but the treatment is different from that of out of pocket patients because of the bureaucratic nature of the NHIS scheme. The hospital does not really have a problem; it is when the HMO responds to the hospital, that is when they attend to the patient.

As observed, care drew upon two things the type of HCF and the number of enrollees' patronising the HCF. As observed, some HCF was over patronized, while the opposite was the case for some others thereby delimiting their access to quality care an interviewee asserted thus.

Being an NHIS-HMO enrollee means signing up for delay here (in the hospital) where a patient has to arrive the premise as early as 6:00 am to hurriedly get treatments only to finish up at 3:00 pm. This has really affected my health seeking behavior.

Regarding process to care, an interviewee summed thus: The medical profiling of HMO patients is such that feels like criminal profiling. It takes too long with a lot of document signing, photocopying of ID card, different Prior Authorization (PA) code request from the hospital to the HMO with a lot of 'madam, please sit down, the HMO is yet to respond to our mail' most times I want to make payment at the cashier stand, but if the PA code arrives, I will not be refunded either by the HMO nor the hospital, so, I am always left with no other choice than waiting and wasting almost my entire day at the hospital for something that should normally not take above an hour if I were to be a fee paying patient. Most times out of five prescriptions, the hospital can only provide one, two is not covered by the scheme, the other two is usually out of stock.

Regarding health services outcome, as observed, interviewers showed little or no positiveness to the expected effect of treatments and interventions accessed. An enrollee noted thus.

I don't know who to even blame, whether it's the hospital or the HMO. Both always have conflicting side of the story. Both play the victim and the enrollee is left with no choice. Personally, I wouldn't recommend the scheme to anyone as I see it as a mere excuse fooling the United Nations. Most times, I am asked to pay the difference for quality medications, tests and the likes. I have to be asking the doctor to be sincere and tell me my health issue as well as the best treatment not as an enrollee but as a patient in need of quality health attention, but I wonder what is the fate of those enrollees who can't afford to make out of pocket payment?

The response above suggest that enrollees experience towards accessing care at the HCFs is bottlenecked (for example, PA code requirement) thereby leading to delay in service delivery and time wasting. The researcher observed that overburdened facilities may have a grossly inefficient impact on health services delivery resulting in long waiting hours.

There is an obvious distinction in services accessed by out of pocket paying patients and enrollees; and enrolees are required or obligated to make payments at the HCFs for relative services or medications considered high in quality contrary to the services covered by the scheme.

The health plan of an enrollee also affects the quality of service rendered, thereby causing enrollees' to succumb to the out of pocket payment method which is perceived to be a more guaranteed route to quality service, this therefore negates the scheme's plan of providing equitable healthcare at a low price. But then, a thorough look at the scheme's logo inscription "national health insurance scheme, easy access to healthcare for all" one may assume the undertone is to provide easy access to healthcare for all not easy access to quality healthcare. This therefore raises the concern for the quality of services accessed at the HCFs by the poor and low economy enrollees'.

Conclusively, putting care in a broader perspective from the IDI and observation, HCFs should aim in direction with the 9th national health conference consideration, which advocacy for health care models includes a developmental program aiming at group works, action based health education and not limiting care to individual healing.

DISCUSSION

This finding related to the major objective of the study, which was to evaluate enrollees' perception of the quality of healthcare services. The null hypothesis was "healthcare services quality does not affect enrollees' perception significantly".

The six elements measured by the research instrument here illustrated medical care items considered relevant to patient's healthcare experience such as humane treatment, promptness of staff, HCP competency and long waiting queue.

Composite data were used to test the hypothesis. The contingency *chi-square* result (P<0.01, χ^2 (16)=32.051) and the Spearman's correlation (.183) showed that the relationship between perception and quality of healthcare service is significant therefore the null hypothesis was rejected. The relatively weak significant relationship recorded in the result may be due to assertion that indication of health care systems modernisation and associated advances in evidence based healthcare are factors raising expectations for quality of care improvements [34,35].

Some interviewed respondents' in the IDI noted that PA code requirement for every process is one of the most frequent reason affecting healthcare services quality and one of the lead cause for long waiting queue. From IDI responses, it is evident that respondents considered the HCFs capable of providing quality services but being an enrollee places a limitation on the quality of their own services, due to either the schemes coverage terms or the individual enrollee's plan. The responses contradicted 36 group and solo practices comparative survey result; 25 finding of

which "87% respondents did not see any significant difference between the services provided under the cash and carry system and the NHIS".

The finding was consistent with the patients low level satisfaction with health service quality surveys in Ghana findings by [37-40].

CONCLUSION

The research finding also reveals that quality of services has a significant relationship with enrollees' perception, which means that enrollees' perception may alter depending on the quality of service accessed at the HCF. Likewise, the researcher concludes that enrollees' perception is sharpened by their experience or the experience of others witnessed or heard.

Moreover, the unexplainable long waiting queue experienced by enrollees' during service delivery for PA codes and eligibility confirmation discourages non-enrolled patients from registering on the scheme and encourages enrolled members to patronize out of pocket payment method in hopes of prompt service delivery. Therefore, if more subscribers are to be enrolled under the NHIS-HMO scheme, HCF as well as other stake holders should limit the time wastage experienced by enrollees during service delivery. To ensure scientific rigor in healthcare services quality measurement; suitability, clinical relevance, context and incorporation practicability are important properties for a realistic measure.

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